SHAME, STIGMA, AND CALLOUSNESS:

A MODERATED MEDIATION STUDY OF SEX OFFENDER EMPATHY STRENGTH

by

Robert M. Ferow

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavior Sciences

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ABSTRACT

Callous, lacking sympathy, heartless, and cold are but a few synonyms for people that demonstrate a deficit in empathy. Psychologists, criminologists, and sociologists have tried to explain this phenomenon of callousness, or lack of empathy found in criminals for hundreds of years. Issues of definitions of empathy, personality disorders, character flaws, and even neurobiological issues have been studied in their relation to empathy. Theories of criminology have been presented to explain the reasons for lack of empathy. However, as of yet, no conclusive findings demonstrate the order or function in loss of empathy strength. This study will endeavor to describe the nature of empathy from the viewpoint of a moderation study that will demonstrate the cause-and-effect relationships of shame proneness, stigma, and empathy strength.

Acknowledgments

I want to take a moment to thank the many people that have assisted me in this journey. I am grateful for my God who has provided for my every need even when I did not see it. I am thankful for the instruction and assistance of Dr. Shelton who helped my understanding of the process of academic research and development of this dissertation. I am thankful to Liberty University for having such an interesting program, allowing for personal development in traumatology and community counseling. Moreover, I want to identify Doctors Volk and Garson for their superb dedication to the development of students such as myself.

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Some other people I need to mention are the people who helped me obtain the data for this manuscript and then understand it. I want to thank, Dr. Joseph McDaniels, Ph.D. LPC-S, LSOTP-S; Ezio Leite, LPC-S, LSOTP-S; Tina Smith, LSOTP; and Shellee Henson, LSOTP for their assistance in helping me find participants. Finally, I want to thank Dr. Shelton of Liberty University and Dr. David Cavazos Ph.D. of Tarleton State University who helped me untangle this monster I created. Without these people in my life, I may never have come to this state of completion.

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List of Abbreviations

Anterior Cingulate Cortex (ACC)

Adverse childhood Experiences (ACEs)

Adrenocorticotropic Hormone (ACTH)

Alcohol and Other Drug Substance (AOD)

Autonomic Nervous System (ANS)

Corticoid Binding Globulin (CBG)

Corticotropin Releasing Hormone (CRH)

Emotional Recognition (ER)

Emotional Sensitivity (ES)

Interpersonal Reactivity Index (IRI)

Internalized Stigma of Mental Illness Inventory (ISMI)

Medial Prefrontal Cortex (MPFC)

National Alliance for Mental Illness (NAMI)

Precuneus (PC)

Registered Sex Offender (RSO)

Sex Offender (SO)

Superior Temporal Gyrus (STG)

Superior Temporal Sulcus (STS)

Theory of Mind (ToM)

Test of Self-Conscious Affect (TOSCA)

Temporoparietal Junction (TPJ)

CHAPTER ONE: INTRODUCTION

Overview

What influences the apparent callousness or a lack of empathy in criminals? Why do serial rapists and molesters seem to act shameless, cold, and yet present as so charismatic when interviewed? Researchers and social scientists have speculated that personality disorders are the cause due to the key components of callousness, manipulation, and deception (Obradovic et al., 2008). However, the psychopathology of callousness or lack of empathy may be due to more complex interactions of interpersonal psychodynamics than previously thought. Personality disorders may be involved, but one cannot rule out components of shame and stigma. The effects of shame, stigma, and empathy have individually been studied extensively. However, no empirical studies of the relationships between these two psychological conditions of shame and empathy and the social condition of stigma have been found to date. This may be due to the numerous difficulties in defining shame, guilt, empathy, sympathy, and the negative influences of stigma.

Commonly studied populations concerning shame and empathy are children, college students, and young adults (Tangney et al., 1992), while stigma has been focused on the mentally ill (Stier & Hinshaw, 2007), general criminals (Moore & Tangney, 2017), and the disenfranchised (Goffman, 1963). Thus, there is data on normative populations across life span that includes criminals of all ages. However, only a few researchers have ventured into the pathological forensic nexus of shame, empathy, and stigma separately, and none were found to look at these three variables in one study. Therefore, a stigmatized population group, male sex

offenders, will be utilized as a focus for this study with the intent to ascertain the influences of shame and stigma on empathy deficit.

Background of the Problem

Early studies of shame began with Freud who held that guilt and not shame was more significant as a malfunctioning superego that he called "moral masochism" (Lewis, 1971). Freud held that shame is a solitary experience and that it alone is what controls one's behaviors (Pajaczkowska & Ward, 2008). Like Freud, many researchers have performed studies on the separate issues of shame, guilt, empathy, and stigma. Benchmark authors include Van Der Kolk, Herman, Bradshaw, and Brown. Bessel Van Der Kolk's (2014) work on the mind-body connection in managing shame-producing traumatic events is related to Herman's (2015) book that looks at recovering from traumatic violence. Brown is the current expert on the issues of shame, guilt, and traumatic victimology (Herman, 2015).

Sexual implications of shame did not begin with Freud in the early 20th century but in early religious teachings. Myriad religions assert that the fall of man (see Gen. 3) is illustrative of the beginning of sexual shame when humans learn of their nakedness and attempt to self-cover with vegetation (Henry, 1706; Constable, 2020). The historical account of blame combined with shame occurs when humans began accusing others due to their shame (Spurgeon, 2018; Constable, 2020). Shame and guilt researchers include Carpenter, Gavanski, IHasson-Ohayon, Lewis, Mason, Niedenthal, and most notably Price-Tangney.

Lewis's (1971) psychodynamic work on shame and guilt is the first modern publication on the topic. Tangney and others followed the works of Lewis on the topics of shame and guilt proneness and its correlation to trauma. Lewis identified that many people will express their

shame-based feeling not as shame but as feeling “depressed, tense, lousy, or blank” (p. 422). Lewis called these emotional expressions of shame “overt unidentified shame” (p. 422), which Lewis stated is linked to depression as a sequential event that ends in guilt.

Stigma has its linguistic origin in Greece with the branding of criminals (Bos et al., 2013). Stigma, in modern times, has been studied and published initially by sociologist Erving Goffman, who wrote *Stigma: Notes on the management of spoiled identity* (1963). Modern stigma researchers include sociologists, psychologists, and criminologists. Goffman, Bos, Stier, Hinshaw, Moore, Tangney, Denver, Pickett, Bushway, and Deluca are other notable researchers of stigma. Special recognition is to be given to Tangney as the crossover researcher of shame and stigma. Additional cross-over studies of stigma and criminology are equally important.

