Article

Victim empathy-based content in aggression treatment: Exploring impact within a secure forensic hospital

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ABSTRACT:

This study explores the impact of inclusion of victim empathy-based content in offender treatment.

It presents first a systematic review of 20 papers, before proceeding to consider a qualitative interviews with therapists (n= 7), and forensic patients (n= 5), who had completed a long-term violence therapy (Life Minus Violence â€“ Enhanced, LMV-EÂ©). The research explored perceptions of forensic patients and treatment facilitators when completing victim empathy work, and explored any negative effects this may have.

Findings from the systematic review indicated five themes: (1) Interventions incorporating victim empathy can be effective; (2) There are positive risk-understanding consequences from completing victim empathy work; (3) Offenders perceive victim empathy positively; (4) The emotional impact of victim empathy work on offendersâ€™ is poorly explored and, (5) Completing victim empathy in treatment groups receives mixed evaluations from offenders. The systematic review was used to inform the interview themes for the resulting qualitative study with facilitators and forensic patients. This study indicated six themes: (1) Victim empathy content facilitates change; (2) Victim empathy content can be difficult for patients; (3) Victim empathy content can lead to an emotional response; (4) Victim empathy content can be beneficial, with the process important; (5) Victim empathy content can help understand risk, and (6) Patientsâ€™ experience of treatment begins before attending sessions.

CUST_RESEARCH_LIMITATIONS/IMPLICATIONS__(LIMIT_100_WORDS) :No data available.

The potential impact of victim empathy content needs to be evaluated before sessions are completed, accounting for client expectations and treatment readiness. This should include ensuring that appropriate support is in place. Any support provided to patients should be regularly reviewed.

CUST_SOCIAL_IMPLICATIONS_(LIMIT_100_WORDS) :No data available.

The study represents the first to apply detailed analysis to this topic area and with a complex group.

RUNNING HEAD: VICTIM EMPATHY IN AGGRESSION TREATMENT

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Abstract

This study explores the impact of inclusion of victim empathy-based content in offender treatment. It presents first a systematic review of 20 papers, before proceeding to consider a qualitative interviews with therapists (n= 7), and forensic patients (n= 5), who had completed a long-term violence therapy (Life Minus Violence – Enhanced, LMV-E©). The research explored perceptions of forensic patients and treatment facilitators when completing victim empathy work, and explored any negative effects this may have. Findings from the systematic review indicated five themes: (1) Interventions incorporating victim empathy can be effective; (2) There are positive risk-understanding consequences from completing victim empathy work; (3) Offenders perceive victim empathy positively; (4) The emotional impact of victim empathy work on offenders' is poorly explored and, (5) Completing victim empathy in treatment groups receives mixed evaluations from offenders. The systematic review was used to inform the interview themes for the resulting qualitative study with facilitators and forensic patients. This study indicated six themes: (1) Victim empathy content facilitates change; (2) Victim empathy content can be difficult for patients; (3) Victim empathy content can lead to an emotional response; (4) Victim empathy content can be beneficial, with the process important; (5) Victim empathy content can help understand risk, and (6) Patients' experience of treatment begins before attending sessions. The results are discussed with attention to similarity in perceptions and experiences between staff and patients, with suggestions made for clinical implications and future research.

Key words: Offender Treatment; Victim Empathy; Life Minus Violence; LMV; Violence; Therapy; Trauma.

Victim empathy-based content in aggression treatment: Exploring impact within a secure forensic hospital.

Empathy, while a contested term, is understood to involve an emotional response, dependent on trait and state influences, as well as a cognitive process, relating to an accurate perception and understanding of others' experiences (Cuff et al., 2016). There is agreement that empathy includes recognising other's emotional experiences, perspective taking, emotional experiences and behavioural responses (Hanson, 2003; Marshall et al., 1995; Pithers, 1994). This paper explores the concept of empathy used within violent offender treatment. Consequently, the term *victim empathy* is employed and refers to the extension of general empathy abilities to general or specific victim groups.

