Does any increase in sexual offenders’ levels of general and victim empathy reduce recidivism?

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Abstract

This literature review will focus on the current research regarding empathy training as a treatment component for rehabilitating sexual offenders. It will outline the different theories of empathy and how these apply to sexual offending, and provide an overview of gaps in existing knowledge. Two research questions emerged from this review: What are facilitator’s views on victim empathy training? If facilitator’s perceive an increase in offenders’ level of empathy for the victim, does this have any bearing on the therapeutic alliance? Different methodological approaches to these research questions are discussed and finally the implications of answering these research questions are outlined.

Keywords: victim empathy, sex offender, therapeutic alliance, treatment effectiveness
Does Victim Empathy reduce Sex Offender Recidivism?

Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>Description of search strategy</td>
<td>3</td>
</tr>
<tr>
<td>Conceptual and definitional problems</td>
<td>5</td>
</tr>
<tr>
<td>Context for review</td>
<td>6</td>
</tr>
<tr>
<td>Theoretical use of empathy in SOTPs</td>
<td>7</td>
</tr>
<tr>
<td>The construct of empathy</td>
<td>9</td>
</tr>
<tr>
<td>Applying empathy models to sex offenders</td>
<td>11</td>
</tr>
<tr>
<td>Why is empathy training seen as so important?</td>
<td>12</td>
</tr>
<tr>
<td>An overview of the review process</td>
<td>14</td>
</tr>
<tr>
<td>Future directions</td>
<td>14</td>
</tr>
<tr>
<td>Application to major research topic</td>
<td>15</td>
</tr>
<tr>
<td>Methodologies</td>
<td></td>
</tr>
<tr>
<td>Quantitative</td>
<td>15</td>
</tr>
<tr>
<td>Qualitative</td>
<td>16</td>
</tr>
<tr>
<td>Awareness of professional issues</td>
<td>17</td>
</tr>
<tr>
<td>Conclusion</td>
<td></td>
</tr>
<tr>
<td>Summary</td>
<td>17</td>
</tr>
<tr>
<td>Implications</td>
<td>18</td>
</tr>
<tr>
<td>References</td>
<td>19</td>
</tr>
</tbody>
</table>
Does any increase in sexual offenders’ levels of general and victim empathy reduce recidivism?

Sexual offending causes a significant degree of harm in society (Webster, Bowers, Mann & Marshall, 2005). The economic cost of sexual offending is also significant, from police investigation and detection through prosecution, incarceration and treatment (Donato & Shanahan, 1999). It is therefore imperative that any intervention effectively reduces the rate of reoffending. The treatment of sexual offenders is relying more heavily on psychologically developed interventions (Mann Ware & Fernandez, 2011) and it has been predicted that there is some particular deficit in empathy for sexual offenders (Day, Casey & Gerace, 2010). This literature review will take a systematic approach to identifying relevant sources for the use of empathy training exercises in sex offender treatment and will be outlined in the following search strategy.

Description of search strategy

For the literature review a specific algorithm was used to search the following online bibliographic databases: PsychINFO, Medline, PsychArticles, DARE and Cochrane databases. The algorithm selected articles that incorporated the concepts of: sexual offenders, treatment effectiveness and empathy (see table 1).

Table 1
Algorithm used for search strategy

<table>
<thead>
<tr>
<th>Concept</th>
<th>Algorithm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual offender</td>
<td>(sex* offender* OR rapist* OR paedophi* OR pedophi* OR child molester* OR unlawful sexual intercourse)</td>
</tr>
<tr>
<td>Treatment effectiveness</td>
<td>(treatment effectiveness OR recidivism OR reconviction OR reduction OR increased empathy OR outcome*)</td>
</tr>
<tr>
<td>Empathy</td>
<td>(empath* OR sympath* OR guilt OR shame OR remorse OR victim orientated OR victims feelings OR empathy role play)</td>
</tr>
</tbody>
</table>

*Note. The Boolean operator ‘AND’ was used to link algorithms in the search bar.*
Abstracts from the initial search results were then examined (see table 3). The following exclusion criterion was applied (see table 2):

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>Book reviews, editorials, repeated papers, general commentaries or reviews of ethics for sex offender treatment, research on violent offenders, research on female sex offenders. Studies which used other treatment modalities, for example EMDR.</td>
</tr>
<tr>
<td>Inclusion</td>
<td>English language papers. Articles from earliest publication, PSYCHO listed as 1977</td>
</tr>
</tbody>
</table>

Once the exclusion criteria were applied the literature relevant to review was examined (see table 3).