Goffman (1963) differentiated stigma into two types. The first is that a person is stigmatized while the latter is that a person is stigmatizable. In other words, the first person is already known as having stigma that is either evident in the form of a deformity or just public knowledge. The second, stigmatizable, means the condition can be withheld, covered, or concealed (Goffman, 1963). Goffman identified three classes of stigma: physical, characterological, and tribal or racial. Included in the characterological type of stigma are specific aspects of mental illness, criminology, addictions, and homosexuality and other passions (Goffman, 1963). Thus, a person can be stigmatized with a known visible deformity that only came from, for example, a war and that person may be inclined to cover or conceal the evidence of the deformity. Another may have an invisible character stigma that if it were known they would experience unbearable emotional and possibly social and financial ostracization. Therefore, stigma, like shame, has been found to be severely damaging (Stier & Hinshaw, 2007). Stigma possesses a spectrum of responses from imperceptible to dehumanizing and intolerable (Bos et al., 2013). Large groups of stigmatized individuals have been studied, including the

mentally ill, the criminal perpetrator, and the disenfranchised (Stier & Hinshaw, 2007; Bos et al., 2013; Moore & Tangney, 2017; Lageson et al., 2019; Deluca et al., 2018).

Empathy, unlike shame or stigma, has an older research history. Empathy was first observed psychologically in the 1700s by German psychologist Titchener (Oxley, 2011). Modern researchers of empathy include empathy and a criminal nexus (Robinson & Rogers, 2015; Pardini & Loeber, 2008; Obradovic et al., 2007; Smallbone et al., 2003), empathy and adolescent development (Pardini & Loeber, 2008), empathy and personality disorders (Marshall & Marshall, 2011; Shirt cliff et al., 2009), empathy and guilt (Howell et al., 2012), and empathy and sex offenders (Pithers, 1999; Smallbone et al., 2003; Nitschke et al., 2012). Yet, like shame and stigma, empathy is also difficult to define.

Theoretical Perspectives

There are many theories about crime and mental illness. Such theories include attachment theory (Jespersen et al., 2009; Levenson et al., 2016; McKillop et al., 2019; Grady et al., 2019; Leach et al., 2015; Davis & Knight, 2019; Kingston et al., 2017; Spehr et al., 2010; Burton, 2003; Felson & Lane, 2009; Braithwaite, 2015), self-control theory (Akers, 1990; Gibbs, 1990; Strayhorn, 2002; Buker, 2011; Seto, 2019; Tuvbald et al., 2017; Garofalo et al., 2018; Klipfel et al., 2017), social control theory (Goode, 2015; Gibbs, 1990; Bos et al., 2013; Denver et al., 2017), and theory of mind (Titchener, 1896; Nowak, 2011). Additional to the theories of crime are the psychological aspects of shame (Bradshaw, 1988; Brown, 2007; Van Der Kolk, 2014; Wilson, 2007; Herman, 2015; Tangney & Dearing, 2002; Hasui et al., 2008; Shiekh, 2014; Tangney, 1990; Tangney, 1994, 1996; Crosskey et al., 2015; Elison et al., 2014; Lewis, 1971; Behrendt & Ben-Ari, 2012; Dorchy, 2017; Herman, 2015; Oktedalen et al., 2014; Levin & Van Berlo, 2004; Pardini & Loeber, 2008), guilt (Wolf et al., 2010; Peters, 2018; Lewis, 1971), stigma (Ahlmeyer et al., 2003; Braithwaite, 2015; Buker, 2011; Cubellis et al., 2019; Evans &

Cubellis, 2015; Felson & Lane, 2009; Garofalo et al., 2018; Graddy et al., 2019, 2018; Klipfel et al., 2017; Marshall et al., 2007; Moore et al., 2016; Seto, 2019; Spehr et al., 2010; Goffman, 1963; Pachankis, 2018; Boyd & Ritsher, 2003; Aggrawal, 2009; Von Krafft-Ebing, 2011; Hothersall, 2004; Schultz, 2004; Levenson, 2007; More et al., 2016; Holmberg & Christianson, 2002; Abderholden, 2020; Marshal et al., 2001; Stier & Hinshaw, 2007; Boyd et al., 2003; Hasson-Ohayon et al., 2012; Jeglic et al., 2012; Tewksbury, 2012; Kerr et al., 2018; Rolf et al., 2017; Rothmund & Baumert, 2014; Carpenter et al., 2016), and empathy (Marshall et al., 1995, 2001; Nowak, 2011; Buber, 1970; Shirtcliff et al., 2009; Oxley, 2011; Marshall & Marshall, 2011; Pithers 1999; Ward & Durrant, 2013; Chrysikou & Thompson, 2016; Robinson & Rogers, 2015; Ahlmeyer et al., 2003; Pardini & Loeber, 2008; Smallbone et al., 2003; Tubvald et al., 2017), each of which have their own theoretical positions to be considered.

Attachment Theory

The attachment theory holds that one's attachments are a key component to the characterological development of the individual (Jespersen et al., 2009; Levenson et al., 2016; McKillop et al., 2019; Grady et al., 2019; Leach et al., 2015; Davis & Knight, 2019; Kingston et al., 2017; Spehr et al., 2010; Burton, 2003; Felson & Lane, 2009; Braithwaite, 2015). The specifics of this theory hold that the parents are the primary factor in the development of males who commit sex offenses, as indicated by the number by percent of female head of household in rural settings (Braithwaite, 2015). Grady et al. (2019) discussed the perspective that sex offenders come from homes where there were fearful and preoccupied attachment styles of distrust and abuse. The Levenson et al. (2016) study using the ACEs identified high percentages of male offenders came from homes where they themselves had been abused in some form. Jespersen et al. (2009) concluded that men from homes where physical abuse occurred more likely to perform sodomy and rape than those from homes where sexual abuse occurred.

Self-Control Theory

Akers (1990) viewed self-control theory as a classical choice model of crime and criminality. Socialization is where sociology separates from psychology in the self-control theory. Sociologists tend to avoid self-control theory as it is more in line with psychology and notions of free will (Gibbs, 1990). Gibbs (1990) affirmed that even Durkheim (the father of modern sociology) stated that self-control is the ultimate product of socialization and that any study of social interaction is a study in the provenance of self-control. Akers (1990) pointed to the "low" self-control theory, proposing the causality as due to socialization issues during early childhood that indicate ineffectual parenting. Akers's work stated that less attachment between the parent and child yielded a lack of awareness of low self-control within the child. Akers then said it is the parent's duty to teach better self-control to the child once the deficiency is observed. Self-control theory brings self-will and choice where shame and guilt reside to the table of discussion.