Empathy deficits may contribute to individuals' risk of engaging in offending behaviour. The *Model of the Empathic Process* (MEP; Barnett & Mann, 2016) indicates that individuals follow pathways to generating empathic responses, via emotional contagion or cognitive appreciation. The model argues that individuals access emotional contagion immediately by either directly imagining the experience of observed individuals or imagining how they would feel in a similar situation, based on their internal beliefs and experiences. They could, alternatively, cognitively appraise a situation by these processes, where emotional contagion occurs simultaneously or after cognitive appraisal. Thus, individuals respond empathically through direct emotional experience or through cognitively driven emotional experiences. Offenders can have deficits in interpreting social cues and recognising others' distress (Archer & Haigh, 1999; Gillespie et al., 2015; Hoaken et al., 2007; Polaschek et al., 2009; Robinson et al., 2012). As empathy may be related to violent and prosocial behaviours (Bock & Hosser, 2014; Ding & Lu, 2016; Jolliffe & Farrington, 2004; Van Langen et al., 2014), specific treatment addressing empathy may be important (van Berkhout

& Malouff, 2016). As offender treatment aims to increase offenders' understanding and skills, victim empathy has become a common inclusion in offence-focused interventions (Carich et al., 2004; Day et al., 2010; Webster et al., 2005).

Literature that explores victim empathy treatment indicates that it is positively appraised by offenders (Levenson et al., 2009; Levenson et al., 2010; Levenson et al., 2014). Levenson et al. (2009) explored the experiences of male sex offenders (n=338), completing CBT-based group sex offender treatment. Ninety-four percent of participants rated accepting responsibility as very important to their treatment recovery, with 92% rating understanding the impact of sexual abuse on victims and others, as equally important. Approximately one fifth of the sample indicated that they would want to spend more time in treatment, covering accepting responsibility and victim empathy respectively. Indeed, the literature indicates that most offenders do not experience adverse or distressing consequences, beyond those expected in victim empathy intervention (Levenson et al., 2009; Levenson et al., 2010; Zosky, 2018), but the emotional impact is yet to be explored.

A useful theory to apply within this context is *Social Identity and Categorization Theory* (SIT; Tajfel, 1978; Turner et al., 1979; Tajfel & Forgas, 2000), aiding an understanding why victim empathy-based content could be distressing. Individuals align themselves to groups, who provide them with a sense of belonging and pride. They may identify themselves with a positively appraised group, or reappraise qualities they have to fit socially desirable groups, to minimise their own negative behaviours and maintain a moral identity, which accepts their offending behaviour challenges. Indeed, individuals who engage in offending behaviours can create positive self-identities through resisting stigmatising labels and attributions placed upon them, consistent with their need to maintain a positive self-esteem and self-identity (Geiger & Fischer, 2005; Ward, 2002; Ward & Mann. 2004). Consequently, offenders may conceal more negative self-identities from others, to protect

themselves from potential adverse effects on their emotional well-being and guard against the negative perceptions of others (Quinn & Earnshaw, 2013). Revealing hidden self-identities can be distressing and are thus worthy of attention, as engaging in victim empathy work can be confronting for offenders, who may experience distress as a result (Quinn & Chaudoir, 2009).

Offenders' response to victim empathy content may also be explained using the *Perception-Action Model of Empathy* (Preston, 2007). The model proposes that individuals' experience of empathy is shared between the observer and the individual that is distressed, with the observation of distress leading to an automatic empathic response (Preston, 2007). Victim empathy content can include methods that encourage offenders to observe and reflect on the emotional impact of their or others' offending (Ireland et al., 2009; Mann & Barnett, 2013). Consequently, offenders may experience distress due to the observation, or presentation, of distress in others during treatment. Shame is also a common response observed in offenders during treatment, which can be a threat to the maintenance of a moral identity (Woodyatt & Wenzel, 2014). Offenders can self-stigmatise, accepting criminal stigmatising labels assigned by others, such as being labelled an 'offender' (Moore et al., 2016; Moore et al., 2018). A consequence of such may result in a poor sense of belonging and further reluctance by offenders to disclose/discuss their identity, especially in psychiatric settings (Newheiser & Barreto, 2014; West et al., 2015).

The current study aimed to explore perceptions of patients and facilitators, in a secure forensic hospital, of victim empathy-based content in therapy delivery. Additionally, it aimed to explore the impact of victim empathy-based content on the wellbeing of both treatment facilitators and offenders. A systematic review was undertaken first, followed by a qualitative interview study with staff and patients, which drew on the themes identified in the systematic review. The research was underpinned by the following questions:

1. What are the perceptions of offenders completing victim empathy-based content?
2. What are the perceptions of facilitators delivering victim empathy-based content?
3. What are the effects of completing victim empathy-based content?

Systematic Review: Exploring Victim Empathy Content in Offender Treatment Programs.