<table>
<thead>
<tr>
<th>Database</th>
<th>Initial results</th>
<th>Relevant to review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cochrane database</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>DARE</td>
<td>10*</td>
<td>5*</td>
</tr>
<tr>
<td>PsychINFO</td>
<td>91</td>
<td>49</td>
</tr>
<tr>
<td>MEDLine</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td>PsychArticles</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>EBSCO EJS</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

Note. *with the search term ‘sex offenders’.
Does Victim Empathy reduce Sex Offender Recidivism?

Conceptual and definitional problems

Before proceeding to the review, the following section will outline concepts and definitions for the reader (see table 4).

Table 4

<table>
<thead>
<tr>
<th>Concept</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Cognitive distortions</td>
<td>Thinking strategies that serve to support or drive offending behaviour in the body of this literature review. For example, thinking that the victim wanted sexual contact because they did not physically resist.</td>
</tr>
<tr>
<td>Criminogenic factors</td>
<td>Risk factors that contribute to offending. These can be static factors, such as gender, or dynamic, such as how much alcohol has been consumed.</td>
</tr>
<tr>
<td>Empathy</td>
<td>The process of understanding emotional states in others, which involves replicating the emotional state to a degree, and acting in a pro-social manner as a response.</td>
</tr>
<tr>
<td>Recidivism</td>
<td>Means any re-offending after being convicted and going to prison. Recidivists have been postulated as offenders with a higher level of risk because they have persevered with a further offence despite having experienced punishment.</td>
</tr>
<tr>
<td>Sexual offenders</td>
<td>Refers to people who have been convicted of a sexual offence, which can include paedophiles and rapists, rather than internet offenders.</td>
</tr>
</tbody>
</table>
Context for review

There were 51,488 sexual offences recorded by police in the UK through 2008/09 (Home Office, 2009). However, under-reporting and low convictions rates mean that many offenders are not convicted. Thorton and Fisher (1993) identified that only 1% of arrests for sexual offences resulted in conviction. This is perhaps exacerbated by victims’ reluctance to report. In a recent review of the reporting for rape, Kelly, Lovett and Regan (2005) concluded that only fifty percent of victims report being raped. Harris and Hanson (2004) stated that from a sample of 4,724 sexual offenders from Canada, the US and Britain 24% had reoffended following incarceration after 15 year follow up. It has been postulated that the under-reporting and reconviction rate meant that actual rates of reoffending is likely 2-3 times more than formal figures (Barbaree & Marshall, 1988; Langvein et al., 2004). Any attempts to reduce the impact of offending are clearly beneficial.

Western approaches have moved from being completely focussed on reducing risk in the short to medium term through custodial sentences to placing a greater emphasis on treatment (Mann, Ware & Fernandez, 2011). The hope has been that treatment approaches would reduce risk past incarceration and community monitoring periods. Medical treatments, including chemical castration, have had mixed results and posed ethical dilemmas (Grubin, 1997; Kleinhans, 2002). Similarly, early behaviourally-based approaches were not well supported and focussed on altering the sexual interests of participants (Alexander, 1999).

More psychologically-based sex offender treatment programmes (SOTPs) were developed from the cognitive approach. These targeted a range of different factors, which were theoretically driven, to reduce the risk of re-offending. Sex offenders who have completed an SOTP have been reported to have 6.5-8% lower recidivism rates than non-treated sexual offenders which represents a 30-40% relative reduction in reoffending (Doren & Yates, 2008).

Research has attempted to identify which particular components of SOTPs account for the reductions in reoffending. Hanson, Bourgon, Helmus and Hodgson
Does Victim Empathy reduce Sex Offender Recidivism?

