AN EXPLORATORY STUDY OF THERAPISTS' PERCEPTIONS ABOUT VIOLENT FEMALE OFFENDERS AND THEIR INFLUENCE ON THE PROVISION OF THERAPEUTIC SERVICES

by

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DEDICATION

This dissertation dedicated to Dr. Arthur Williams who served as my mentor throughout the doctoral program. Words really cannot express my gratitude for the opportunity to work alongside you and learn from you over these years. Thank you for your wisdom and guidance, and believing in me when I didn’t believe in myself. I truly hope I have made you proud.

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ABSTRACT

GISELLE S. CUNNINGHAM
AN EXPLORATORY STUDY OF THERAPISTS' PERCEPTIONS ABOUT VIOLENT FEMALE OFFENDERS AND THEIR INFLUENCE ON THE PROVISION OF THERAPEUTIC SERVICES
Under the direction of Karen D. Rowland, Ph.D.

Mental health counselors are constantly challenged with allowing themselves to be human, maintain empathy, and remain clinically sound while working with diverse client populations; including those that have been convicted of crimes. There has been limited research conducted on counseling professionals and their provision of treatment services to violent female offenders. The purpose of this study was to explore the personal attitudes, values, and expectations of clinicians working with this population, and whether or not the provision of therapeutic services is affected by personal perceptions and biases. In addition, this study aimed to add to the limited literature on violent female offenders and promote future research into the needs of this group of women and the mental health professionals who serve them.

This exploration of therapist perception allowed for greater understanding of how issues such as stigma, gender-role stereotypes, and bias held towards this population impact the counseling relationship. This study utilized a phenomenological research design where the researcher was the primary instrument of data collection.
The sample consisted of 10 participants: five licensed professional counselors, four associate licensed professional counselors, and one master's level counselor in training. Face to face, semi-structured interviews were conducted where tailored research questions explored the influence of therapist perception on the experience of establishing rapport, assessment, and treatment of this population. The analysis of participant responses led to the emergence of six major themes a) genuineness/authenticity, b) counselor diversity, c) empathy, d) experience, e) supervision and consultation, and f) self-care.

The significant finding of this study was the recognition that counselors' self-awareness about their own negative perceptions could assist with reducing barriers to forming the therapeutic alliance with this population. The results of this study are relevant to counselor education programs and supervisors as it provides a greater understanding and meaning of the therapists' conceptualization of their experiences of their work with violent female offenders. This study also encourages further research into offender perception of treatment services, as well as preventative measures to reduce rates of burnout, vicarious trauma, and counter-transference amongst counselors in training and licensed counselors who are working with this population.
CHAPTER 1

INTRODUCTION

In the counseling field, mental health professionals are often faced with clients that may present with more severe trauma histories than others. Interpersonal traumatic experiences have been found to be associated with both short-term and long-term negative outcomes, including but not limited to: decreased physical, emotional, and sexual health, as well as a decline in general functioning (Bright & Bowland, 2008). Clients suffering from extensive trauma history need more specific therapeutic interventions to effectively manage symptoms stemming from the psychological pain associated with that suffering, including acts of violence towards self or others. Herman (1997) argued that women who survive complex traumatic experiences have increased risk for developing personality disorders, harm in other relationships, self-injurious behaviors due to self-loathing, poor interpersonal relationships or feelings of connection to her surroundings, an impaired sense of safety, and feelings of guilt and shame (as cited in Bright & Bowland, 2008, p. 376). As a result, there is a charge or obligation placed upon mental health professionals throughout their graduate degree programs and once they are working with diverse populations in the field.

Miller, Miller and Stull (2007) note that to address the needs of diverse clientele, "the counseling profession has established standards to promote counselors’ multicultural competence" (p. 325). This obligation and use of professional standards emphasizes
counselor objectivity and suspension of all personal expectations, biases, values, and beliefs, in order to efficiently and effectively assist the clients they serve. Miller et al. (2007) point out that negative attitudes and behaviors of counselors have been found to impact counseling processes. Having a non-judgmental stance in the therapeutic relationship is important because expectations based on stereotypes can impact or change the perceptions of social information or events (Willis, Hallinan, & Melby, 1996). Yet, despite a clinician’s attempts to remain fully objective and nonjudgmental, there are times when personal expectations, biases, values, and beliefs may be evident throughout the course of therapy. Link and Phelan (2001) express that stigma exists when people distinguish and label human differences, dominant cultural beliefs and link labeled individuals to undesirable characteristics or negative stereotypes. Labeled persons are placed in distinct categories to accomplish some degree of separation, and experience status loss and discrimination which can lead to unequal outcomes (Link & Phelan, 2001, p. 367). While the process of classifying behaviors can be deemed as helpful for recognizing patterns of offending and character traits, it can be detrimental in other aspects in the lives of the people who are stigmatized.

Subconsciously, some level of bias may be demonstrated or reflected especially when working with a population the therapist has a strong opinion about, or that society or dominant culture has already looked down upon. However, clinicians may be unaware of engaging in judgmental practices while providing therapeutic services to these distinct populations, such as providing therapy to women who have committed violent crimes. While a majority of these women receive sentences for non-violent crimes like
prostitution, fraud, or drug offenses, they have been often negatively perceived by society and have received labels such as "evil," "women gone bad," "not really women," and "incapable of change" (Singer, Bussey, Song & Lunghofer, 1995, p. 103). Undesirable behaviors in women are considered to be more negative than men (Page, 1987). Social roles and sex roles can impact or influence perceptions of an individual's behavior (Poole & Tapley, 1988) as violation of sex roles leads to social condemnation and negative psychosocial consequences (Taubman, 1986).

Therapist or clinician bias can be a significant barrier to violent female offenders as clients needing access to adequate mental health services as it can affect diagnosis, level of care, or the treatment approaches utilized. Findings by Vogel, Epting and Wester (2003) support this as they present that the client's biological sex has been found to influence counselors initial descriptions and interventions; while Tomlinson-Clarke and Camilli (1995) note sex has also affected diagnosis and severity ratings (as cited in Miller et al., 2007, p. 325). Additionally, issues surrounding competency, ethical principles, and degree of clinician personal awareness or insight arise when discussing potential instances of prejudicial behavior towards female violent offenders. Gross and Robinson (1987) point out that ethical implications such as doing harm, disrespecting clients' autonomy, and provision of ineffective counseling services can occur when the counselor lacks the appropriate knowledge, skills, or understanding of people that may be of a different race, culture, or social class; such diversity can be seen in offenders found in the criminal justice system. Miller et al. (2007) findings also reflected a need for counselor education programs to prepare counselors to be competent in working with clients from
diverse cultural groups.

To effectively serve clients that have frequent outbursts of aggression or violent episodes due to trauma history, mental health professionals must be knowledgeable about diagnostic criteria for mental health disorders, psychological theories, a variety of beneficial treatment modalities, as well as be willing to engage in ongoing self-assessment when dealing with extreme cases of maladaptive behaviors in clients. However, due to a lack of research about how perceptions are structured, it is difficult to understand the relationship between perceived risks and crime with respect to gender (Richards & Tittle, 1981). Professionals at mental health hospitals or clinics, prisons or detention centers, and private practice, are frequently faced with the immense responsibility of evaluating individuals for mental fitness in regard to potential for violent behavior, and determining if the individual should remain in society; yet few have been trained for this responsibility (Gross & Robinson, 1987). Work with forensic clients occurs in two types of settings: incarceration which includes work in jails, prisons, and treatment centers facilitated by corrections and criminal justice professionals; and community based programs that provide educational services to clients who are on probation or parole (Mottern, 2007, p. 33).

Despite the current trend to push for the use of community based mental health interventions such as an outpatient level of care or wrap around services at the onset of displays of aggressive behavior to reduce the frequency of inpatient treatment, some individuals may be unable to respond to therapy in an appropriate manner; resulting in violent criminal behaviors such as assault, homicide, and possibly even serial murder.
Gross and Robinson (1987) suggest with violent clients mental health professionals must “carefully consider their level of competence to make the diagnosis of dangerousness, then proceed judiciously” (p. 342). The Region of the Americas has the highest estimated rates of homicide with an annual rate of 28.5 deaths per 100,000 population (World Health Organization [WHO], 2014). According to the World Health Organization, approximately 1.43 million people die from incidents of self-inflicted or interpersonal violence (Siever, 2008), with female offenders being found capable in committing unspeakable violent crimes.

Traditional values in society uphold a more favorable view of male sex roles than female sex roles (Poole & Tapley, 1988). In cases where females have been charged with violent crimes, clinicians may experience a significant amount of cognitive dissonance and have difficulty engaging and providing services within the therapeutic relationship, or may rely on myths and stereotypes to aid in evaluation and treatment. Sinha and Kumar (1985) note that people form expectations based on stereotypes about crime, criminals, and socioeconomic status, and they experience cognitive dissonance when there is an inconsistency and “one cognitive element implies the opposite of another” (p. 485). Cultural-role stereotypes regarding appropriate and inappropriate ways of emotional and behavioral expression affect the perception and disposition of both male and female clients (Page, 1987). Levy, Stroessner and Dweck (1998) present that people make extreme trait and evaluative perceptions of a group when forming stereotypes, and these stereotypes then serve as the primary root for quickly judging groups and their members, including but not limited to, groups such as violent offenders.
While it has been identified that men are substantially more likely to commit serious violence than women (Harer & Langan, 2001); men and women mostly commit similar crimes, but the rates of female offending are significantly lower than male offenders across all crime categories (Rossegger et al., 2009). Gender is considered to be one of the strongest predictors of violent crime; with data consistently supporting that males commit more crime than females (Denno, 1994). As a result, a majority of research regarding mental illness, trauma history, and effective treatment modalities has been centered on male violent offenders. Many of the existing evaluations of prison-based treatment programs focus specifically on men, only a few studies have assessed outcomes for women in prison-based programs designed specifically for women, and fewer studies have compared and contrasted specific factors associated with outcomes relative to men or women (Messina, Burdon, Hagopian, & Prendergast, 2006, p. 8). Singer et al. (1995) support this notion as they note that there has been limited clinical and research investigations on incarcerated women; and the services provided to this population have been inadequate.

Rudolph (1996) presents that most forensic psychologists admit a predictor of future violence is past history of violence per research on male offenders, however with females this profile is far from infallible. The current policies and practices regarding offending and treatment have been formulated on male offenders due to males engaging in more delinquent and criminal acts than females; however the confirmation of the gender differences between male and females can be observed in offending patterns on a national and international level (Cauffman, 2008). While findings from prison-based
treatment evaluations for men have been shown to reduce recidivism and drug use, and
greater success with continued outpatient treatment, these findings cannot be generalized
to women as men and women have different pathways to crime and addiction, men and
women enter into treatment for differing reasons, and women’s correctional facilities may
not have the resources and services afforded to men (Messina et al., 2006). Stefanakis
(2008) points out that people who have been found guilty and convicted of violent
offenses or other crimes, are generally stigmatized as unchangeable, they are labeled and
pathologized by society. In turn, therapist perceptions, expectations, attitudes, and biases
can stem from societal and cultural norms. Drapalski et al. (2009) note a vast percentage
of jail inmates suffer from mental illness, with substance abuse disorders, major
depression, psychotic disorders, and post-traumatic stress disorder occurring most
frequently, and women having higher rates of mental illness than men.

Tyler, Sherman, Strang, Barnes, and Woods (2007) identify that punishment such
as incarceration, is used as a means to lower rates of reoffending by incapacitating
offenders with hopes of instilling fear of future punishment in themselves and others.
Deterrence-based strategies are the most common means used within the United States to
decrease recidivism (Tyler et al., 2007, p. 554). However, deterrence-based strategies
may actually increase levels of recidivism due to the lack of rehabilitation programs
offered to offenders, the expense of the maintenance of correctional systems, and
weakened relationships between the law and the communities they serve (Tyler et al.,
2007). Singer et al. (1995) found that serving time in a correctional facility may be less
traumatic than the everyday experiences of female offenders in society such as poverty,
violence, and victimization; and until female offenders have access to viable options or resources there will no change in behavior and there will be a higher chance of recidivism. Messina et al. (2006) found there is potential for women to be successful and reduce rates of recidivism if they actively participate in prison-based therapeutic treatment programs and aftercare treatment, similarly to men. These findings suggest that mental health treatment is necessary and imperative for offenders both inside and outside of the criminal justice system aiming to demonstrate effective behavior management during incarceration and prior to release from jail or prison upon reintegration into society.

Singer et al. (1995) suggest that in regard to treatment of women in correctional facilities, mental health and substance abuse screening and treatment services and referrals should be readily available during incarceration as well as appropriate discharge planning to community resources to reduce recidivism. Clinicians should be mindful of the potential ramifications associated with the influence of personal attitudes towards violent female offenders and its impact on the utilization of appropriate treatment interventions for this population. Goffman (1963) highlights that people tend to make certain assumptions as to what the person before them ought to be. He further points out that if evidence is presented that suggests a stranger possesses a less desirable attribute that makes him or her different than others, he or she may be considered to be bad, dangerous, or weak, and considered tainted or discounted in some way (Goffman, 1963).

By imposing consequences of removing women from their neighborhood via arrest or inpatient treatment, the justice system affects social identity by ostracizing them
and affirming deviancy resulting in women being labeled mentally ill, substance abusers, or criminal offenders (Alarid & Vega, 2010). As a result, specific therapeutic modalities found to be efficient when working with female violent offenders may be bypassed subconsciously due to the therapist having a strong opinion related to the nature of the crime or behaviors being targeted during treatment. Bernier and Dozier (2002) found that akin to clients’ variability in accepting objections to their current style of functioning, therapists may also vary in their “ability to provide the trust and security necessary for a corrective emotional experience to take place” (p. 41) in the therapeutic relationship.

Historically based on myths and stereotypes, female offenders have been categorized as more emotional beings when engaging in crimes and are typically labeled as victims of previous trauma or abuse (emotional, sexual, or physical). Substance abuse, aggression, or antisocial personality disorders are consistent with male gender role stereotypes, while neurosis, anxiety, or depression would be more aligned with female gender role stereotypes (Page, 1987, p. 54). Sympathy for female defendants charged with murder who have a history of being victims of domestic violence stems from paternalistic views of women being the weaker sex (Ramsey, 2010). However, Cauffman (2008) identifies that gender role expectations have changed following the progression of the women’s liberation movement as female behaviors have become more “masculinized” as evidenced by increases in physically aggression or violence.

Harer and Langan (2001) suggest women are more likely to kill a family member or boyfriend, whereas men are more likely to kill an acquaintance or stranger. Watzke, Ulrich, and Marneros (2006) express that while it is evident male and female offenders
may differ with regard to the types of crimes committed, both groups are equally capable of being convicted for violent and non-violent offences; and females who committed violent offences tended to often commit homicide, while men who committed violent offences usually committed assault and battery, as well as robbery and extortion. DePrince, Combs, and Shanahan (2009) note women exposed to interpersonal trauma such as sexual assault in their youth are at increased risk of exposure to interpersonal trauma later in life, especially when early interpersonal trauma is perpetrated by someone close such as a parent or caregiver. DePrince et al. (2009) also speculate that re-victimized women hold negative expectations of others within interpersonal relationships including expectations of harm, according to the schema hypothesis of re-victimization.

Allwood and Bell (2008) note that further research needs to be done to explore the mechanisms between violence exposure and violent behaviors, as cognitive acceptance of violent behaviors or violent acts in order to emotionally adapt or make oneself desensitized to violence, eventually perpetuates the cycle of violence itself. Therefore, it would be beneficial to gain understanding from the female offender’s perspective about her trauma history and how it has impacted or resulted in subsequent acts or decision making related to displays of violence. Exploring violent female offenders’ subjective experience can allow for the development and implementation of therapeutic interventions that address issues related to trauma, that are also efficient in managing outbursts of violence, aggression, or destruction, as well as reduce or eliminate homicidal thoughts or behavior; however, clinicians must be willing to engage with this target population from an open-minded perspective.
Statistical Representation of Women in Criminal Justice Institutions

Kubiak, Kim, Fedock, and Bybee (2012) define violent acts as those that involve force, or threat of force, and include offense types such as homicide, robbery, assault, and those sexual in nature. Within the US criminal justice system women comprise 24% of those arrested with 5% of those sentenced for a violent offense (Kubiak et al., 2012). The female arrest rate for violent crimes have increased somewhat due to the policing of low level crimes and reclassification of simple assaults as aggravated assaults (Cauffman, 2008). Legal consequences for violent offenses can range from community supervision/probation, incarceration in local jails, or incarceration in state prisons, depending on the severity of the crime. In women’s facilities 34% of inmates comprise of violent offenses, while 30 % have property offenses, and 27% have drug offenses. The authors note that women with violent offenses have a 49% recidivism rate, mainly with drug related crimes (Kubiak et al., 2012).

In the state of Georgia as of January 2015, there are 1,563 females incarcerated for violent crimes, with 356 women sentenced to life, 29 sentenced to life without parole, and one sentenced to death (Georgia Department of Corrections, 2015). The female offender population is viewed as the fastest growing population with a recidivism rate of 19%, with 2,929 women being admitted into prison under new sentences annually (Georgia Department of Corrections, 2015). Female offenders tend to resort to crime following a long history of sexual and or physical abuse, unhealthy interpersonal relationships and substance abuse issues. Approximately 50% have been physically abused while 45% have a history of sexual abuse, and in 75% of female offender
convictions drugs were involved (Georgia Department of Corrections, 2015). As noted by The Georgia Department of Corrections (2015), children of female offenders are seven times more likely to become incarcerated than those of non-incarcerated females. The rate of incarcerated women has been increasing steadily, yet research is minimal on female inmates as both the policies and mental health treatment implemented in the correctional system are based on studies of male inmates (Drapalski, Youman, Stuewig, & Tangney, 2009). Based on the increased rates of arrests of female offenders, it is evident there is a need for valuable and effective intervention by mental health professionals.

Criminal Justice Treatment Programs

With more than 1.6 million men and women incarcerated in the state and federal prisons, reintegration into the community or re-entry programs have been in great demand (LeBel, 2012). Mental health professionals and criminal justice departments have been actively seeking ways to collaborate and provide effective methods of therapeutic intervention to reduce incidents of criminal activity, especially regarding violent crimes. Mental health units have been established in correctional systems as a result of case law to ensure that mentally ill inmates are treated in a timely and humane manner consistent with community standards (Carpenter & Spruiell, 2011, p. 367). Restorative justice programs spawned from peacemaking criminology, seek to promote local solutions to crime that focus on prevention, less repressive responses to crime, and more re-integrative social programs once crime has occurred (Wheeldon, 2009, p. 93). As a humanistic approach to crime control, peacemaking criminology holds that rather than
the use of punishment and retribution as a means of social control, reconciliation through mediation and dispute settlement ought to be emphasized (Wheeldon, 2009, p. 93).

Tyler et al. (2007) note the need for collaboration as per sentencing policies in the judicial system, numerous offenders that were incarcerated are being released from jails and prisons, prompting discussion about how the community can cope with offender re-entry into the general population. High costs of maintaining large prison populations prompt inquiry into effective alternatives to imprisonment, including interventions at the onset of initial criminal activity (Tyler et al., 2007). Criminal justice treatment programs have been developed and geared towards violent male offenders, especially those who have been found to have a mental illness. Singer et al. (1995) point out however, that incarcerated women also have an extensive history with both criminal justice and mental health services due to issues with psychological distress, mental illness, or co-occurring substance abuse.

While there are violent female offenders who receive mental health services in prisons or jails, their treatment is impacted in numerous ways as most interventions may have been formulated based on society’s stereotypical view of women. Young women seem to define themselves in relation to what others think, making it more difficult for women to resist stigmatizing labels and terminate social relationships that devalue them (Alarid & Vega, 2010, p. 78). Herman (1997) argued that women who survive complex traumatic experiences have increased risk for developing personality disorders, harm in other relationships, self-injurious behaviors due to self-loathing, poor interpersonal relationships or feelings of connection to her surroundings, an impaired sense of safety,
and feelings of guilt and shame (as cited in Bright & Bowland, 2008). Messina et al. (2006) observe that women were more likely than men to present greater challenges to treatment practitioners possibly due to severe substance histories, coexisting physical health and psychological problems, and victimization sexually and physically as children.

Additionally, treatment programs may fail to sufficiently address history of abuse or trauma in women or severe and persistent mental illness, supporting the need for therapeutic interventions for violent female offenders to be tailored differently than their male counterparts. Alarid and Vega (2010) suggest that by creating gender responsive correctional programs, women would be able to have positive self-esteem development, greater self-awareness, and a sense of her own identity to reduce internalization of negative self-images, association with criminal identity, and future influences of criminal behavior. Historically, to understand the characteristics, history, and symptoms of females with illegal, aggressive, or violent behavior, the most frequently utilized research method was controlled follow up and cross sectional studies with predominantly white samples (Rappaport & Thomas, 2004). However, this also speaks to the increased need for a more cultural approach to research on violent female offenders, as a perspective from diverse groups of women and their trauma histories could lead to additional considerations that can be addressed with this population.

Based on societal gender norms, the contrasts between men and women are also apparent in the criminal justice system by the separate male and female correctional facilities and the types of treatment programs offered in prisons or jails. Male offenders’ display of violent behaviors are often linked to their innate aggressive drives and not
often associated with mental illness. Conversely, female violent offenders are more often considered to have mental illness after engaging in a violent offense. There is limited information about the prevalence of mental disorders in female prisoners. However, there have been studies that reflect that all mental disorders could be found more in female prisoners than in women who were not offenders, and mental disorders were found more frequently in women in comparison to male counterparts (Watzke et al., 2006). Poole and Tapley (1988) support this by noting that behaviors considered appropriate for men such as aggression if displayed by women, causes women to be labeled as deviant. As a result, medical and psychological evaluators may focus on the emotional state of the female when making a diagnosis, resulting in more therapeutic treatment for the female violent offender rather than the male (Gurian, 2011). However, there has also been evidence of gender based leniency at the sentencing phase for female offenders, which could be considered to be a form of reverse discrimination (Nagel & Johnson, 1994).

With male prison systems often plagued with a higher number of detainees arrested for murder or violent assault, aggression, and destructive behaviors, there tends to be more incidents of fights, creation of weapons, sexual assaults, and substance abuse. Female prison systems tend to have a lower occurrence of these events, more camaraderie amongst inmates, program interventions, and family or community supports in comparison to the male facilities.

Violent offending is predominantly a male phenomenon as evidenced by a snapshot of the United States where a majority of the inmates in jails and prisons are male (Lewis, 2010). Lewis (2010) suggests incarcerated women are a group with
significant trauma history and often engaged in high risk lifestyles (p. 225). Education is also a risk factor for both men and women as those that did not graduate high school or obtain a general equivalency diploma were more likely to engage in violence (Harer & Langan, 2001). Violent offenders may have the potential to receive commuted sentences or a reduction of the length of imprisonment as a reward for good conduct during incarceration, resulting in an increase in reintegration into the community (Gurian, 2011). However, difficulties implementing treatment for violent offenders include the community mental health centers concern about dealing with defendants who were perceived as more dangerous than the population they traditionally serve due to issues of clinician competence, as criminal charges increase the likelihood of lawsuits if defendants (clients) commit further crimes in the community (Miller, 2003).

In determining whether or not the courses of treatment or therapeutic interventions utilized with female violent offenders are effective, mental health professionals would need to have an understanding about the legal system, the offender’s competency status, the criminal charges resulting in arrest and length of sentence, history of mental health diagnosis and treatment, diagnosis of intellectual disability or developmental disability, history of abuse or trauma, displays of behaviors in the correctional facility, as well as awareness of personal biases that could affect treatment. There are several theories about the prognosis of treatment and effectiveness of specific modalities that may be beneficial or effective when working with a female violent offender. As recommended by Carpenter and Spruiell (2011), an inmate centered approach that integrates modern scientific approaches with the realities of the prison
system holds the greatest promise for the development of more effective treatments (p. 379).

In terms of client characteristics and therapist traits, it has been suggested that the client-counselor match accounts for a greater outcome and a corrective emotional experience in therapy (Bernier & Dozier, 2002). When treatment simultaneously enhances client adaptation and satisfaction as well as strengthens the working alliance, there is no need for punitive measures to enforce compliance with treatment (Carpenter & Spruiell, 2011). Nonetheless, Strubel (2007) cited that in violent offenders, personality disorders and paraphilias are notoriously resistant to treatment. By examining the history of abuse or trauma, psychiatric disorders, thoughts, emotions, and behavioral characteristics of the female violent offender, the process of implementation for a specific therapeutic modality to address trauma history and reduce rates of recidivism can be explored.

Relevance to Mental Health Treatment in the Criminal Justice System

Hubbard (2007) noted that treatment programs currently being used in the correctional system utilize techniques based in cognitive behavioral theory (CBT) or social learning theory (SLT). CBT seeks to change social cognitive deficits and distortions through defining the problems, generating alternative solutions, anticipating consequences, monitoring behaviors, and prioritizing responses (Rappaport & Thomas, 2004). The structure found in CBT has been noted to change the cognitive deficits and distortions found in aggressive and violent individuals (Rapport & Thomas, 2004). In examining violent offenders and mental disorders, 16 symptoms consistent with a
description of psychopathy have been identified including: superficial charm and good intelligence, absence of nervousness, lack of empathy, and lack of remorse, as well as failure to follow a specific life plan (Salekin, Worley, & Grimes, 2010). However, research on psychopathy can be misinterpreted, inadvertently promoting beliefs that the condition is not reversible with interventions (Salekin et al., 2010). Group modalities appear to be particularly useful with violent offenders that have deficiencies in sociality (Winter, 2007, p. 264).

Lewis (2010) proposed gender differences in psychopathology are not distinct due to the severity of the disorder as evidenced by incarcerated female offenders having similarities with male counterparts. Psychopaths of both sexes are often regarded as considerable violent risk and generally respond poorly to treatment (Wynn, Hosie, & Petterson, 2012). Antisocial personality disorder has received limited attention in incarcerated female populations, primarily because of the link between antisocial personality disorder and impulsivity or aggression, strong association with criminal recidivism, poor treatment response, co morbidity risks, and risks of suicide (Lewis, 2010). However, violent female offenders may also seek to explain murder as a result of physical or mental abuse, creating the potential for sympathetic treatment by the criminal justice system (Gurian, 2011). Psychological assessment of the violent offender has often focused on prediction for future violent acts, typically without consideration of the personal meaning of the offender’s actions or behaviors in relation to the nature of the crime (Winter, 2007). This is especially interesting when considering female violent offenders as their violent acts may have been consistent with their worldview or
meaningful or traumatic events. Treatment programs for violent offenders with psychopathy should incorporate more elaborate and intensive therapeutic intervention programs involving individual psychotherapy, treatment of family members, and group interventions; therefore the scope, intensity, and duration of treatment are vital components in working with female violent offenders (Salekin et al., 2010).

It is possible that within the confines of a prison treatment adherence could be monitored and a combination of psychotherapy can be utilized to decondition the female violent offender from engaging in maladaptive violent behaviors or thoughts (Strubel, 2007). Salekin et al. (2010) identified potential problems regarding treatment of the psychopathic personality that can be found in female violent offenders as: concerns about a violent offender's motivation to change, manipulative or deceitful behaviors in therapy, lack of real displays of emotion, and the risk of engaging in therapy with psychopathic individuals. However, CBT has been found to be significantly successful at reducing rates of recidivism by targeting antisocial attitudes held by violent offenders by applying a variety of behavioral techniques such as role playing, reinforcement, and modeling (Hubbard, 2007). CBT also has positive effects in correctional settings as prison staff are able to be trained in a short period of time, and has been found to be significantly successful at reducing recidivism in female offenders (Hubbard, 2007).

Mental health professionals working in or alongside the criminal justice system should be aware of effective treatment modalities when developing programs for violent female offenders and be sure to include trauma focused interventions for offenders that have extensive trauma histories, as well as information to dispel myths or stereotypes
about women. While there are numerous challenges in trauma assessment, it is important for clinicians to be mindful of the variation in trauma type and the association with gender, instead of assuming that women's trauma responses reflect greater susceptibility to pathology (Bright & Bowland, 2008). Clinicians must be competent in the diagnosis and treatment of psychiatric disorders, knowledgeable about the criminal justice system and legal statutes, aware of the distinctions between violent male and female offenders, as well as their own attitudes towards women. Alarid and Vega (2010) identified that women who viewed themselves as criminals also tended to be associated with criminal or deviant groups, making it difficult to disassociate themselves from stigmatizing labels and negative social relationships and thereby leading to further instances of criminal behavior and re-entry into the criminal justice system.