Social Control Theory

In the early 1900s, Ross proposed a connection between social order and social control (Goode, 2015). Deflem stated:

> Social control is perhaps the guiding concept in the field of deviance; it is on the foundation of the concept of social control that everything that is important about deviance and how it operates in social collectivities and, more generally, the society itself, rests. (Goode, 2015, p30-31)

Social control theory asserts that people react to influences by external controls for the betterment of society through conformity to social norms of socialization interactions (Gibbs,

1990). Gibbs (1990) added that it is social control theory that discusses the use of mechanisms that control social deviant behaviors using external third parties of society. In 1934, Mead purported that the I and the me of an individual perform self-criticism, which Mead ascribed to be an aspect of social control that is intended to improve society (Goode, 2015, p. 34).

Negative Influences of Stigma

Denver et al. (2017) identified Tannenbaum's (1938) work titled *Crime and the community* as a historical account of the effects of stigma on criminal deviance. Sociology of the 1960s provided the perspective that labeling as part of social control is where society defines deviance (Goode, 2015, p. 369). Stigma affecting society as a whole, as well as groups of people and individuals (Bos et al., 2013). The only way for a stigmatized individual to function is to distance the self from their reality or hide their social deviant behaviors that cause stigma from others (Bos et al., 2013). Labels that stigmatize have lifelong effects that increase deviant behavior (Denver et al., 2017). Thus, the sociological theory of social control brings stigma to the table for conversation.

Theory of Mind

Early psychological analysis examined the process of cognitive and affective consciousness (Titchener, 1896). Theory of mind focused on defining and analyzing the aspects of awareness and the connection of emotions, thoughts, and the complexity therein (Titchener, 1896). Ruhl (2020) identified theory of mind being first defined in 1978 as a mental ability to attribute thoughts, feelings, beliefs, and knowledge to others as well as oneself.

Titchener (1896) took personal ideas of empathy from *Einfühlung* as constructed by the German romantic Philosopher Lipps. Lipps suggested that having empathy towards others is limited, such that the empathizer must have had a similar experience in order to be empathic (Nowak, 2011). Lipps held that one must project the emotion for *Einfühlung* to transpire

(Nowak, 2011). Titchener believed that all emotions had physical reactions that were capable for self-awareness and awareness by others when the emotion achieved a sufficient threshold of stimulus to evoke awareness in others. Titchener also concluded that strong emotions were short-lived while weaker emotions longer lasting. The weaker strength longer lasting emotions were coined moods, while the stronger ones were called passions (Titchener, 1896). Titchener then linked moods and passions to cognition and explained that only when one has had similar life experiences can one relate or have re-cognition of the emotion in others (Titchener, 1896). This aspect of mood and passion is important due to the findings of perception research that concluded that individuals react differently to similar or identical stimulation of affect depending on the mood and or passion they are in at the time of the re-cognition (Nowak, 2011). Therefore, empathy is studied as cognitive and affective as it requires both cognition of the emotional state of self as well as others.

Empathy and Sympathy

Einfühlung (empathy) is not the same as *Verstehen* (sympathy) even though both were simultaneously developed in romantic philosophical concepts (Nowak, 2011). Sympathy does not possess the emotional re-cognition of *Einfühlung* (Nowak, 2011). Lipps, along with Robert and Friedrich Vischer, held that *Einfühlung* was much more than simple understanding of the emotions of others on a cognitive level (Nowak, 2011). They proposed a positive meaning of an opening up to the external world to the understanding of the internal world of the self (Nowak, 2011). In 1905, Husserl criticized Lipps and Vischer, citing that there was a spiritual component that is shared when two people experience *Einfühlung* on a phenomenological level (Nowak, 2011).

Finally, for *Einfühlung* and not *Verstehen* to happen, direct contact must take place. In her 1916 dissertation on the problems of empathy, Stein concluded that it was phenomenological

(Nowak, 2011). Stein determined that in *Einfühlung,* the I and you relationship is never mixed and that the emotions of others can only ever be experienced as otherness (Nowak, 2011). Therefore, the confusion of empathy and sympathy continues. However, in the 1930s Buber reframed the I-you relationship to look at the I-thou after discussing five alternatives of I-I, I-It, It-It, We-We, and the Us-Them to finally arrive at the I-Thou phenomenology of *Einfühlung* (Buber, 1970).

Shame, stigma, and empathy have been studied since the 1700s to current post-modern history, and each (shame, stigma, empathy, and crime) has its own theories that yield personal opinions. However, the juxtaposition of shame, stigma, empathy, and sympathy in the various theories of crime and theory of mind construct is where the reader now finds themselves. These elements become interlinked within the individual and beg the question of how these all work against the individual. This question leads to the purpose of this research study.

Purpose of the Study

The purpose of this study is to examine sex offender (SO) intrapersonal relationships of shame, stigma, and empathy. Sexual offenders are required to process their offenses during treatment and risk assessment sessions. They are often unable to express or admit to their behaviors due to personality disorders and or being criminogenic in nature (citation). Regardless of the foundations of this empathy deficit, many clinicians continue to focus on helping the offender (adult) and the respondent (juvenile) to develop victim empathy as part of their therapeutic goals to reduce recidivism. However, empathy deficits or callousness are viewed as a strong inhibitor to recidivism prevention. Furthermore, this empathy deficit or callousness is also seen as a form of treatment resistance often observed as denial (More et al., 2016).

Research Questions

The purpose of this study is to examine the mediating relationship of shame to stigma, shame to empathy, stigma to empathy, and the total moderation of shame and stigma with empathy. Shame and stigma will be examined as independent variables to determine the influence they have on empathy strength. In addition, stigma will be viewed as a moderator of shame and the reduction of empathy strength. The findings of this study add to the current research on shame, stigma, and empathy in general as well as the forensic nexus that they share as predictors and moderators of empathy deficit.

The variables in this study include shame, stigma, and empathy. Shame is an independent variable and is assumed to be a preexisting condition in the sex offender. Stigma will be viewed both as a mediated and a moderated variable. Empathy strength is the identified dependent variable that is anticipated to have an observed reduction. The predictor variable is the stigma, as it will predict the moderation or the loss in empathy strength as well as the mediation effect of empathy.

The research questions for this study are as follows:

Research Question 1: relationship sequence

RQ1a: What is the relationship between shame proneness (trait shame) and stigma?

Hypothesis: Sex offenders have an increased shame proneness that increases the relationship with stigma.

Figure 1: Model of research question 1a.

RQ1b: What is the relationship between trait shame/shame proneness and empathy?