(2009) completed a meta-analysis of 23 recidivism outcomes studies, examining the components of different treatment programmes and their effectiveness in reducing recidivism. Their meta-analysis provided further evidence that the rates of reoffending for treated sexual offenders were significantly lower than untreated sexual offenders. The researchers also concluded that SOTPs adhering to the risk-need-responsivity principles (RNR) were more likely to demonstrate a more significant treatment effect. SOTPs adhering to RNRs resulted in a lower rate of reoffending post-release compared to those who did not receive treatment or dropped out of treatment. Bonta and Andrews (2007) stated the RNR principles; that human service interventions would need to target treatment at those of greatest risk of reoffending. Address criminogenic need, which are the factors that contribute to likelihood of reoffending. Finally, treatment should be responsive to the learning styles and abilities of the offender in order to maximise efficacy of delivery.

Theoretical background to the use of empathy-building components for sexual offender treatment programmes

Among the criminogenic factors identified, modalities to increase offenders’ levels of empathy have gained some prominence (McGrath et al., 2009). It was assumed that there are particular indices that separate sexual offenders from those who do not sexually offend. Being able to empathise with the emotional states of others was therefore proffered as a protective factor against committing sexual offences, as one would be able to appreciate the emotional distress the offence would inevitably cause to the victim (Marshall, Marshall, Serran & Fernandez, 2006).

The research literature has identified that sex offenders demonstrate significantly less empathy for victims of sexual abuse, particularly victims of their own offence compared to other offenders (Marshall & Eccles, 1998; Pithers, 1994). Sex offenders also appear less able to recognise emotions compared to non sexual offenders and community controls (Hudson et al., 1993; Gery, Miljkovich, Berthoz & Soussignan, 2009). This may indicate that failure to recognise emotions is linked to higher risk of sexual offending. Brown, Harkin and Beech (2012) identified sex offenders who had sufficient levels of general empathy still do not apply this to their
Does Victim Empathy reduce Sex Offender Recidivism?

own victims. They caution that this could be due to the use of cognitive distortions, to help offenders minimise the impact of their offence. Cognitive distortions have been hypothesised to be couched in information processing biases, based on assumptions and preconceived ideas about others, the same basis for empathy, as argued by Meneses & Larkin (2012).

However SOTPs that have focussed on increasing empathy have at best demonstrated mixed results in reducing recidivism, with most showing no association (Eastman, 2004; Hanson, Morton-Bourgon, 2005). Jolliffe & Farrington’s (2004) meta-analysis of 35 studies identified a significant negative correlation between empathy and offending. However, correlations do not inform causation and, when intelligence and socio-economic status were controlled, the correlations were non-significant. This would indicate that other criminogenic factors take precedence. The conclusion has been that as a criminogenic principle, developing victim empathy has been more theory-led than evidence based. Despite the lack of empirical support, empathy training has been included in the majority of SOTPs. McGrath et al. (2009) identified that 92.7% of 329 community SOTPs and 87.5% of 79 residential SOTPs had a specific component to address empathy in sexual offenders based in North America. The majority of victim empathy interventions take the form of role-plays (Pithers, 1997).

It is unclear whether having a lower level of empathy is even a criminogenic factor for sexual offending at all. Joliffe and Farringdon (2004) identified that the relationship between having low scores on empathy measures and committing violent offences was relatively strong; whilst it was relatively weak for sexual offending. Kraemer et al. (1997) stated that criminogenic dynamic risk factors can only be classified as such if they have been linked to a reduction in recidivism rates. Hanson et al. (2002) have argued that having low levels of empathy is not a criminogenic factor for sexual offending because it is unclear whether it meets this standard. They identified the key criminogenic factors for sexual offending as: sexual deviancy, sexual preoccupation, low self-control, grievance thinking and lacking intimate relationships with adults (Hanson & Morton-Bourgon, 2005). Hanson, et al. (2009)
Does Victim Empathy reduce Sex Offender Recidivism?

highlighted that addressing non-criminogenic factors may also be important for successful treatment.

The construct of empathy

Bateson (2009) argues that empathy is in conceptual disarray. Models have since been generated that separate empathy into affective and cognitive components. It has been noted that different measures of empathy have focussed on one aspect rather than taking account of both (Grady, Broderson & Abranson, 2011).