The primary aim of treatment when working with female violent offenders would be to promote positive self-esteem; the development of positive interpersonal relationships with others evidenced by increased empathy; enhanced responsiveness to therapeutic interventions by marked participation in individual, family, and group therapy; as well as completion of assignments given in session; self awareness to reduce and eventually eliminate delinquent behaviors pertaining to trauma history; and to reduce rates of recidivism. Mental health professionals must be mindful about female violent offenders' responses to therapy to discern between honest and manipulative behaviors and effectively treat and make disposition recommendations (Salekin et al., 2010).

Statement of the Problem

The aspect of treating individuals with severe trauma history within the
A therapeutic relationship can appear to be a daunting task. Interpersonal trauma can be defined as physical, sexual, and psychological abuse or violence towards an individual that is committed by strangers, acquaintances, or family members (Bright & Bowland, 2008). Mental illness as a whole tends to be approached by clinicians as something that can be managed from a holistic perspective with rapport established within the therapeutic relationship, the use of the right treatment interventions with psychiatric medications if necessary, a conducive environment to psychological and emotional healing, and a client willing to actively participate and respond to therapy. However, in some cases, individuals with a history of extreme traumatic events appear to be unable to respond to various treatment interventions at lower levels of care such as in community settings, and in some instances will engage in crimes such as physical assault and homicide. Watzke et al. (2006) found indications of a more complex psychopathology for violent offenders in comparison to nonviolent offenders.

Historically, the individuals whom have been identified and sensationalized in the media as perpetrators of violent offenses in this capacity are male, yet there are a significant amount of female violent offenders. This places emphasis on the need to gain understanding about the complexity of imprisoned offenders as high prevalence and comorbidity rates of mental disorders result in an urgent need for therapeutic services during imprisonment and after release, with the potential to contribute to a more favorable legal prognosis and decreased chance of re-entry (Watzke et al., 2006). Researchers have tried to gain understanding into the family of origin issues, personality characteristics, and mental disorders that are typically present in male violent offenders.
Yet, Rudolph (1996) pointed out that at least half of all women incarcerated in the criminal justice system were the victim of abuse as either an adult or child, with the following personality characteristics noticed amongst abuse victims: low self-esteem, defective superego formation, feelings of worthlessness and hopelessness, social isolation and alienation, and powerlessness. However, there has been limited research on the mindset of people who work with female violent offenders. Thomas (1973) identified that unwanted biases and premature verbal interventions can be introduced during behavioral assessment which could misdirect the course of therapy (p. 108). Clinicians can experience emotions such as anger, hate, sexual feelings, and fear when working with clients, which impacts clinical decision-making and behavior towards clients (Okamoto & Chesney-Lind, 2000).

As a result, the purpose of this research was to explore the attitudes, values, and expectations mental health professionals have about female violent offenders, and how these perceptions and biases impact mental health or substance abuse treatment provided to this population. By exploring the myths and stereotypes held by clinicians associated with this target group, findings may suggest that the traumatic experiences correlated to the commission of violent crimes in female offenders may often be either neglected or overused in diagnosis and treatment recommendations. Through the identification of perceptions and biases, clinicians are able to recognize areas of impairment or limitations when working with this target population and promote the use of more effective ways to address client needs and improve clinician competency through future research.
Purpose of the Study

Singer et al. (1995) identified that female criminality was a much neglected area of research until the 1970's possibly due to women not being considered to be a significant threat to society as they commit more non-violent crimes, or due to women representing a small proportion of inmates in correctional facilities, and the inaccessibility to appropriate services and research for women due to unequal economic and political status. No studies could be found that linked criminal justice populations of women and their concerns about the perceptions of stigma (LeBel, 2012). The purpose of this study was to examine the personal attitudes, values, and expectations of clinicians working with violent female offenders and whether or not the provision of therapeutic services to this population is affected by personal perceptions and biases. Counselors need to be mindful that women are socialized from birth according to a sex-role or gender stereotype and in practice, counselors themselves may also be impacted by a similar process of socialization (Sheridan, 1982). Miller et al. (2007) identified that possible limitations that can be associated with conducting research on therapist perception include: concerns about social desirability in respondents’ based on their educational sophistication, sensitivity to cultural issues, and perceived negative consequences associated with expressions of bias; in addition to reliance on self-reported data which could lead to underestimation of bias.

Currently, violent female offenders may obtain courses of treatment that only consider traditional gender roles, myths, and stereotypes about women found in society, thereby allowing for a mental health professional’s biases, values, and perceptions to
potentially negatively impact the therapeutic process. Society’s view of females may also include personality characteristics such as women are passive, weak, or nurturing; resulting in the lack of implementation of specific interventions that may be more stringent yet appropriate; especially when the female has engaged in heinous crimes. Male violent offenders on the other hand may also receive courses of treatment which may be deemed excessive and inhumane due to gender roles assigned to males, as well as characteristics associated with males of being strong, cold, and calculated. Based on the perceptions, values, or biases of mental health professionals about incarcerated women who commit violent crimes, the current treatment options provided may be determined to be ineffective or inefficient. Bermudez (1997) suggested that in order to reduce instances of pathologizing a client and to be clinically effective, therapists need to assess their own biases.

Clinicians should assess whether or not their current theoretical orientation or conceptualization of clients incorporates the oppression related to socially prescribed gender roles, and if not incorporate alternatives to reduce incidents of bias (Eriksen & Kress, 2008). Research into therapeutic interventions utilized with female violent offenders and clinician practice is necessary and beneficial to find effective and efficient methods of treatment to reduce rates of recidivism if offenders were to be deemed eligible for discharge from the justice system and mainstreamed back into society.

Theoretical Framework

The theoretical framework for this study was rooted in exploring components related to the therapeutic alliance between clinicians and violent female offenders.
Boysen and Vogel (2008) highlighted that in the counseling field biased attitudes that can influence the treatment of diverse clients are considered to be dangerous due to the potential for negative outcomes. Polascheck and Ross (2010) pointed out that there is skepticism on whether or not it is possible to form a therapeutic alliance with this population. Bordin (1979) defined the working alliance between therapist and client as one where there is an agreement on goals that will be worked on by both parties, there will be collaboration on the tasks used to achieve the goals set forth the in therapeutic services, and an overall bond that facilitates collaboration between the client and therapist (as cited in Polascheck & Ross, 2010).

Despite some change in the design and delivery of offender rehabilitation programs, the treatment process and other responsivity factors such as therapeutic alliance, therapist’s perceptions of clients motivation to change, stage of change, and treatment outcomes have received little attention (Polascheck & Ross, 2010). Empirical research on the therapeutic alliance with offenders has been scant, and its effects on therapist’s perceptions of clients’ motivation to change during therapy remain to be examined (Polascheck & Ross, 2010, p. 101). A corrective emotional experience in therapy allows for the client to safely alter his or her rigid relational patterns by experientially relearning new interpersonal experiences with the therapist within the counseling relationship (Bernier & Dozier, 2002).

As noted by Polascheck and Ross (2010), how therapists conduct themselves in therapy is an important determinant in the provision of effective offender treatment services and offender change. Clinicians who have interpersonal skills such as warmth,
empathy, are directive yet collaborative and rewarding have a more positive response from their offender clients (Polascheck & Ross, 2010). Through the use of interventions that alter beliefs about the nature of human traits there may be a way to reduce the occurrence of negative perceptions and increase policies and treatment programs to resolve disadvantages experienced by negatively stereotyped groups (Levy, et al., 1998).

This research employed a phenomenological approach to gain understanding of the therapist experience in order to obtain perspectives on potential barriers to forming the therapeutic alliance with violent female offenders. Phenomenologists research the life world of the counselor, providing an opportunity to gain a greater understanding of the counselor's roles and functions (Denton, 1981). The descriptive data gathered from this qualitative study reflected a variety of themes. However, all themes presented the need for clinician self-awareness and recognition of the potential for bias and how bias may impact treatment provision. Exploring therapist perception with regard to the therapeutic alliance supported the need for increased empathy and sensitivity to this target population during the treatment experience, which could ultimately lead to improved counselor-client relations.

Research Questions

Upon review of the literature related to trauma, women and violent behavior, and mental health programs in the criminal justice system, there was clear evidence of lack of research into the provision of treatment services with this target population and the individuals who provide these services. The following research questions were developed to explore further and address this gap in the research:
1. What are your perceptions of violent female offenders and how do they impact your selection of treatment approaches or interventions used with this population?

2. How might the perceptions of violent female offenders differ amongst counselors in training, licensed associate professional counselors, and licensed professional counselors?

3. What are the challenges in your ability to establish rapport and actively participate in the therapeutic relationship with violent female offenders in comparison to female clients who have not committed any crimes?

4. What are some examples of the stereotypical beliefs held about women and actual violent crimes committed by women that have resulted in your experience of cognitive dissonance during provision of treatment services?

5. How does your examination or assessment of the trauma histories of violent female offenders compare to assessing the trauma histories of women who have not been arrested or incarcerated (is it more thorough or less intensive)?

6. How might working with violent female offenders result in you experiencing vicarious trauma, counter-transference, and burnout more frequently than working with women who have not been arrested or incarcerated?

7. How does your level of self-awareness or insight about your perceptions or biases held towards violent female offenders reflect an increased or decreased level of competency and use of appropriate treatment intervention strategies?
Nature of the Study

The study proposed to explore the perceptions of mental health counselors in training and licensed clinicians in the state of Georgia working with violent female offenders who have a history of being charged with, or convicted of violent crimes and are currently in a correctional facility, inpatient facility, or in outpatient community setting receiving mental health and/or substance treatment. This research will add to the scarce literature on violent female offenders and to support the need for the implementation of counselor education and supervision competency focused techniques for master’s level counselors in training, licensed associate professional counselors, and licensed professional counselors, working with violent female offenders.

A qualitative approach was utilized to explore if clinician perception negatively impacts the therapeutic relationship as evidenced by inability to establish rapport with violent female offenders; if clinician attitudes towards violent female offenders affects the use of appropriate therapeutic interventions; if violent crimes committed by women and the stereotypical beliefs held about women create cognitive dissonance in mental health professionals; if trauma histories of violent female offenders may be either overlooked or solely explored by clinicians when addressing violent criminal behaviors in women; if clinicians who work with this population suffer from vicarious trauma, counter-transference, and burnout more frequently; if increased self-awareness or insight about negative perceptions towards this target group could assist clinicians with increasing their level of competency and using appropriate treatment intervention strategies that are effective in reducing rates of recidivism with violent female offenders;
and if there will be a difference between the attitudes, expectations, and biases towards violent female offenders held by mental health professionals based on education level and experience in the field.

Conducting interviews during a qualitative study provides the researcher with an opportunity to gain perspectives of the participants (Kolb, 2012). Qualitative studies allow for deeper understanding of personal experiences of the participants involved. Therapists may unknowingly have certain biases and underlying assumptions about clients they serve (Bermudez, 1997). By engaging in qualitative research, the perceptions and expectations of clinicians working with violent female offenders can be explored and meaningful information can be obtained about their process of providing therapeutic services to this population.

Limitations and Delimitations

The study explored the perceptions of therapists who work with violent female offenders and their impact on the provision of mental health and or substance abuse treatment services. There are several limitations within this study. Data obtained was based on self-report and raised the possibility of under reporting of incidents of bias due to social desirability concerns. Findings cannot be generalized to other mental health professionals or all counseling professionals. Findings also differed at the levels of licensure, licensed professional counselors versus associate licensed counselors, and unlicensed, master's level counselors. Findings were potentially impacted by the role of supervision in clinical judgment. Specific considerations were not addressed directly such as socioeconomic status and race of women the clinicians came in contact with. Age,
racial, or cultural differences could also address other disparities associated with provision in treatment. The research did not delineate how therapist gender differences could also affect the experience of working with violent female offenders.

Another limitation that presented in the study was researcher bias. The researcher is a licensed professional counselor with previous experience of working with women who have been charged with and convicted of violent crimes. The researcher was aware of personal thoughts, feelings, and reactions to the experiences expressed by the participants in the study. Denton (1981) noted cognitive bracketing is the "conscious, intentional, intellectual act of setting aside accustomed perceptual sets and interpretive frameworks," (p. 597). Bracketing was utilized by the researcher as a means to lessen the potential effects of preconceptions during the study.

Significance of the Study

This research adds to the literature and contributes to the counseling field by encouraging ongoing self-assessment and professional development amongst mental health professionals who work with violent female offenders in the criminal justice system. The research assists with exploring the impact that clinician perception and cultural stereotypes has on the therapeutic treatment of violent female offenders and support mental health professionals with gaining greater understanding about adequately serving this population. The reflection of therapist values, biases, and assumptions about what is considered to be normal behavior results in expectations formed by both the client and therapist (Bermudez, 1997).

By engaging in research in this area, more effective training and continuing
education can be conducted to enhance professional development and practice and reduce rates of burnout, vicarious trauma, and counter-transference. This study addressed the quality of care being provided to violent female offenders to improve clinician effectiveness and productivity, and ultimately promote offender adherence to treatment programs and motivation to seek continuous treatment for those who are incarcerated and eligible for release in the future by improving the quality of the therapeutic alliance.

Summary

Chapter 1 addressed the rationale for this study to be conducted, the importance of exploring therapist perception and bias towards female violent offenders, and the impact of perception on the treatment interventions used to decrease rates of recidivism in female violent offenders. Chapter 2 will consist of a comprehensive literature review exploring aspects such as the types of crimes and consequences associated with female violent offenders, risk factors for violence and aggression, mental illness, history of trauma, stereotypes and myths associated with women, and the history of therapeutic treatment interventions in the criminal justice system and the community used with violent offenders, as well as how therapists’ perception and bias impacts the ability to determine and address the current needs for this target population.

Chapter 3 will present information about the methodology of the study including the hypotheses, sample information, the research design and instrumentation, as well as the procedures for obtaining and analyzing the data, study limitations and delimitations.
Definition of Terms

The following terms have been defined as they are significant to this study: counselor in training, licensed counselor, trauma, violent female offender, therapeutic services, criminal justice system, and perception.

Counselor in Training

Counselor in training for the purpose of this study is defined as a master’s level counseling student obtaining his or her master’s from an accredited institution and participating in an internship in the state of Georgia where he or she has had to engage in the provision of therapeutic services to violent female offenders; or an individual who has completed a graduate degree program in counseling and is actively working towards licensure, that has engaged in the provision of therapeutic services to violent female offenders.

Licensed Counselor

Licensed counselor for the purpose of this study is defined as a mental health professional with a minimum of a master’s degree in a mental health related field and is licensed as an associate professional counselor or professional counselor in the state of Georgia with work experience in the provision of therapeutic services to violent female offenders.

Trauma

Trauma is defined as an individual’s experience of physical, sexual, and psychological abuse or violence perpetrated by family members or strangers that result in decreased physical, emotional, and sexual health, as well as a decline in general
functioning (Bright & Bowland, 2008).

Violent Female Offenders

Violent female offenders for the purpose of this study, this term refers to adult women who have been convicted of aggressive or violent crimes including but not limited to: aggravated assault, battery, robbery, and murder.

Therapeutic Services

Therapeutic services for the purpose of this study, this term refers to the provision of mental health or substance abuse screening or assessment, crisis intervention, or direct and ongoing counseling services in a correctional facility or in an outpatient agency, or inpatient psychiatric facility or other treatment facility.

Criminal Justice System

Criminal justice system this term refers to the agencies utilized to manage crime and punish people who are convicted of criminal offenses in society. It is encompassed of law enforcement, the court system and interrelated organizations.

Perception

Perception for the purpose of this study, this term refers to the personal thoughts, beliefs or opinions held by counselors in training or licensed counselors in relation to violent female offenders. Link and Phelan (2001) note that based on negative perceptions of others, people form expectations that can lead to the devaluing, rejection, and discrimination of others.
CHAPTER 2
REVIEW OF RELATED LITERATURE

This literature review presents the body of knowledge relevant to this topic of study and the target population of mental health professionals who work with female violent offenders. Factors such as violence, trauma, mental illness, and the criminal justice system, will be defined. However, these concepts will be specifically addressed in relation to female violent offenders and the attitudes, stereotypes, and expectations held by society, the criminal justice system, and mental health professionals. In addition to defining core concepts of this qualitative study, additional factors will also be presented including: counselor competence, cognitive dissonance, risk factors for female violent offenders, access to resources for treatment, education, the family system and other relational factors.

Violence and Aggression Defined

Ramsey (2010) stated when examining homicide across centuries and geographic boundaries, men tend to outnumber women as both the perpetrators and victims (p. 45). Rossegger et al. (2009) presented however, there has been a notable increase in female offending in the United States prompting the exploration of the characteristics of female offenders, the types of crimes women commit, the circumstances under which women commit offenses, and the determining risk factors for repeat offending. The authors also suggested that the origins of male offending cannot just be transferred to female
offenders as women may have entirely different factors responsible for those actions (Rossegger et al., 2009). However, there have been alternative reports that violent crime among women has maintained some relative stability since the 1960’s with a decreased rate of homicide and robbery; however there has been an increased rate in assaults (Kubiak et al., 2012). Kruttschnitt and Gartner (2008) explained that while fewer women act alone in the commission of violent crimes like assaults, there has been an increase in gun use in homicides, and female violent offenders report that their crimes tend to be motivated by the need for money and or drugs. Females tend to show emotional instability, verbal violence, and manipulation of social networks, and to a lesser degree than males engage in criminal behavior and instrumental violence (Wynn et al., 2012).

Violence is certified as an international public health problem; it is often regarded as a result of anger as threat perception is intrinsic to anger activation, which could lead to violent action (Novaco, 2011). Kubiack et al. (2012) have provided a definition of violence as offenses or acts that involve the use of force, or the threat of force. Siever (2008) presented that premeditated violence also known as predatory, instrumental, or proactive violence, is not associated with frustration or response to an immediate threat; rather it is a calculated behavior with specific objectives considered. Affective violence however, is defined as violent behavior symptomatic of affective disorders, schizophrenia, attention deficit disorders with hyperactivity, drug abuse, or epilepsy and other related conditions, that can be a destructive or aggressive response beyond control to a real or perceived stimulus that serves to attack or inflict pain (Miller, 1986).

Warren et al. (2002) listed violent crimes as capital murder, homicide, second
degree murder, accomplice to murder, attempted homicide, manslaughter, abduction, assault, malicious wounding, felony assault, hurling missile, simple assault, abuse and cruelty, and child abuse. However, violent female offenders could be found guilty of crimes with a sexual component as well. Brown (2007) noted murder is classified under the umbrella of violence, with the definition of murder provided by the Federal Bureau of Investigation (FBI) as the willful killing of one human being by another. Snow (2002), pointed out that there are two behavioral patterns that are clear indicators of future assaults or murders: episodes of increasing violence, and sudden, violent, irrational outbursts. There are various types of murder: mass or multiple murder is committed by the same person or persons, involves more than one victim and are committed during one event; serial murders are committed by the same person or persons, involve more than one victim and are completed over different periods of time; single incident murders involve crimes of passion, rapes and robberies, and one and one killings; vehicular homicide results from negligent or reckless driving, or driving under the influence of drugs or alcohol; while manslaughter or accidental homicide is murder committed without malice and may be accidental in nature (Brown, 2007). Murder is generally not a planned crime and often occurs impulsively, in the heat of an argument or fight, with the offenders not being in control of their faculties (Snow, 2002). However, neonaticide offenders kill newborn babies within 24 hours of birth (Wilczynski, 1997).

Aggression is viewed as displays of physical acts or verbal statements utilized by one individual to create harm or pain in another person. Taubman (1986) noted that while aggression exists in both males and females; the expression of aggression is shaped
by experiences formed by cultural norms and interpersonal interactions. Siever (2008)
pointed out that the most widely utilized classification of aggression is premeditated
versus impulsive aggression; however, aggression can be classified in numerous ways,
including by the target of aggression whether it is directed to self or others; the mode of
aggression whether physical or verbal or indirect or direct; and the cause of aggression
such as a medical reason. In contrast, impulsive aggression is a response to a perceived
stress associated with negative emotions such as fear and anger following a precipitating
event and is also known as reactive, affective, or hostile aggression (Siever, 2008).
However, Siever (2008) suggested that impulsive aggression becomes pathological when
the display of aggression is exaggerated in comparison to the precipitating event. Grusec
(1992) noted that Freud believed that the cause of aggression was an exposure to
frustration linked to an innate drive. Social learning views suggest that aggressive
reactions to frustration could be altered through learning; interestingly, socialization can
also create high levels of frustration which could lead to further displays of aggression
(Grusec, 1992). While violence is commonly identified as physically destructive acts of
aggression, it can also be applicable to psychosocial assaults that destroy an individual’s
sense of autonomy, identity, reality, self-esteem, and in some instances deprivation of
love and care (Taubman, 1986).

How does Violence Develop in Female Offenders?

Cowan, Langer, Heavenrich, and Nathanson (1969) presented that children
acquire adult moral standards through a process of imitating observable behaviors and
values. In examining the cognitive processes found in violent youth, children exposed to
violent behaviors or aggression learn either experientially or vicariously to utilize aggressive or violent behaviors as a means to get their needs met (Allwood & Bell, 2008). Parental behavior either fosters or hampers internalization of children’s issues surrounding the control of aggression, development of resistance to temptation and guilt, and the attainment of behaviors related to culturally acceptable gender roles (Grusec, 1992). Parents are not the exclusive source of moral judgment and behavior in children and adolescents as there are influences from extra-familial adults, peers, and other symbolic models throughout the developmental stages (Bandura, 1969). According to Stoddard, Zimmerman, and Bauermeister (2012), risk factors associated with incidents of violence and aggression in youth include: attention problems, learning problems, antisocial behavior, hopelessness, witnessing violence, violence victimization, and associations with negative peer influences. More importantly, potential for violent and aggressive behavior is increased when environmental and familial factors include children or adolescents who observe or experience aggression, or cultural, psychosocial, or socioeconomic factors are conducive to aggression, or there is genetic predisposition (Siever, 2008). The relationship found between violence exposure as a child or adolescent and display of violent behaviors and aggression towards others have been supported by theoretical models which encompass sociocultural, socio-cognitive, and behavioral adaptation theories (Allwood & Bell, 2008).

Two factors that predict disciplinary problems and crime as juveniles and adults in women include abnormal movements and neurological abnormalities (Denno, 1994). Examples of violent behaviors in children and adolescents consists of: explosive temper
tantrums, displays of physical aggression, fighting, threatening behaviors or attempts to hurt others, homicidal ideation, use of weapons, cruelty to animals, fire setting, destructive behavior and vandalism (American Academy of Child and Adolescent Psychiatry, 2012). Tarter et al. (2002) pointed out that violent behaviors in adolescents occur due to deficiencies in social skills necessary for conflict resolution; false beliefs that violent behavior is socially acceptable; the inability to effectively express or manage feelings of anger; misperceptions about the intent of others in interpersonal relationships; hopelessness about the future or lack of direction; low self-esteem; violence potential and expression; aggressive adolescents affiliating with similar peer groups; and substance use. Interestingly, though low self-esteem is considered to be an important factor in the etiology of female offending as it may weaken ties to society and cause a female to withdraw from interpersonal relationships; high self-esteem can also be considered to be a form of motivation for high risk behaviors such as criminal activity (Hubbard, 2006).

Rapport and Thomas (2004) highlighted that youth violence and aggression often emanates from multiple risk factors including biological vulnerability; inconsistent, overly permissive, or harsh discipline; community deprivation, ease of access to guns or other weapons, and exposure to violence either by history or at the present time. Rates of violence increase during adolescence with adolescent males and females suffering consequences such as imprisonment, injury, and death; violent behavior during adolescence is a risk factor for ongoing violence into adulthood (Stoddard et al., 2012). Research has supported there is a strong continuity in violence between childhood, adolescence, and adult life (Rappaport & Thomas, 2004, p. 260). However, Cauffman
(2008) pointed out female juvenile offenders have a less likely chance of being tried as an adult as only 7 percent of the 1 percent of youth cases transferred to adult court are female. There have been some discrepancies found in the sentencing for female juvenile offenders, where findings have reflected either lighter or harsher sentences than their male counterparts (Cauffman, 2008).

Peer group rejection and victimization are considered to be risk factors for violence and aggression in early childhood (Rapport & Thomas, 2004). Williford and DePaolis (2012) explained female adolescents engage in relational aggression by using peer relationships as a vehicle to inflict harm on others through manipulation, harassment, and gossip. Bandura (1969) notes that in children and adolescents, adult standards of behavior are substantially changed by conflicting standards of behavior demonstrated by peer models or influences. Rapport and Thomas (2004) presented that association with delinquent peers was predictive of self-reported violence in adolescents; yet associating with peers who did not participate in antisocial or violent behavior appeared to promote reduction in the likelihood of further incidents of violence.

Risk and Protective Factors for Continuing Violent Behaviors

In assessing risk of recidivism or risk for criminal activity, strong predictors or risk factors include substance misuse, history of physical and/or sexual abuse, economic marginalization, and psychiatric disorders such as depression and PTSD (Stuart & Brice-Baker, 2004). Risk factors are circumstances which promote a greater potential for adolescents to be at risk for engaging in violent and aggressive behaviors into adulthood (Stoddard et al., 2012). Tarter et al. (2002) highlighted that it is difficult to identify youth
that are at high risk for violent behavior in adulthood due to the complexity of predisposing factors, the variety of psychosocial factors, and contingency on social contextual factors. Risk factors for crime may differ depending on race and gender and each offender’s path to crime may vary (Hubbard, 2006). Winter (2007) noted that psychological assessment of violent offenders tends to focus on prediction of potential for future violent acts without consideration of the personal meaning associated with the offender’s actions or behaviors. However, per findings from Tarter et al. (2002), childhood psychiatric illnesses and non-standard or unpredictable behavior and emotional regulation, are important risk factors for predicting incidents of future violence in adolescents. Both adult male and female violent offenders were found to have a history of adverse childhood family constellations such as absent and or criminal parents, or neglectful parents (Rossegger et al., 2009). Snow (2002), pointed out that there are two behavioral patterns that are clear indicators of future incidents of violence: episodes of increasing violence, and sudden, violent, irrational outbursts.

According to the American Academy of Child and Adolescent Psychiatry (2012), risk factors that increase the potential for violence in adulthood are history of violence; genetic factors; exposure to violence in the media via television, the internet, music, or video games; severe stressful family and socioeconomic factors; and brain damage from a head injury. Additional considerations regarding risk factors for violence include the lack of utilization of appropriate mental health or medical assessments to identify possible diagnoses that contribute to violent behavior in youth. Mueser and Taub (2008) noted that the prevalence of PTSD has not been thoroughly examined in adolescents with
severe emotional and behavioral disorders due to the frequent treatment challenges presented by this group including: their possible involvement in mental health, school, and juvenile justice systems; level of cognitive functioning, risk for out of home placement; and their difficulty with transitioning to a capable adult. In children and adolescents, the aftereffects of trauma may be carried into adulthood and the trauma may have severe repercussions on developmental expectations and acquisition of age appropriate competencies (James, 2008). Siever (2008) identified that an individual’s susceptibility to aggressive or violent behavior is heightened and may manifest into extremely psychotic and deviant behavior such as murder, rape, and serial killing when there is a coexisting cognitive impairment, poor reality testing, an altered mood or anxiety state, substance abuse, and re-exposure to trauma.