Hypothesis: Sex offenders have a relationship between trait shame/shame proneness and empathy that shows an empathy strength reduction observed as callousness.

Figure 2: Model of research question 1b.

RQ1c: What is the relationship between stigma and empathy?

Hypothesis: Sex offenders have an increased relationship between shame and stigma.

Figure 3: Model of research question 1c.

RQ1d: What is the relationship between shame (state shame) and stigma?

Hypothesis: Sex offenders have an increased state shame that increases the relationship with stigma.

Figure 4: Model of research question 1d.

RQ1e: What is the relationship between shame (state shame) and empathy?

Hypothesis: Sex offenders have an increased state shame that increases the relationship with empathy.

Figure 5: Model of research question 1e.

RQ1f: What is the relationship between shame (state shame) combined with trait shame to empathy?

Hypothesis: The combination of state and trait shame increases the relationship with empathy strength reduction.

Figure 6: Model of research question 1f.

RQ1g: What is the relationship between shame (state shame) combined with trait shame to stigma?

Hypothesis: The combination of state and trait shame increases the relationship with stigma.

Figure 7: Model of research question 1g.

Research Question 2: Mediation sequencing

RQ2a: Does stigma mediate the relationship between trait shame/shame proneness and empathy strength/callousness?

Hypothesis: Stigma influences the relationship between trait shame and empathy.

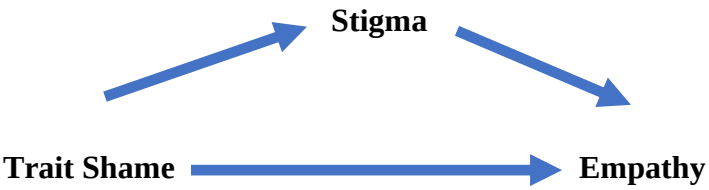


Figure 8: Model of mediation question 2a.

RQ2b: Does stigma mediate the relationship between state shame and empathy strength/ callousness?

Hypothesis: Stigma influences the relationship between state shame and empathy.

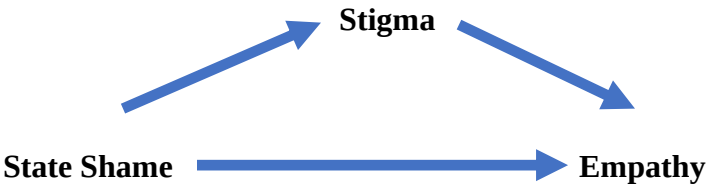


Figure 9: Model of mediation question 2b.

RQ2c: Does stigma mediate the relationship between trait shame and state shame and empathy strength/callousness?

Hypothesis: Stigma influences the relationship between trait shame and empathy.

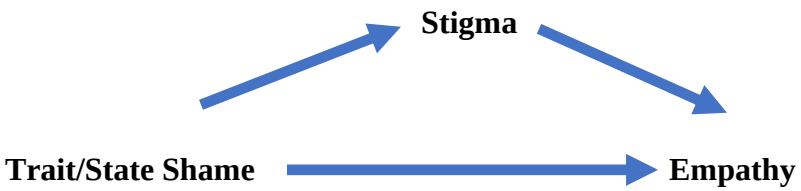


Figure 10: Model of mediation question 2c.

Limitations to the Study

There are some possible limitations to consider in this study. Research participation may be low due to the fear of public exposure and will need to be addressed in the methods section to ensure privacy. Additional limitations may include statistical significance if a Sobel test is not possible due to reduced sample size, in which case a bootstrap of standard error will be used. Furthermore, no instrument for stigma for this population exists and a modified tool will be utilized that has not been verified for internal validity.

Lastly, a confounding effect may be detected related to the actions of engagement by the act of discussing shame and stigma with the sex offender population as encountered in the use of the tools and the interactions of the research assistant. This confound will be addressed as part of the manipulation. The sequencing of participant with tool will be utilized to hopefully manage confounding possibility.

Definitions

The terms clarified for this study include:

1. *Empathy - Einfühlung* (empathy) is the emotional 're-cognition' of another's emotional state due to personal experience with same or similar emotional states and is not the same as *Verstehen* (sympathy) (Nowak, 2011).
2. *Guilt* – Guilt is the short-lived negatively-charged self-perceived moral violation of a committed behavior or action (Wolf et al., 2010).
3. *RSO* - Registered sex offender.
4. *Shame* - The negatively charged and internalized self-evaluation on a global totalitarian condition that states "I am unworthy, bad, unlovable, broken, flawed, unacceptable, deviant, [and] morally corrupt" (Bradshaw, 1988; Brown, 2007; Van Der Kolk, 2014; Herman, 2015).
5. *Sympathy - Verstehen* (sympathy) is the 'understanding' of another's emotional state though the person has had no prior personal experience with said emotional state (Nowak, 2011).
6. *Stigma* - Stigma is a prejudiced, negative stereotype with a marginalized condition experienced by individuals for perceived conditions or states viewed as morally or characterologically reprehensible by society or the self that leads to the perceived need for secrecy (Goffman, 1963; Pachankis, 2018; Boyd & Ritsher, 2003).

Significance of the Study

This study can have potentially significant outcomes for future research in counseling and not just for the SO. The possibility exists that the SO's experience with sex offender stigma is preventing the client from making a change (Rothmund & Baumert, 2014; Stier & Hinshaw, 2007; Jeglic et al., 2012; Kerr et al., 2018; Rolf et al., 2017; Tewksbury, 2012). Guilt rather than shame is perceived as being more prosocial (Tangney, et. al. 2011) . The treatment of choice to date is focused on helping the SO change from shame focused to guilt (Lewis, 1971). This shift

aids in victim awareness and in the ability to express regret. Shame proneness, however, prevents the SO from recognizing the lack of empathy, which prevents the SO from developing victim awareness and guilt-based prosocial change (Barnett & Mann, 2013).

Therefore, this study has several purposes. The first is to clarify the relationship between shame, stigma, and empathy. The second is to perform a moderation mediation study to make observations of the sequence and/or intensification of the relationships. Lastly, this study will hopefully increase the therapeutic awareness of stigma's causal effect on what many would view as denial or therapeutic resistance.

The first and second purposes are conjoined. The clarification of the causal relationship of shame, stigma, and empathy will allow more research to expand on this triad of criminogenic qualities. The observation and measurement of the sequence in a mediation model could lead to deeper understanding of the ways to reduce stigma while increasing therapeutic engagement and reducing the recidivism of the sex offender. The observation and measurement of the moderation model will hopefully bring new insight into the need for therapists to check stigmatizing bias in their attempts at developing a therapeutic alliance with sex offenders. Additionally, the moderating effects of stigma on empathy may deepen the therapeutic use of a trauma-informed approach in the treatment of sex offenders in general.