Building on this understanding, Davis (1994) suggested four components of empathy: antecedents, process, an interpersonal component and an intrapersonal component. It is important to note that Davis’ model does not overtly state that there is a requirement for an affective component in empathising, which is a serious flaw in the model. The cognitive component of empathising has been hypothesised to be an executive function (Hodges and Wegner, 1997; Hoffman, 2000). Indeed, victim empathy work has been somewhat ineffective with offenders who have learning difficulties (Courtney, Rose & Mason, 2006), lending support to this view that offenders with poorer executive function are less able to use empathy. Outcomes from this cognitive process take inter- and intra-personal forms, utilising some form of social behaviour and paralleling the affect of the target.

Another model of empathy, which was developed from the assumption that empathic understanding is based on early experiences with care-givers, was proposed by Marshall, Hudson, Jones and Fernandez (1995). They suggest a four stage model of empathy that involves recognition of emotion, perspective taking, emotional replication to appreciate the affective state of others and response decision. Baron-Cohen (2011) argues that the response decision would need to be pro-social to be classed as true empathy, since not-acting or enjoying the sensation could be seen as a form of sadism. Marshall et al.’s (1995) model has been criticised for being developed as a fixed staged process. However, it includes an affective-cue recognition process and overt affective component, that is lacking in Davis’ (1994) model. The misreading of affective cues has been identified as a particular area requiring further
Does Victim Empathy reduce Sex Offender Recidivism?

research (Wastell, Cairens & Haywood, 2009, Pickett, 2007, Gannon, 2009) whilst preliminary studies have demonstrated that this may be lacking in some sexual offenders.

The search strategy yielded no literature cross referencing the empathy literature developed in the field of clinical psychology and sex offender research. This would suggest that the concepts of empathy SOTPs are working with are based on theoretical models which may not represent the most up-to-date understand of the concept of empathy. Another way in which to conceptualise empathy, or at least part of the process of empathising, may be an approach promoted by Peter Fonagy and colleagues in the attachment literature: mentalisation. Mentalisation focuses on a persons’ ability to use their imagination to perceive and interpret intentional mental states in others. It has been hypothesised that the function of mentalising may be inhibited by the threat of physical violence (Fonagy, 2003), which may be relevant in violent offenders but has not been applied to sexual offenders.

Carre, Stefaniak, D’Ambrosio, Bensalah and Beche-Richard (2013) identified developing empathy is contingent on the ability to know that another person’s emotions are separate from one’s own. It has been argued that this occurs through marked mirroring (Marshall & Marshall, 2011). Fonagy and colleagues state that a failure to differentiate one’s emotional state as separate from others is described by the concept of psychic equivalence. An example of this may be provided by Castellino, Bosco, Marshall, Marshall and Veglia, (2011). They demonstrated that child molesters within their study were able to infer thoughts and intentions of others, but were unable to understand that others also had this ability; to hold separate and distinct beliefs of their own about the contents of other minds. Marshall and Marshall (2011) argued that people in a state of psychic equivalence experience emotional contagion and rather than addressing the distress of others, become self-focussed and attempt to self-soothe. They suggest that sex offenders may do this by employing cognitive distortions. It is important to note that the concept of mentalising has also been criticised for being the least novel in its description of a basic human function (Allen & Fonagy, 2006). It has also been argued that the quality of affective empathy omits mentalising as a useful explanation. Gallagher (2007) described the affective
Does Victim Empathy reduce Sex Offender Recidivism?

empathy component of empathy as non-mentalising, because it occurs too quickly (Pithers, 1999) and is a subconscious process (Meneses & Larkin, 2012).

Barnett (2013) and Carre et al. (2013) argued that alongside the cognitive and emotional components of empathising, there was a necessity to manage personal distress and situational factors, to reduce the difficulties with psychic equivalence. These components are supported by developmental and neuroimaging studies (Decety, 2010; Decety & Jackson, 2004; Decety & Svetlova, 2012). However, these studies have been conducted on non-sex offenders and may not be applicable to this group. Marshall & Marshall (2011) proposed an updated model of empathy, which included a component for managing personal distress. Following this Carre et al. (2013) proposed The Basic Empathy scale for adults, which may be a more robust measure of general empathy, including a component for managing personal distress, and could be used as a screen in SOTPs.