An adolescent’s susceptibility to aggression and violent behaviors may manifest in a different manner depending upon the context in which it occurs (Siever, 2008, p. 430). Stoddard et al. (2012) identified promotive or protective factors such as positive personal assets and access to resources within their environment reduce the risk of violence and encourage healthy development within adolescents for successful transition into adulthood. Adolescent promotive factors include social skills, school achievement, connections to the school environment, sense of hope and purpose, and interactions with pro-social peers that model positive behavior (Stoddard et al., 2012). However, Stoddard et al. (2012) pointed out that while promotive factors may be similar for adolescents across genders, the ease of access or availability to promotive factors may differ as males have higher levels of risk exposure and lower levels of protective factors than females.
Rappaport and Thomas (2004) encouraged mental health professionals to carefully identify the cumulative impact of risk and protective factors on adolescents; assess acute safety needs for the adolescent and others around him or her; evaluate the onset, severity, and progression of the violent and aggressive behavior; pinpoint comorbidity issues, and determine the adolescent’s motivation for change and self-reflection to lessen the potential for continued violence. Stoddard et al. (2012) suggested facilitating the utilization of promotive or protective factors in violent adolescents by incorporating therapeutic interventions that promote cognitive and behavioral competence, confidence; build character; encourage kindness; engage them in positive interpersonal relationships with family members, peers, and other supportive adults in the community; and allows exposure to positive role models. Culturally based treatment approaches that are strength based encourage sustaining family relationships, building community connections, and incorporating cultural identity and pride that can help reduce the risk of violent behavior as minority adolescents progress into adulthood (Stoddard et al., 2012).

Examining the Concept of Trauma in Violent Women

Trauma can be defined as being confronted with an event that promotes a perceived, experienced, or witnessed threat to the physical and/or emotional well being of an individual. Victimization experiences of interpersonal violence such as childhood physical or sexual abuse or domestic violence and sexual assault are common among incarcerated women (Kubiak et al., 2012). Stuart and Brice-Baker (2004) identified that a Department of Justice study found that 78% of mentally ill female inmates reported a
history of physical or sexual abuse. Physical and sexual assault victims have long term effects of the initial psychological trauma (James, 2008). The original trauma can be relieved at unexpected times, recreating the original experience of feeling helpless and vulnerable all over again (Flemke, 2009). In children, the aftereffects of trauma may be carried into adulthood and the trauma may have severe repercussions on developmental expectations and acquisition of age appropriate competencies (James, 2008). Allwood and Bell (2008) presented that female adolescents or young adults have been found to experience greater incidents of interpersonal and sexual violence and have increased potential to be victimized in their home environment; while male counterparts were found to be more likely exposed to neighborhood violence either as a witness or a victim.

Girls are much more likely than boys to become victims of child sexual abuse, with abuse starting at an earlier age, are more likely to be assaulted by a family member, with abuse lasting for a longer period of time (Chesney-Lind, 1989). Often, young women that are sexually abused tend to run away from home due to the ease of access victimizers have to them, but once on the streets they are forced further into crime as a means to survive; as evidenced by women engaging in behaviors such as stealing food, money and clothing or they may exchange sexual favors for food, money, and or shelter (Chesney-Lind, 1989). Chesney-Lind (1989) noted these incidents of sexual abuse create short term and long term effects related to trauma including fear, anxiety, depression, anger and hostility, as well as inappropriate sexual behavior, running away from home, difficulties in school, truancy and early marriage. Rossegger et al. (2009) also supported that female offenders were more likely to have a history of childhood physical,
psychological, and sexual abuse in addition to being current victims of physical, psychological, and sexual abuse; as a result they show increased levels of substance abuse and were more often suffering from physical and mental illness.

Despite evidence that most people who have been abused do not become violent criminals, abuse does appear to be a frequent feature in the history of violent individuals and if the impulse to violence is provoked by abuse is also accompanied by brain abnormalities, the affected individual may be at a higher risk for engaging in violence due to compromised impulse control (Ostrosky-Solis et al., 2008, p.1227). Allwood and Bell (2008) found that incarcerated youth with histories of physical abuse tended to engage in higher rates of violent crimes in comparison to youth that were not abused. Traumatic stressors can create an overwhelming sense of vulnerability and powerlessness in women (Flemke, 2009). Histories of abuse in childhood and adulthood have been linked to displays of violent behaviors in adult women (Kubiak et al., 2012). Stuart and Brice-Baker (2004) also identified that physical and sexual abuse rates for women increase during adulthood, with women who report being abused by someone other than a relative being more prone to committing a crime against unrelated individuals. Abuse and victimization are major characteristics in the life experiences of female violent offenders; as a result severe post traumatic symptoms can hinder positive responses to therapeutic interventions and the recovery process (Sacks et al., 2008).

Allwood and Bell (2008) sought to assess how the post trauma symptoms and cognitions related to violence translate into further incidence of violence in adulthood. Utilizing a cross sectional study, the authors hypothesized that females experienced
higher rates of exposure to in home violence while males experience higher rates of exposure to community violence, and higher levels of PTSD would be found when exposed to in home violence (Allwood & Bell, 2008). The authors noted that their findings support the information found by other research conducted from various theoretical approaches reflecting that youth learn from and acclimate to their environment. Allwood and Bell (2008) found that in females PTSD symptoms mediated the relationship found between the exposure to violence as re-experiencing traumatic symptoms was greatly linked to females engaging in violent behavior. The authors also found that an acceptance of a culture of violence is viewed as a positive way to build social relationships following youth exposure to violence in the home setting. Allwood and Bell (2008) recommended that trauma treatment be implemented when necessary in order to address both trauma symptoms and cognitive biases found with incidents of aggression in youth which can therefore reduce the likelihood of violent behaviors in adulthood.

Exploring Mental Illness in Violent Female Offenders

Miller (1986) suggested that mood or affective disorders in children and adolescents are manifested in different ways as symptoms may be influenced by psychosocial factors, or occur outside of cultural context and could potentially lead to violence. If an adolescent experiences an inexplicable variation in his or her mood psychological helplessness occurs; in order to cope, maladaptive techniques may be utilized such as: disordered eating, substance abuse, delinquent behaviors, and displays of aggression which could result in suicide, homicide, accidental death or injury (Miller,
1986). According to Denno (1994), violent female offenders “must traverse a greater moral and psychological distance than males.” Warren et al. (2002), noted that incarcerated females have demonstrated higher rates of mental illness than women in the community. Female violent offenders are often more prone to mental illness such as trauma spectrum disorders, depression, anxiety disorders, and psychosis (Rossegger et al., 2009). James (2008) identified that there is evidence that intense and continuous stress from trauma can create long term or permanent changes in the brain. Females who view themselves as bad, unworthy or inadequate, in opposition to feelings of guilt, regret, or remorse in relation to bad behavior, are frequently associated with interpersonal problems such as anger, withdrawal, or aggression (Rhatigan, Shorey, & Nathanson, 2011). Adolescent females with primary depression may develop defense mechanisms in response to affective and cognitive distress (Miller, 1986). The mental health problems or symptoms assessed in male and female inmates differ, with women being typically assessed for PTSD and borderline personality disorder in contrast to male inmates (Drapalski et al., 2009, p.195).

Post traumatic stress disorder (PTSD), is an identifiable anxiety disorder which is caused by an extremely traumatic event and is a cross cultural occurrence found in people across all racial and ethnic groups (James, 2008). Allwood and Bell (2008) highlighted that symptoms of PTSD consisting of increased arousal, emotional numbing, emotional disengagement, physiological arousal, and outbursts of anger have also been linked to subsequent violent behaviors in incarcerated youth. In order to diagnose PTSD, an individual must have been exposed to trauma in which he or she faced an event that
involved actual or threatened death or serious injury, or a threat to the well being of self or others; the individual persistently re-experiences the traumatic event through recurrent intrusive thoughts, nightmares, flashbacks, intense psychological distress, and physiologic reactivity; the individual persistently avoids internal or external cues/ stimuli that resembles the traumatic event; the individual has persistent symptoms of increased nervous system arousal that were not present before the trauma; and the disturbance following the traumatic event causes clinically significant distress or impairment in social occupational, or other areas of living (James, 2008).

Contributing factors for developing PTSD include lack of education, low economic status, increased number in the family, gender (as females are at a greater risk), younger age at the time of trauma, being unmarried, and lack of family support systems (James, 2008). Human acts of trauma create more victims of PTSD when the trauma directly affects the social support system of the family; examples include Holocaust survivors, hostages, rape victims, children of murdered parents, and victims of incest (James, 2008, p. 132). Taubman (1986) highlighted that factors such as childhood development, specific trauma, and society’s valuation of men creates certain attitudes and tendencies about displays of violence and aggression in women. While severe trauma may be present, women are be expected to abandon, deny, or become alienated from their own experience to meet the consensus and social norms of dominant culture (Taubman, 1986). However, intense trauma may lead to the development of severe mental health issues and need for ongoing treatment or crisis intervention from mental health professionals.
Severe mental illness can be defined as major depressive disorder, depressive disorder not otherwise specified, bipolar disorder I and II not otherwise specified, schizophrenia spectrum disorder, schizoaffective disorder, schizophreniform disorder, brief psychotic disorder, delusional disorder, and psychotic disorder not otherwise specified (Becker, Andel, Boaz, & Constantine, 2011). Becker et al. (2011) presented that deviant behavior is typically viewed as criminal when males are the perpetrators, however it is considered to be psychopathological when females are the offenders. Psychopathy represents a personality disorder defined by a cluster of affective, interpersonal, and behavioral characteristics, including egocentricity, excessive manipulation, deceitfulness, shallow affect, lack of empathy, guilt, or remorse, as well as propensity to violate social and legal expectations and norms (Ostrosky-Solis et al., 2008, p. 1223). Psychopaths are thought to be responsible for over half of all serious crimes (Wynn et al., 2012). However, female violent offenders differ in the extent that their actions are consistent with their view of themselves and the world (Winter, 2007). Suspicious attitudes, bizarre forms of thinking, and social isolation found with cluster A personality disorders could possibly be linked to the violent female perpetrators (Warren et al., 2002).

Williford and DePaolis (2012) pointed out females have an increased risk for aggression during the transition to puberty. Adolescents labeled as difficult and antisocial in the school and home environments could possibly internalize and incorporate those damaging labels with their self-concept (Miller, 1986). Negative self-perception results in preoccupation and emotional arousal which distract an individual
from performing effectively, or managing behavior appropriately (Grusec, 1992).

Education is a risk factor for male and female adolescents as individuals that do not graduate from high school or obtain a general equivalency diploma are more likely to engage in violent or aggressive behaviors (Harer & Langan, 2001). For both males and females, delinquency and violence are associated with learning disabilities and low achievement (Denno, 1994).

Miller (1986) explained further that intermittent outbursts of violence occur in episodic dyscontrol syndromes associated with temporal lobe epilepsy and can result from trauma, minimal brain dysfunction, tumors, infections, hypoglycemia, and cerebral vascular disease, and may also be found in schizoaffective disorder, paranoid schizophrenia, and drug abuse. Rapport and Thomas (2004) reported that there is a moderate relationship between illegal drug use, alcohol abuse, and violence in adolescents. Goldberg (1995) explained that in women, being a victim of childhood sexual abuse, physical abuse by the father, having one or more alcoholic parents, having a spouse or partner who abuses substances, and domestic violence is associated with higher incidences of substance abuse. In women, more severe use of alcohol and drugs was related to decreased perceptions of social support and decreased social network (Staton-Tindall, Royse, & Leukfeld, 2007).

Examples of socially inappropriate or maladaptive behaviors associated with women who abuse substances include: child neglect and child abuse, damage to unborn children, drunk driving, prostitution, the spread of sexually transmitted infections or diseases, shoplifting or other forms of non-violent theft, dealing drugs, disorderly
conduct, dependency on welfare or other economic assistance programs, poor job performance, and high costs linked to medical, law enforcement or social services (Goldberg, 1995). Specifically, there has been an identified relationship between the intake of amphetamines and homicidal behavior (Miller, 1986).

Episodic and impulsive verbal and physical aggression is frequently seen in personality disorders, with 47% of men and 21% of women diagnosed with antisocial personality disorder (Siever, 2008, p. 430). Wynn et al. (2012) highlighted that studies have suggested that psychopathy is less frequent in women than in men; however, the diagnostic tools were created and employed primarily with male populations. The authors also noted that female inmates often show more symptoms related to an axis 1 diagnosis than male inmates; and tend to have diagnoses of emotionally unstable personality disorder instead of antisocial personality disorder, but there is a connection between psychopathy and substance abuse (Wynn et al., 2012). Wynn et al. (2012) pointed out that research suggests that treatment should focus on preventing violence and other more specific negative behaviors as female offenders with close and frequent supervision while on parole had a significantly lower chance of recidivism. D’Andrea and Pole (2012) also suggested that in working with females that have extensive and complex trauma history, there is a greater benefit from therapeutic interventions that promote relaxation, relationships, affect, and meaning making rather than re-exposure to trauma stimuli.

Neurological Factors related to Violence or Aggression

Unfortunately, many mental health professionals are unaware of neurological factors that can result in the display of aggressive or violent behaviors in women and how
those factors may impact consequent therapeutic interventions and their effectiveness.

Siever (2008) presented that impulsive aggression has considerable heritability and notes that gene-environment interactions play a significant role in aggressive and antisocial behaviors. Neurotransmitters such as serotonin, dopamine, and norepinephrine as well as brain structures have an important role in moderating behavior and emotional functioning. Serotonin stimulates the receptors in the prefrontal cortical areas involved in the modulation and suppression of aggressive behaviors; as a result, selective serotonin reuptake inhibitors (SSRIs) reduce incidents of impulsive aggression, while the depletion of serotonin is linked to decreased cooperation and perceptions of trust (Siever, 2008). Dopamine and norepinephrine could increase the potential for other directed violence or aggression, as dopamine is linked to the initiation and performance of aggressive behavior (Siever, 2008). Siever (2008) pointed out that reduced subcortical reactivity at the glutamatergic/gabaminergic (GABA) receptors may contribute to increases in aggression. Low cortisol levels have also been found in adolescents with disruptive behaviors, antisocial criminal offenders, and domestic violence perpetrators that abuse alcohol (Siever, 2008).

The amygdala serves as the center for emotions, reactions, and motivation; however, oxytocin reduces amygdala activity which could contribute to a feeling of hostility, fear, and mistrust and lead up to a display of violence or aggression (Siever, 2008). Additionally, Siever (2008) presented that damage to the ventromedial prefrontal cortex in the brain results in severe disruption of emotion and diminished cognitive abilities in both children and adults; while the potential for tumors, lesions, and localized
seizure activity in the temporal lobe of the brain can also be linked to violent and aggressive behaviors. Without fully understanding the potential neurological factors that may be associated with violent behaviors in female offenders, mental health professionals may not be able to recognize when the use of improper therapeutic techniques and medication management may be negatively impacting treatment.

Socio-demographic characteristics of Female Offenders

Baer and Bandura (1963) found that children who were exposed to human models displaying aggression on film as well as children who were exposed to real life observations of aggression, increased their own aggressiveness and molded the style of their aggressive behaviors as children reproduced the aggressive behaviors they witnessed; however the most influential method of eliciting aggressive behavior in children was via exposure to human models portraying aggression on film. Biological and environmental factors are predictors of delinquency and violent offending in females (Denno, 1994). Both male and female violent offenders were found to have a history of adverse childhood family constellations such as absent and or criminal parents, or neglectful parents (Rossegger et al., 2009). Negative and stressful home environments where an adolescent’s parent may engage in substance abuse or suffer from a psychiatric illness puts the adolescent at greater risk for disengagement from the family, difficult temperament, and displays of aggression (Tarter et al., 2002).

Williford and DePaolis (2012) found that girls with poor or insecure attachments with their parents or caregivers are at an elevated risk for aggressive behavior and victimization. Denno (1994) noted that in regard to violent offending, indicators of family
stability were important for men and women, however the lack of foster parents and absence of a father figure were significant in female adult offenses. Other socio-demographic aspects include: poor socio-economic backgrounds, equal rate of previous psychiatric hospitalization, to be less educated, and under or unemployed at the time of the offense. (Rossegger et al., 2009). For both male and females, delinquency and violence are associated with learning disabilities and low achievement (Denno, 1994).

Chen and Paterson (2006) presented that socioeconomic status (SES) is associated with less adaptive psychological characteristics in childhood and adulthood. Socioeconomic status can be measured at multiple levels including the characteristics of the individual, the family, and the neighborhood. Family SES impacts physical and psychological health in ways such as conflicts and unresponsive parenting styles, while individual SES relates to perception of social standing relative to peers (Chen & Paterson, 2006). Chen and Paterson (2006) found that negative objective values such as lower neighborhood education, employment status, and income, were associated with higher levels of hostility, discrimination, and perceived threat in adolescents. Unfortunately, Stoddard et al. (2012) noted that ethnic minority children are in danger of exposure to violence and unhealthy development if they grow up in disadvantaged areas with limited access to resources. However, higher subjective perception of family status was associated with higher levels of optimism, self esteem, and perceived control in adolescents (Chen & Paterson, 2006). This places emphasis on the need for greater access to treatment services and supportive therapy to aid family systems in areas that have been classified as lower SES.
Female Offenders’ Victims and Crimes

Wilczynski (1997) noted that violence is classified as either minor: such as a slap or smack with no visible injury; moderate: such as a temporary short lived physical injury which may cause bruising; and severe: violence with or without the use of a weapon which results in serious or permanent injury like fractures. Victims of female violent offenders are often the people closest to them, including parents, husbands, boyfriends, and children; with the violent crime more likely to be committed in the home environment (Rossegger et al., 2009). Prior to a child’s death, severe violence/injury is often perpetrated by men and occurs on a frequent or constant basis rather than in isolated incidents; however, women tend to utilize explicit threats or attempts to kill the child (Wilczynski, 1997). Women whose criminal behaviors violate sex stereotypes or gender roles result in them receiving more punishment than men, especially in incidents of child abandonment or assault or any other unladylike offense (Nagel & Johnson, 1994).

Due to social and cultural restraints on female behavior, females who become delinquent or violent appear to deviate from the norm significantly on biological, psychological, and sociological levels than males (Denno, 1994). Female offenders are either the conspirator or someone who instigates without actually committing the crime; an accessory to the crime playing a secondary role in the offense; a partner or someone who equally engages in the commission of the crime; or the sole perpetrator (Kruttschnitt & Gartner, 2008). Males are more likely to be arrested for violent behavior than women, with “being male” considered to be a significant predictor of criminal violence based community based epidemiological studies on self-reported violence (Becker et al., 2011).
In the United States, typically in cases of both fatal and non-fatal intimate-partner violence females are primarily the victims and males are the perpetrators; however females tend to commit domestic violence homicides after feeling as if they have suffered years of physical abuse, exhausting all resources for assistance, when they feel trapped, and are in fear of losing their own lives (Ramsey, 2010).

Weizmann-Henelius, Putkonenm, Naukkarinen, and Eronen (2009) highlighted that alcohol intoxication and illicit drug use are among the contributing factors to increased risk of violent behaviors in women; with a majority of female offenders intoxicated by alcohol or a combination of alcohol and drugs at the time of the crime, and victims of intoxicated women being less emotionally close to the perpetrator than in cases of non-intoxicated women.

Female Offenders in the Criminal Justice System

Female offenders have been marginalized by the criminal justice system based on the use of theories of criminal behavior and studies related to pretrial, prosecution, and sentencing outcomes derived from male patterns of criminality (Nagel & Johnson, 1994). The focus on research related to males in criminal justice systems has ignored the role that the victimization of women has played with regard to her relationship with crime (Chesney-Lind, 1989). Legally, gender neutrality is difficult to address in situations where there are differences between gender socialization and social conditions (Labelle & Pimlott Kubiak, 2006 p. 424). Labelle and Pimlott Kubiak (2006) pointed out that within the institutions of the criminal justice system the population of female prisoners is rapidly growing. The authors go on to note that between 40-60 percent of incarcerated
women were exposed to some form of physical or sexual abuse on a more frequent and severe basis than non-incarcerated women and typically, women who are found in jail or prison systems are women of color from lower economic status (Labelle & Pimlott Kubiak, 2006).

Labelle and Pimlott Kubiak (2006) identified that historically women have been viewed as moral and nonviolent, with female criminals seen as failures to upholding gender norms. Gender stereotypes of women include females are weaker and more passive than males and therefore are inappropriate for incarceration or imprisonment, women are more submissive and dependent than men and thus less responsible for their criminal acts, and women are more easily managed than men and would be more responsive to rehabilitation efforts (Nagel & Johnson 1994). However, female prisoners are often subjected to sexually degrading treatment including harassment and sexual assaults by male prison staff, which has led to the decline in the number of female prisoners that participate in prison based rehabilitation programs (Labelle & Pimlott Kubiak, 2006).

Willis et al. (1996) explained that stereotypical beliefs about women that are ethnic and racial minorities in domestic violence situations contribute to biases expressed by law enforcement and the society, as less police intervention occurs. Approximately more than half of incarcerated women are age 30 and under, did not graduate high school, are ethnic minorities, lived with physically violent or abusive men and/or are survivors of sexual abuse, are single, widowed or divorced women with children (Stuart & Brice-Baker, 2004, p. 31). Ball, Karatzias, Mahoney, Ferguson and Pate (2013) also presented
female offenders often have issues of poverty, stigmatization, substance abuse, childcare problems, mental illness, history of abuse and trauma, as well as a lack of supportive friends or family. Being incarcerated at an earlier age was related to a decreased social network among incarcerated women (Staton-Tindall et al., 2007). Chesney-Lind (1989) cited her own previous research and identified that interviews with women in prison support that there is a relationship between childhood victimization and criminal careers as evidenced by reports of a majority of the female offenders in the sample reporting childhood physical or sexual abuse or history of rape. History of abuse prompting young girls to run away led to engaging in prostitution or petty property crimes, as well as drug experimentation or addiction, ultimately encouraging these activities into adulthood, becoming women with lack of education or occupational skills (Chesney-Lind, 1989).

For women with a history of abuse, the utilization of self-destructive behaviors such as failure to participate in training and therapeutic programs as well as self-injurious behaviors and suicide attempts can be seen as attempts to escape from the prison environment which limits the physical and psychological capability for women to escape from new incidents of abuse, or memories of previous abusive situations (Labelle & Pimlott Kubiak, 2006). Labelle and Pimlott Kubiak (2006) also noted that individual response to trauma is a subjective experience dependent on the victim’s perception of how life threatening the traumatic event is. In the criminal justice system, women who have prior experience with physical or sexual abuse before incarceration, additional trauma exposure increases the rates for mental illness and physical illness.

Short et al. (2009) noted prison staff in correctional facilities have the important
task of identifying and implementing interventions for female prisoners that may be at risk for self-harming behaviors; the authors examined the attitudes prison staff have regarding women who self-harm. The authors noted prison officers view self-harming behaviors in female prisoners as manipulative or exploitative techniques to get what they want rather than within the scope of suicidal gestures (Short et al., 2009). Prison staff was able to recognize that self-injurious behaviors may occur due to past histories of family neglect, situations of domestic violence, histories of sexual abuse, mental illness, and substance abuse in combination with feelings of isolation found with living in a prison environment (Short et al., 2009). Prison officers and some healthcare staff identify manipulative or non-genuine self-harming behaviors as a learned behavior utilized in order to obtain a desired result and categorized the injuries associated with those incidents as superficial or threats (Short et al., 2009). Attempting to distinguish between non-genuine and genuine self-harming behaviors in female prisoners results in issues with providing appropriate treatment and supportive services as needed (Short et al., 2009).

Short et al. (2009) pointed out that female prisoners who self-harm that are labeled as ‘non-genuine’ create feelings of anger and resentment in prison officers who are faced with the task of providing attention, time, and resources to those who they feel are being manipulative. Issues also arise in correctional facilities based on the dual relationships that can occur, where the role of a prison officer takes precedence over being a mental health nurse, or a healthcare professional. Competence in managing this population is also a factor as the authors note that lack of training with female prisoners
who self-harm results in feeling unsupported and low confidence in prison officers (Short et al., 2009). Short et al. (2009) suggested implications for future practices include training prison staff in a manner which supports viewing each female prisoner as an individual, addressing misperceptions about self-harming behaviors, suicide, and high-risk groups, developing specifically tailored interventions to address specific behaviors, and providing opportunities for consultation and supervision and support on a regular basis.

The authors found that prison staff that feel unsupported will leave female prisoners unsupported as well which supports the concept of burnout and possible negative views and attitudes towards female prisoners occurring over time in correctional facilities (Short et al., 2009).

The Criminal Justice System and Punishment of Female Offenders

Stefanakis (2008) points out that violent offenders can be considered one of the most disenfranchised groups in society based on the government’s function to punish and incarcerate individuals who perpetuate acts of crime and violence. Staddon (1984) identifies that there are three basic properties of the relationship between punishment and the behavior that elicits punishment: 1) punishment occurs following the crime or negative behavior; 2) the severity of the crime or behavior, increases the severity of the punishment; and 3) punishment reduces the level of crime or incidents of negative behavior. Stefanakis (2008) lists that fining, monitoring, imprisoning, and executing violent offenders are official forms of punishment used to hold offenders accountable for their actions and implemented by state legislated officials through the criminal justice
system. Recidivism is considered to be a pattern of criminal re-offense resulting in multiple (two or more) criminal convictions (Stuart & Brice-Baker, 2004, p. 37). The use of punitive measures are sought to decrease rates of recidivism, discourage other members of the population from engaging in criminal acts, and increase the safety of the community from violent offenders, however in actuality, research has shown that punishment actually increases re-offending rates by about 25% (Stefanakis, 2008).

Approximately 12% to 24% of incarcerated women in federal and state prisons are considered to be mentally ill, and according to The Bureau of Justice Statistics, mentally ill individuals have extensive history of criminal activity and are more likely to have higher rates of recidivism in relation to violent crimes (Stuart & Brice-Baker, 2004). It can also be argued that the use of punishment prevents offenders from taking ownership of their criminal acts or behaviors (Stefanakis, 2008).

Since 1980 there has been a marked increase in the rates of growth of female offenders in the criminal justice system, surpassing male offenders (Stuart & Brice-Baker, 2004). Drapalski et al. (2009) explained that jails are defined as the location where female offenders are first processed following arrest, and they await trial and sentencing, or in incidents where the sentence is less than one year, complete their sentence. Female offenders that are convicted and receive sentences of more than one year are transferred to state or federal prisons (Drapalski et al., 2009). About 14% of the arrests of female violent offenders are due to violent crimes such as murder, robbery, and aggravated assault; however women are likely to be incarcerated for drug related offenses (Stuart & Brice-Baker, 2004). However, female offenders with drug offenses or property offenses
were considered to have higher rates of recidivism than violent offenders, possibly due to
the longer sentences received for violent crimes (Stuart & Brice-Baker, 2004).

Historically, the majority of violent criminal offenders have been male (Nagel &
Johnson, 1994). Denno (1994) presented that the perception of women being lesser
involved in violent crime was generally attributed to biology or sexuality, with society
believing myths such as women were only capable of a lower level of criminality because
they lacked the intellectual functions required of crimes such as robbery, murder, and
assault. Willis et al (1996) pointed out that gender roles have an influence on culpability
in situations involving violence against women. In the late 1800’s and early 1900’s,
women’s defense cases typically involved justifiable situations where the deceased man
drove the female to kill or use lethal force, such as incidents of self-defense due to
domestic violence (Ramsey, 2010). Nagel and Johnson (1994) pointed out that in the late
1970’s and 1980’s the pattern of women receiving preferential treatment in criminal
sentencing was first recognized and later attributed to chivalry and paternalism, or a
protective attitude towards women.

Walker (2011) noted that in regard to sentencing, women and white defendants
were more likely to have their cases rejected than males and minorities. Nagel and
Johnson (1994) highlighted that judges are selectively chivalrous during criminal
sentencing as minority women tend to be treated more harshly than the criminal justice
system than white female offenders, and chivalrous treatment is reserved for middle and
upper class women who conform to gender stereotypes (p.188). Stefanakis (2008)
supported this notion by pointing out that jails and prisons are filled with marginalized
populations such as the poor and minority groups. Research has shown that during the sentencing stage, adult female offenders receive more favorable sentences such as suspended sentences or probation, than male offenders convicted of similar offenses and possessing similar criminal histories (Nagel & Johnson, 1994).

In reviewing cases that are considered to be heinous or extremely violent, there is always a question regarding the offender's level of competence. Chesney-Lind (1989) proposed that the criminal justice system has upheld and reinforced historical views of patriarchal authority. Paternalism equates women as children, viewing them as incapable of assessing information and making responsible decisions, thus less culpable for their criminal behavior (Nagel & Johnson, 1994, p.189). Sexualization of female deviant behaviors is the reason why criminal activities were overlooked in the past (Chesney-Lind, 1989). Issues that may further impact a convicted female offender's sentencing include consideration about her child care responsibilities or pregnancy status, evidence of psychological coercion, her emotional condition, or her role in the offense (Nagel & Johnson, 1994).