Method

Procedure

A systematic review of the literature was undertaken to identify the impact of empathy content on psychological functioning and aggression. This followed PRISMA guidelines. Search terms were 'Victim OR Offence AND Empathy OR Consequences AND Effects OR Impact OR Results AND Psychiatric OR Offender OR Patient OR Prisoner'[1]. Two hundred and twenty-nine papers were initially identified, with a review of abstracts reducing this to 20 (see * in reference list). Thematic Analysis was employed to determine, analyse and report themes (patterns) within the data using the process identified by Braun & Clarke (2012). A coding scheme was developed to capture patterns in the data, with the qualitative analysis program, NVivo, used to generate codes. The data was explored and reviewed on multiple occasions, allowing for common themes to be identified. Inter-rater reliability was conducted on 10% of the dataset, demonstrating good evidence of reliability.

Results

Five themes were identified: (1) Interventions incorporating victim empathy can be effective; (2) Positive risk-understanding consequences from completing victim empathy work; (3) Offenders perceive victim empathy positively; (4) The emotional impact of victim empathy

[1] Databases that were searched included PsychInfo, PsychArticles, Criminal Justice Abstracts and SocINDEX

work on offenders' is poorly explored; (5) Completing victim empathy in treatment groups receives mixed evaluations from offenders. Next is an illustration of each theme.

Theme one - Interventions incorporating victim empathy can be effective

Most studies included explored treatment incorporating various modules and content, in addition to victim empathy. Only four papers focused exclusively on victim empathy content or treatment. The remaining papers reviewed interventions that included victim empathy work but did not connect this with specific outcomes. Thus, the direct relationship between completing victim empathy work and outcomes was not made. This theme comprised two subthemes, as follows:

Subtheme one - Interventions that have victim empathy aspects report reductions in offending attitudes: Five studies explored the impact of victim empathy content on cognition (Bairn et al., 1999; Foubert, 2000; O'Donohue et al., 2003; Stephens & George, 2009; Wakeling et al., 2013). Stephens and George (2009) examined the impact of a rape prevention intervention with male college students (n=137), finding that the use of victim empathy, using video material, resulted in decreased rape myth acceptance during a five-week follow up period. However, this was not effective for individuals classed as 'high risk' of rape. Similar findings were reported by O'Donohue et al. (2003) and Foubert (2000). However, Bairn et al. (1999) explored the use of psychodrama, which aimed to increase victim empathy in a group of male sexual offenders (n=9).

Subtheme two - Interventions that have victim empathy aspects report positive impacts on criminogenic factors: Seven studies explored the impact of victim empathy content on other criminogenic factors, including empathy ability and awareness of their behaviour (Bairn et al., 1999; Marshall et al., 1996; O'Donohue et al., 2003; Schewe & O'Donohue, 1993; Stephens & George, 2009; Wakeling et al., 2013; Zosky, 2018). Stephens and George (2009) examined a rape prevention intervention with male college students

(n=137). They found that inclusion of victim empathy increased participant's empathy towards victims, sustained over the five-week follow up period. Schewe and O'Donohue (1993) evaluated the use of two rape prevention interventions in 'high risk' men (n=68); one designed to increase victim empathy, the other to decrease rape myth acceptance. The findings indicated that the empathy treatment increased participants' victim empathy ratings and decreased rape myth acceptance more than the no treatment or rape myth groups.

Theme two – There are positive risk-understanding consequences from completing victim empathy work

Three studies explored offenders' perceptions of change following completion of victim empathy work (Levenson et al., 2009; Levenson et al., 2010; Schewe & O'Donohue, 1993). Levenson et al. (2009) found that, in sexual offenders in treatment (n=338), over 80% stated that they learned more about their past offending and about preventing future offending. Schewe and O'Donohue (1993) evaluated the credibility of two interventions designed to reduce risk of rape perpetration, one designed to increase empathy and one designed to reduce rape myth acceptance (n=68). Participants that completed the interventions felt both interventions were helpful in reducing their future risk of rape perpetration.