Chapter Summary

The problem that this study will investigate is the apparent deficit in empathy experienced by adult male sex offenders that is often viewed as resistance to therapy in the form of denial or callousness of a criminogenic nature. The causal relationship of shame, therapeutic engagement, stigma, and empathy deficit will be studied with therapeutic engagement manipulated in a mediation moderation study design. The hope is that the conclusion will show the domino effect relationship of shame proneness, engagement, stigma, and empathy deficit.

Additionally, the moderation effect of stigma on empathy deficit will be studied. Furthermore, the prediction of empathy deficit due to the effects of mediation and moderation will be identified.

The hope is that this study will add to the empirical research on shame, stigma, and empathy. Additionally, it will add to the development of clinician bias awareness to recognize the effects of stigma on the sex offender population. Increased stigma from perceived bias that leads to poor therapeutic outcomes due to empathy deficit seen as resistance to treatment will be studied. Finally, this study will lead to more research and generate new questions in the fields of shame, stigma, empathy, and the criminogenic nexus.

CHAPTER TWO: LITERATURE REVIEW

Overview

Research into the criminal aspects of sex offenders (SOs) has a long history. The moral panic of sex offenders in public has its onset in the 1930s and found strength in the Wetterling Crimes Against Children and Sexually Violent Offender Registration Act of 1994 (Cubellis et. al., 2019). Issues of personality disorder and callousness or empathy deficits, criminality of self-control deficits, poor parental involvement, and childhood maltreatment have been the subject of focused research in past decades (Goode, 2015).

The use of empathy as a therapeutic direction to bring SOs from denial to acceptance of personal responsibility has been perceived as a therapeutic necessity. Therefore, the overarching focus of this study is the issue of the apparent lack of empathy among male sex offenders (SOs) in therapeutic settings and therapeutic focus on the need to develop victim empathy within the SO. This paradigm of teaching victim empathy is not empirically proven. However, it is upheld as the therapy of choice by many therapists of sex offender treatment (Anna Salter, March14th, 2022) . Therefore, the influences of stigma and shame on empathy will be considered in this study.

Conceptual Perspective

Influences in this study include one theory on crime, two theories on sexual offending, and one theory on stigma. The theories include the general theory of crime, also known as the self-control theory of crime, and the victim perpetrator or abused abuser theory. Labeling theory is the theory focused on stigma. Each theory has attempted to explain the cause as well as motivations for sex-related offenses (Ahlmeyer et al., 2003; Braithwaite, 2015; Buker, 2011; Cubellis et al., 2019; Evans & Cubellis, 2015; Felson & Lane, 2009; Garofalo et al., 2018; Grady et al., 2019; Grady et al., 2018; Klipfel et al., 2017; Marshall et al., 2007; Moore et al., 2016;

Seto, 2019; Spehret et al., 2010). Additionally, both theories on crime, self-control theory and victim perpetrator theory, have identified correlations to criminogenic psychopathy (Buker, 2011; Garofalo et al., 2018; Klipfel et al., 2017; Marshall et al., 2007; Tuvblad et al., 2016; Seto, 2019). Stigma as an influencing force is viewed in labeling theory as the motivating factor behind the SO's attempts to curtail their public image and cope (Evans & Fera, 2019).

Self-Control Theory

The *General Theory of Crime* by Gottfredson and Hirschi (1990) attributes the cause of crimes to be low self-control on the part of the offender. This theory maintains that children develop low self-control that remains constant throughout their lives. This is linked to Freud's pleasure principle that labels inability to delay self-gratification as impulsivity or failure to think about future consequences (Lewis,). Buker (2011) argued that this concept is overly simplified and has much more complexity than originally speculated. Buker concluded that familial relationships, biogenetic factors, family structures, education, and religious involvement each influence an individual's development of self-control in very complex ways.

Self-control theory is a primary predictor of criminogenic behaviors and can be conceptualized in the individual's impulsivity and lack of self-regulation (Seto, 2019). Self-control theory and self-regulation are about predicting recidivism (Seto, 2019). Criminogenic traits include callousness, self-centeredness, and emotional dysregulation (Tuvbald et al., 2017; Garofalo et al., 2018). Some have concluded that sex offending is more personality related rather than other forms of pathology due to personality traits with deficits in self-regulation and interpersonal relationships (Klipfel et al., 2017). However, Klipfel (2017) indicates that a lack of self-control does appear to be in line with personality trait disorders.

Garafalo et al. (2018) reported that child sex offenders show less personality disorder and personality maladaptation than other non sex offenders, thus bringing potential limitations to the

self-control theory. Bolstering the self-control theory is the evidence that SOs also have deficits in identity integration and interpersonal functioning (Garofalo et al., 2018). Additionally, child sex offenders often have documented deficits in intimacy with adults (Marshall et al., 2001). Moreover, further studies have demonstrated that SOs have selective deficits regarding their victims (Garofalo et al., 2018). This selectiveness further limits the strength of the self-control theory. Garofalo et al. (2018) concluded that due to findings of child molesters not having a psychopathic dimension, stigma may be involved in moderating self-control aspects.

Abused Abuser and Attachment theories (Theories on SO)

The belief that sex offenders were themselves sexually abused is an old idea stemming from years of studies that was repeated frequently (Jespersen et al., 2009). The link between child abuse and criminal offending was confirmed by the Adverse Childhood Experiences (ACEs) study (Levenson et al., 2016). The ACEs study found that 48% of the male SO respondents reported having four or more ACEs in their childhood (Levenson et al., 2016).

The abused abuser theory is difficult to specify causality due to the amount of poly victimization that the average SO experiences in childhood (Jespersen et al., 2009). Early studies of sex offenders were linked to poor early childhood attachment to fathers as per Bowlby's (1944) study on juvenile thieves (McKillop et al., 2012). Bowlby's attachment theory holds that people develop either healthy or unhealthy attachments with childhood caregivers and that it is the unhealthy attachment styles that lead to offender personality traits as strategies to manage or cope with the world (Grady et al., 2019). Grady et al. (2018) confirmed the finding that the father has a more prominent role in the SO population regarding parental relationships. Closely related to the issue of parent child relationship is the theory of the sexual victim becoming sexual offender (Leach et al., 2015; Davis & Knight, 2019).