Modern American trials allow for the reduction of charges of murder to manslaughter by accepting extreme mental or emotional disturbance self-defense in cases of women who commit homicide out of fear (Ramsey, 2010). Women who engage in violent criminal behaviors are mainly considered to be mentally disturbed or ill for their actions (Wilczynski, 1997). Competence is defined as the ability of a defendant to understand a possible waiver of rights in the event of a guilty plea or waving the right to counsel (Siegert & Weiss, 2007). Competence suggests that a defendant has a rational as
well as factual understanding regarding the proceedings against him or her, and the defendant is able to consult with his or her lawyer with a degree of rational understanding. Forensic mental health experts for both the defense and prosecution assess and testify that the defendant is aware of what he or she is charged with, the roles and functions of the participants in the trial process, what the consequences would be if the defendant is found guilty, as well as the defendant’s basic constitutional rights (Cheatham & Litwack, 2003).

Miller (2003) suggested there are two main populations of incompetent defendants, those with axis I psychotic disorders and primary cognitive deficits, those that are developmentally disabled and those that have organic conditions. Miller (2003) noted competence to stand trial is the most common psychiatric evaluation requested by the court system as the Supreme Court mandates that defendants must be mentally well and physically present to defend themselves adequately against criminal charges. Yet, the crucial issue for mental health professionals in assessing mental capacity in the criminal justice system is not whether a psychiatric diagnosis is present, but whether the patient has the mental abilities required to make the decision at hand in a meaningful way (Walie & Berghmans, 2006).

Thorough comprehension in the area of competency is necessary in relation to behavioral assessment, treatment interventions, or consequences being implemented by clinicians in the criminal justice system. As presented by Pakhomou (2004), “the family of a violent offender raised the issue of competency at the time when the convicted perpetrator was awaiting execution on death row, motion was granted by the court and
the offender diagnosed with schizophrenia received an indefinite stay of execution” (p. 227). Situations such as the example provided by Pakhomou brings to light potential ethical issues regarding treatment of individuals who have been provided life sentences, or sentences with opportunity for parole. Mental health professionals must be aware of ethical standards and practice within the boundaries of their own competence to implement interventions that are appropriate to the population that is being served.

While research has been conducted into gaining understanding into the family of origin issues, personality characteristics, and mental disorders that are typically present in male violent offenders there has been limited research into the mind of the female violent offender. Ethical and legal issues present themselves when assuming commonalities between male and female violent offenders and assessing competency of a violent female offender in the prison system based on that perspective. Inaccurate assessment of competency in the criminal justice system can result in improper utilization of therapeutic interventions being implemented prior to a violent offender’s release back into society, or of severe legal consequences such as life imprisonment or the death penalty. Mental health professionals should have legal knowledge and experience to evaluate criminal defendants, to be familiar with diagnostic categories found in general clinical practice such as personality disorders, dissociative disorders and malingering (Miller, 2003).

By examining the history of abuse or trauma, mental diagnosis, thoughts, emotions, and behavioral characteristics of the female violent offender, a more accurate picture of the individual’s competency may be able to be depicted. While methods may vary, most mental health professionals assess across similar constructs including: current
mental status, understanding of charges, understanding of trial procedures, ability to utilize attorney’s services, medical history, mental illness history, retardation, emotional immaturity, and self-control (Mayzer, Bradley, Rusinko, & Ertelt, 2009). Dunn and Jeste (2003) pointed out that individuals with psychiatric disorders, particularly illnesses affecting cognition, appear to be at an elevated risk of impaired understanding of consent which could affect competence. However, recent studies have shown that performance by patients with severe mental illness such as schizophrenia on measures of decision making capacity can be improved with educational interventions (Dunn & Jeste, 2003). Criminal punishment or sentencing imparts blame on the offender and incorporates the use of deprivation of freedom and moral stigma associated with incarceration; therefore the severity of the sentencing imposed has to be consistent with the nature of the crime and the female offender’s level of culpability (Nagel and Johnson, 1994).

**Perception of Women in Society**

Fisher, Dulaney, Fazio, Hudak, and Zivotofsy (1976) cited Broverman that women are stereotypically perceived to be less competent, less independent, less objective, and less logical than men, and have more interpersonal sensitivity, warmth, and expressiveness. Goldberg (1995) pointed out that women have also been considered to be unreliable, illogical, emotionally unstable, and incapable of handling mechanical, mathematical, competitive, or leadership tasks. In patriarchal cultures women and children are viewed as property (Taubman, 1986), with many cultures supporting ideals that females are to be elaborately dressed, wear make-up, gentle, passive, dependent, and subordinate to men (Goldberg, 1995). Cultural ideals, gender stereotypes or sex roles
related to women are frequently reinforced by the media, as seen in movies, television shows, magazine images, and heard in music (Goldberg, 1995). In relation to women who have been found guilty of violent crimes, typically discrimination comes from the general public who deem them least deserving of a second chance based on the incongruence between gender stereotypes and behaviors (LeBel, 2012).

Treating Violent Female Offenders from a Therapeutic Perspective

Throughout the twentieth century, society has viewed rehabilitation as the primary reason for incarceration with the notion that punishment should be best suited to the offender and the crime, with consideration of the offenders past life and habits (Nagel & Johnson, 1994). Additionally, rehabilitative sentencing serves to promote the offender’s need for treatment and not just to reflect the type of crime committed (Nagel & Johnson, 1994). Women’s perception of social support is most strongly influenced by the amount of time they are incarcerated and away from family and friends versus their criminal activity (Staton-Tindall et al., 2007). Drapalski et al. (2009) explained that incarcerated women are more inclined to have physical health problems, extensive trauma histories, lack of or limited financial resources, and possible mental health issues prior to and following incarceration, therefore services in the criminal justice system as well as community should be tailored to this target population. Issues with access to treatment and comprehensive forms of treatment may result in undermined participation in treatment programs for mental health or substance abuse in women as interventions should address the multiple problems women may be facing (Goldberg, 1995).
Sheridan (1982) noted that counselor’s inability to recognize women’s issues could result in a focus on the client’s internal world, rather than the environmental influences of the client (p. 82). Allwood and Bell (2008) suggested that limitations associated in studies of violence and trauma and the development of effective interventions to effectively manage behaviors include the reliance on self-reported trauma experiences, mental health symptoms, and violent behaviors; as well as unreliable reports of youth trauma experiences by parents or guardians. Therapist perception or bias can negatively impact work with violent offenders as the clinician may view violent offenders as individuals that can be taught a better way of life with the clinician having an expert role (Stefanakis, 2008). However, a therapist’s ability to acknowledge common themes and recognize the humanity in violent offenders can create lasting change and exploration of compassion in psychological interventions (Stefanakis, 2008).

Special treatment models of gender equality emphasize the cultural and biological differences between men and women and advocate the need for special protection of women’s interests based on those differences (Nagel & Johnson, 1994, p. 195). Gender specific treatment approaches on a preventative scale, during incarceration and following release are needed to address issues that specifically impact female offenders, including but not limited to sexual abuse, sexual assault, domestic violence, depression, pregnancy and motherhood in order to reduce the occurrence of recidivism (Stuart & Brice-Baker, 2004). When engaged in the therapeutic relationship, clinical concerns should be whether or not the influence of sex role stereotypes reinforce social and intrapsychic conflicts in women (Broverman et al., 1970).
Modern counseling theories encompass psychodynamic approaches to treatment of violence and aggression and stem from a problem focused orientation. Modern psychotherapy approaches include psychoanalytic, social learning, cognitive and behavioral. Menninger (2007) expressed that aggression focuses on action or behavior as opposed to emotion or affect, and from a psychoanalytic perspective it is an instinctual drive distinct from sexuality. Trauma occurs when control is compromised, and as a result post traumatic symptoms and violent behaviors reflect the ego’s attempts to regain mastery by either re-experiencing and reprocessing the trauma or distancing from the trauma by regaining a sense of integrity and control (Menninger, 2007, p.119). Violence occurs following the experience of frustration or injury which can be real or perceived and is experienced as a profound narcissistic injury; dependent upon the intensity and severity of the frustration or injury and the integrity of the individual’s ego, an affect response can range from anger to rage, to a display of violent behavior (Menninger, 2007, p.126). Traumatic events in childhood that are related to interpersonal relationships can produce destructive emotions of hostility, hate, and rage and result in the use of defense mechanisms such as externalization, projection, and displacement (Menninger, 2007). Cauffman (2008) noted that female delinquents have a higher rate of mental health issues which supports the need for effective interventions aimed at prevention before chronic behavioral issues develop in at risk female teens.

Osofsky (2003) proposed that psychoanalytic perspectives can be beneficial in developing violence prevention and intervention treatment programs due to psychoanalysis being insight oriented and developmental which prompts the therapist to
have a greater understanding about the potential for transference and counter-transference and identify problem solving techniques for clients. Developmental aspects that impact youth reactions to violence include their assessment of the threat, the intrapsychic or internal meaning they attribute to the observed or experienced violence, their emotional and cognitive ways of coping, their capability to tolerate strong affects, and their flexibility and capacity to adjust to changes in their life (Osofsky, 2003, p. 532). Violence intervention programs with a psychoanalytic orientation are designed to prevent incidents of violence and reduce the following: rates of exposure to violence or trauma; mental health issues following exposure to violence or trauma; comorbid conditions; interference with normal developmental transitions; academic performance; family functioning; and onset of behavioral and conduct disturbances (Osofsky, 2003, p. 541).

Hubbard (2007) presented that modern therapeutic treatment programs currently being employed by correctional facilities utilize techniques based in cognitive behavioral theory (CBT) or social learning theory (SLT). CBT attempts to change social cognitive deficits and distortions in violent individuals by assisting them with defining their problems, generating alternative solutions, anticipating consequences, monitoring behaviors, and prioritizing responses (Rappaport & Thomas, 2004). CBT targets antisocial attitudes by applying a variety of behavioral techniques such as role playing, reinforcement, and modeling and has been found to be significantly successful at reducing rates of recidivism (Hubbard, 2007). Siever (2008) suggested that either a psychodynamic approach such as transference based therapy or a cognitive behavioral approach like dialectical behavior therapy could potentially increase an adolescent's
capability to suspend and inhibit violent behavior, increase the effectiveness of verbal communication, and reduce excessive emotional reactions.

Postmodern counseling theories utilize a strengths-based model and a constructivist way of thinking within the treatment program in order to allow the client to form solutions based on his or her experience. Stefanakis (2008) noted that mental health professionals could use narrative approaches as more effective interventions when working with violent offenders. Conoley et al. (2003) identified advantages of Solution Focused Therapy (SFT) as being a brief, strength-based therapy that focuses on additional development on the solutions the client already employs to manage their issues. Wehr (2010) noted that SFT proposes the client has the inherent ability to help him or herself therefore the goal of this therapy is to build confidence and instill hope, as clients are the experts for their own lives. Utilizing SFT with violent adolescents could be beneficial as it allows for an environment conducive to personal growth, awareness, and behavioral change without punishment, criticism, or blame; it encourages adolescents to identify the purpose of their negative behavior in relation to wants and needs that they perceive are not being met, they are then able to set goals for the future (Lethem, 2002).

Drapalski et al. (2009) sought to compare male and female inmate mental health symptoms and examine the differences amongst the genders in mental health treatment prior to and during incarceration. Findings supported that women experienced clinically significant symptoms of anxiety, borderline features, somatic concerns, trauma related symptoms, high rates of drug related problems, and women tended to seek and be enrolled in jail based mental health treatment programs; proposing the need for effective
treatment interventions tailored to women that addresses post-traumatic stress disorder and borderline personality disorder during incarceration as well as upon release back to the community. However, the need for assessment and treatment is necessary for all inmates regardless of gender (Drapalski et al., 2009).

Bias in the Treatment of Violent Female Offenders

Offenders with mental illness get arrested for similar reasons offenders without mental illnesses do, however for a majority of offenders with mental health issues, the lack of mental health treatment proposes that there were missed opportunities to provide interventions such as medication or other mental health services, which could have reduced the frequency of arrest for those whose symptoms led directly to criminal behavior (Becker et al., 2011). Psychological theories of deviant behavior lead to expectations of gender differences, especially with regard to women and crime (Richards & Tittle, 1981). Research has suggested that therapists are not immune from the same gender based emotional stereotypes that popular culture also endorses (Perrin, Heesacker & Shrivastav, 2008, p. 715). Cultural-role stereotypes regarding appropriate and inappropriate ways of emotional and behavioral expression affect the perception and disposition of both male and female clients (Page, 1987). Demographic data, chief complaint, and personal history obtained when determining a mental health diagnosis, also has a strong impact on the predisposition of a clinician toward a patient (Bamgbose, Edwards, & Johnson, 1980, p. 606).

There are a combination of factors that affect female communication of depression or other distress, including the interaction between cultural norms and display
of emotions (Norman, 2004). Drapalski et al. (2009) identified the variety of mental health treatment options available to women including: assessment or screenings, crisis intervention, psychotherapy groups, psycho-educational groups, inpatient or outpatient individual therapy, family therapy, or couples counseling. However, access and availability of mental health treatment for female offenders may vary and differ in facilities and while women may have access to treatment programs, it is not clear on whether or not programs would engage and retain participation from women (Drapalski et al., 2009). Thomas (1973) explained that implied criticism present during assessments and therapy sessions can create defensiveness in the client, resulting in lack of retention in treatment programs. Unfortunately, cultural influences, stereotypes, as well as clinician prejudices or concerns can negatively affect the provision of available services to violent female offenders.

Within the therapeutic relationship, personal biases can tremendously impact clinical decision-making especially when the attitudes, sex, and gender role orientation of the clinician is taken into account (Page, 1987). As a result, violent female offenders may experience hesitancy within therapeutic relationships or feel judged or extensively penalized by both male and female clinicians due to adherence to cultural stereotypes and the imposition of personal values in treatment, especially when the female has committed heinous crimes. Male clinicians have expressed concerns related to real or perceived legal consequences when working with high risk females due to potential for flirtation and sexualized behavior occurring within the therapeutic relationship (Okamoto & Chesney-Lind, 2000).
Eriksen and Kress (2008) presented that female and male clients who present with the same mental health symptoms can obtain different diagnoses based on the impact of gender stereotypes. Women have had consistently higher rates of depression than men, potentially due to referral and treatment biases, social roles and expectations, biological and reproductive differences, higher rates of victimization and poverty, and the under diagnosis of males (Norman, 2004). Severe psychopathology tends to be diagnosed more frequently in minorities and individuals from lower socioeconomic classes, and females (Bamgbose et al., 1980, p. 606). This is evident, as findings suggest, that rates of inpatient hospitalization were highly related to whether or not the client’s behavior was congruent to gender role stereotypes; with women more likely to be hospitalized in cases involving antisocial disorder or substance abuse, maladaptive behaviors deemed unacceptable for women (Page, 1987). In addition, females who appeared to violate the stereotypical gender role characteristics remained in psychiatric facilities longer and were considered to be more seriously disturbed than others, with discharge planning taking into consideration sex role factors such as marital status and employment instead of degree of psychopathology (Page, 1987).

Women have higher rates of mood, anxiety, and eating disorders as well as borderline, dependent, and histrionic personality disorders (Eriksen & Kress, 2008). Historically, male social workers viewed women as passive and dependent and only truly happy in a submissive role to their husbands, being mothers to their children, and while doing housekeeping; through this lens women are seen as inferior to men which results in an anti-therapeutic process (Fisher et al., 1976). Sexism is viewed as a concept that is
reflected throughout the educational process found in social work courses based in the works of Freud, Lidz, and Erickson that tend to promote strict gender roles and identity development (Fisher et al., 1976).

Mental health clinicians have different standards for male and female clients, with healthy women being seen as more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, their feelings are more easily hurt, more emotional, more conceited about their appearance, less objective, and with a dislike for mathematics and science (Fisher et al., 1976). Poole and Tapley (1988) explained that clinicians also expect male and females to adjust their behavior to their environment, with more masculine behaviors linked to work environments and feminine behaviors expected in the home.

In the past, women were bound to laws of coverture which deemed them to be under the control and protection of their husbands because they were considered to be physically and emotionally weak, unable to participate in business or politics, unequal, and subordinate to men (Ramsey, 2010). Fisher et al. (1976) presented that traditional expectations held by psychologists are that women should be more passive and dependent than men, and that assertiveness is viewed as hostility. As a result of these views on female clients, the authors engaged in research to determine how views about sex and sex roles impact the clinical judgment, opinions, and treatment provided to clients by social workers (Fisher et al., 1976).

Cultural stereotypes include the view that women are more emotionally expressive than men which could result in a negative perception of a female in therapy if
she is not forthcoming with information. Findings from the study were contradictory to the prevailing opinions of the times, as results did not support anti-female bias, continuity of negative cultural stereotypes of women, or stereotypical sex-role standards despite education and training (Fisher et al., 1976). Instead, Fisher et al. (1976) pointed out that the participants in the research did not view aggressive women as more disturbed or less mature than passive women, and the social workers’ own sex barely influenced decision making during therapeutic practice which could have been a reflection of the changing perception of women’s roles in society and the recognition and attempt to reduce the incidents of discrimination faced by women in the mental health field previously.

Sheridan (1982) identified that in relation to sex bias and sex-role stereotyping, there have been discrepancies in reports of its prevalence in the profession based on the use of differing studies or research in the area. Sheridan (1982) cited Smith (1980) and presents that:

In order for counseling to have an adverse effect on female clients the clinician would have to harbor sex-stereotypical concepts about women, allow sex stereotypes to be incorporated in assessments or clinical interviews rather than evaluating the characteristics of the client herself, behave in ways that reflect biased judgment of the client, and the client herself would have to perceive the reaction of the therapist and accept the recommendation or pressure associated with the gender stereotypes (p. 81).

Davidson and Abramowitz (1980) noted that while patient gender has possibly little to no effect on clinician reactions or favoritism in treatment, male and female clinicians
sometimes chose different characteristics or qualities to describe patients, with treatment
goals of the opposite gender being more endorsed by the clinician. Stereotypically
masculine traits are often considered to be more socially desirable than female traits (I.
Broverman, D. Broverman, Clarkson, Rosenkrantz, & Vogel, 1970). Davidson and
Abramowitz (1980) further suggested that male mental health professionals have a “sex
role stereotypic conception of the mentally healthy woman” (p. 386). Men and women
are systematically trained to fulfill different social roles and clinicians tend to assume that
for women to be healthy, she must successfully adjust to and accept the behavioral norms
for her sex, despite these behaviors being less socially desirable and less healthy for
competent mature adults (Broverman et al., 1970).

Pressure associated with gender stereotypes was evident in childhood when youth
who displayed behavioral or mental health symptoms that were considered to be
incongruent with stereotypical gender roles were viewed as more disturbed and in need of
therapeutic intervention with dismal prognosis, in comparison to children who
experienced symptoms congruent with gender (Davidson & Abramowitz, 1980). Girls in
turn, were predominantly referred to treatment for defiant and verbally aggressive
behavior, considered to be outside of their gender role (Davidson & Abramowitz, 1980).
Broverman et al. (1970) sought to find out whether clinical judgments characterizing
healthy or mature individuals differed based on the sex of the client. Findings supported
that “clinicians have different concepts of health for men and women and differences
parallel the sex-role stereotypes prevalent in our society” (p. 5).

It could be argued that less experienced mental health professionals would be
more prone to sex or gender stereotyping and bias in therapy than seasoned professionals in the field. However, level of experience did not make clinicians more or less prone to bias (Davidson & Abramowitz, 1980). Findings suggested diagnostic severity in relation to assessment and treatment was found to be related to professional discipline amongst male nurses, male social workers, male psychologists, and male psychiatrists, while female mental health professionals tended to provide more lenient psychiatric diagnoses for female clients under 30 years of age (Davidson & Abramowitz, 1980).

Richards and Tittle (1981) explained that women are expected to have more conservative orientations towards the law and social norms than men.; therefore females who commit crimes that are considered to be serious, immoral, or heinous, receive sanctions based on how they “ought to behave” irrespective of the severity of the actual crime committed. Many problems presented by female clients reflect societal norms and once psychiatric diagnoses are provided they may promote further stigmatization and blame or pathologize the client (Eriksen & Kress, 2008). Clinician use of subtle or blatant labeling of client behavior can create additional issues that were not previously present, exacerbate existing problems, or contribute to the fulfillment of labeling prophecies, especially in violent female offenders who are being held to more stringent behavioral assessments and are at risk for additional legal penalties (Thomas, 1973).

While violent female offenders may risk stigmatization in treatment, additionally the process of reintegration into society has failed to incorporate the subjective perspective of formerly incarcerated persons as they are also forced to live with the stigma and label of being an ex-offender (LeBel, 2012). However, while there is a
legitimate risk for inappropriate stigma placed on violent female offenders, there are special precautions that need to be taken during treatment as some violent offenders with mental illness have been found with symptoms consistent with psychopathy including: superficial charm and good intelligence, absence of nervousness, lack of empathy, and lack of remorse, as well as failure to follow a specific life plan (Salekin et al., 2007).

In terms of clinician perception and challenges in working with a population that may have significant trauma history and engage in criminal behavior, cognitive dissonance may arise. Cognitive dissonance exists because an individual’s behavior is inconsistent with his or her self-concept, and an effort to reduce cognitive dissonance results in maintaining the sense of self as morally good and competent (Ruiz & Tanaka, 2001). This is frequently seen in therapeutic relationships where clinicians may attempt to maintain a level of objectivity yet experience discomfort when faced with situations where they encounter bias or counter-transference. Ruiz and Tanaka (2001) explored whether or not cognitive dissonance influences the level of helpfulness in individuals, or does helpfulness affect cognitive dissonance and result in an attitudinal change in individuals. Ruiz and Tanaka (2001) found that a high level of dissonance arousal creates too much tension which interferes with other feelings or thoughts and inhibits concern for a person in need, and an attitudinal change was found to be significantly less likely to occur after they have helped. Such findings support the potential concerns about clinician perception of his or her effectiveness while working with violent female offenders.

Individuals respond differently to information dependent upon whether or not the information has positive or negative implications for themselves, their beliefs, or their
personal goals (Ask, Reinhard, Marksteiner, & Granhag, 2011, p. 290). Ideally, clinicians would not have biases, however if bias is present, it is preferred that bias has limited impact on clinical judgments (Perrin et al., 2008). In order to effectively treat violent female offenders, therapists should utilize behaviorally neutral interviewing in order to reduce likelihood of distortion during clinical assessment (Thomas, 1973). Eriksen and Kress (2008) highlighted that individuals who feel victimized do not make progress in therapy so potential ways to acknowledge societal problems that negatively impact clients include: therapists reframing rather than diagnosing; providing alternative diagnoses to avoid pathologizing the client; and feminist analysis which explores both male and female societal positions. Clinicians should also change their perspective and listen to the stories behind the individual in order to get the whole picture (Stefanakis, 2008). Ultimately, clinicians’ self-awareness of gender stereotyping could clarify inaccurate perceptions of clients and aid in a more comprehensive assessment of clients’ level of emotional functioning and treatment needs (Perrin et al., 2008).

Potential Treatment Considerations for Violent Female Offenders

Women who commit crime in general are considered to acting outside of the norm for the female gender in society. Women who commit violent crimes such as assault and murder are viewed as anomalies as they challenge the schema set forth by society. In considering the assessment and treatment of violent female offenders, there are concerns about the risk assessment techniques used for women because of the gender differences evident in the quality, frequency, intensity, and etiology of violence (Garcia-Mansilla, Rosenfeld, & Cruise, 2011, p.623). Goldberg (1995) identified that oppression
appears to be a causal factor in creating and maintaining chemical abuse and dependency among women, as well as a significant factor interfering with services that would help recovery (p. 790). Stuart and Brice-Baker (2004) recommended that per their findings, preventative intervention programs that address the issues of young women and girls such as the pervasiveness of abuse, psychiatric disorders, risks of drug abuse, and criminality may be more effective in lower socioeconomic status communities. Improving the self-esteem of women could empower them to act independently of male or romantic partners and could help with preventing the development of substance abuse in order to self-medicate in women, especially in incidents of physical or sexual abuse or domestic violence (Goldberg, 1995).

Norman (2004) pointed out that there are sex differences in symptom reporting, help seeking, social support, coping styles, treatment utilization, and life stress. The gender differences in relation to participating in mental health treatment are supported as females are more prone to perceive the need for treatment, have positive attitudes towards treatment, and seek treatment for mental health issues in community settings than men (Drapalski et al., 2009). Becker et al. (2011) found that females with severe mental illness utilize more outpatient mental health services and fewer inpatient or emergency room services than males. Female offenders may see more benefits from treatment in correctional facilities as there are fewer stigmas associated with treatment and few barriers to accessing care there than in the community, and they tend to do so more than male offenders (Drapalski et al., 2009).

Gender specific treatment methods are viewed as effective for female offenders
due to the ability to address multiple components that could impact the behavior management of the female offender including family and peer environments (Cauffman, 2008). According to Collins and Nee (2010), strength-based approaches utilized in rehabilitation of offenders have moved away from well-established risk based models, as a means to incorporate hope, independence, self-worth, and a sense of wellbeing. Stefanakis (2008) identified that use of compassion in the therapeutic session can lead to the development of social connections that assist in decreasing incidents of crime and violence as correct utilization of compassion by clinicians elicits feelings of empathy and a desire to change in violent female offenders. Paul Ekman (2003) noted that physiological activation in an aggressive or violent person diminishes once the person is in the context of another person demonstrating compassion, love, and kindness (as cited in Stefanakis, 2008). Approaches based in compassion also build and strengthen the therapeutic alliance which could in turn promote adherence to treatment and reduced risk of recidivism (Stefanakis, 2008). However, the use of unconditional positive regard, compassion, genuineness, and instillation of hope may be difficult for clinicians experiencing internal conflicts due to the crime committed.

In order to effectively begin working with violent female offenders using a more integrative approach, therapists need to be able to clearly recognize circumstances where they feel they are unable to be objective and seek appropriate supervision, consultation, or refer the client to another therapist who would be able to effectively engage in treatment interventions. Violent female offenders are classified by the nature of their offenses and receive psychiatric treatment in the jail or prison system if they have a
mental health diagnosis. Potentially by utilizing a qualitative approach and engaging in research with the clinicians who provide direct therapeutic services to violent female offenders, specific themes regarding perception, core values, potential for personal bias, reliance on cultural stereotypes or myths, will be revealed and assist with determining how to reduce incidents of therapist burnout, experience of vicarious trauma, or countertransference, and promote the implementation of more effective therapeutic intervention and greater understanding of the offender's subjective experience.

Summary

In summary, the overview of the literature has supported the need for mental health professionals to be aware of the possible personal, ethical, and legal implications associated with assessment and provision of therapeutic interventions for violent female offenders. Examining the historical views of gender roles and expectations of women in society, as well as the nature of crimes committed by violent female offenders and exploring the reasons why these women commit violent crimes within the confines of a therapeutic alliance can result in cognitive dissonance within the mental health professional. While mental health treatment for female offenders with extensive trauma history is necessary and important for effective behavior management prior to potential release or during incarceration, it is important for a clinician to be trained in the following areas: competency assessment; trauma assessment; violence risk assessment; therapeutic interventions that address trauma; and the criminal or violent behaviors being targeted in the criminal justice system. Along with education and training, clinicians must also be insightful and willing to engage in continuous self-assessment when working with violent
female offenders. Clinicians must practice within their scope of competence and be aware of personal biases that could interfere with them making appropriate therapeutic recommendations for treatment and determining a violent female offender's ability to manage behavioral outbursts of violence, aggression, destruction, or reduce or eliminate homicidal thoughts or gestures.
CHAPTER 3
METHODOLOGY AND PROCEDURES

Research can be defined as a systematic process of collecting, analyzing, and interpreting data to promote increased understanding about a phenomenon (Leedy & Ormrod, 2010). In order to address the research questions proposed in this study, mental health professionals who have either conducted an assessment on, or provided direct therapeutic services to, women who were charged with or convicted of violent crimes, were interviewed and asked to describe their experience during provision of services. The interview questions were posed in favor of obtaining the perspective of the mental health professional and how culture, the profession, perceptions, expectations, biases, values and beliefs, impact their experience while engaging in clinical work with this target population. It was through this lens, the participants' experiences, meaning, and understanding of themselves and their role as professionals working with violent women were expressed; in order for the participants, researcher, and ultimately the reader, to gain awareness about the additional processes found within clinical interactions with violent women that compose the research.