Applying empathy models to sex offenders

A compounding difficulty has been noted in that sexual offenders have displayed discordant levels of empathy towards other victims of sexual offences than their own (Fernandez & Marshall, 2003; Fernandez, Marshall, Lightbody, & O’Sullivan, 1999; Marshall, Champagne, Brown, & Miller, 1997; Marshall, Marshall, Serran & O’Brien, 2009; Marshall & Moulden, 2001). The research from validation of the Child Molester Empathy Measure (CMEM) highlighted that paedophiles are able to empathise with children who are sexually abused by others more so than with their own victims. However they demonstrated generally less empathy for sexual abuse victims compared to children who were accident victims (Joliffe & Farrington, 2004). This would highlight that, according to Marshall et al.’s (1995) model, some sexual offenders are able to recognise affective cues in others and react pro-socially, but through some other process specific to their victims or criminal act, empathising is not completed. It may be as Fonagy (2003) states in the mentalising literature that offenders use a sort of ‘pretend mode’ when expressing empathy, which may not have a true affective component. Therefore it would seem that measures and treatments
Does Victim Empathy reduce Sex Offender Recidivism?

would have to be focussed on victim-specific empathy, which is also genuine, to be valid.

There is a lack of empirical evidence to validate the use of empathy building techniques in SOTPs. There is also the difficulty of reliably measuring empathy in a way that is responsive to the needs of the offender. Despite this, it has been highlighted as a particular strength of SOTPs by those participating in these programmes (Colton, Roberts & Vanstone, 2009; Levenson, MacGowan, Morin & Lotter, 2009; Levenson, Prescott, & D’Amora, 2010; Pribyl, 1998). A section on methodologies will cover some of the particular techniques used in these studies.

Why is empathy training so important for participants and programme developers?

Victim-specific empathy has not been associated with general empathy, but has been linked to cognitive distortions (Webster and Beech, 2000). Marshall, Marshall, Serran, and O’Brien, (2009) stated that cognitive distortions typically served to reduce shame and maintain self esteem. This process then inhibits empathising and may help to explain why some sexual offenders are able to exhibit empathy in some circumstances, but not when considering the affective state of the victim Hanson (2003). If this is the case then SOTPs that target cognitive distortions may therefore have an impact on the outcome measures for victim empathy. Similarly offenders may focus on their own self soothing if overwhelmed by the distress of the victim (Hanson 2003). Marshall and Marshall (2011) argued that sexual offenders use cognitive distortions to achieve this.

Marshall, Marshall, Serran and Fernandez (2006) predicted a particular problem with attempting to increase offenders’ empathy for victims. They hypothesised that displaying empathy was linked to other evaluation processes such as shame and guilt and that both these states would have an impact on self esteem. People convicted of a sexual offence have been identified as having lower levels of self esteem compared to people who offend in non-sexual ways (Marshall, 1997; Marshall, Barbaree, & Fernandez, 1995; Marshall, Champagne, Brown, & Miller,
Does Victim Empathy reduce Sex Offender Recidivism?

1997; Marshall, Champagne, Sturgeon, & Bryce, 1997; Marshall, Cripps, Anderson, & Cortoni, 1999; Marshall, Marshall, Serran, & O’Brien, 2009; Marshall & Mazzucco, 1995). This is not necessarily surprising given that sexual offences are amongst the most abhorrent to the general population, compounding the likely withdrawal of social support for sexual offenders after convictions (Kleinhans, 2002).

However, it has been shown that lower levels of self esteem do not predict recidivism. This is possibly because sexual offenders generally have lower levels of self esteem, so this cannot be used to differentiate recidivists from non-recidivists (Hanson & Bussirere, 1998; Hanson & Morton-Bourgon, 2004).