Theme three - Offenders perceive victim empathy favourably

Five studies explored the perceptions of clients who have completed victim empathy content (Colton et al., 2009; Levenson et al., 2009; Levenson et al., 2010; Schewe & O'Donohue, 1993; Zosky, 2018). Studies that explored offenders' perception of victim empathy work received positive evaluations. For instance, Levenson et al. (2009), in a sample of male sexual offenders (n=338), found that 94% and 92% of the sample, respectively, found accepting responsibility and understanding the impact of their offending to be important to them. In addition, 80% of the sample stated that they were satisfied with their treatment and

felt that this had been helpful for them. Levenson et al. (2010) also found a significant positive correlation between offenders' perceived importance and satisfaction. Furthermore, Colton et al. (2009) found, in a smaller sample of sexual offenders (n=33), that 57% felt victim empathy work was helpful in increasing their knowledge and awareness of victim impacts.

Theme four – The emotional impact of victim empathy work on offenders' is poorly explored

One study explored offenders' perceptions of attending victim impact panels (Zosky 2018, n=340), with this focusing on intimate partner violence. Here, only five percent of offenders reported that hearing victim accounts led to the triggering of prior traumatic experiences. Participant comments related to recounting experiences of exposure to violence in childhood. The researchers suggested that the trauma trigger did not relate to the victims' experience but to memories of their own abuse. Offenders also described emotions, such as empathy, remorse and sadness, which they felt were appropriate. However, there was no further attention to emotional impacts in the literature, which highlights the paucity of attention to such reactions.

Theme five - Completing victim empathy in treatment groups receives mixed evaluations from offenders

Five studies explored the mode of treatment in relation to victim empathy content (Colton et al., 2009; Day, 1999; Levenson et al., 2009; Levenson et al., 2010; Pithers, 1994). However, findings were mixed regarding whether this should be completed in a group or individually. Levenson et al. (2009) found that 90% of their sample felt sharing their offending experience with other offenders, including being confronted in a group, was important to them. However, 31% also felt that they would rather have attended individual rather than group treatment. Colton et al. (2009) explored offenders' (n=35) perceptions of a

Sexual Offender Treatment Program (SOTP) and found that offenders preferred not to be in groups with 'high risk' sexual offenders, did not want to hear about the problems these individuals had, with group sessions creating emotions such as anger, confusion and a loss of hope.

Qualitative Study of Experiences: Exploring Patient and Treatment Facilitator Experience of Completing Victim Empathy Content in a Secure Forensic Hospital

Method

Participants

Treatment facilitators (n=7) and patients (n=5) who had completed either group (n=3) or individual (n=2) aggression treatment took part. The facilitator sample (male, n= 3 and female, n=4) held various roles; namely, trainee forensic psychologists (n=4), forensic treatment facilitator (n=1) and nurse therapists (n=2). All facilitators had facilitated the offence focused treatment in its entirety, and most had completed both group and individual treatment (n=6). The patient sample was all male and had completed a long-term aggression focused treatment - Life Minus Violence – Enhanced (Ireland et al., 2009). This is a Cognitive Behaviour Therapy (CBT) based, multi-module long-term treatment program. It has a dedicated module that focuses on victim empathy and consequences.

Interview schedule

An interview aide-memoire was developed, informed by the systematic review. The interviews employed here aimed to explore with participants their understanding, perceptions and experiences of victim empathy-based treatment.

Procedure

The study formed part of an approved service evaluation for the participating NHS organisation. Informed consent was gathered from all participants. All were provided with an information sheet outlining the service evaluation and debrief information. Participants completed interviews. Each interview ranged from 30 to 60 minutes. Participant responses were transcribed.

Analysis

Thematic Analysis was employed (Braun & Clarke, 2012). Each transcribed interview was read thoroughly before the coding process was started and then coded using a qualitative data coding program[2]. A deductive coding strategy was developed, focusing on participants understanding of victim empathy-based treatment, affective responses and perceived benefits or limitations (Braun & Clarke, 2012). Inductive coding was employed, in response to meaningful information in the interview data, such as the delivery of the intervention and participants expectations of the intervention. Each interview was given a label to allow for anonymity (Facilitator Participant = F1; Patient Participant – P1).

Results

Overall, six themes were identified. There were four shared themes between facilitator and patient participants. These included: (1) Victim empathy content facilitates change; (2) Victim empathy content can be difficult for patients; (3) Victim empathy content can lead to an emotional response; (4) Victim empathy content can be beneficial, with the process important. One theme was identified as unique to facilitator participants, namely ‘victim empathy content helps understand risk’. One theme was identified as unique to patient

[2] NVivo (QSR International)

participants, 'patients' experience of treatment begins before attending sessions'. Each theme is illustrated next, commencing with the shared themes.