Research Design

Leedy and Ormrod (2010) noted qualitative research focuses on phenomena as they occur in their normal environment and seek to evaluate the complexities of that phenomena from the subjective perspective. Qualitative research utilizes and emphasizes
practices that are "inductive, generative, constructive, and subjective" in nature (Lincoln & Guba, 1985, p. 336). Merriam (1988) presented that by engaging in qualitative research there is the ability to examine multiple realities. The primary goal of the researcher is to gain understanding with the participant being the expert of his or her own perceived reality (Gale, 1993). Denton (1981) identified that phenomenological description is one of the most comprehensive modes of inquiry available for understanding the roles and functions of the counselor (p. 596). Also, a qualitative phenomenological research design is appropriate when there is limited information about a phenomenon (Munhall, 1989).

Phenomenologists research the life world of the counselor by exploring "the counselor's story as told and seen from several perspectives and then compared with the stories of others" (Denton, 1981, p.596). Creswell (2007) noted that phenomenological research designs allow for the depiction of experiences shared by the participants in the phenomena being explored. Phenomenological inquiries aim to detail the core meanings attributed to the participants experience without generalizing, analyzing, or explaining or making inappropriate assumptions (Moustakas, 1994). As noted above, the goal of this type of approach is not to yield an explanation, but instead a greater understanding of what the counselor perceives as being meaningful action (Denton, 1981). Meaningful action is defined as three elements that form an act: the behavior, its motive, and its intent or purpose (Denton, 1981, p. 596).

Sampling

Purposive and snowball sampling was utilized to obtain participants for the study.
Purposeful sampling allowed for the selection of participants who can inform an understanding for the research problem and central phenomenon within the research (Creswell, 2007). This process of inclusion allowed subjects, places, and other important aspects of the research site to be represented appropriately to produce emerging themes (Bogdan & Biklen, 2003). As expressed by Bogdan and Biklen (2003), snowball sampling consists of identifying potential participants that may fit the criteria and be appropriate for the study. This study incorporated licensed professional counselors and other mental health professionals including social workers as a means to identify individuals who fit the inclusion criteria.

Participants

While there is no perfect number that exists, the researcher should choose a sample size that will support the use of purposive sampling and provide a variety of experiences pertaining to the phenomena being explored (Creswell, 2007). Eight participants have been often considered to be a suitable number of participants for qualitative studies (McCabe, 2007). For this study, interviews were successfully completed with ten diverse participants, with various levels of education and training, and all participants engaging in professional practice in the state of Georgia. The participants consisted of four clinicians licensed at the associate level, five professional counselors, and one master’s level counselor in training.

There was one male participant and nine female participants. All participants resided in the metro-Atlanta area of the state of Georgia. All participants were English speaking, and were between the ages of 26 and 55 years old. Due to the diverse racial and
ethnic makeup found in the counseling profession and in the metro-Atlanta area, it was estimated that the majority of study participants would be Caucasian and African American. Eight of the study participants were African American, and the two remaining participants were Caucasian and biracial (Caucasian and African American) respectively. The sample size was sufficient based on the literature regarding conducting qualitative phenomenological research.

Procedure and Setting

Following researcher approval from the Institutional Review Board (IRB), the researcher recruited participants through professional counseling organizations in the state of Georgia, and referrals from other mental health professionals in correctional, outpatient, and inpatient settings, as well as engaging in personal solicitation. After the researcher provided a letter detailing the study and the researcher’s contact information to mental health professionals affiliated with professional organizations and to identified professionals who could supply referrals for possible participants, a total of 13 responses were received via email and telephone call regarding interest in the research. However, two of the potential participants did not respond in a timely manner regarding scheduling the interview, and one participant was not eligible to participate. The researcher communicated with the identified interested participants via email and telephone call and provided them with a formal letter advising of the purpose of the study and specifying criteria for possible participants. The researcher then utilized a screening form to ensure the participants would be appropriate for the study prior to scheduling the interview. After verifying eligibility, participants were contacted and a date, time, and location was
determined.

The ten remaining participants were all recruited via recommendations from other mental health professionals and were able to be successfully scheduled to complete the interview in its entirety. Each participant completed a demographic questionnaire, and was given a pseudonym and coded identifier to ensure confidentiality. Participants also received and signed informed consent forms at the time of the interview which reviewed the potential benefits and risks to participating in the study, discussed audiotaping of the interview, and advised of the ability to withdraw at any time. To effectively comprehend the complexity behind maintaining balance and remaining objective when working with populations that there are strong opinions about, face to face semi-structured interviews were conducted. The researcher sought information about participant experiences while working with this population related to their ability to suspend or manage their personal beliefs in an effort to have an effective therapeutic relationship.

In utilizing such a methodological approach, the purpose was to gain understanding of the participant’s subjective experience about their ability to remain objective. Rapport was established between the researcher and each participant and the interview was conducted using specific questions developed by the researcher regarding therapist perception and therapeutic treatment of violent female offenders. Debriefing occurred upon conclusion of the interview to ensure participants did not experience any discomfort based on the subject matter and also in an attempt to process their reactions to the interview. All participants denied having any discomfort during or after the interview. Referral resources for counseling services were deemed unnecessary by all participants.
due to lack of distress. All interviews were audiotaped and transcribed verbatim within ten days upon completion of the interview, with data analysis occurring during and after collection of the data to increase integrity of the study.

Instrumentation

Qualitative research utilizes the researcher as the primary instrument of data collection (Bogdan & Biklen, 2003; Creswell, 2007; Merriam, 1998). Additional means of data collection included a screening form, demographic questionnaire, and semi-structured open-ended interview questions. The following section provides a detailed description of the instrumentation for this study.

Researcher

The researcher conducted individual, in person, semi-structured interviews. The primary researcher is a West Indian female doctoral candidate in a counselor education and supervision program at a southeastern private university. The researcher was aware of the potential for personal assumptions to be present during data collection based on researcher life experiences and point of view.

Lin (2013) noted the process to temporarily suspend the researcher’s existing personal biases, beliefs, preconceptions, and assumptions about the phenomenon to get the essence of what is being studied is known as epoche. Otherwise known as bracketing, this is used as a means to leave the researcher bias out of consideration while research is being conducted (Lin, 2013). The researcher’s world view and personal biases are factors that may influence qualitative research; the researcher must be cognizant of the potential limitations of the study and communicate these to the readers (Kolb, 2012). However,
bracketing permits the researcher to see and describe phenomenon from a variety of perspectives and to allow for a variety of interpretations and conceptualizations by having the researcher put aside his or her perceptual sets so that the phenomenon can be seen for what it is and untainted (Denton, 1981). To aid in minimizing researcher bias, reflexive journaling and peer debriefing was conducted. However, it should be noted the following assumptions were held by the researcher:

1. Counselors and counselors in training hold stereotypes of what violent female offenders may be like in treatment and in the community.

2. Remaining objective when a female client has committed a violent crime may be difficult for counselors, but may become easier with time and experience.

3. Counselors and counselors in-training may not be authentic in their experiences with violent female offenders which would impact the therapeutic relationship.

4. Counselors may experience frequent burnout and incidents of vicarious trauma due to the need to be empathetic to clients who may potentially have significant trauma histories.

5. Supervision, consultation, and self-care may not be utilized as much as it should be while counselors engage with violent female offenders.

Screening form

The screening form was used by the researcher to gather information about prospective study participants to verify they met the criteria for research. Questions were related to the criteria of the study and participants were asked to provide a time, date, and
location for the interview to be conducted after confirming study eligibility. The screening form content consisted of the following questions: (a) how did you hear about this research, (b) are you currently a master’s level counselor in training, a licensed associate professional counselor, or a licensed professional counselor, (c) have you interned or worked in a setting (correctional facility, inpatient psychiatric facility, or outpatient agency) that engages in provision of therapeutic services to violent female offenders, (d) how long have you worked with this population (violent female offenders), (e) are you willing and able to take part in an audio-taped interview lasting approximately up to 30-60 minutes?

Demographic questionnaire

All participants completed a demographic questionnaire that allowed the researcher to collect personal and professional background data. The demographic questionnaire requested the following information about each participant: (a) age range, (b) gender, (c) race, (d) level of education, (e) professional setting, (f) number of years in the field, (g) number of violent female offenders he or she has worked with, (h) his or her view on stereotypes held towards violent female offenders, (i) was he or she engaging in supervision or consultation while working with this population, and (j) was it difficult to engage in self-care practices while working with this population.

Interviews

To promote greater understanding of an individual’s experience, metaphorical and personal descriptions are deemed to be more valid (Denton, 1981). In order to obtain this understanding, the researcher will engage in semi-structured, in person, audiotaped
interviews. The method of the phenomenological interview is informal, interactive, and employs open-ended questions and comments (Moustakas, 1994). Merriam (1998) identifies that the semi-structured interview is guided by a list of questions; however there is a modification of the wording and ordering of questions for each participant in the study.

The interview was guided by the research questions: (a) what are your perceptions of violent female offenders and how do they impact your selection of treatment approaches or interventions used with this population, (b) how might the perceptions of violent female offenders differ amongst counselors in training, licensed associate professional counselors, and licensed professional counselors, (c) what are the challenges in your ability to establish rapport and actively participate in the therapeutic relationship with violent female offenders in comparison to female clients who have not committed any crimes, (d) what are some examples of the stereotypical beliefs held about women and actual violent crimes committed by women that have resulted in your experience of cognitive dissonance during provision of treatment services, (e) how does your examination or assessment of the trauma histories of violent female offenders compare to assessing the trauma histories of women who have not been arrested or incarcerated (is it more thorough, or less intensive), (f) how might working with violent female offenders result in you experiencing vicarious trauma, counter-transference, and burnout more frequently than working with women who have not been arrested or incarcerated, (g) how does your level of self-awareness or insight about your perceptions or biases held towards violent female offenders reflect an increased or decreased level of competency and use of
appropriate treatment intervention strategies?

The investigative questions were crafted based on researcher personal experiences along with information obtained from the review of the literature. Through the use of qualitative investigation via semi-structured interviews, results can be used to improve the quality of training for mental health professionals to provide services to violent female offenders, improve the effectiveness of services already being provided by licensed clinicians, and ultimately to reduce incidents of recidivism as violent female offenders may increase adherence to treatment due to feeling a genuine connection during the therapeutic process.
CHAPTER 4
RESULTS

Introduction

Chapter three provided an overview of the methodological processes used to direct this research. A phenomenological qualitative approach to data analysis was used to obtain and reflect the research findings of this study. Qualitative research is not designed to be conclusive; it is a stimulus for ongoing conversation (Kline, 2008). As noted in the previous chapter, this phenomenological inquiry intended to present the core meanings attributed to the participants experience without generalizations, analysis, explanation, or making inappropriate assumptions (Moustakas, 1994). This chapter presents an overview of the data collection and analysis, the overview of the emergent themes found from the study participants, and a summary of the participants’ perceptions of providing therapeutic services to violent female offenders.

Data Collection and Analysis

For this study, data was collected through 10 face-to-face, audio-taped, semi-structured interviews. The interviews conducted during this qualitative study provided the researcher with an opportunity to gain perspectives of the participants (Kolb, 2012). By utilizing semi-structured interviews, the personal perceptions and experiences with violent female offenders and their impact on the therapeutic relationship and provision of services were able to be discussed. There were no unusual circumstances or variations
encountered during data collection. Audiotapes were transcribed within 10 days of
interview completion, with participant names and identifying information being changed
to ensure confidentiality.

Upon completion of the transcription of the interviews, data analysis was
conducted utilizing a phenomenological approach. Transcribed data was analyzed
utilizing the transcendental phenomenological method to answer the primary research
questions and focus on the core meanings and experiences of the participants of the study
(Moustakas, 1994). The responses provided by each participant allowed for emerging
themes to be extrapolated and noted after thoroughly reviewing each transcription.
Individualized themes were identified through each participant’s responses and gathered
to note the emergence of commonalities shared within the experience of providing
therapeutic services to violent female offenders. Coding of research content was
completed manually, without the use of qualitative analysis software. The collective core
themes allowed for a description of participant perceptions to be integrated; resulting in
the ability to address the underlying inquiry for this research, does therapist perception of
violent female offenders impact the provision of therapeutic services to this population?

Qualitative research is a time consuming, intimate and an intense experience
(Patton, 2002). The researcher is the primary source of data collection while the
participants are the primary source for data (Patton, 2002). Each transcription was
reviewed to ensure accuracy and all participant responses were read multiple times in
order to develop a comprehensive understanding. Reflexive journaling was done to assist
with researcher reflections on the participant interviews as well as documenting
observations, behaviors, feelings, and thoughts; allowing for the recognition of themes pertaining to the study process. Important words, phrases, or sentences were selected after examining the participants’ responses for common ideas, patterns, and relationships, and then categorized. These significant statements were highlighted with each participant’s direct responses to the interview questions, ultimately producing meaning units that were clustered into core themes indicating a mutual experience.

Phenomenologists seek to understand the meanings of human experiences or explore concepts from a new and fresh perspective (Lin, 2013). This study aimed to explore how therapist perception about violent female offenders impacts the provision of treatment. The following questions directed the research: a) what are your perceptions of violent female offenders and how do they impact your selection of treatment approaches or interventions used with this population, b) how might the perceptions of violent female offenders differ amongst counselors in training, licensed associate professional counselors, and licensed professional counselors, c) what are the challenges in your ability to establish rapport and actively participate in the therapeutic relationship with violent female offenders in comparison to female clients who have not committed any crimes, d) what are some examples of the stereotypical beliefs held about women and actual violent crimes committed by women that have resulted in your experience of cognitive dissonance during provision of treatment services, e) how does your examination or assessment of the trauma histories of violent female offenders compare to assessing the trauma histories of women who have not been arrested or incarcerated (is it more thorough, or less intensive), f) how might working with violent female offenders
result in you experiencing vicarious trauma, counter-transference, and burnout more frequently than working with women who have not been arrested or incarcerated, and g) how does your level of self-awareness or insight about your perceptions or biases held towards violent female offenders reflect an increased or decreased level of competency and use of appropriate treatment intervention strategies? The findings from this phenomenological inquiry reflect some commonalities in the experiences of counselors working with violent female offenders.

Thematic analysis conducted through iterative processes of familiarization, coding, theme development, defining themes and reporting, allows for the identification of themes and patterns from qualitative data (Weisser, Bristowe, & Jackson, 2015). Once patterns, themes, and categories have been established, then exploration and analysis can take place using an inductive approach (Patton, 2002). Thorough examination of the patterns that emerged from all participants led to the identification of significant themes pertaining to the meaning of their therapeutic experience with violent female offenders. The main essences recognized within this shared experience of working with this target population were: a) genuineness/authenticity, b) counselor diversity, c) empathy, d) experience, e) supervision and consultation, and f) self-care. While these main themes appeared to capture the essence of the participants’ experiences in this research, they are not generalizable to all therapists who have worked with violent female offenders.

Evidence of Trustworthiness

Lincoln and Guba (1985) present that credibility, transferability, dependability and confirmability must be established in order to reflect trustworthiness in qualitative
research. Nuttall (2006) identified that transferability means the researcher is responsible for presenting study findings in a way that allows others to apply the knowledge or insights to other target groups; dependability is reflected by including references that support the findings of the data being studied; and confirmability shows the neutrality or objectivity in qualitative research by obtaining confirmation that findings result from the study itself, and not researcher bias. In this study, transferability was addressed through the use of rich description, dependability through the use of numerous references, and confirmability was addressed through the use of a reflexive journal to allow for deeper understanding of the research process and to minimize potential bias. Researcher reflexivity is a procedure where researchers self-disclose their assumptions, beliefs, and biases that shape their inquiry; by acknowledging these beliefs and biases initially, readers can understand the researcher’s positions and then bracketing can take place (Creswell & Miller, 2000).

Creswell and Miller (2000) noted validity in qualitative research is usually conducted by employing either one or more of the following procedures: member checking, triangulation, thick description, peer reviews, researcher reflexivity, external audits, and reporting the results. Triangulation can be defined as a process utilizing the combination of two or more viewpoints to increase validity and credibility of research findings (Creswell, 2007). Lincoln and Guba (1985) reinforced this by noting that member checking or peer review supports credibility in qualitative research. Peer reviewers who are not affiliated with the research may assist with establishing validity (Creswell & Miller, 2000).
Following referrals by professional counselors unrelated to the research, two peer reviewers were utilized for this study based on their experience and training in qualitative research and their impartiality to the subject matter. The first peer reviewer was a female, licensed professional counselor (LPC) in the state of Georgia. The second peer reviewer was also a female, licensed professional counselor (LPC) in the state of Georgia who also has an Ed.S. Both peer reviewers provided feedback regarding the emerging themes they noticed during their review of the transcriptions for data analysis. Peer reviewers also provided their personal reactions and feelings related to their examination of the data.

Themes

Through thematic analysis, connections among participants’ experiences were made. Participant responses were analyzed by identifying significant statements and clustering them into themes; synthesizing themes into a description of participant experiences; and constructing a composite description of the essence of the experiences noted. Verbatim statements obtained from participant interview responses were utilized during data analysis to cultivate the commonalities in the themes. The major themes that will be discussed were presented based on their prevalence throughout participant interview responses.

The first theme that emerged was the importance of genuineness/authenticity as a means to establish rapport within the therapeutic relationship and effectively help this population in treatment. Subthemes included counselor stereotypes and rapport building. The second theme was counselor diversity; describing how subthemes or factors such as counselor race, gender, socioeconomic status, life experiences or background, could
impact the counselor-client relationship and create barriers. However, matters regarding
diversity and how they manifest in treatment may not be noticeable to the therapist at the
onset of working with this population. Empathy was identified as the third theme, and
spoke to the participants’ understanding of the violent female offenders and their personal
histories and the circumstances that may have led to their incarceration. Subthemes
included cognitive dissonance and issues with boundaries.

The fourth theme, experience, describes how participants addressed feelings of
inadequacy or incompetence with regard to being qualified to provide services to this
target population. Subthemes encompassed being teachable and self-awareness of one’s
competence. Supervision and consultation was the fifth theme to emerge. Participants
expressed a desire to utilize colleagues and supervisors to assist in gaining knowledge
and support when there were perceived deficits in providing therapeutic services with this
population. Subthemes involved countertransference and a supportive work environment.
The final theme addressed self-care and the importance of recognizing when self-care
would be necessary. Subthemes included safety concerns, vicarious trauma, and burnout.
The participants verbatim responses relevant to the themes and subthemes identified will
be discussed later in this chapter.

With regard to study participants, all six themes emerged for 70% of the sample,
four themes emerged from the responses of one participant (10%), while the remaining
20% (two participants), reflected four of the emerging themes. The theme of
genuineness/authenticity emerged for all participants (100%), self-care emerged for 90%
of the sample. Table 1 provides an overview of the essences of the experiences identified.
Table 1

*Themes for Therapists’ Perceptions of Violent Female Offenders and their Impact on Treatment*

<table>
<thead>
<tr>
<th>Major Themes</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genuineness/Authenticity</td>
<td>Stereotypes, Rapport building</td>
</tr>
<tr>
<td>Counselor Diversity</td>
<td>Race, Gender, Socioeconomic status, Life</td>
</tr>
<tr>
<td></td>
<td>Experiences/Background</td>
</tr>
<tr>
<td>Empathy</td>
<td>Cognitive Dissonance, Boundaries</td>
</tr>
<tr>
<td>Experience</td>
<td>Being Teachable, Competence</td>
</tr>
<tr>
<td>Supervision &amp; Consultation</td>
<td>Countertransference, Supportive work</td>
</tr>
<tr>
<td>Self-Care</td>
<td>environment</td>
</tr>
<tr>
<td></td>
<td>Safety concerns, Vicarious trauma, Burnout</td>
</tr>
</tbody>
</table>

Participant Summary

This study utilized ten participants that met the criteria for engaging in this research. All participants were either master’s level, licensed at the associate level, or fully licensed professional counselors in the state of Georgia who have worked with violent female offenders in various settings including outpatient agencies, inpatient facilities, or in correctional facilities. The participants’ age range was 26 to 55 years old, with a minimum of 1 year and a maximum of over 15 years of clinical experience. All participants were given pseudonyms for the purpose of this research. Each participant engaged in a semi-structured audiotaped interview that lasted approximately 30-45 minutes. Table 2 provides a listing of offenses reported by clients to study participants.

Table 2

*Reported Offenses Committed by Violent Female Offenders in Treatment*

<table>
<thead>
<tr>
<th>Offense Reported</th>
<th>Assault &amp; Battery</th>
<th>Attempted Murder</th>
<th>Child Abuse</th>
<th>Domestic Violence</th>
<th>Malicious Wounding</th>
<th>Murder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant (P#)</td>
<td>All P 2, P 8</td>
<td>P 7</td>
<td>P 1, P 2</td>
<td>P 4</td>
<td>P 3, P 4</td>
<td></td>
</tr>
<tr>
<td>Experience</td>
<td>P 1 – P 10</td>
<td>P 3, P 4</td>
<td>P 10</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 3 provides a snapshot of the ten participants. The study participants were primarily female (90%), and majority African American, at 80%. Additionally 50% of the participants were licensed professional counselors, 40% were licensed associate professional counselors, and 10% was master’s level. Only 20% of the participants worked with less than five violent female offenders.

Table 3

Demographic Information

<table>
<thead>
<tr>
<th>Participant</th>
<th>Sex</th>
<th>Age Range</th>
<th>Race/Ethnicity</th>
<th>Professional Level</th>
<th>Number of years in the field</th>
<th>Professional Setting</th>
<th>Number of violent female offenders treated</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Lisa</td>
<td>Female</td>
<td>36-49</td>
<td>Caucasian</td>
<td>LPC</td>
<td>0-3</td>
<td>Crisis worker</td>
<td>1-4</td>
</tr>
<tr>
<td>2 Lori</td>
<td>Female</td>
<td>26-35</td>
<td>Biracial</td>
<td>LAPC</td>
<td>5-10</td>
<td>Private practice</td>
<td>5-10</td>
</tr>
<tr>
<td>3 Carol</td>
<td>Female</td>
<td>36-49</td>
<td>African American</td>
<td>LPC</td>
<td>1-4</td>
<td>Private agency</td>
<td>5-10</td>
</tr>
<tr>
<td>4 Jasmine</td>
<td>Female</td>
<td>26-35</td>
<td>African American</td>
<td>LAPC</td>
<td>10-15</td>
<td>Outpatient agency</td>
<td>1-4</td>
</tr>
<tr>
<td>5 Maya</td>
<td>Female</td>
<td>26-35</td>
<td>African American</td>
<td>LAPC</td>
<td>0-3</td>
<td>Inpatient facility</td>
<td>5-10</td>
</tr>
<tr>
<td>6 Veronica</td>
<td>Female</td>
<td>26-35</td>
<td>African American</td>
<td>LPC</td>
<td>10-15</td>
<td>Inpatient facility</td>
<td>5-10</td>
</tr>
<tr>
<td>7 Mike</td>
<td>Male</td>
<td>50 +</td>
<td>African American</td>
<td>LPC</td>
<td>10-15</td>
<td>Outpatient agency</td>
<td>16 +</td>
</tr>
<tr>
<td>8 Mary</td>
<td>Female</td>
<td>36-49</td>
<td>African American</td>
<td>LPC</td>
<td>15 +</td>
<td>Correctional Facility, Outpatient &amp; Inpatient facility</td>
<td>16 +</td>
</tr>
<tr>
<td>9 Gabrielle</td>
<td>Female</td>
<td>36-49</td>
<td>African American</td>
<td>Masters Level</td>
<td>5-10</td>
<td>Outpatient/Community Service organization</td>
<td>11-15</td>
</tr>
<tr>
<td>10 Taylor</td>
<td>Female</td>
<td>26-35</td>
<td>African American</td>
<td>LAPC</td>
<td>0-3</td>
<td>Outpatient agency</td>
<td>5-10</td>
</tr>
</tbody>
</table>

Participant 1

Participant one, Lisa, is a Caucasian American female and licensed professional
counselor (LPC), in the 36-49 year old age range. At the time of the interview, Lisa worked as a crisis counselor. However, Lisa also had experience providing counseling services in outpatient settings and private practice as well. Lisa was the first participant interviewed for this research. The interview took place at a coffee shop at a private table that was sufficient for the recording to be conducted. Her clinical understanding of this population came from working with violent female offenders who were convicted of committing assaults on their partners. She appeared to be excited and comfortable throughout the interview as she was smiling, talkative, and cooperative with the researcher during the process. Six primary themes emerged from this interview: genuineness/authenticity, counselor diversity, empathy, experience, supervision and consultation, and importance of self-care.

Lisa was able to identify how the first emerging theme of being her genuine self in the therapeutic relationship would allow her to be more open and create a space for vulnerability; even with perceived difficulty regarding having these women as clients. She also acknowledged the second prominent theme of counselor diversity; noting her being a Caucasian female with a different background as well as her level of education and privilege, could impact her ability to establish rapport with these women. The third theme of empathy reflected her ability to be honest about not feeling the same desperation as the women who committed violent crimes may have felt in their respective situations; however, she still sought to gain understanding of their experience in order to adequately help them.

The fourth theme of experience highlighted Lisa’s openness about the challenges
of being a new therapist and having barriers present initially with this population. Still, she noted the perceived barriers gradually diminish over time with clinical experience and it is important for you to "allow yourself to be re-educated as a clinician" when conceptualizing about these clients. Supervision was the fifth theme evident in Lisa’s interview as she spoke about the benefits of receiving supervision and having support with these clients with violent histories. The sixth and final theme evident within Lisa’s interview was self-care, as she noted that there would be a concern about burnout based on counselor approaches and expectations with these women.

Participant 2

Participant two, Lori, is a biracial (Caucasian and African American) female and a licensed associate professional counselor (LAPC) in the 26-35 year old age range. Lori was providing counseling services in a private practice at the time of the interview, and had additional counseling experience working at the Department of Family and Children Services (DFCS), as a crisis counselor, and at various outpatient agencies in the past. The interview took place at Lori’s home which provided a private and more comfortable experience for her. Lori reported clinical experience with violent female offenders who were convicted of assault, domestic violence battery, and attempted murder. She was interested in the research questions, relaxed, talkative, and pleasant during the process. Six main themes emerged from her interview: genuineness/authenticity, counselor diversity, empathy, experience, supervision and consultation, and the importance of self-care.

Lori acknowledged the first emerging theme of genuineness by presenting that
with violent female offenders it is imperative the counselor is his or her most genuine self while building rapport due to the significant trust issues that may be present. Counselor diversity was the second theme that surfaced as Lori’s own family background influenced her decision to get into the counseling field. Lori’s third theme of empathy was visible as her own life experiences include having a diagnosis of post-traumatic stress disorder, which assists her in relating to symptoms that can be found in the possible history of trauma within this group of women. The fourth theme of experience was noted as a way to increase the level of comfort with violent female offenders, with the more experience obtained, the more comfortable a clinician will feel. The fifth theme to emerge was the need for supervision. Lori noted based on her responses that as a new therapist, while the counselor may have the education and training, he or she is still unsure of his or her effectiveness and is putting the experience into context with relation to the therapeutic relationship. The sixth and final theme apparent in this interview was the importance of self-care due to the amount of distressing material that can be present while doing work with this population.

Participant 3

Participant three, Carol is an African American female and licensed professional counselor (LPC) in the 36-49 year old age range. Carol worked as a case manager at the time of the interview, but had history of providing counseling services in outpatient settings and a private agency. The interview took place in a private office conference room. Her knowledge of this population stemmed from working with violent female offenders who committed murder, infanticide, and aggravated assault. Carol was easily
engaged in the interview and appeared to be comfortable with the researcher throughout the process. She was thoughtful, pleasant, and candid with her feelings. Six principal themes emerged from this interview: genuineness/authenticity, counselor diversity, empathy, experience, supervision and consultation, and the significance of self-care.

The first theme to emerge from Carol’s responses was genuineness. She expressed the need to be aware of inauthenticity when working with this population as the women are perceptive and can sense counselor judgment, which would impair developing rapport. Carol points out the second theme of counselor diversity noting being a female herself creates sensitivity while engaging with violent female offenders. The third theme to surface from her interview was the importance of empathy, as these women would come into treatment with distrust. Experience was the fourth theme identified, as Carol explained educational titles have little to do with your ability to actually engage in quality therapeutic work; however, life and work experience are related to counselor effectiveness. Utilizing supervision was the fifth emerging theme and Carol alluded to its benefits in reducing incidents of countertransference and projecting stereotypical beliefs onto the women in this population. The final theme of self-care was apparent because while therapists want to provide good care, Carol emphasized the need to set firm boundaries to avoid burnout and vicarious trauma experiences.