If facilitators feel that it is important for sex offenders to develop empathy, then this could impact on the therapeutic alliance, which was identified as accounting for 28% of the variability in outcome measures through a factor analysis of 44 participants (Rothman, 2007). Sex offenders have reported that it is important for them to know that their therapist is trustworthy, able to accept them and robust enough to continue the work (Drapeau, Korner, Granger, Brunett & Casper, 2005). Bremer (1992) reported that participants cited the experience of a caring relationship, which enabled them to identify and express their inner emotional states, helped to effect change. Experiencing a positive relationship may therefore be highly beneficial to a client group who typically lack meaningful relationships with adults. Indeed, it may be a therapeutically corrective experience for participants to feel accepted after disclosing their offence which could enhance intimacy (Jennings & Sawyer, 2003; Yalom, 1995). Geist (2009) commented that to build empathic rapport in a therapeutic alliance, it was important for the client to experience empathy. Experiencing empathy in this way may be reparative for the client who has not experienced an attentive approach to their feelings before (Bozarth, 2009, Rogers, 1959). Development of intimacy skills have also been inversely related to recidivism rates (Hanson & Harris, 2001; Hanson & Morton-Bougon, 2005). Conversely, Farrenkopt (1992) found that therapists who experienced group members as lacking responsibility and motivation to change, had a sense of rising anger, emotional hardening and were more likely to adopt a confrontational style. This may be pertinent as a sexual offender’s reason for becoming involved in treatment may initially be about reducing their sentence (Salter 1988).
An overview of the review process including gaps in existing knowledge

At present there is a lack of an empirically validated theory of empathy that has enough explanatory power to generate testable hypotheses. As a symptom of this, psychometrics to quantitatively test the proposed varying aspects of empathy are still in development. Whilst some do exist, they appear to address one aspect of the hypothesised empathy construct rather than all facets of the construct. Researchers have identified affective cue discrimination as one particular under-researched area in the treatment of sexual offenders. Taking into account that being able to identify emotions in others has been posited as the first step towards initiating a process of empathising, it would be important to explore this area further in helping to inform the exploration of empathy. However the literature has suggested that sexual offenders are able to empathise with others generally, but appear not to with their own victim. It would therefore be important to identify whether affective cue discrimination is inhibited for individuals similar to the victim.

Despite the lack of empirical backing, empathy training continues to be used in the majority of SOTPs. It has also been identified that sexual offenders have found this to be one of the most important aspects of treatment. It is unclear why this difference is present. Clearly there is an investment in this form of intervention which would merit further investigation. A key component that is missing from the current literature base is whether SOTP facilitators also see this aspect of the programme as useful.

Future directions

From this literature review it has been possible to synthesise the following research questions:

1. What are facilitator’s views on victim empathy training?
2. If facilitator’s perceive an increase in offenders’ level of empathy for the victim, does this have any bearing on the therapeutic alliance?
Does Victim Empathy reduce Sex Offender Recidivism?

Application to major research topic

Considering the literature base about victim empathy is an important adjunct to the interaction between therapist and offender. The outcomes from therapy are dependent on the quality of the relationship between offender and therapist. Understanding the key conditions for forming effective therapeutic alliances is an important contributing factor for treatment success (Rothman, 2007).

Methodologies

Quantitative methodologies.

One of the main debates in this area of work is how to measure treatment effectiveness, which can be a particular difficulty when using quantitative approaches. Sexual offences can be difficult to prosecute without strong forensic evidence (Peterson, 1987), cases may collapse or offenders may plead guilty to lesser offences to mitigate prosecution for more serious offences. It is therefore difficult to achieve a reliable picture of recidivism rates. Some researchers have argued that it is important to focus on proximal measurements over distal measurements, which is the actual shifts towards treatment goals rather than recidivism rates (Grady, Broderson & Abramson, 2011). Jung and Gulayets (2011) commented that changes in recidivism rates may be more due to local criminal justice practice processes rather than treatment effects.

The heterogeneity of sexual offenders as a group makes it difficult to generalise findings from one study to the next. For example, different scales have been developed to measure offence-related attitudes of rapists and child molesters (Grady, Broderson & Abramson, 2011). Treatment programmes also differ in the degree to which they adhere to RNR principles, as well as incorporating different programme components (Hanson et al., 2009). There is a lack of controlled trials that utilise randomisation; it has been historically argued that not providing treatment to
Does Victim Empathy reduce Sex Offender Recidivism?

sexual offenders is unethical. However, in a recent Cochrane review Dennis et al. (2012) argued that this is based on the faulty premise that the experimental condition of treatment is superior to the control of custodial sentence. These debates need to be considered in researching treatment outcomes.

In terms of particular measurements of empathy for sexual offenders, another variable that needs to be controlled is social desirability effects. Offenders are able to manipulate measures of empathy with high face-validity (Serran, 2002) whilst implicit measures of empathy may lack specificity. For example, the ‘mind in the eyes’ test has been hypothesised to target affective cue discrimination (Baron-Cohen, 2011), but does not inform on the other theorised constructs involved in empathy. It is important to note that the constructs around empathy are poorly defined and a qualitative approach may be most appropriate in addressing questions related to the interplay between therapeutic relationship and victim empathy training.