Shared Themes

Theme one - Victim empathy content facilitates change

Both patients and facilitators described behavioural or cognitive changes after completing victim empathy content. There was mutual understanding that this content could provide skills and learning that is conducive to reducing levels of violence after treatment. Four subthemes emerged from the analysis, as illustrated next.

Subtheme one – Increased awareness of self: Four facilitators and four patients described victim empathy content as an effective facilitator of learning. This included patients learning about their own risks and cognitions and the need to change their behaviours, e.g.:*"[it] helped identify triggers for their harmful…behaviour, whereas they couldn't before"* (F2) and *"[victim empathy-based content] helped me to understand my emotions and the situations before [offence] happened"* (P4). This also involved three patients considering their offences in new ways or with a different perspective, e.g.: *"I found that I had not thought about how many people I affect"* (P6).

Subtheme two – Increased awareness of others: Four facilitators and three patients described patient development following their engagement in victim empathy-based treatment. They perceived their ability to consider other's feelings to increase, e.g.: *"Before the client focused on self-impact…after they talked more about other's-impact"* (F2) and *"I sympathised with [the victim] after learning about the consequences of what I did"* (P1).

Subtheme three - Reducing aggression: Four facilitators and three patients described victim empathy-based treatment as helpful to the goal of reducing future aggression, through increased recognition of empathy and victim consequences, e.g.: *"[victim empathy-based treatment] is helpful to reduce proactive…and reactive aggression….They start to recognise*

empathy as an important skill in reducing aggression" (F5) and *"I leaned to be assertive but not aggressive…its ok to be angry but I don't let it turn to aggression"* (P2).

Subtheme four - Skill development: Five facilitators described victim empathy content as an effective facilitator of skill development, particularly for cognitive skills such as perspective taking and consequential thinking, and cognitive empathy, e.g.: *"they can understand when they do something, what it will cause, such as consequences for self and others"* (F5). However, while one facilitator noted the importance of developing skills through skills practices, another felt patients were not always able to use them outside of the treatment setting; *"I don't think they [patients] apply the skills that well"* (F1).

Theme two - Victim empathy content can be difficult for patients

Victim empathy content was recognised as difficult for patients to complete. Three facilitators and two patients described this to involve skills patients may already have a deficit in, which can lead to them experiencing difficulties in completing treatment. This included, for instance, difficulties with perspective taking and consequential thinking, e.g.: *"some [patients] can't see past the immediate consequences"* (F2) and *"[Victim empathy-based treatment] is good but depends on insight so it has limits. Also depends on their acceptance of behaviours"* (F6). Indeed, one patient found the reflective nature of victim empathy content to be difficult to process, causing negative feelings: *"it upset me really, I felt as though I was dragging up painful memories of the past. We also did a scenario, which was painful….it reminded me of everything I didn't want to be reminded of"* (P4).

Theme three - Victim empathy content can lead to an emotional response

Five facilitators and four patients referred to victim empathy-based treatment leading to an emotional response in patients. Five subthemes were identified and illustrated next.

Subtheme one - Patients experienced a range of emotions: Four facilitators described observing emotional responses in patients, while completing victim empathy content. This

was also highlighted by three patients. Negative emotions appeared to result from the focus on the victim of the offence and recollection of memories associated with their offences, which could negatively impact their treatment engagement, e.g.: *"one patient got annoyed for focusing too much on the victim"* (F5), and *"where the clients showed more anxiety, it could have inhibited responses"* (F4). A patient commented on how; *"I felt feelings I haven't felt in a long time, like sadness"* (P4).

Subtheme two - Reluctance to complete victim empathy work: Three facilitators described some apprehension and reluctance when discussing victim empathy content, both from facilitators delivering this and patient reactions to content. For instance, one considered a patient's perspective, reporting how, *"they [patients] think it is worse than it is"* (F5). However, facilitators also described feeling apprehensive about delivering victim empathy-based content: *"I considered 'just doing enough' and stopping when module goals are met"* (F2).

Subtheme three - Coping with emotional responses: Three facilitators described how, whilst some participants described being emotionally affected, this was managed effectively and did not have a lasting effect, with a need for additional emotional support recognised for some e.g.: *"[they] are not overly distressed…they manage it well"* (F7) and *"some [patients] require more emotional support...they don't have as good coping strategies"* (F5).