Participant 4

Participant four, Jasmine, is an African American female and licensed associate professional counselor (LAPC) in the 36-49 year old age range. At the time of the interview, Jasmine worked as a case manager linking violent female offenders to
community programs. She also had prior experience providing counseling services in both outpatient and inpatient settings. The interview took place in a quiet and private office setting. Jasmine’s familiarity with the research topic stemmed from her work with violent female offenders who were convicted of malicious wounding in domestic situations, assault on law enforcement, and murder. Jasmine was attentive and forthcoming with information throughout the interview process. She appeared to be comfortable with the researcher as noted by her pleasant demeanor, however her responses were concise. Four noticeable themes emerged from this interview: genuineness/authenticity, empathy, experience, and the importance of self-care.

Jasmine’s first identified theme was genuineness or authenticity. She expressed her attempts to work with her clients on an individual basis, not based on the stereotypes of violent female offenders that could potentially impact her ability to be authentic in the relationship. The second emerging theme was empathy as she noted the backgrounds of these women may have significant histories of trauma, substance abuse, in addition to underlying mental illness. The third theme of experience was apparent as Jasmine verbalized without experience, professionals may have difficulty working with this population as their perceptions may be skewed and they may not know how to provide adequate treatment. The fourth and final emerging theme in this interview was the importance of self-care. Jasmine was able to highlight the importance of separating herself from her work in an effort to avoid instances of burnout.

Participant 5

Maya, an African American female and licensed associate professional counselor
(LAPC), was participant five. Maya is in the 26-35 year old age range, and at the time of the interview, she worked in an inpatient psychiatric facility. Maya had previous clinical work experience as a crisis counselor and some study related work experience as a probation officer. The interview took place at a coffee shop at a private table which allowed for privacy. She worked with violent female offenders who served sentences for assault. Maya was energetic and appeared to be interested in the interview subject matter. She appeared to be comfortable with the researcher as evidenced by her smile, being talkative, and cooperative. Six central themes emerged from this interview: genuineness/authenticity, counselor diversity, empathy, experience, supervision and consultation, and the benefits of self-care.

Maya’s first emerging theme was genuineness/authenticity as she was able to identify that how she presents herself in session can impact her relationship with these women. Her second prominent theme was counselor diversity, as she was able to acknowledge how being an African-American female and a counselor could also impact client perceptions of her and vice versa, especially with a majority of her clients being African American themselves. The third theme to come forth was empathy, as Maya highlighted the difficulties that could be found within the relationship because of trust issues with this population.

Experience was the fourth emerging theme in Maya’s interview as she expressed that more bias towards this population was evident with the less experience held by the counselor. Her view of violent female offenders as their own culture aided in her desire to become more self-aware of the quality of work she was providing to them. The fifth
theme to manifest from her responses was how beneficial supervision would be to assist in working through counselor bias and potential countertransference. Receiving feedback, engaging in consultation, and discussion amongst peers was also important to maintaining competency in her opinion. Self-care was the final theme to emerge as Maya explained there are circumstances with this target population that would take more of a toll on the counselor, so self-care would be necessary to reduce instances of burnout and vicarious trauma.

Participant 6

Participant six, Veronica, is an African American female and licensed professional counselor (LPC) in the 26-35 year old age range. At the time of the interview, Veronica worked as a supervisor of an inpatient psychiatric facility and was pursuing her doctorate degree in counselor education and supervision. However, she also had previous experience providing counseling services in outpatient agencies, mobile crisis teams, and private practice. The interview took place in a quiet and private office setting. Her clinical experience with this target group came from working with violent female offenders who were convicted of assault and battery. Veronica appeared to be relaxed during the interview process as she was friendly, talkative, and cooperative with the researcher. Six striking themes emerged from this interview:
genuineness/authenticity, counselor diversity, empathy, experience, supervision and consultation, and importance of self-care.

Genuineness/authenticity was the first theme to manifest in Veronica’s responses. She emphasized the significance of suspending judgment and seeing the humanity in this
population as the stereotypes associated with violent female offenders are quite
dehumanizing. The second theme to be revealed was counselor diversity. Veronica
acknowledged as a female working with females, additional issues may present in
session.

Empathy surfaced as the third theme; as Veronica pointed out in her opinion
therapists do not try to get a true understanding of the client experience. The fourth
emerging theme was experience and the importance of being trained in a manner that
suggests a holistic view of the client in order to avoid a narrow scope of practice with this
population. The fifth theme of supervision was a constant underlying subject throughout
Veronica’s interview. She elaborated on the importance of having a supportive work
environment, as well as consultation and supervision to avoid incidents of
countertransference and to address therapy concerns. The final theme of self-care was
also recurrent in her responses; especially fear of safety and concerns about burnout when
engaging in treatment with this population.

Participant 7

Participant seven, Mike, is an African American male and licensed professional
counselor (LPC) in the 50 and older age range. At the time of the interview, Mike worked
as a case manager and in an outpatient agency. He has had previous experience with
substance abuse and family violence programs. The interview took place in an office
setting that allowed for privacy. His knowledge of violent female offenders stemmed
from his work with women who were guilty of assault or battery in domestic violence or
child abuse situations. Mike initially appeared to be unsure of the interview process, as
evidenced by him voicing he was nervous about the questions posed to him. However, his concern lessened as the questions were asked, he appeared to be comfortable with the researcher, was calm, engaged, and thoughtful with his responses. Five chief themes emerged from this interview: genuineness/authenticity, counselor diversity, empathy, experience, and the importance of self-care.

Genuineness/authenticity was the first theme to come forth in Mike’s interview as he emphasized counselor honesty and seeing these women as human beings is vital to forming the therapeutic relationship. The second theme to emerge was counselor diversity issues as Mike verbalized that as a male working with violent female offenders who may have been traumatized or victimized by males, the counseling relationship may be negatively impacted. As a result, his third theme of empathy surfaced as there was a significant amount of distrust present while he tried to engage with these women. The fourth theme of experience was apparent as he described that with education, training, and personal experience you will be more equipped to address the needs of this population. Mike also stressed the need to be teachable throughout the process of working with these women as a means to gaining rapport and respect. Self-care was the final theme to emerge from Mike’s interview as he discussed the stories shared by these women can have an emotional impact on you and result in vicarious trauma if you are unable to have firm boundaries.

Participant 8

Participant eight, Mary, is an African American female and licensed professional counselor (LPC) in the 36-49 year old age range. Mary worked at a state-funded inpatient
psychiatric facility at the time of the interview; however, she also had experience providing counseling services in outpatient settings and correctional facilities. The interview took place at a coffee shop at a private table. Mary verbalized that her experience with violent female offenders stemmed from her clinical practice with women whom were convicted of assault and attempted murder. She appeared to be comfortable throughout the interview as she was attentive to the researcher, smiling, talkative, playful, yet cooperative during the process. Four predominant themes emerged from this interview: genuineness/authenticity, empathy, experience, and supervision and consultation.

The first theme to emerge from Mary’s responses was the need for genuineness/authenticity. When working with these women, fear and stereotypes can influence the therapeutic relationship and diminish the level of understanding about the client experience that can take place. Empathy was the second theme to come forth as she noted due to the amount of distrust that can be present in the counseling relationship it would be hard to gain understanding. However, she identified once there is a good rapport, there may be issues surrounding over empathizing and overstepping boundaries within the counseling relationship due to the client background. The third theme revealed in Mary’s responses was experience, with her acknowledging newer counselors may be more afraid and unable to see the underlying causes of the behavior rather than the crime itself. The fourth and final theme to materialize from Mary’s interview was the necessity of supervision and consultation as a means to learn appropriate ways to handle issues such as countertransference in order to avoid treatment disruption.
Participant 9

The ninth participant, Gabrielle, is an African American female in the 36-49 year old age range. Gabrielle is a master’s level counselor, actively working towards obtaining her associate licensure. At the time of the interview, Gabrielle worked at a community service organization, but she had previous experience working at an outpatient agency. The interview took place at a coffee shop in a semi-private setting. Her knowledge of violent female offenders came from working with women who were found guilty of assault with a deadly weapon, and assault or battery in domestic violence situations. Gabrielle was very engaged in the subject matter, appeared to be comfortable with the researcher, and was open and talkative throughout the interview. Six main themes emerged from this interview: genuineness/authenticity, counselor diversity, empathy, experience, supervision and consultation, and the importance of self-care.

Gabrielle’s first theme to emerge from her responses was genuineness as she expressed that in joining with these women they need to feel the counselor is authentic in his or her desire to help and to get to know them without a predisposed idea of their needs. Counselor diversity was the second theme to materialize as Gabrielle expressed her own background as a female counselor with a family member who was a violent female offender, could alter her perceptions. The third theme to become apparent was empathy due to the level of distrust in these clients, and the ease of overstepping boundaries that could be present due to the traumatic histories and experiences they may have had.

Experience was the fourth theme to surface as she verbalized there is a naivety
associated with newer clinicians, but once you have been working in the field you begin to narrow your scope on the amount of work that can be done. Gabrielle’s views led to the fifth prominent theme garnered from her interview responses, the need for supervision. She expressed how the stories shared by these women can have a direct personal and professional impact and highlighted incidences of her own bias. Further supporting if not addressed via supervision or consultation in an appropriate and timely fashion, the effects could lead to impairment in areas of her personal and professional life. Her statements also encouraged the need for the sixth and final emerging theme, self-care. Gabrielle was able to note that along with the potential for vicarious trauma, there is a sense of helplessness associated with providing services to this population which could lead to counselor burnout.

Participant 10

Participant ten, Taylor, is an African American female and a licensed associate professional counselor (LAPC) in the 26-35 year old age range. At the time of the interview, Taylor worked as a case manager. However, Taylor also had prior experience providing counseling services in various outpatient agencies, including a Methadone clinic. Taylor was the final participant interviewed for this research. The interview took place in a private and quiet office location. Taylor shared her understanding came from working with violent female offenders that were convicted of manslaughter, assault, and battery related to domestic violence. She appeared to be confident and relaxed during the interview as she was thoughtful and forthcoming with her responses, and cooperative throughout the process. Six salient themes emerged from this interview:
The need to be genuine or authentic emerged as Taylor's first theme as she emphasized the need to be nonjudgmental in the counseling relationship in order to facilitate an environment conducive to treatment. Her background of working with at-risk youth led to the second emerging theme of how a counselor’s own diversity can be helpful in engaging with these women. The third theme to be revealed was empathy. Taylor highlighted how a counselor’s empathy and the client’s understanding of empathy could lead to actual work being done in the therapeutic relationship.

Taylor's views on the fourth theme of experience were apparent in her differing perspective on how new counselors may handle this target population. She noted seasoned professionals may take a more general one size fits all approach, while new counseling graduates would be more in-depth and thorough in their treatment approaches. Supervision and consultation, while not overtly expressed, surfaced as the fifth theme with her discussion of the importance of processing through the client experience in order to overcome potential biases. She acknowledged her final emerging theme of self-care several times throughout her responses, as she truthfully identified an issue with her "need to save the world," and the reality of the potential for vicarious trauma.

Findings

Each participant in the study was able to conceptualize and verbalize their interpretation of providing therapy services to violent female offenders from a unique standpoint. Through the similarities found in the participants perspectives in their
experiences, emerging themes were able to capture the essence of the impact of therapist perception on providing therapeutic services to violent female offenders.

Phenomenological analysis of participant interviews utilized the answers to each research question to generate the recurring themes among the study participants. As noted previously, the common experiences of the counselors in the sample consisted of six major themes: a) genuineness/authenticity, b) counselor diversity, c) empathy, d) experience, e) supervision and consultation, and f) self-care. Kline (2008) advised researchers should include sufficient participant quotations in the results so reviewers and readers can judge the consistency of the data and findings. The following section provides the results of the analysis, including the verbatim responses from the participants which produced the salient themes that manifested in the discussion of therapist perceptions about this target population and their effects on treatment provision.

Genuineness/Authenticity

The primary research question guiding this study was, “What are your perceptions of violent female offenders and how do they impact your selection of treatment approaches or interventions used with this population?” The first emerging theme was the need for therapists to come into the counseling relationship with “genuineness or authenticity.” Identified subthemes of stereotypes and rapport building addressed how therapists being disingenuous could significantly interfere with the therapeutic relationship. The first theme, “genuineness or authenticity,” illustrated the desire for therapists to be open and unbiased in clinical practice. Yet in actuality, participants were able to formulate how stereotypical beliefs are present within the counseling relationship.
and the possible damage that can result while trying to build rapport.

Participant one, Lisa, expressed that the initial perception of violent female offenders can influence therapist opinions about the client’s prognosis and them actively engaging and progressing in treatment. Lisa stated, “My thought at first was, you sort of perceive this really tough veneer, you wonder, am I going to be able to get through that, to this person, to be able to help them” (personal communication, January 3, 2016).

Participant two, Lori, noted that by coming into the counseling relationship from a neutral standpoint, the treatment experience may be more positive. Lori shared, “The ones that I had, have been in prison and they were in social service programs so they are usually far more polite, and willing to work. Actually I just treat them like I would a regular client” (personal communication, January 10, 2016).

Carol, the third participant, shared her perceptions of these women noting they had significant trauma history and cycles of self-defeating behavior or negative interpersonal relationships.

For the experience that I have, most of these women have a long history of trauma themselves, abandonment issues, violent pasts, and so not all, I really don’t know the percentage, but some of those typically don’t become aggressive, they are typically the submissive passive, always in domestic violence. But those that become offenders or get into the legal system for whatever reason that’s how they express themselves, that’s how they deal with their stress when they are confronted with certain things. So I have noticed the long history of trauma, of abandonment, and there’s a cycle of abuse and violence and then how to treat
those women, because a lot of them are tormented with how I was supposed to break the cycle and I didn’t, so there is a lot of self-loathing (personal communication, January 15, 2016).

Participant four, Jasmine explained her perceptions surrounding this population of women have been tied to their mental state as “Some of them fluctuate on their mental stability, so it makes it more difficult to work with them” (personal communication, January 16, 2016). However, she shared her attempts to be genuine within the therapeutic relationship.

I do try not to take it as a group, and kinda group them all together and take interventions based on them being a female, or a female that has committed murder. I think I have gained a level of insight that has increased my awareness of being able to take one person’s situation and base interventions on that rather than the population as a whole (personal communication, January 16, 2016).

The fifth participant Maya, also noted how her stance of providing services to this population could allow for a more genuine interaction, “I’m a big proponent of multicultural competencies, and I consider violent offenders to be their own culture” (personal communication, January 16, 2016).

Participant six, Veronica suggests that it would be beneficial to be open to the experience and recognizing the humanity despite the nature of the offense.

Just treating everyone the same, not being judgmental, and just looking at everyone as a human first as I said, and then if there is issues as it comes to
aggression whether they have a history of it or not, just address it appropriately with the right support (personal communication, January 23, 2016).

Mike, the seventh participant, also encouraged therapist honesty while engaging with these women as he explained,

We are all human, we all have our issues and if a counselor has an issue that is what that particular individual went through, these women are really, really, good at picking that up... These women are pretty smart, pretty clever, you know, they have been through some things and they know how to read people real good. So you know, if you come in there a lot of times, if you’re scared they will pick right up on it, you have to be honest with them, you have to be straight up with them. You don’t have to tell them your life story, but you have to be honest, because they can read you and they can tell a fake (personal communication, January 25, 2016).

Participant nine, Gabrielle, expressed that there may be barriers to being genuine as well. The biggest issue in joining is telling them that you are not here to set ideas of what they should do, you are here for them. And that you are here to help them – encourage them rather- to do, solve, create, whatever they want and not some predisposed notion rather of what you think they need (personal communication, February 1, 2016).

Taylor, the tenth participant also highlighted the importance of breaking barriers down to create an authentic encounter with these clients.
For me in the first counseling session, I try to meet them where they are. I try to scratch that, “I’m the therapist you’re the client,” I just talk to them like I am having a casual conversation. I think that once they are able to understand “ok, just because she is sitting on the other side of the table doesn’t mean she is being judgmental,” I try to establish rapport that way to break down those barriers (personal communication, February 4, 2016).

Stereotypes. Biases and prejudices that result in the perception of differences rather than real differences may reduce the efficacy of therapeutic treatment efforts for female offenders (Kyne & Williams, 2007, p. 96). Lisa, in her interview, provided examples of the stereotypical beliefs held about this population, sharing “These women are not feminine, not lady like, that they are tough, not loving, not smart, that they will never change their lives, they are not making the best of their abilities, and that they are not taking opportunities” (personal communication, January 3, 2016). She also noted the following about the stereotypes of violent female offenders.

I think a lot of the stereotypes that get put on offenders, if you were to dissect that stereotype there would be a lot of personality disorder stuff in there, but I cannot tell you how many people I have talked to who have been incarcerated and there is no personality stuff in there, it’s mostly depression, trauma history and possible substance abuse. So many of these stereotypes are tied in with a personality disorder diagnosis, and majority of the people including these two women that I have interfaced with that had interaction with the legal system in some way, did not have that you know. Wow, gosh, I never thought about that (personal
Lori noted that in her experience the violent female offenders she worked with displayed behaviors that were aligned with patriarchal society views of women.

You know what, in my experience they usually still are meek, very passive people or individuals. Most of them you would not even know or assume they had any violent history. The majority of them I saw, felt wronged by the person they abused or tried to kill, boyfriends, husbands, girlfriends... Most of the time it was related to a significant other that had hurt them in some type of way but their personality did not seem more aggressive in any type of way, umm if anything maybe more meek than anything actually (personal communication, January 10, 2016).

Carol noted the obstacles that can present in treatment with acknowledging the labels that may have been placed on violent female offenders by society.

As a clinician, I don’t, I see that that person is a person, at the end of the day they have feelings. Whatever they were going through at that time, I don’t know what they were going through all I know is what brought them in that moment and how do you move forward from that. How do you, because they have to live with that. Some people, you have those that are sociopaths but that’s a very small percentage of those folks. They had the same I don’t want to say opportunities as I did, but still would be the same emotions, issues, changes through life, and so be careful to not to place what a woman’s role or a man’s role is, be careful not to do that because you don’t know, it’s the individual that you are looking at and that
you are trying to help. And if I am already putting “you are supposed to be a mother, you are not supposed to kill your kids,” how do I know that I would not do the same thing if I was not put in the same circumstances? I cannot say that. Because they may not have had the support that I had had, they may not felt that they had a choice, so who am I to judge (personal communication, January 15, 2016)?

Jasmine verbalized common stereotypes that violent female offenders face and how those views can affect them negatively in the community.

I think a lot of... or some people may stereotype them as always going to be violent, difficult to manage or handle, especially in the community. A lot of my clients are in the hospital, one of the jobs I have to do during their process of trying to get out, is I am finding them placement. They are stereotyped just based on the crime and especially when it is compared to men. In some people’s minds they expect men to commit these crimes a little bit more than females, so then they look at a female and they have committed murder or have done this and done that, they want to put all of these safe guards in place for them that they may not necessarily do for males (personal communication, January 16, 2016).

Maya suggested there are stereotypes related to the client’s opinion of therapy, “First and foremost, they are probably there because they don’t want to be, they are being forced to be there either by the courts, the hospital, or the police or whatever.” However, there are also stereotypes related to race and decision-making skills of these women.

In the community I work with it’s a lot of African American women. So it’s the
stereotype that they are in gangs, or the reason that they are doing it is because they got caught up with the wrong man, or the wrong crowd. They kinda just follow the leader, they are disrespectful, back talking, those type of stereotypes in general, when you add the violent part to it (personal communication, January 16, 2016).

Veronica identified similar stereotypes about violent female offenders with respect to personality, motherhood, and the therapeutic experience.

Hmm, I would say some of the stereotypes that you might see or believe in are that women who have a history of violence may not be nurturing in nature, they may not have the ability to be great mothers, they may be very impulsive in nature, and possibly that they may not be a great client as far as your ability to change their behaviors, or help them to change their behaviors (personal communication, January 23, 2016).

Veronica also pointed out that the racial or ethnic background may also influence the stereotypes placed on these women and the reason for their crimes.

Depending on the cultural background it may be different stereotypes that you would see, maybe a Caucasian female that is coming to you with a history of assault. I think the type of assault that you may think of, or the reason behind it might be different than if a person of color is presenting and is your client (personal communication, January 23, 2016).

Contrary to Jasmine’s remarks about her own challenges with reintegrating female violent offenders in the community and receiving more safeguards placed upon
them due to their history, Mike expressed, “From a man’s perspective they feel they are a little more lenient when it comes to women. You know that they [women] should get just as much time as the male. That’s one of the biggest stereotypes you know” (personal communication, January 25, 2016). Participant eight, Mary, identified stereotypes such as “That they come from a poor socioeconomic class, poor education, that all of them are black (chuckles), that they are on some type of substance, and some of them aren’t, that some of them are in gangs” (personal communication, January 28, 2016).

Rapport Building. Whether therapists are aware of it or not, their values, biases, and assumptions about what is normative is communicated through their words, body language, interactions, and other behaviors (Bermudez, 1997, p. 254). Lisa conceptualized that how these clients are perceived would provide an inauthentic therapy experience as she went on to express,

I hear a lot of people with these stereotypes in the world, you know and they have never been in that situation, and nobody in recent generational memory in their families have been in a situation where there was potentially desperation, and so that’s why I think that can be a barrier. And sometimes I even will hear counselors say things, that tell me this is a barrier; that this counselor has a mindset about a person who’s had this experience, and I see that as a problem. On one hand there is reality and in our field there are trends and there are patterns, but underneath those different patterns there is a human being, and if you don’t get past that how are you going to help that person (personal communication, January 3, 2016)?
Lori highlighted that by being authentic in the relationship, the women in this population may be able to be more receptive to the therapist.

I find that you probably would have to be the most genuine self when building rapport. Most of these women have had very difficult lives, so they have big trust issues. People have violated their trust in more ways than one. So, it usually takes a lot of time, and you tend to, I tend to be more “real” in the session, as in putting forth some of my personality so that you understand I am a real person and I understand that things happen, and people make mistakes, but if you don’t want to continue to live your life the way you are living, we have to do some things differently (personal communication, January 10, 2016).

Carol verbalized how important it is for therapists to be aware of their presentation to the clients.

On the part of the therapist or clinician, it’s their job to be aware of their short comings or their insightfulness to be able to reach out to this person. It’s funny with clients, if you already say you read a note about somebody oh they have all this stuff going on you have already formed your preconceived notions you go and get your client from the front they see it on your face already like, “oh, you’re one of them,” and they shut down because of how you already presenting. So it’s a two way street. As supposed to be trained clinicians, you go in with a clean slate (personal communication, January 15, 2016).

In order to have the opportunity to have a positive experience in treatment, Carol recommended,
Make them part of the process, I can’t go in thinking ok, this person got this and judging them by what someone else may say, I have to give them a chance if I want to build rapport. My ultimate goal is for them to get better (personal communication, January 15, 2016).

Jasmine continued to explain her position on how mental instability can affect counselor-client interactions, as she stated “I think they may be a little more guarded so it makes it a little more difficult to establish that relationship and a level of rapport needed to move forward in treatment with them” (personal communication, January 16, 2016). Jasmine went on to indicate other potential issues such as high levels of mistrust, “I think their level of trust or being able to trust someone is reduced other than females that may not have committed violent offenses” (personal communication, January 16, 2016). Maya supported Jasmine’s views on the potential for mistrust to take place as she shared,

Just building that rapport in general, at this point if they are meeting me and they have such serious violent charges, then they have had pretty negative interactions with the law, with any system, so it’s pretty hard to gain their trust at this point (personal communication, January 16, 2016).

Mary further reinforced this shared notion with her statements as she explained,

A lot of times it is a little hard because they don’t trust authority, no matter who. They feel that the system has failed them so many times. Or by the time they finally get to the see me at the hospital they have been arrested a few times, and they have been in prison, and however they were treated. I hear a lot of them say when they went to jail they weren’t given meds in jail. Um, and they may have
asked for their meds, or in jail they diagnosed them with this, and they never got the medication (personal communication, January 28, 2016).

As a result of experiencing this lack of trust, Mary noted it may not be as challenging to establish rapport with women who are not violent offenders.

It is easier to build with women who do not have that history because sometimes at that point, they come in and they know something is not right, they want help. A lot of times the other women are already on defense, they are always looking for the con, or you know like “you are just doing this, you are not vested, you don’t care, or why do you care when so many other people haven’t cared” (personal communication, January 28, 2016).

Taylor suggested that a criminal background may not be the only barrier to establishing rapport, but it also depends on the client’s readiness for treatment.

I won’t say it is difficult just because of their criminal background, it depends on the individual. I have had clients who had charges for manslaughter or assault with a deadly weapon, but it just depends on if they are ready for treatment. Because I think that once you have reached that point where you have recognized “ok, these are the things I have done,” you know, “I have identified this is not the way I want to lead my life, I want to move forward.” I think once you have that frame of mind, that you want to move forward, I really don’t think having the charges or not having the charges would make a difference in how receptive they are to the counselor or treatment. I just think that as the individual, you just have to come to terms with “I am ready to move on, I am ready to deal with my
demons.” But, I really would say in my opinion - that you know it is more difficult for women who have that background versus women who don’t, I just think it is their position and the mind frame that they have relative to treatment (personal communication, February 4, 2016).

Counselor Diversity

Race, Gender, Socioeconomic Status, Life Experiences/Background. Bermudez (1997) noted rigid formulation of the therapist’s worldview can limit clinical effectiveness in treatment. In acknowledging how her own race and gender could potentially be an obstacle in her ability to engage with these women, Lisa expressed “I think that is just in everyday life, I mean, I am also coming to this from a background I’m white, so I am privileged, in education, and all of that” (personal communication, January 3, 2016). Lori pointed out that her own family experience heavily influenced her willingness to work with these women.

I feel like I am very competent working with this population. It’s actually why I got into therapy because my uncle was in prison. I felt like people who were in prison were given the wrong stereotypes and he served 7 years. He got out, has been out for the last 20 years, he has never gone back, but he had a bunch of charges, he did a lot of things. So having that experience with him, when I got to college that is what I wanted to do, I wanted to graduate, work with ex-offenders and help them come back into the population because I felt like it was terrible to think that just because I made a mistake, or my impulses got the best of me, or “shit happens,” at the end of the day, who am I to judge? And they need a little
more assistance than the average person (personal communication, January 10, 2016).

Carol identified how her gender impacts her interactions with the women in these circumstances, and also noted the possibility for either herself or a family member to be in a similar situation.

Being a woman myself dealing with that population I am more sensitive to that from the jump, because a) I could have someone in my family who is in that situation, or even like I said everyone’s life goes a different way, it could easily be me I always feel like that, it could be me sitting in this chair (personal communication, January 15, 2016).

Maya also communicated how factors such as race, gender, and background can create barriers as well.

Then me being a female, counselor, African American, I’m aware of how I present myself, so a lot of times I have issues with them thinking that I am better than them, or them thinking that I would not know anything about their situation because I don’t come from a particular background according to them so, kind of balancing that out, especially with females in general. Just having to get used to there is always that competition factor, in a lot of people’s minds especially if they have a violent background because that is usually what’s going on in there (personal communication, January 16, 2016).

Veronica also recognized the potential for the competition factor that Maya alluded to, as she voiced,
Sometimes it is easier said than done, and being the same gender you might forget your role and get caught up in a battle or a conflict between you and your client. I think it is kind of something that you can’t avoid, but it is going to be very important that you’re mindful of it when it does occur, so that you can, you know do what you need to do to get back on the right track (personal communication, January 23, 2016).

As the only male participant in the study, Mike, also identified how his experience of being the opposite gender could also pose challenges with this population.

One of the most difficult to work with, with me being a male, are the females that have been abused by a spouse or another male. So those are the most difficult to get engaged, because you have to try to establish some trust, you know what I mean, and umm, it’s kind of difficult for them to break that, “every man ain’t the same” (personal communication, January 25, 2016).