**Qualitative methodologies.**

Qualitative methodologies may be more appropriate for this field of research given the need for further exploratory work of concepts and models. Qualitative methods have been used to assess sexual offenders’ understanding of empathy following a diagnosis of learning disability (Courtney, Rose & Mason, 2006) and it has been highlighted that using qualitative methods is more robust in helping participants to shape their own voice (Gilbert, 2004).

The majority of qualitative methodologies focus on survey data (Bremer, 1992; Levenson, MacGowen, Morin & Lotter, 2009; Levenson, Prescott & D’Amora, 2010). These take the form of consumer satisfaction surveys on a set number of questions, where participants regularly cite victim empathy training and therapeutic alliance as important. Farrenkoft (1992) developed a structured questionnaire survey for SOTP facilitators from pilot interviews with 17 participants. However, it is unclear what methodology was used in this process. One study has used interpretative phenomenological analysis (Sandhu, Rose, Rostill-Brookes & Thrift, 2012) which recognises the interviewer’s bias when asking facilitators about the emotional
Does Victim Empathy reduce Sex Offender Recidivism?

challenges of working with sex offenders with learning difficulties. Another study has used grounded theory in assessing offenders’ affective empathy (Webster & Beech, 2000) although it is unclear why this method was chosen over other qualitative approaches. Finally, Drapaeu et al. (2005) used plan analysis to identify sex offenders’ particular motivations for engaging in therapy as this method is partly focussed on the wishes or goals of participants. Clearly qualitative methods have much to offer this area of research.

Awareness of professional issues

This literature review highlights the importance of professionals considering the way they connect with clients to enable effective therapy. There are ethical considerations that make it difficult for researchers to examine this topic. High quality randomised controlled trials are difficult to complete considering the ethical dilemma of offering no treatment to offenders. It is important that researchers in this area acknowledge the limitations imposed by difficulties in measuring this particular population.

Conclusion

Summary.

This literature review had identified that quantitative meta-analyses of SOTPs has identified that including victim empathy training does not seem to impact on recidivism rates. There are a range of methodological and theoretical difficulties which may account for this. For example: the models of empathy these interventions are based on may not be adequate, it may be useful for further research to be conducted with models of empathising from other fields, like mentalisation. The results from the meta-analysis outcome studies on SOTPs are juxtaposed to the results from qualitative studies with offenders. What appears to be missing from this research area is the SOTP facilitators view on the victim empathy modules and whether delivering these affect their therapeutic relationships with clients.
Implications.

It is important to investigate why the empathy role-plays in SOTPs are so widely employed. If there are no benefits to this work, which it is hypothesised can cause distress to participants (Pithers, 1997), then they may need to be withdrawn. Any further research into the empathy construct in this field would be able to inform the developing theoretical models of empathy. This literature review has also highlighted the limitations of the models of empathy developed in the field of forensic psychology. Another way in which empathy could be measured is neurologically. Lenzi et al. (2013) have conducted functional MRI studies on attachment styles and looking at emotional faces, however this study was conducted with non-offending females, this technique could be applied to sex offenders to identify whether biological factors underlie their apparent disorder in empathising with victims. Finally, the research question, whether empathy training serves to strengthen the therapeutic alliance, allows for exploration of an aspect of SOTPs that has not been addressed. Qualitative interviews with SOTP facilitators, to explore concepts linked to this research question, would therefore be appropriate.
Does Victim Empathy reduce Sex Offender Recidivism?

References


Does Victim Empathy reduce Sex Offender Recidivism?


Does Victim Empathy reduce Sex Offender Recidivism?


Does Victim Empathy reduce Sex Offender Recidivism?


Does Victim Empathy reduce Sex Offender Recidivism?


Does Victim Empathy reduce Sex Offender Recidivism?


Does Victim Empathy reduce Sex Offender Recidivism?


Does Victim Empathy reduce Sex Offender Recidivism?


Does Victim Empathy reduce Sex Offender Recidivism?


Does Victim Empathy reduce Sex Offender Recidivism?