Subtheme four – Not being distressed by emotions: Four patients described either not being emotionally affected, or feeling that their responses were appropriate or manageable. Whilst one patient described not being upset by the victim empathy work, three described experiencing an emotional effect, but felt that this was not upsetting or negative. For example: *"I was sad, obviously, but not in a bad way"* (P3) and *"I felt bad but I expected to and it wasn't a negative thing"* (P1).

Subtheme five – Longevity of emotional impact on patients: Two patients described the impact of their emotional experiences to have lasted longer than the treatment session. However, a sustained, long-term impact was not clearly indicated, e.g.: *"it affected me for the rest of the day and the day after"* (P1).

Theme four: Victim empathy content can be beneficial, with the process important

Five facilitators and four patients described victim empathy content as largely positive. There were two subthemes:

Subtheme one – Victim empathy-content is positive: Three facilitators and four patients noted positive experiences. Facilitators, as an illustration, described observing change in patients and patients responding well to the content. For example, *"When I asked the client, they felt the victim empathy aspect was important"* (F2). Patients described victim empathy content positively. They outlined benefits, such as feeling pleased to have done it, to have increased their insights, to have found talking about victims helpful, and feeling listened to throughout the process; *"I enjoyed the work, especially completing [victim empathy] letters"* (P2), and "*I benefitted from doing role plays to practice what I learned"* (P3).

Subtheme two – Treatment process: Five facilitators described the process of delivering victim empathy-based content. The delivery of the content using group or individual methods was considered important. For example, group treatment was considered helpful by one facilitator: *"group work can be helpful as it be challenging and encourage debate from other group members"* (F1). Three facilitators described individual treatment to be more able to engage patients and manage any potential impact the content could have on group processes, e.g.: *"Clients respond more in individual treatment…it allows them to get involved more*" (F1).

Treatment Facilitator only theme

Theme five - Victim empathy content can help understand risk

Three facilitators described victim empathy content as an important aspect of violence risk reduction, noting *"you couldn't meet the [risk reduction] aims without it"* (F7). They felt that it was helpful to address future violence risk. However, one facilitator felt that victim empathy content was also a useful way of assessing a patient's future violence risk, *"even if you aren't getting feedback from the client, the information is good for [an] assessment of risk"* (F6).

Patient only theme

Theme Six – Patients experience of treatment begins before attending sessions

This comprises two subthemes, as follows.

Subtheme one – Patients' experience emotions prior to sessions: Three patients described emotional experiences that were activated before completing victim empathy content, which increased their apprehension and anxiety. For example, one patient stated: *"you need to be careful about what you say… I thought what if I say something that could be taken the wrong way"* (P1).

Subtheme two – Patients have prior expectations for victim empathy-based treatment: Three patients described unfounded expectations for victim empathy content before engaging, connected to their victims and the process, e.g.: *"I thought my personal victims would come up and be analysed"* (P2), and *"I expected to do some work but also that we would go through it as quickly as we can"* (P4).

Discussion

Findings indicate that facilitators and patients have some similar experiences of victim empathy-based content, sharing four themes; 1) Victim empathy content facilitates change, 2) Victim empathy content can be difficult for patients, 3) Victim empathy content can lead to

an emotional response and 4) Victim empathy content can be beneficial, with the process important. Overall, victim empathy-based content was perceived positively, as it was considered a useful addition to violence treatment, helping build skills and knowledge, along with contributing to an expected reduction in future violence risk. Patients experienced emotional responses during treatment, though this was not always perceived as distressing. In addition, patients did report negative emotions, such as anger, sadness and apprehension. However, this was perceived by most participants as appropriate and not distressing, with some patients reporting this as helpful for their re-evaluation of their offending and/or specific victims.

Patients felt able to learn skills conducive to empathy, such as perspective taking, through victim empathy content. This corresponds with existing literature that suggests cognitive elements of empathy are an effortful skill, requiring active participation by an individual (Day et al., 2010). This may provide some support for the Model of the Empathic Process (MEP; Barnett & Mann, 2016), whereby patients in the current research demonstrated both affective and cognitive elements of empathy, which were developed through the completion of victim empathy treatment. As perspective taking is related to empathy and offending (Barnett & Mann, 2013; Martinez et al., 2014), it is positive that this was reportedly impacted on by the treatment. It may also support the use of specific methods to increase offenders' perspective taking (Seinfeld et al., 2018).