The abused abuser theory rests on the findings that 70% or more of SOs were themselves abused (Leach e. al., 2015). Reinforcing this construct is the finding that males abuse by fathers were found to produce more hypersexuality than those who endured other forms of abuse by a parent (Kingston et al., 2017). The ACEs study confirmed that define this acronym (CSAs) abused by a family member had significantly higher amounts of depression, anxiety, and reduced adult functioning (Levenson et al., 2016), while poly-victimization of any kind (physical, sexual, emotional) at any developmental age yielded higher risks of sexual offending (Leach et al., 2015; Grady et al., 2018).

Kingston et al. (2017) found that 78% of sexually abused minors, 61% of physically abused minors, and 88% of emotionally abused minors obtained treatment for a sex-related issue. They report that sexual abuse remains "as an important etiological correlation among adolescent sexual offenders" (Kingston et al., 2017, p.). Empirical studies have shown that childhood maltreatment, insecure attachments, and emotional dysregulation are linked to violent sexual experiences in youth (Grady et al., 2018; Kingston et. al., 2017). Furthermore, Davis and Knight (2019) expressed that psychological abuse is part of all other forms of abuse. Jespersen et al. (2009) concluded that SOs of children had higher rates of their own childhood sexual abuse, while SOs of adult victims had higher rates of physical and emotional abuse as well as observed parental violence. Bolstering this aspect is the finding that SOs of adult females have less history of childhood sexual abuse than their child victim counterparts (Spehr et al., 2010). Additionally, Spehr et al. (2010) found that SOs of child victims describe their mothers as unloving, inconsistent, and abusive, where SOs of adult victims identified fathers as uncaring and abusive. Therefore, it seems that any form of abuse in combination with psychological abuse as poly-abuse can lead to the abused becoming an abuser.

Imitation and modeling are the most widely accepted learning mechanisms to explain the sexually abused turning sexual offender (Burton, 2003; Jespersen et al., 2009; Davis & Knight, 2019). Bandura's social learning theory holds that a possible cause of victims sexually acting out is from learning by experience or witnessing (Felson & Lane, 2009). Felson and Lane (2009) identified three studies that showed victims of physical abuse tend to be violent, while 70% of sex offenders reported having been sexual victims first. Imitation and modeling of social learning more accurately identify the causality of sex victims being sex offenders; however, attachment theory still remains a confounding element to the social learning theory of the abused abuser (Burton, 2003).

A major limitation of the abused abuser theory is in the number of victims verses offenders. Jespersen et al. (2009) addressed this issue identifying the gross divergence of sexually abused females and the low numbers of female SOs in comparison to the low numbeCrs of male abused victims and the high numbers of male SOs. Currently there remains too many variables for any one study to give definitive evidence for or against this theory (Braithwaite, 2015).

Individual differences also play a role in the abused abuser theory. Insecure attachment may be a key focus. Grady et al. (2018) concluded that insecure attachments in youth have increased mental health issues such as personality disorders, psychotic disorders, AOD substance disorders, and emotional regulation disorders.

Labeling Theory (Theory of Stigma)

The combination of a stigma and sexuality can be found historically, dating back to early codexis such as the Septuagint of the 2nd and 3rd century. Specific sexually related incidents are recorded in the Bible to include rape, gang rape, incest, adultery, drug coercion, sexual harassment, homosexuality, bestiality, necrophilia, and exhibitionism (Aggrawal, 2009). These

sexual issues have continued into the present postmodern age. Taboos specific to sexuality, sensuality, and physical contact are brought together as evidenced by the historical biblical accounts of a death penalty for such behaviors.

The sex offender, regardless of the theories discussed above, intuitively knows that a sexual offense is, by its very nature, an act viewed as taboo in society (Cubellis et al., 2019). Taboo awareness has its history in religion. The religion of Christianity is one that cites equality between men and women while elevating the sex/love bond to a moral and spiritual level and placing sensuality at odds with the acceptable public morality (von Krafft-Ebing, 2011). Von Krafft-Ebing was not the only theorist to discuss sexuality in the late 19th century. Sexuality was also a prime focus of Freud's work (Hothersall, 2004).

Labeling of sex offenders as deviant began in America in the 1950s, but the theory of labeling founds its voice in the 1960s as a criminological theory (Schultz, 2014). Schultz (2014) cited that such labels as sex offender have a social interaction where the offender is labeled as deviant. This label identifies the person as being below the rest of society and is the only type of crime that comes with an ongoing mandate for containment for the safety of children (Braithwaite, 2015).

Public perception of the offender as deviant and highly likely to reoffend has influenced societal management of SOs (Levenson, 2007; Schultz, 2014). Registered sex offenders (RSOs) have reported finding life difficult due to the legal requirement of being listed on a registry of criminal status following the completion of their incarcerations (Moore et al., 2016). Community integration seems to be the link that the RSO should attempt to obtain for prosocial actions consisting of employment, schooling, church, and family matters (Moore et al., 2018). Such areas of life that are difficult include employment, housing, shopping, church, and relationship gatherings (Schultz, 2014), and these issues even bleed into one's family and their relationship

with employers (Cubellis et al., 2019). Moore et al (2016) cited the offender registration of the late 1990s that included images of the RSOs, addresses of RSOs, and in some locations the informing of the surrounding neighborhoods of the existence of the RSO presence as being the onset of the SO's need to manage and cope with derogatory labels. Sex offending is one type of concealable criminal offense that registration makes public. Moore et al. (2018) concluded that convicted offenders have increased work but decreased wages and fewer housing opportunities.

Sex offenders have been shown to be stigmatized (Cubellis et al., 2019). SOs self-report being treated as less than human, without human respect or dignity, and endorse feelings of alienation (Holmberg & Christianson, 2002). This seems to be part of the anticipated stigma that RSOs experience during the registration process. Moore et al. (2018) concluded that perceived and anticipated stigma is harmful not only to the RSO, but also to the estimation of risk and recidivism. Moore et al. stated that it is important to examine relevant global variables to specific stigmatized groups. Additionally, when an offender does not view themselves as being part of a stigmatized group, they will reject the self-stigma (Moore et al., 2016).

RSOs with emotional regulation problems and those that socialize with other SOs have increased proneness for negative stereotypes and will internalize anticipated discrimination that increases their self-stigmatizing (Moore et al., 2018). Offenders must reconcile negative stereotypes and stigma (Moore et al., 2016); therefore, RSOs will use coping strategies to manage these negative effects (Evans & Cubellis, 2015; Marshall et al., 2001). Forms of denial such as rationalization and justification are common strategies used by SOs (Moore et al., 2016). Consequently, it appears that the anticipated or internalized stigma can increase mental health issues (Boyd et al., 2003), which may lead to an increase in offender recidivism and continued use of AOD substances (Moore et al., 2016).