Gabrielle mentioned how gender roles could pose a problem when working with marginalized groups, “As women, I think we are very empathic and we put ourselves in a situation” (personal communication, February 1, 2016). Yet, she explained how her own family background could heavily influence her ability to be empathetic while working with these women if she was not cognizant.

I had a family member that was this person, um who, on one hand I am like, “can you get it together, you have no idea what you are doing to your family, I don’t want to hear you whining about how you are going to do the work one more time and everyone can help you.” And so I think on one level I’m not necessarily the
most sympathetic, but what I can do though, is because I know this particular family member did not have this history [trauma], knowing that helps me because then I can say, “we are not talking about that, we are not talking about you, we are not talking about your family” (personal communication, February 1, 2016).

Taylor noted, “I used to work in corrections at the YDC (Youth Detention Center) with at risk youth. A lot of the time I dealt with kids who had sodomy charges, I did have a couple kids who actually committed murders” (personal communication, February 4, 2016). She communicated how her employment background led to her ability to have a better frame of mind when engaging with this target population.

Empathy

The therapeutic relationship calls for the use of empathy as a manner to join with the client. However, study participants verbalized how their various experiences with being empathetic to violent female offenders led to incidents of being overly empathetic, not empathetic enough, or being challenged on their capability for empathy.

Lisa shared that while she would attempt to empathize and gain understanding about the experience of these women and their violent crimes, she had to be honest about her own feelings.

Um, I think one thing for me that I try to be aware of is that even though I may be able to share in the feeling, and empathize in the feeling that turned them to act. Knowing that I haven’t been in a position where I felt like that is what I had to do to keep myself safe, or to make myself heard. I try to be really aware that even though I empathize with that feeling, I have not been in that situation. For me
there is a lot of desperation in that, um, in both of my situations, it was relationship issues where the women were engaging either with their partner or with someone who was a threat to their relationship, and you know that gives me a lot of pause. The desperation they must have felt, for them to take that measure and I try to always remind myself I have not felt that level of desperation. Even if I can identify with that feeling of worrying about abandonment or losing that person I haven’t been in that situation where I had to take that action, or felt like that action is what I had to do (personal communication, January 3, 2016).

Lori expressed that at times it was positive to identify common experiences with these women.

I was diagnosed with post-traumatic stress disorder in 2008, and I specialize in trauma focused CBT with adolescents and minors. I have done a lot of extra things on people who have trauma because I can relate to it and so forth. Um, I generally, when I am meeting people, it is always comforting that they have similar symptoms. My favorite symptom is hypervigilance [laughs] it’s absolutely my favorite one, and not everyone has it, but I know I have it. So if my clients are telling me stories and so forth, I’m like “Oh, I know what that is, I have a name for it,” and when I found out what I had and my symptoms had names, it was very comforting. So I like to give things a name, not to purposely categorize, but it is nice to have some type of category to put the stuff in. Absolutely and totally you can experience these things (personal communication, January 10, 2016).

Carol relayed how violent female offenders may come into the therapy experience
doubtful the therapist would be empathetic to their experience.

With the behavioral health, we already have the, “you are trying to figure me out, you are trying to read my mind, you are trying to fix me and there is nothing wrong with me, I don’t need this, you don’t know me you have no idea what I have been through” (personal communication, January 15, 2016).

Mike shared his similar experience of being met with suspicion while trying to be empathetic. Noting the women would make remarks such as, “Have you been there, do you know my pain, do you understand what I am going through, what is happening with me” (personal communication, January 25, 2016).

Jasmine shared how there would be a great need for empathy due to the possible history of trauma stemming from various disturbing events in the lives of these women.

The population that I deal with or have experienced, yes, they have usually some history of trauma whether physical or sexual as well, as a lot of them have other underlying causes besides their mental health, they have long histories of substance abuse as well. So, I tend to do a little more thorough assessment of what their background may be to get a hold of something that may have triggered the aggression (personal communication, January 16, 2016).

Maya also shared similar views posed by Jasmine as she stated,

I try to see what their background is because I think that a lot of female violent offenders have some kind of history growing up I’m always conscious of the fact that our surroundings influence what is going on. Because in most cases they are coming in inpatient on a 1013 (involuntary psychiatric hold), they have some kind
of mental health component going on with it, I try not to separate that from the violence. I try to think of it as being congruent so it’s not that they are just violent, but there is something else triggering it. The systems base is generally where I start but as far as groups and when I am assessing, I just try to come to at it from their point of view to help them see what their part is, in what is going on. I believe in trying to strengthen that personal accountability (personal communication, January 16, 2016).

Veronica highlighted that therapists may not be as open to sharing in the feelings and experiences that violent female offenders may have had, resulting in a lot of their stories being untold.

I think unfortunately women who have a criminal background they are automatically judged to be violent; and channeling in on history of trauma is not as welcoming or not done in a thorough manner; as opposed to someone that doesn’t have a background... Unfortunately I don’t think clinicians or therapists think to themselves or ask themselves, “Wow, I wonder what kind of traumatic experience that person may have had in their life.” So yea, so I think we overlook it a lot especially in this population, definitely (personal communication, January 23, 2016).

However, Mary expressed how once the traumatic histories of these women are uncovered, it may be difficult for counselors to maintain appropriate boundaries at times.

I think a lot of them have had a lot of traumatic history. They have, some have been abused from family members, on the street. I forgot one told me the term, I
forgot what the street term is, but she was actually used in lieu of payment for
drugs for her mother. But she had a term for it, and whatever term she used, I had
never heard it before, and I thought I was kind of savvy with street and drug lingo
and so when she said it, I asked her and said, “Oh she used me in lieu of
payment.” And I said “Oh,” and I just wanted to hug the poor baby. So yea, a lot
if it is the stuff we never think of they’ve experienced (personal communication,
January 28, 2016).

While over empathizing may occur, Mary identified that counselor empathy could
provide opportunities for these women to gain insight and better decision making skills.

I think because after a while I’ve learned not to just take what I read at face value.
It’s a story behind everything, like you know, whether it might be an excuse or
whatever, but it’s their excuse and in their world it was justified. So then just to
find out like what happened to get you there, which was one of the reasons why I
wanted to get into this field - was to find out what got you there, what was your
thought process? To just you know... and to let you know too you weren’t wrong
with it. Because you know I think society so often when they have been arrested
wants to say “you were wrong,” but you know they weren’t. They already beat
themselves up about it. You know you served your time, you dealt with it, you are
sorry, when you sleep I don’t know if that still eats you up at night, but I am going
to help you process through it so that it doesn’t happen again. There are better
choices than that, you are not a punk for walking away, you are not a punk for
letting police get involved to handle a situation, even if you think they have failed
you so many times. Keep reaching because you may get that one officer, that one
EMS worker who will do it, that will help you (personal communication, January
28, 2016).

Gabrielle highlighted how therapists may be less empathetic due to how they believe they
are viewed by violent female offenders themselves.

Oh wow, because people who have, especially when they have been incarcerated
have a very limited view of folks in our situation. They sort of see
therapists/social workers as ok, what can I get from you and what do you want,
you want to hear my story again? They have seen “you” a million times, they are
tired of you. So what they really do is they come to you a bit jaded about the
therapeutic process, because at this point, they have already seen two therapists.
Maybe a therapist in jail, or maybe their probation officer or social worker asked
them to seen them. So their idea is not that you are going to be able to do much
for them, they kind of see you as a means to an end. “Oh, I need to see you so I
can do whatever, or get off of my probation” (personal communication, February
1, 2016).

On the other hand, Gabrielle also noted some of these women may be comfortable
sharing their stories regarding trauma and seeking counselor empathy or sympathy as a
form of possible manipulation.

Women who have these incarcerations are so used to telling their story they are
like “alright this happened and I got this and here you go,” give it everything… I
would say the biggest difference would be whether or not they are just telling
their story to do so because they are arrested. Because you also realize that if I am arrested and I am going before a judge, I want to make myself seem as - I don’t want to say pathetic that is not what I mean, but I want to certainly seem as, “Oh, please help me judge,” you know as possible, so I am going to give my full history. I am going to be, “Oh, this happened” (personal communication, February 1, 2016).

Taylor verbalized that despite the challenges that may occur; a clinician’s ability to be empathetic can result in a valuable therapeutic moment with this population.

One of the experiences that I did have, this particular woman was a victim of molestation when she was younger, she met her husband, but before then had a string of bad relationships whether it was verbal or physical abuse. She was in this marriage or what not, and obviously her knowing it wasn’t healthy and it wasn’t something that she needed to do, that was her sense of security... Even though these people have these backgrounds, they went through these experiences, you have to dig a little bit deeper to realize or to figure out what went on that led them to this place. What happened in their lives or during the course of their lives. And with her uncovering that, it made sense, I think it changed the way that I interacted with her, I was a little more empathetic because you know she was abused, emotionally and psychologically. It did change the way that I approached therapy, the demeanor I had around her. I think with her, I was able to be more silent, and really just let her express herself because I felt like she really never had a period in her life where she had someone she could vent to; and it would be
constructive as she would have to come to terms with her feelings (personal communication, February 4, 2016).

Cognitive Dissonance. Sinha and Kumar (1985) note that people form expectations based on stereotypes about crime, criminals, and socioeconomic status, and they experience cognitive dissonance when there is an inconsistency and "one cognitive element implies the opposite of another" (p. 485). Lisa verbalized an example of coming to terms with the experience of cognitive dissonance while working with these women.

I remember I was very nervous about this, and I wondered how she would be. I remember like seeing this she had this like a protectiveness to her which makes sense, every time you talk to a counselor most people are protecting themselves but then there was this vulnerability. You know and when I found out umm you know her mom had died, she had lost custody of her youngest children and she was trying to live a life where she was trying to get custody back of her youngest ones, I mean it just opened a whole new door, it was an amazing experience (personal communication, January 3, 2016).

Lisa later went on to expand upon her previous statements about experiencing cognitive dissonance, pointing out how gaining insight into her own perceptions allowed her to view these women in a more positive light.

When I first started working with these women I just expected hardness & resistance and toughness, and kind of, I was expecting pardon my French, kind of a "f you" attitude. These women, the amazing thing is that they so opened my eyes to show, that's not true and if you see that toughness, they had to develop it
to protect themselves. They might not be here if they hadn’t developed that exterior. So I also came to see it, as that was my stereotypical perception as I approached cases. But I also came to see that even if that is true in cases and there is that toughness, there is a reason it’s there, it’s a coping mechanism for a lot of the women that were involved because they were vulnerable in situations in some cases that is the only reason they are here (personal communication, January 3, 2016).

Lori on the other hand, honestly expressed that while engaging in clinical work with this population she was unsure if she experienced any cognitive dissonance, as she was more focused on utilizing the skills learned from her education and training.

I don’t think I was even in that zone to even think about that, I was relatively new at being a therapist, so I think I was probably concentrating on, did I get all the techniques I was supposed to use in doing this, am I being helpful. I will go with yes though, I am not very sure (personal communication, January 10, 2016).

Jasmine communicated that she has experienced cognitive dissonance due to the female offender’s mental instability being linked to the violent crimes that were committed previously.

Regarding cognitive dissonance I would think so, I think that just has to do with the fact that most of the females that I have dealt with were found to be in a state of mind at the time of the crime where they were not stable - so I am not necessarily looking at them you know, based on their crimes and I am making a stereotype on their ability to move forward because of that. I’m kinda taking them
at a trying point from here and working with them based on what they are giving me at the time (personal communication, January 16, 2016).

Maya presented how being faced with stereotypes and experiencing cognitive dissonance led to her having increased mindfulness.

Cognitive dissonance for me it's safety issues. Honestly, like trying to scope it out to see like am I going to be safe in this scenario, do I need to be in a room with twenty doors, that kind of stuff. That they have no home training, or that their family life was a certain way and that is why they are the way they are. I think those are some of the stereotypes I personally had to work through or deal with. It didn’t match up with what I thought, especially with me being an African American woman from a community such as that, shedding that skin and being a counselor, just being aware (personal communication, January 16, 2016).

While Veronica was unsure if she experienced cognitive dissonance while working with this population, she acknowledged how safety concerns could influence rapport with the client, similarly to Maya.

I am not sure I have encountered cognitive dissonance, but I will say as a clinician safety comes first. If I am told before I see a client that they have a problem with aggression or a history of violence, automatically I am thinking about my safety first, and if I go in with any fear or any hesitation, obviously that might get in the way of establishing a good rapport (personal communication, January 23, 2016).

Mary also shared the same sentiments about safety, but like Maya she was able to point out how gaining additional knowledge about the circumstances that led to the event, may
create cognitive dissonance.

Yea, um, you know that person and they tell you, “I got out for murder in 2005,” and you’re like “Oh, I am sitting an arm’s length across from you” (chuckles), you kinda want to take the pen and keep it closer to you, or “can I see your pen? And you are like - nooo, you can’t see my pen” (chuckles) you know. But then when you find out why they did it, it may have been vehicular homicide because they were out drinking, it changes the dynamic of why. Or even if it was you know they got into a fight with someone and then at the end when the person made it to the hospital they died, oh, well what was the fight? It makes you ask those questions more. Were you just on the street looking for a fight, or was it something where you defended yourself, or you felt you had to defend your honor and it just went too far (personal communication, January 28, 2016)?

In discussion about cognitive dissonance, Gabrielle voiced she expected there to be distinctions in the women’s background experiences and their violent crimes based on race.

Probably that there would be a greater racial divide, when in actuality, when I dealt with women their stories were exactly the same. I thought I would see “oh, these folks do this and these folks do that,” but it really was very little. And when you find people in that position you find that they had very little issues. I thought that people from different cultures and backgrounds would feel differently, and they don’t (personal communication, February 1, 2016).

Boundaries. In an attempt to ensure treatment goals will be addressed
appropriately, clinicians may set limits to maintain a working relationship and promote client progress. Carol explained that while empathy was necessary in the therapeutic relationships, limits still need to be set in order to ensure these women can gain insight into their behaviors and make better choices going forward.

So the focus of course is support, support, support, supportive therapy, CBT, DBT also help. Trying to deal with the trauma, and trying to build up and figure out their triggers and so they can identify those triggers so that they are not just having that excuse I just blacked out or went wild, whatever no, you put yourself in a certain situation and you keep putting yourself in a certain situation so it's not so much blaming the victim, but it's like what can we do differently, what's a different path with that, and so first building that rapport being on their side but also setting that boundary with them showing them that look either you can go down A or you can go down B, you always have a choice. And your choices have consequences to those (personal communication, January 15, 2016).

Veronica also supported the need to set boundaries and limits with this population in order to undertake the work that needs to be done.

I have found women with that background, they might be a little more sensitive and they are more defensive in my work with them. So just making sure that I am clear, that I am directive. That I am also sensitive to maybe what they may have experienced, is important. Also setting boundaries with them as well (personal communication, January 23, 2016).
Experience

Participants described how the combination of life experience, education, and professional experience can impact the ability to actively participate in treatment. Lisa suggested there will be some challenges as a new clinician and especially working with a target group such as violent female offenders.

I think that when you're first starting out, you haven't met enough people to know, and you are learning, and your counselors are saying really if you are working harder than the client that is not the way that it is supposed to work, but if you feel that challenge, you don't believe it until you have had that experience.

For me, now that I have had the experience, I've talked with people on a regular basis in my work, who may have convictions in their history and it's like one thing I am aware of, but I don't see it as a barrier anymore because I have had the experience of working with enough people, just being there and creating that space, I'm seeing that there weren't barriers, at least with the women I have worked with, there weren't (personal communication, January 3, 2016).

Lori seconded the notion of the potential for growth with experience per her statement, “Well I think the more experience you have with individuals just in general is going to change your approach and how comfortable you are” (personal communication, January 10, 2016).

Carol voiced that therapist life and professional experience in combination with education and training can lead to their perception of violent female offenders.

My personal opinion, I don’t believe it has anything to do with your title, it’s your
experience. You can have someone coming in going to school because you know, that was me, I was aggressive, I was in and out, and now I feel like I’m better, feel like I’m stable and I want to help women so I am going to go into this field. So, I can better interact with them, it depends on the person’s experience. Or you have some people coming up I remember some people in my class thinking you could be financially ok in this field, they get there and experience some days and be like “whoa,” they have these stereotypes in their head from what they see on TV what they have experienced and they bring that stuff in. But I actually feel in this field when you go through the whole process as far as your internship, practicum, supervision it is going to make you or break you. And if it doesn’t you will see the quality of your work as a therapist, do you keep clients? How is their progress? Because at the end of the day, it may not be the client, it may be you projecting that stuff on them. So for me, you may find a LAPC that may be more conscious and more insightful than someone with a LCSW or doctorate, so it depends on you first, rather than what your title is (personal communication, January 15, 2016).

Jasmine revealed that in her opinion, when working with a target population such as violent female offenders, therapist experience is key to satisfactory treatment provision.

I think just depending on the level of experience that professionals have with them, their perceptions of them may be a little skewed and they may not have a good grasp or understanding of different or various aspects of things they may be
dealing with or the various aspects of their life, their background. So it makes it a little more difficult for those who have not worked with that type of population for long periods of time to get a good understanding to provide the level of treatment that they may need (personal communication, January 16, 2016).

Maya expressed how her own encounters as a new counselor working with this population created some fear, however over time and with experience that fear lessened. As for counselors in training, I know when I was in training, violence kind of scared me a bit, so I can imagine they would have more stereotypes and more negative perceptions about violent offenders, females particularly. And that would kind of influence their bias, versus someone who has been in the field a while and has worked inpatient or in jails. Inpatient or jail setting, since you see it so regularly, you may become indifferent in a way, because you see it so regularly. You have to kinda say ok, sometimes they are in and out, or they may keep coming back. Now if you are in a community setting, I think that that would give you more empathy or you would have more of a viewpoint of trying to change things, not even just at the individual level, but advocating. But I think that comes with experience and knowing what you want to do. So as a training counselor, I think it would be more bias (personal communication, January 16, 2016).

Veronica explained that it is important to obtain appropriate training in addition to experience to be more open to this population and the potential for client progress in treatment.

I think the perception is different based on training. Because me being a clinical
professional counselor I am trained to look at a person on a holistic level, looking at different - basically conceptualizing their issues more realistically than just looking at the presenting problem, and how they present themselves when they have their first encounter. I think some other professions, like social work, or those with a criminal background that may be doing some form of counseling may already have a preconceived notion or negative perception of females that have a violent background, or that are known to be physically aggressive, or have assault charges. I think as a clinician if you are just more mindful that the person is a human first and not automatically assuming that this person is going to attack you, I think you will go a little further with building rapport and being successful in treatment. Also being mindful you have to consider they do have a history, and how your work with them may be different from someone who may not be able to deal with conflict or disagreements in a more healthy manner (personal communication, January 23, 2016).

Like other study participants, Mike supported the notion that therapist professional experience is a big factor in successful treatment.

I think a lot has to do with their experience coinciding with the experience of the individual that they are working with. The level of training yea, and definitely the educational level, some of them with a few years in the field and been doing it a while, that comes into play too (personal communication, January 25, 2016).

Mary shared her opinion that without experience new counselors may be unable to realize the possibility of other factors being in play at the time of the violent crime. She stated,
"They might be a little afraid or might automatically think that they maybe had plotted to do it, instead of maybe looking at it like it was an impulse to something else" (personal communication, January 28, 2016). She elaborated on how she is able to assess for other factors such as substance abuse or mental illness as a result of her professional experience.

I always ask about if they have had any prior arrests, and that is even if they don't come in for an assault charge. That is when I find out a lot about the charges that they have had, whether it was due to fighting, but then you find out in the method of the fighting that they picked up objects, you know or things like that. So then I ask about well have you ever been diagnosed, are you taking your medications, when was the last time you took them? So a lot of times I think that a lot of that is based on the impulsivity, because of the mental health issues too, so they are not able to kinda rationalize. And, when you are angry it is kind of hard to be rational anyway, but most people, "normal people," can kinda say, "if I do this, this is gonna happen," or, "you are not worth going to jail," or, "I do value your life." And I think when they have their mental health, or they just see that rage, or even battered women syndrome, their rationale is out, they don't see that. They just "I wanna hurt you, just as much as you hurt me" (personal communication, January 28, 2016).

Gabrielle seemed to agree with the views expressed by the previous study participants with regard to experience, but also presented that with experience comes a sense of realistic professional expectations.
I think that whenever you are in training you have sort of a bright-eyed look. You pull out your DSM and your "how to do therapy 101," and you say the right things and you believe that it would make this huge difference and what you learn, whether it be associates, and certainly as you become seasoned. I would say someone with an associate's level, you are becoming far more realistic perhaps, but you still have sort of an idealism in terms of what you are going to change. Once you are licensed, you are sort of like "alright, if I can make a difference in this one person," that you have a much more narrow view on what you can do. I think that when you are still in school, and this is my opinion, you really believe you are going to invent the intervention that seriously changes the tide and it is going to empty all the female prisons, and you don't realize until you are out there, and you have been doing this work for a while, wow, you are just really making a dent (personal communication, February 1, 2016).

However, Taylor had a unique outlook on how new counselors may approach working with the women in this target group.

I think it is different based on level of education because I think you know, new graduates they would probably be a little more in-depth; they would probably try to search for things or be outside of the box. I think the more seasoned you are, once you have seen it all, once you have seen too many, you know - clients who have dealt with those issues, you have kinda seen them all. I think that you just kinda go on your knowledge base up until that point. I guess I would say like your instincts. With the more seasoned professionals, I just really think that their
perceptions may just be a little more broad. I don’t think they take the extra time to research family history, or even try to figure out why this person is offending. Is it a pattern, the social aspect, more environmental, were they victimized, were they abused as children, as adults? You know, there is a large trend that I am getting into now, where a lot of women and children I have treated have been involved in sex trafficking, so there are a lot of different dynamics.

I think that maybe the LAPC’s or maybe the graduates who are just getting into the field, I think they may probably be the ones to look into those other areas. Whereas I think the more seasoned are just like, “this may be textbook,” or they kinda just settled for a type of protocol or what-have-you that they’re used to dealing with to address those issues, if that makes sense (personal communication, February 4, 2016).

Being Teachable. The ability to be flexible and open to learning is imperative to therapist personal and professional growth. Both Lisa and Lori suggested that while there may be strong opinions held about violent female offenders prior to engaging them in treatment, the hope is that these negative notions should be able to diminish over time with experience and continued education. However, Lisa maintained that if negative or judgmental beliefs continue to be present, then “As clinicians, if we are having those things [negative perceptions], we need to be open to being re-educated or we need to be working with a different population” (personal communication, January 3, 2016). Mike also promoted that clinicians should be open to learning from this population as a way to build rapport, “Just say, hey, teach me. Allow yourself to be teachable man, if you don’t
know, don’t fake it” (personal communication, January 25, 2016).

Competence. Over time and with experience in the field, clinicians aim to become more proficient at providing effective services to the clients they serve. Lisa conveyed the experience of working with this population leads to increased expertise as a clinician.

I think it increased the level of competency because I was definitely anxious about working with the women because of the way they would present in an outside social setting, I was definitely anxious about it. But the fact that this person came from a totally different life experience could connect with them, it made me realize how important it is to be aware, it made me competent because I was able to help these two women on two particular issues, and it also gave me the courage to be vulnerable for myself as a counselor, to not have a barrier up for them (personal communication, January 3, 2016).

Supervision and Consultation

Bernard and Goodyear (2009) define supervision as an intervention provided by a senior member of a profession to a junior member of the same profession. Supervision incorporates evaluation of the junior member’s professional functioning and the quality of services he or she offers to clients over time. Consultation occurs when an experienced clinician meets with a colleague to get ideas about how to manage cases that may be perceived as difficult, or to assist with maintaining objectivity (Bernard & Goodyear, 2009). Lisa shared how there could be a significant amount of distress present in the past or current lives of these women.

In my experience, their trauma histories are severe not always like physical
trauma, but like emotional trauma as well. One of my clients was molested and she really hid this for a really long time, a long, long, time, and when it finally came out when she would be working around things with that, it was like she turned into a 16 year old kid. It was like her whole presentation and everything and I was like, "oh my gosh this is it." And the other woman it was the trauma of loss. You know, and when I would be working with her, even though she was an adult and she had four children it was like she was a child wandering looking for her mom. And in my experience they had some of the worst trauma, with the exception of the children I work with now, little kids, as adults they had some of the worst trauma of any adults I have worked with in terms of loss and stuff like that. The only other people that I’ve worked with that had trauma at that level, are some children that I worked with (personal communication, January 3, 2016).

Lisa noted how having access to good supervision while working with these women afforded her the opportunity to see her clients from a different perspective.

Yes, I will be honest my supervision on site wasn’t that great, but my supervision at grad school was phenomenal and we talked a lot about that, and it was really good to be able to share you are seeing things and opening doors and stuff and having that support. And also to see that these clients have these issues with these violent histories they didn’t have the personality disorder issues, but then I had another client who did not have the criminal issues but did have personality disorders and it was weird because her presentation was more like the stereotypes you get told and these two women were nothing like the stereotypes you bring
into it and that was eye opening and when one of my supervisors was pointing that out it was like “Ding” (personal communication, January 3, 2016).

Lori reflected the need for supervision and consultation to assist with therapist insecurity and to gain a better understanding of client needs to ensure use of effective treatment modalities, and to avoid hindrances in the therapeutic relationship.

Let’s say for example, they are coming to see me for depression, I give them a couple of skills and those skills are either cheesy or boring or they don’t like them, then they are more likely to be questionable when they come back to the session, I may get cussed out, they may not come, or they’re usually forthright with it and say, “I don’t like this, I am not doing it, and it’s not helpful.” That usually causes a bigger barrier because then to them I’m not understanding what’s going on with them, I am not meeting their needs. But I am, with my education and background I am, but not in real life (personal communication, January 10, 2016).

Countertransference. Counselors that have unresolved personal issues and are engaging in the provision of therapy services may experience unconscious positive or negative reactions towards violent female offenders. Carol discussed how supervision and consultation would be applicable to ensure these clients are receiving quality treatment in the event countertransference.

It depends on your self-care and you being in tune with what is going on internally with you because countertransference goes both ways. It goes back to those stereotypical type of things - if I have already judged you, I put you in this
corner, so I am going to treat you differently. Is that good care? That’s not good care, I always go back to that (personal communication, January 15, 2016). However, Veronica expressed, “I think it is quite normal to experience some kind of transference or vicarious trauma, only because it can be very intense,” (personal communication, January 23, 2016). Presenting that some experiences with this population, including the potential for countertransference, should be expected.

Mary disclosed how her interaction with a violent female offender prompted her to become more aware of her own countertransference that could have had adverse effects.

It really did something to me, and I just wanted to hug her because I also realized reading her chart and stuff she hadn’t that. I just wanted to go home and like knit the baby a sweater. I mean that is just how much it...you know, at that moment... I have always been able to say I can work with any population, pedophiles - all stuff, because I had some experience with them working at DJJ. But this is the first one that I said, I don’t think I could work with that because I would have more empathy, more counter transference. It would be more a mother-daughter type thing than any other type of session. So when she went somewhere else it was almost kinda like a relief. Because every day I wanted her to be ok (personal communication, January 28, 2016).

Gabrielle also disclosed a significant moment in her clinical practice that promotes the necessity for supervision to address countertransference in order to avoid counselor impairment.
There was this specific person, a woman whose daughter was sexually abused by her boyfriend’s stepfather and it was very violent. She went to the judge and she tried to do everything possible, and the judge basically said since there was not a proper forensic exam then nothing could be done. Her boyfriend eventually got tired of the isolation from his family and he went back to being involved in that family. So she received a charge of stalking after pretty much making phone calls and threats, you know, things that I could understand someone doing. Not getting any satisfaction, basically a judge saying sorry, but you know... And she had a lot of proof, pictures... And I noticed I couldn’t stop thinking about her, I couldn’t stop thinking about myself in her position, I couldn’t stop thinking “she’s right, whatever she wants to do, I’m behind her.” And, “that’s not ok, it’s not appropriate,” but I couldn’t put her out of my mind, and even now I kind of have the attitude you know, that if he showed up missing, it would be nothing to anybody, it would be good for humanity (personal communication, February 1, 2016).

Supportive Work Environment. Employers that promote counselor wellness in addition to client wellness may assist with the various challenges that can arise for therapists who treat this population. Maya identified how supervision and consultation aid in allowing therapists to feel supported when working with populations such as violent female offenders.