Emotional responses were evidenced as resulting from both delivering and receiving victim empathy-based treatment. This was consistent with previous research (Elias & Haj-Yahia, 2019; Zosky, 2018). It is certainly not unexpected for those with an offence history to experience negative emotions relating to their offending (Jackson et al., 2011; Tangney et al., 2011). Shame, for example, may impact ones' self-identity, which may make empathy based-content particularly salient (Pinto-Gouveia & Matos, 2011). Nevertheless, the concept of

empathy involves a range of responses, including affective, cognitive and physiological components (Cuff et al., 2016; Jolliffe & Farrington, 2006). As such, some affective response by patients in this study may be a natural response to their offending, rather than distress that is caused by the specific intervention methods employed.

Patients also described negative experiences when completing victim empathy content, including experiencing distress and having existing difficulties in the skills required to meaningfully engage in treatment. These appeared to begin before attending sessions, impacted by their (unfounded) understanding and expectations of the treatment. Given the association between perspective taking and violence, initial deficits in skills conducive to empathy are certainly expected (Barnett & Mann, 2013; Elsegood & Duff, 2010; Seidel et al., 2013). However, it was also clear that distressing emotions, in response to considering patients' own offending or victims is important (Crisford et al., 2008; Gray et al., 2003; Zosky, 2018), as this may represent a barrier for their meaningful engagement and internalised motivation for change (Burrowes & Needs, 2009, Ward & Gannon, 2006). Offending can be highly stigmatised. It can therefore be challenging to an offenders' self-identity (Cubellis et al., 2019; Evans & Cubellis, 2015; Tewksbury, 2012), which is likely to have changed since their offending behaviour occurred, given their engagement in offending-behaviour treatment. Reflecting on their past offence(s) may challenge their current self-identity and cause distress, such as anger or anxiety.

Limitations

There are limitations to the current research that need to be accounted for. While the interviews were informed by a systematic literature review, no standardised or validated measures were used to capture emotional responding. Therefore, it is possible only to understand the subjective experiences and thoughts of participants. In addition, causal relationships between victim empathy-based content and participant's experiences cannot be

determined, which limits the extent to which victim empathy content can be understood as a causal factor for any emerging emotional experiences. Furthermore, the participants that were included in the research, including facilitators and patients, all completed/facilitated a specific offender program. Although this programme employed victim empathy material, which was consistent with other offence-focused programmes, the findings of the interview study cannot necessarily be generalised to other offender programs.

Importantly, there could be a suggestion from the systematic review that empathy intervention could impact on intermediate variables relevant to offending, such as attitudes and empathy, assessed over the short term. However, we are unable to offer evidence in relation to the longer-term impact, including re-offending. The issue of method can also not be avoided, namely the fact that the empathy content was largely embedded within broader treatment programmes. Although we focused on a single programme, with attention to the victim empathy content, it is certainly the case that the impact of the empathy component could be influenced by the content that preceded it. Nevertheless, the current qualitative approach is not seeking to offer definitive conclusions, but rather to outline emerging themes and aid directions for further enquiry. Such future enquiry may explore the adoption of more experimental/quasi-experimental approaches to consider the impact of empathy. It could also explore the appropriateness of empathy-based approaches for all offenders, accounting for offence type (i.e. sexual and/or violent offenders), including those who may present with characteristics that suggest a 'classic' empathy approach may have some challenges in application (e.g. those with clinical psychopathy, those with developmental disorders).

Implications

Despite the noted limitations, the findings have some potential clinical implications for delivering victim empathy content with offending populations. Since it was indicated that some patients had existing deficits in the skills required for victim empathy work, facilitators

could evaluate individual ability to complete the treatment prior to engagement and provide appropriate support. Indeed, the potential impact of victim empathy content needs to be evaluated *before* sessions are engaged in, accounting for client expectations and treatment readiness. This may include ensuring clients are provided with accurate information about victim empathy work and offered support throughout. Facilitators should be aware of the potential distress that clients may experience when completing victim empathy content and ensure appropriate support is provided, including post sessions, with this reviewed regularly.

Implications for practice

- Definitive conclusions cannot yet be drawn in relation to the emotional impact of victim empathy work on those with an offence history. Equally, assumptions of harm cannot yet be made. There needs to be recognition that some clients view empathy work positively.
- Consideration should be given to whether group or individual empathy delivery is fitting to a particular client, accounting for their wider characteristics and individual needs, prior to the intervention commencing.
- Interventions that incorporate victim empathy work can have benefit and promote change; focus could be directed to exploring *who* they can be applied to and *how*.

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