Shame

"Shame is one's own experience" (Lewis, 1971, p 2). Jacoby (2016) discussed the biblical experiences of Adam and Eve in the recognition of their nakedness and the use of loin coverings as the initial shame experience of man. The uncovering or nakedness of man in view of the divine was described by Jacoby as being irrevocably tied to the personal experience of sexuality and the action of being exposed to the divine ideal. Thus, shame is related to one's personal experience in a relationship to an ideal or perfected divine.

The phenomenology of shame is so unique that Broucek (1991) stated that in knowing one's shame one knows psychopathology. Before Broucek, Lowenfeld (1976) stated that shame inhibits man's degenerating tendency towards a perverse infantile fantasy life. If one combines these two statements, it would be logical to state that shame-based pathology is about a perverse infantile fantasy life. So, more clarification is needed to understand shame better.

Shame Defined

Shame is difficult to define yet a proper definition must be agreed upon before it can be understood. Shame has been defined in many ways by many people, with a separation between guilt and shame happening relatively recently (Tangney, 1990). Elison et al. (2014) cited Lewis's (1971) work which stated that shame is hard to self-identify, yet is also one of the more difficult and painful emotions to manage. Shame is an alarm alerting one that a threat exists to one's personal value, status, and rank that influences the hierarchical need to belong and the basic need for human contact (Elison et al., 2014). Due to the difficulty to provide a simple definition of shame, more explanation is needed from various perspectives.

Psychoanalytical

It is advisable to discuss shame from the Freudian psychodynamic view when addressing the topic. Shame was studied under the psychoanalytic school and defined as components of the

ego and the super ego by Freud (Wilson, 2007; Tangney & Dearing, 2002; Hasui et al., 2008; Shiekh, 2014). In 1908, Freud wrote that shame was a formidable repressive force linked to the anal erotic impulse experienced during toilet training and the action of voiding (Akhtar, 2015). Freud continued setting the foundation for the guilt and shame relationship when he tied one's fantasy life to feelings of shame and preferential acceptance of sharing one's guilt of one's actions over one's phantasies (Akhtar, 2015). Freud moved away from the issue of shame placing shame under guilt as the stronger of the two. In 1933, Freud took this topic of shame and postulated that it was a female character defect after he had stated in 1930 that shame was due to genital exposure and vulnerability (Smolen, 2015).

Freud's ideas on shame developed and continued into the 1950s when others postulated that shame was a narcissistic reaction to failure of the ego ideal (Lewis, 1971; Smolen, 2015). Furthering the ideas of Freud was Erickson, who placed shame in a developmental stage offset by autonomy and paired with doubt (Smolen, 2015). Erickson tied shame to the anal stage of development and postulated that trust was required otherwise a negative or bad internalized self-identity would ensue (Smolen, 2015). The idea of exposure and vulnerability continued with Erickson, who held that inadequacy and the defective self would follow exposure (Smolen, 2015).

The psychodynamic research of shame as a topic went through much development in the 1960s, 70s, 80s, and 90s. The late 60s and early 70s was when Kohut postulated that shame was centered on the self with regards to exposure and linked to humiliation experiences (Akhtar, 2015). Chasseguet-Smirgel, a French psychoanalyst, added in the 1970s that shame and suicide are linked in that one "dies of shame" (Chasseguet-Smirgel, 1985). In the 1980s, Morisson added six major points of shame to the general definition when he used the phrase:

> I am weak, I am dirty and an item of disgust, I am defective, I lack control over my mind and body, I am sexually excited by suffering and degradation, and I fear that showing myself will result in mockery and punishment. (Salman Akhtar, 2015, p. 98)

Wurmser (1999) expressed how shame is a fear of disgrace with intense, global extreme conflicts by the inner judge concerning sexual traumatic exposure that leads to dehumanization.

Phenomenology

Shame and anxiety are related to the personal experience of shame though qualitatively different. Anxiety precedes the anticipated experience of shame (Jacoby, 2016). Jacoby (2016) stated the shame-anxiety dilemma is focused on asking the self about the ability to fulfill the expectations of others or self. This is related to possessing positive self-esteem, which is described as a healthy self-love (Jacoby, 2016). Anxiety as a personal fear of weakness in view of public attention can lead to a reaction formation of increased shyness and avoidance of situations (Jacoby, 2016). This begs the question of the formation of the experience of shame.

Developmental

The formation of a personal experience of shame has an early childhood beginning. Jacoby (2016) described the psychoanalytic perspective of Erikson and Jung and discussed the formation of shame as tied to anxiety in the anal stage of child development. This is affiliated with the visual cliff experiment where a child reacts to the facial expression of the primary caregiver of either happy or fearful, and thus the child proceeds or not respectively. During this same time frame the child is undergoing increased awareness of parental facial recognition coinciding with the removal of the diaper during changing and the reaction of the parent (disgust) where the child learns shame based on the parental response to the excrement of the child (Gilbert & Andrews, 1998; Jacoby, 2016). Jung described this association of the dark side of the behind as being under the control of others. As such, the child learns that it is an act and

action of shamefulness (Gilbert & Andrews, 1998; Jacoby, 2016). Due to the uncovering action of the "behind" during diaper changing, the infant learns that shame of that region is associated with a need to remain covered or hidden.

Morality

Jacoby (2016) discussed the actions of Adam and Eve in the biblical account of man's awareness of nakedness in the garden as the first written expression of experiencing shame. Personal experience of shame requires the orientation of the self in space with relationship to others (Lewis, 1971). Furthermore, the biblical account describes the male blaming the female for the fall, thus attempting to relieve himself of responsibility (Constable, 2020). Therefore, the self as a starting point lead to the ability to place blame on others (Lewis, 1971).

Moral Shamelessness

Shamelessness as a lack of morality has minimal research outside of the theological realm. Shamelessness in sexual matters as viewed by Freudians as masculine and an indication of psychological health (Broucek, 1991) was made null, as Kohlberg (1977) identified that moral judgment is not enough to make moral actions. Moral developmental theorists such as Kohlberg (1997) and Wolf (2010) hold that morality is the sole realm of family teaching.

Direct and removed judgments of the self by the self are the psychological components of moral self-awareness (Mandelbaum, 2020). The removed judgment as an observer by Adam and the directed judgment as the agent by Eve shows this moral awareness discussed by Mandelbaum (2020) regarding moral judgments of right and wrong behavior in the biblical account of shame entering the world. Lewis (1971) expressed that the identification of the painful source of shame need not be correct for it to be valid, equating the experience to a missing extremity (Lewis, 1971). However, Lowenfeld (1976) discussed the biblical mosaic laws as indicating that man was not to "uncover" or expose "the shame" of a female. Lowenfeld linked the external sex

organs of the self as shameful and needing continual moral coverage. Thus, one takes misdirected shame as read in the story of Adam's shifted blame to Eve in the garden and can better express what Lewis poorly describe as an example of a painful phantom limb (Lewis, 1971).