I try to make sure I that I am aware of my perceptions and biases and I think that constantly checking in with myself, of course with supervision, and with
coworkers, because whenever we come across something that's that difficult it's great to have people right there in the moment who can understand or more than likely have seen the assessment themselves so you can get some feedback. That has increased how I feel, how competent I am, or as far as knowing when I need to learn more or get advice from someone else and not just thinking that I know what I am doing; but, at the same time not being completely uncomfortable working with that population (personal communication, January 16, 2016).

Veronica noted how lack of a supportive work environment or access to supervision could result in burnout.

Burnout depends on the work environment you have, what kind of work setting you are in, but yes definitely because most professionals who experience burnout more than likely they experience burnout because of organizational factors, maybe just not having enough support, not having enough supervision, not having a safe environment to even treat or have a therapeutic relationship with females who are violent or have criminal backgrounds with physical aggression (personal communication, January 23, 2016).

Self-care

Participants voiced the need to take part in recreational or leisure interests promoting physical, emotional, and mental wellness. Recommendations for diminishing the potential of vicarious trauma include focusing on counselor self-care, work related practices, along with supervision (Sommer, 2008). Lisa was very open about her utilization of self-care activities to take care of herself while engaging in clinical work
with this population stating “My thing was swimming I swam religiously 3-4 times a week 1hr a week, and if I didn’t do that... I don’t know how I would do this work” (personal communication, January 3, 2016).

Safety Concerns. Maya mentioned safety as an honest concern for her while working with violent female offenders. Veronica and Mary were also in agreement that there is potential for real threats to therapist safety based on the past offenses of these women. Veronica identified her fear for her safety was her main challenge while trying to establish rapport with this population.

I think the challenge is for one, is feeling that you are safe as a clinician. That you are safe to do your job, that you have administrators or coworkers, or staff there to support you if there is ever a situation where your female client may become aggressive while in treatment. Another challenge too, just depends on what is going on with that client, like if there is transference going on. You know, and someone who had history of being aggressive to another woman, and here you are as a therapist who is a woman also, there might be some transference going on that you may have to address, before you can really build a rapport. Also there can be a misconception that just because you don’t have a client with a background of being physically aggressive you may put your guard down and not be sure that it could possibly happen as well while doing the session (personal communication, January 23, 2016).

Vicarious Trauma. Sommer (2008) notes that vicarious trauma can result from direct engagement with clients whom have experienced severe trauma resulting in the
counselor’s experience of a combination of post-traumatic stress disorder (PTSD) symptoms including but not limited to: intrusive thoughts of client stories, avoidance of client related stimuli, or hypervigilance. While many counselors are exposed to trauma, not all counselors will experience vicarious traumatization (Sommer, 2008). Vicarious trauma does not reflect inadequacy or ineffectiveness of the counselor, however awareness and the appropriate management of practitioner trauma is essential to counselor wellness (Sommer, 2008). Mike shared his opinion that therapists can be faced with an emotional charged therapeutic experience while working with these women that could lead to vicarious trauma.

I don't think burnout is a really big factor. I think the vicarious part of it because some of the stories you hear, wear on you. Not saying it would burn you out, but it could break you down and you could become vulnerable, male or female you know. So you experiencing that, you gotta have a strong heart, but you gotta have a strong mind, you gotta be able to put up, you gotta be strong because they are going to present some really horrific stuff to you, and if you get sucked in, it can be tough. Just like the Madea movie I was watching the other day, where the lawyer was padding charges on the woman - that really happens (personal communication, January 25, 2016).

Gabrielle’s response reflected Mike’s views regarding how the stories shared by these women could have a tremendous impact on the therapist. Through her experience, it is evident that self-care practices are necessary to maintain mental wellness.
You know very often these stories are sort of re-told from great-grandmothers, to mothers, to women, to their children, these constant histories, repeats, and loops of abuse and it makes you feel very, very helpless, in terms of being able to really stop the system. And I would say it is very hard to put it out, so to work with this primarily would not be something I would necessarily choose, because I know for me in particular it was very difficult for me to put it down. It was very difficult to stop hearing that particular story, I can remember her saying that her daughter asked her, “when will it stop hurting when I pee,” and I can remember thinking that’s when I would go and do something to that person and I can understand it, and I remember thinking yea, I could understand that. I don’t think I handled it as well as I should have, I definitely discussed it with colleagues, but it was um... I needed to tell the whole story, and nobody wanted to hear it because of how graphic it was, so I think I just sort of ran it in myself over and over again. I know if I saw her for a session I would just close the door and cry because I don’t know how she is doing it. She was trying very hard not to get locked up, so she wanted to be there for her child, but she desperately wanted to do something to this person, so her big issue was sort of um a dual message. One part of her was like “if I was a good mom, I would go attack this person,” but the other part of her was like, “if I am a good mom, then I won’t go to jail for attacking this person.” So yea, I don’t know if I did handle it well (personal communication, February 1, 2016).
The potential for vicarious trauma was also recognized by Taylor who conveyed that in addition to living with the stories of these women, the pressure to try to provide them with effective treatment services could create distress as well.

I think it does have a tendency to allow for vicarious trauma. I think just as therapists you see people, things, and situations differently anyways. So I think that you know, treating clients that have all these histories, I think it has a significant impact. It is really hard when you are trying to go the extra mile and you are taking it home, maybe trying different modalities, or trying to incorporate other service providers, or core services, to increase the likelihood this client will succeed (personal communication, February 4, 2016).

The participants’ responses reflected a need for more education on the signs and symptoms of vicarious trauma to aid in recognition and immediate intervention in an effort to reduce the potential for impairment in clinical practice.

Burnout. Clinicians may experience psychological, emotional, and physical exhaustion related to service demands and a poor organizational system while working with this population; resulting in counselor intolerance or lack of motivation, which negatively impacts treatment (Bernard & Goodyear, 2009). Lisa voiced there may be instances of burnout due to counselor inaccurate impressions of what characteristics are necessary to engage in treatment with violent female offenders.

Yeah, you know there are some people in our field who have, I think, a hardness and I don’t. A part of that is because I feel like who I am, not having that hardness is the way that I help people. So I could see that if people were getting burned out,
that they might keep these notions about women to keep themselves safe, but it seems like you wouldn’t take care of yourself. And the more experience you have the more you are going to realize that you create the space and there aren’t barriers (personal communication, January 3, 2016).

Lori elaborated on the concept of self-care and its relevance especially when working with violent female offenders.

As far as self-care, I think if anything it is probably a reminder to me, on a regular basis to be more mindful that you do have certain things that you need to continue to work on and certain things that just are life in general. Kinda like take it easy on yourself, it is a struggle you are working on different things. So self-care I think is just more about time, less about the clients, more about the job, and less about them. If you have inmates and all of them have trauma and you are trying to help them get to a certain place in life and they are in prison, then absolutely I think it would [cause burnout], it would be really heavy emotions all on a regular basis, so it can be hard to separate yourself from that and not get caught on the rollercoaster that they go through, because these stories are sad, these stories are horrific, they make you think twice about what human beings actually do to each other so, I think whoever works in this population should absolutely take more time to utilize the skills that we give others (personal communication, January 10, 2016).

Carol emphasized the need to put self-care practices into action to avoid burnout in spite of the demands that may be placed upon a therapist working with this population.
If there is something that comes up for me, where I am like ok that does not feel right, or I am putting my stuff in this, that I need to consult and to refer to someone, hey I need to talk to you, or I need to take care. Self-care, self-care, self-care, that's how that works. Because if you are constantly, with any type of situation but especially with that population - there are implications: probation officer calling you, pending court case coming up, or due to this they have been removed from their family support. I have to be aware that I may be their only person, I need to be aware that I still have my limitations on how I am. I can't rescue them, I can't take away the legal charges, so that goes back to being insightful and aware of what is going on with me, but always trying to get support for myself. My job is not to fix them it's to support and work with them and if I find myself leaning towards the burnout side, I have to be aware that I need to get the support I need so that I can more help the person (personal communication, January 15, 2016).

Jasmine explained her ability to integrate self-care has assisted her with effective coping. As far as burnout is concerned I haven't dealt with that, I've learned over the years how to kinda separate myself from it and shut that part of my life off when the time comes, but when I am actually at work it can become overwhelming. But luckily I have reached a point in my career where I don't let it overwhelm me, so I do try to do activities to kinda keep my mind focused on other things at times to not be consumed with work or clients (personal communication, January 16, 2016).
Veronica shared “It’s definitely possible for clinicians to become more burned out with working with this population. Yes definitely, if they don’t have the right support to address issues as they come” (personal communication, January 23, 2016). Taylor admitted to her own struggles with behaviors that could lead to burnout, and acknowledged it is something she has to continuously keep in mind.

Um, well one of the things I am currently working on as a therapist, would be my need to want to save the world. When I see my client going through something, I find that sometimes they don’t have the confidence they may need to get them on the path where they are ready to address issues. I want to be their number one cheerleader, I want to encourage them and be able to help them instill their confidence; where I can be able to kind of back away and let them navigate their own treatment. Sometimes I feel like, some of the clients that I have had, they don’t have any self-esteem, they have no one who believed in them. It’s possible, it’s a process, but for me I really try to go the extra mile to let them realize who they are, let them know everyone is recovering from something, everyone has made mistakes, and you don’t have to be defined by the mistakes that you have made. I think it does affect burnout because I am going the extra mile to help them develop a frame of reference for the way that they see themselves. I think it does have more to do with burnout and it is very frequent for me, and that is why I have to work at it, get my consultation, figure out other ways that I can go about it (personal communication, February 4, 2016).

Her example identified how burnout can occur due to lack of firm boundaries in practice.
Summary

Chapter four presented the research findings from the phenomenological analysis of therapist perceptions about violent female offenders and their influence on the provision of therapeutic services. The emerging themes and subthemes indicated there were commonalities found in the essence of the experience among counselors working with this target population and their perceptions about the women they serve. The essence of the experience encompassed a combination of a desire to be non-judgmental and proficient as a counselor, yet some hesitancy due to the perceived or real challenges associated with establishing rapport which could be related to safety concerns or client distrust, in addition to the potential for experiencing countertransference, burnout, and vicarious trauma. Participants in this research shared issues pertaining to self-awareness regarding bias or the potential for bias, boundaries with respect to client trauma, as well as the need to be open to learning. These results promote how supervision and consultation are essential to maintaining counselor competency within their scope of practice with violent female offenders.

The subsequent chapter will emphasize the importance of the findings of this study in relation to the existing literature pertaining to therapist perceptions and their impact on the provision of treatment services to violent female offenders. Implications for counselor educators and supervisors and counseling professionals will also be discussed. Additionally, the limitations of this study will be presented and recommendations for future avenues of research will be included.
CHAPTER 5
DISSCUSSION, RECOMMENDATIONS, AND CONCLUSION

Discussion

Qualitative research can allow counselor educators and students to expand their awareness of alternative approaches to exploring inadequately researched areas and spark conversations about important issues (Kline, 2008). This research allowed counselors to share their perceptions about providing therapeutic services to violent female offenders in various settings. Study participants were able to identify the importance of life experience, education, training, and supportive work environments, in relation to possible fear of safety and vulnerability, trauma exposure, and burnout that may occur while working with this population. With six predominant themes emerging, the importance of genuineness/authenticity, impact of counselor diversity, the need for empathy and barriers to being empathetic, the professional growth that comes from experience, the benefits of supervision and consultation, and finally, how self-care is essential to counselor well-being.

Each participant in the study appeared to be open and honest with their thoughts about the provision of mental health or substance abuse treatment to this target population. Some participants were able to verbalize concerns for personal safety with regard to providing therapy to women with a history of violence. Other participants expressed a desire to explore the underlying causes for the display of aggressive and
violent behaviors that led to their incarceration. Several participants identified their experiences with these women as a great learning experience and a way to increase their level of competence and clinical skills. Genuineness/authenticity emerged for all 10 participants (100%), while self-care emerged for 90% (9 people) of the sample. The results of this study indicated that there is a need for continued education, training and supervision and support for the mental health professionals who work with these women. In addition, it supports future research into the need for tailored treatment interventions for this population.

Researcher Reflection

As a licensed professional counselor in the state of Georgia, this researcher’s professional experiences have provided an opportunity to engage with a diverse group of clients, including women who have been convicted of violent crimes. There was always an interest in the female experience of severe trauma, and how trauma can manifest into displays of aggression or violent behavior. This research was initially based out of a desire to identify protective factors that assisted women who had severe traumatic experiences with their decision making skills, anger management, interpersonal skills, and stopped them from going down self-destructive paths, including paths that could lead to incarceration for violent offenses. It was through this interest and desire to gain understanding about female violent offenders this researcher sought to explore their perceptions of what treatment interventions would have been effective in decreasing rates of recidivism and assisting them with reintegration into the community. However, before addressing the perceptions of the violent female offenders themselves, it was imperative
to get an idea of how these women were being perceived by professionals who were providing their treatment. In the attempts to find extensive research on this population and their treatment experiences as well the experiences of the treatment providers, this researcher was unsuccessful.

This researcher decided to add to the limited existing research on this population by engaging in a study of therapist perception to allow open and honest discussion about these women as clients, the perceived barriers to engaging with these women, as well as the stereotypical beliefs that surround these women that can affect treatment provision. There was an initial concern about conducting the interviews due to the nature of the clients, as well as the potential responses that would be given. However, it was a pleasant surprise to see the willingness of the study participants to engage in the interview process and to allow themselves to be honest about the potential for bias, or even fear, while working with this population. All participant responses had an undertone supporting authenticity in order to build rapport, as well as the need for empathy, continuing education, training, supervision, as well as to practice self-care. The emerging themes allowed this researcher to obtain the essence of the therapist experiences of working with these women, despite the diversity of the participants themselves. It was an honor to engage in this research and to learn from the participants.

Limitations

Data obtained was based on self-report and raised the possibility of participants under reporting incidents of bias due to social desirability concerns. Findings cannot be generalized to other mental health professionals due to a number of factors. Based on the
The qualitative nature of the study exploring the essence of the participants’ experiences, results differed at the licensing levels (master’s level/unlicensed, LAPC, LPC) as well as the amount of clinical practice. Additionally, participants were obtained from the Southeast region of the United States, in the surrounding areas of the metro Atlanta area in Georgia.

The research did not delineate how therapist gender differences could also affect the experience of working with violent female offenders; there was only one male participant in the study. This sample was also made up of a majority of African American females. This research did not take into account how factors such as counselor race, age, or cultural difference may impact the therapeutic alliance or the use of treatment approaches. Furthermore, specific considerations about the violent female offenders the clinicians came in contact with were also not addressed directly, such as the socioeconomic status and race of the women. Age, racial, or cultural differences of the violent female offenders could also address other disparities associated with provision of treatment.

Recommendations

Implications

This study supported the use of phenomenological methods to further explore and address the needs of violent female offenders. There are several practice implications that can be noted throughout this research. The first and foremost resulting from this study reflects that counselors identify violent female offenders as people and not by the nature of their offense in order to establish rapport and form a therapeutic alliance. The second
would be to obtain supervision and consultation as appropriate to effectively address incidents where counter-transference may be present, additionally if there are incidents of vicarious trauma, and burnout. Another implication would include the need for self-awareness to ensure clinicians are practicing within their scope of competence and are not impaired. Therapists need to learn how to assess their own biases in order to be clinically effective (Bermudez, 1997, p. 254). Most of the participants in the study were able to link concepts of support, supervision, and self-care as key factors for therapist well-being while providing therapeutic services to this target group.

There is a need for counselor educators and supervisors to examine multicultural factors associated with marginalized populations to promote counselor competency with diverse individuals or groups. The study also reflects benefits of recognizing potential barriers to empathy, especially with regard to populations where strong opinions or values may lie; in order to teach counselors about self-awareness of bias or transference to ensure good practice. The necessity to acknowledge counselor impairment and implement interventions to aid students or counselors to ensure the safety of both the counselor and the clients he or she serves is also evident per participant responses. Most importantly, gatekeeping should be conducted to ensure quality of clinicians versus quantity to enhance the profession and quality of services.

Implications for practice include the need for counselor mindfulness with regard to how they engage with these women in treatment. As expressed by all study participants, counselors would be more efficient in the therapeutic alliance if they were more authentic. It is imperative that counselors are also aware of potential triggers,
sensitive issues, or the need for support, as well as other agencies that may be involved in
treatment including the court system, probation/parole, or DFCS to reduce pressure
during the treatment process. Additionally, counselors would benefit from supervision or
consultation to aid in minimizing bias in practice by having a safe and open space to
disclose their feelings and thoughts. Finally, interventions should be tailored to meet
individual client needs, and not generalized as one-size-fits-all model.

Other implications that are evident from this study include the need to explore the
treatment options available to violent female offenders. The growing population of
violent female offenders suggests the need to address how trauma history, substance
abuse, environment, and interpersonal issues can impact these women. Through
qualitative research, the needs of violent female offenders and the counseling
professionals who serve them can be addressed. While counseling professionals will have
opinions and emotions related to the clients they serve, it is clear that at times therapist
perception can be a barrier to actively forming and participating in a therapeutic
relationship. Thereby creating more potential for situations where there is lack of
genuineness in the counseling relationship, or over identification with the client resulting
in counselor impairment.

Future Research

Future research would be needed to determine how counselor education programs
and supervisors are able to assist counselors in training, associate professional
counselors, and professional counselors with processing incidents of counselor personal
bias and perception hindering the treatment process. This study promotes the need for the
discussion to be held about counselor perception and how it impacts the provision of therapeutic services, as it demonstrates it is not uncommon to have strong opinions or feelings about clients, but self-development is necessary to ensure clients will not be harmed while receiving treatment. It encourages further qualitative research to gain perspective from violent female offenders with regard to their experiences with treatment providers and their perceived therapeutic needs. This study also supports the necessity of further exploration into the self-care practices of counselors that work with this population frequently. Additionally, this study boosts the need for research into the life experiences of violent female offenders to aid in reducing stigma; and to identify effective treatment interventions that have resulted in lowered rates of recidivism.

Conclusion

Current policies and practices regarding offending and treatment have been formulated on male offenders due to males engaging in more delinquent and criminal acts than females; however the confirmation of the gender differences between male and females can be observed in offending patterns on a national and international level (Cauffman, 2008). A predictor of future violence is past history of violence per research on male offenders, however with females this profile is far from infallible (Rudolph, 1996). There are several important implications in a system that is gender-biased, especially in the sentencing and treatment of criminal offenders (Kyne & Williams, 2007, p.89). Gender bias not only has an effect on the severity of the legal consequences they receive, but on the rehabilitative programs available for these women as well.

LeBel (2012) noted that with regard to women in the criminal justice system,
there are no studies that could be located concerning perceptions of stigma. There has been no research that has investigated the perceptions of causality for offending for female offenders among providers of treatment services (Kyne & Williams, 2007). The goal of this research was to address gaps in the knowledge about this population and the mental health professionals who serve this target group. Incarcerated women are a group with significant trauma history (Lewis, 2010). As a result, women are more likely than men to present greater challenges to treatment practitioners possibly due to severe substance histories, coexisting physical health and psychological problems, and victimization sexually and physically as children (Messina et al., 2006). This further supports the need to explore and address the needs of mental health professionals and violent female offenders.

This research provided a look into the perceptions of the mental health counselors has implications for the counselors working with serving this target population in a variety of treatment settings. As therapists are not immune from the same gender based emotional stereotypes that popular culture also endorses (Perrin et al., 2008, p. 715). Clinicians can experience emotions such as anger, hate, sexual feelings, and fear when working with clients, which impacts clinical decision-making and behavior towards them (Okamoto & Chesney-Lind, 2000). However, if therapists are able to increase awareness of their own negative perceptions there may be a more favorable therapeutic experience for both the counselor and client.

Through the use of a phenomenological approach, the essence of the experience of working with violent female offenders was expressed through the stories of 10
counselors with diverse work experiences. Creswell (2007) pointed out that the essence of the phenomenon being studied in phenomenological research is the common experiences of research participants. Phenomenology aims to help professionals develop sensitivity and empathy towards the people they serve (Lin, 2013). By obtaining the essence of the phenomenon regarding therapist perception and its impact on treatment provision to violent female offenders, a greater appreciation for the clinician experience is garnered. In addition, an understanding of potential barriers to the therapeutic alliance can be obtained which could lead to more effective treatment planning to allow for realistic client outcomes.

In closing, though the criminal histories of these violent female offenders exist, their pasts do not define them. As noted by participant three, Carol, “With each person you are aware of what they have going on because of the legal implication, but that should not change the way you treat them” (personal communication, January 15, 2016). Therapists’ perceptions of violent female offenders should not have adverse effects on treatment provision, but instead promote increased self-awareness due to the potential for bias to become a factor within the therapeutic relationship.
REFERENCES


APPENDIX A

MERCER INSTITUTIONAL REVIEW BOARD APPROVAL
13-Nov-2015

Ms. Giselle S Cunningham
Mercer University
Penfield College of Mercer University
2990 Flowers Road South
Atlanta, GA 30341

RE: An Exploratory Study of Therapists’ Perceptions about Violent Female Offenders and Their Influence on the Provision of Therapeutic Services
(H5511313)

Dear Ms. Cunningham:

Your application entitled: An Exploratory Study of Therapists’ Perceptions about Violent Female Offenders and Their Influence on the Provision of Therapeutic Services (H5511313) was reviewed by the Institutional Review Board for Human Subjects Research in accordance with Federal Regulations 21 CFR 56.110(a) and 45 CFR 46.110(b) (for expedited review) and was approved under Category 6, 7 per 45 CFR 46.116.

Your application was approved for one year of study on 13-Nov-2015. The protocol expires 12-Nov-2016. If the study continues beyond one year, it must be re-evaluated by the IRB Committee.

Item(s) Approved:
New Application for qualitative research study using a phenomenological research design where the researcher is the primary instrument of data collection. Use of audio recordings and interviews.

Please complete the survey for the IRB and the Office of Research Compliance. To access the survey, click on the following link: https://www.surveymonkey.com/A7G3T3R

Respectfully,

Ayda Chambless Richardson, M.Ed., CPR, CIM
Member
Institutional Review Board
Mercer University IRB & Office of Research Compliance
Phone (478) 301-4101
Fax (478) 301-2329

1400 Coleman Ave * Macon, Georgia 31207
(478) 301-4101 * FAX (478) 301-2329
APPENDIX B

INVITATION TO PARTICIPATE LETTER
Dear Participant,

My name is Giselle S. Cunningham, I am a doctoral candidate in the Ph.D. program for Counselor Education and Supervision in Penfield College of Mercer University. I am conducting a qualitative research study about therapists' perceptions about violent female offenders and their influence on the provision of therapeutic services to this target population. This letter is to inform you of this research and to ask if you would like to participate by engaging in a semi-structured, in-person, audiotaped, interview for this study. Mercer University's IRB requires investigators to provide informed consent to the research participants.

Title of Project: An Exploratory Study of Therapists' Perceptions about Violent Female Offenders and Their Influence on the Provision of Therapeutic Services.
Investigator Name: Giselle S. Cunningham
E-Mail Contact Information: cunningham_gs@mercer.edu

If you would be interested in participating in this study or have any questions about it, please contact me for further information at the email noted above. Mercer University's Institutional Review Board (IRB) reviewed the study #H1511315 and approved it on 13-Nov-2015.

If you have questions about your rights or are dissatisfied at any time with any part of this study, you can contact, anonymously if you wish, the Institutional Review Board by phone at (478) 301-4101 or email at ORC_Research@Mercer.edu.

Thank you in advance for your time and participation in this research!

Giselle Cunningham, MS, LPC, NCC, ACS
Counselor Education & Supervision Doctoral Candidate Penfield College, Mercer University
Informed Consent Form

You are being asked to participate in a research study conducted through Mercer University. Before you give your consent to volunteer, it is important that you read the following information and ask as many questions as necessary to be sure you understand what you will be asked to do.

Purpose of the Research
This research study is designed to explore the personal attitudes, values, and expectations of clinicians working with violent female offenders and whether or not the provision of therapeutic services to this population is affected by personal perceptions and biases. The data from this research will be used to add to the limited literature on violent female offenders and promote future research into the needs of this group of women and the mental health professionals who serve them.

Procedure
If you volunteer to participate in this study, you will be asked to take part in a semi-structured, in person, audio-taped interview. Your participation in the interview should only take up to one (1) hour of your time. The interview will be scheduled at a time and location of your convenience, preferably one that allows for privacy, comfort, and minimal interruptions.

Potential Risks or Discomforts
While there are no foreseeable risks associated with this study due to the minimal level of risk associated with participation, there is a possibility you may experience some mild discomfort. This discomfort could be physical, psychological, or emotional, as you will be asked about your perceptions and clinical practice with regard to a specific population. If you experience any discomfort or distress at any time, you have the right to cease participation in the interview temporarily or permanently.
Potential Benefits of the Research
There are no costs to participating in this study. You will gain insight into your experiences in the field, your use of effective coping strategies, supervision, and consultation to ensure effective clinical practice. Your shared experiences will assist with filling the gap in counseling literature regarding this target population and counselor experiences. This study will assist counselors in training, and counselors licensed at the associate and professional level with recognizing personal incidents of bias which could impair functioning.

Confidentiality and Data Storage
Your responses will be kept confidential and no identifying information will be used in the study. All participants will be assigned a pseudonym, all findings will be summarized and reported in a group format when reporting the results of this study. Data will be stored for a period of 3 years, in a secure, locked, file that only the student investigator will have access to.

Participation and Withdrawal
Your participation in this research study is voluntary and you have the right to decline involvement at any time. You will not be penalized if you choose to stop participation.

Questions about the Research
If you have any questions or concerns about this research, please speak contact the student investigator Giselle Cunningham at cunningham_gs@mercer.edu or the faculty advisor Dr. Arthur J. Williams at williams_j@mercer.edu.

This project has been reviewed and approved by Mercer University's IRB. If you believe there is any infringement upon your rights as a research subject, you may contact the Chair, at (470) 301-4101.

☐ I consent to being audiotaped  ☐ I do not consent to being audiotaped

Signature of Research Subject  Date

Participant Name (Please Print)  Date

Please return one copy of this consent form and keep one copy for your records.
SCREENING FORM

PARTICIPANT: __________________________________________________

REFERRED BY: __________________________________________________

(a) How did you hear about this research?

(b) Are you currently a master’s level counselor in training, a licensed associate professional counselor, or a licensed professional counselor?

(c) Are you currently interning or working in a setting (correctional facility, inpatient psychiatric facility, or outpatient agency) that engages in provision of therapeutic services to violent female offenders?

(d) How long have you been working with this population (violent female offenders)?

(e) Are you willing and able to take part in an audio-taped interview lasting approximately up to 30-60 minutes?

DATE: ________________

TIME: ________________

INTERVIEW LOCATION: ___________________________________________
APPENDIX E

DEMOGRAPHIC QUESTIONNAIRE
DEMOGRAPHIC QUESTIONNAIRE

1. Are you: a) Male  b) Female  c) Other ____________

2. What is your age range? a) 20-25  b) 26-35  c) 36-49  d) 50 +

3. What is your race/ethnicity?
   a) Asian or Pacific Islander  e) Black/African American
   b) Hispanic/Latino  f) American Indian/Native American
   c) Biracial/Multiracial  g) White/Caucasian
   d) Middle Eastern  h) Other ________________

4. Choose your professional level:
   a) Counselor in training (Master’s level counseling student/counselor)
   b) Associate professional counselor (LAPC)
   c) Licensed professional counselor (LPC)

5. How many years of experience in the field do you have?
   a) Master’s level Internship only  d) 10-15 years
   b) 0-3 years  e) 15 + years
   c) 5-10 years

6. Which of the following best describes your professional setting?
   a) Correctional Facility
   b) Outpatient Mental Health/Substance Abuse Agency
   c) Inpatient Psychiatric/Substance Abuse Facility
   d) Private Practice
   e) Other ______________________

7. How many female violent offenders have you worked with in your experience?
   a) 1-4  b) 5-10  c) 11-15  d) 16+

8. Which of the following best describes your view on stereotypes held towards female violent offenders?
   a) There are no stereotypes  b) There are stereotypes  c) Unsure

9. While working with this population were you under supervision or engaging in consultation?
   a) Yes  b) No  c) N/A

10. While working with this population did you find it difficult to engage in self-care practices?
    a) Yes  b) No  c) N/A