Shame Reactions

Tangney (1996) discussed the difficulties of identifying shame and guilt as each has no clearly definable facial expression unlike other emotions. Lewis (1971) previously affirmed that the experience of shame carries with it a demonstrable, observable reaction of head down, poor eye contact, body slumped, presenting the self as small as possible, blushing face, and a flooding of emotional reactions so primitive that hiding or running away is the only recourse. Gilbert and Andrews (1998) proposed that shame reactions may be like those of panic attacks as experienced in individuals with social anxiety and phobic persons, citing that both have a focus on negative self-evaluation.

Shame as a Cognition

Shame is the focused internalization or cognition of a negative evaluation of the self with self-perceptions of devaluation as a reaction to public exposure and disapproval of some impropriety or shortcoming (Tangney, 1990). Brown (2007) stated that shame is an intensely painful experience that includes belief in being flawed and unworthy of acceptance and belonging by others. Brown added that shame includes cognitive words such as devastating, consuming, excruciating, small, rejected, and stained (Brown, 2007). Similarly, Bradshaw (1988) applied toxic shame to this category as a cognition, stating that to be ashamed means something is wrong with the individual by the individuals' own thoughts. Contrary to Brown, Lewis (1971) identified that shame is void of words and is an internal auditory dialogue during which the self is condemned by the self.

The cognition of shame is one of learned conditioning (Gilbert & Andrews, 1998). The mixing of shame-based affects makes this potentially confusing yet also highly explanatory of shame's complexity. Shame can become linked to fear, anxiety, anger, disgust, or any potential combination of thoughts or emotions dependent on the theme that the individual attaches the thoughts and feelings of shame to (Gilbert & Andrews, 1998). An example could be a three-year-old who shares her artwork with a parent and receives praise in the words of being smart or good—or the opposite—of being condemned for causing a mess with the papers. In this example, the child attaches the theme of good or bad to herself in the context of her artwork. Here, one finds the formation of the hot thought that at later ages happen so fast that the now adult child no longer recalls the formation event but only the affective reaction of feelings (Gilbert & Andrews, 1998).

Shame as an Emotion

Tangney (1990 & 1996) discussed how shame is an emotion that is primarily exhibited at specific times. Shame is an irrational emotion to most adults as it is self-centered and narcissistic (Lewis, 1971). Gilbert and Andrews (1998) added that shame interrupts positive social interactions. Shame is associated with anger and aggression, heightened emotional dysregulation (Elison et al., 2014), alcoholism, drug use, and burnout or compassion fatigue (Crosskey et al., 2015).

Shame and Anxiety

Anxiety, the master emotion, is connected to one's vulnerability awareness related to the unknowns of existence (Jacoby, 2016). Jacoby (2016) added that guilt and shame are the progeny of anxiety and are separately distinguishable, but that shame is a particular type of anxiety (Jacoby, 2016). Gilbert and Andrews (1998) further claimed that fear in avoidance behavior as seen in panic is related to the fear of feeling ashamed.

Shame is part of the alarm system of anxiety telling one that there is threat to the self as a decline in relationship value as a part of basic human need (Elison et al., 2014). The emotional connection of shame to anxiety is similar to the fear of death itself (Jacoby, 2016). Perceived threat detection within the self-concerning the negative or harmful evaluation by others is thought of as a form of evolutionary anxiety seen as paranoid anxiety (Matos et al., 2013). This fear is not only external but internal, or a combination thereof (Gilbert & Andrews, 1998). External shame caused from outside of the self is also referred to as field dependent and is directly associated with the anxiety of being exposed publicly (Gilbert & Andrews, 1998; Jacoby, 2016; Stuewig et al., 2010; Elison et al., 2013; Wurmser, 1999; Lewis, 1971). Conversely, internalized shame is a negative self-evaluation, is field independent, and is associated with the anxiety of violating personal values or mores and often has more guilt than shame attached to it (Gilbert & Andrews, 1998; Lewis, 1971; Leary, 2015).

Social anxiety and paranoid anxiety have some distinctions. Social anxiety focuses on the self in relationship to self-evaluation of how others perceive the self, while paranoid anxiety is an evaluation of the malevolent intent of others directed to the self (Matos et al., 2013). The key distinction is perceived malevolence and negative intent. Matos et al. (2013) asserted that these two anxious perceptions can overlap as both types are focused on the self in the perceptions of others. This is identical to the field dependent perceptions described by psychoanalytic theorists such as Lewis.

Shame and Humiliation

The word humiliation comes from the Latin root *humilis,* meaning lowly or brought down to a low place (Gilbert & Andrews, 1998). Gilbert and Andrews (1998) reported that many theorists classify shame and humiliation in the same category. Yet they also reported that many other theorists hold a differing viewpoint. Gilbert and Andrews (1998) asserted that shame is a

moderator modifier. “[S]elf-psychologists, following the ideas of Kohut (1977), see grandiosity as central in human development and shame acting as a modifier of it” (Gilbert & Andrews, 1998, p. 9). Unlike shame, humiliation has a phenomenological connection to what someone else has done to another person, while shame is self-inflicted (Gilbert & Andrews, 1998). In other words, one makes themselves unattractive to others due to shame that is self-created, while humiliation is the result of one being made temporarily unattractive by the actions of another.

Aspects of Shame

Shame versus guilt, shame and trauma, shame and criminology, shame, and empathy as well as shame and stigma have all been studied. Now, specific aspects of shame will be addressed as they pertain to determining the relationship that shame has with stigma and empathy within the male sex offender population.

Guilt and Shame

Shame and guilt, once thought of as interchangeable, are even today used equally (Brown, 2007). However, shame and guilt are not the same (Wolf et al., 2010). Guilt shares aspects with shame that include internalized negatively charged emotion and morality-based emotion that are invisibly experienced. Guilt and shame are like states and traits. A state is a temporary psychological condition that is emotionally based, whereas a trait is an aspect of one’s basic makeup that is consistent over time (Peters, 2018). Shame is the longer-lasting internalized trait of a personality that is associated with violating personal standards (Wolf et al., 2010). Guilt is the short-lived state that is connected to the actions that harmed others (Wolf et al., 2010).

Shame and guilt can be experienced simultaneously. Shame as an emotion is about being publicly exposed, while guilt is private (Wolf et al., 2010). Lewis (1971) described experiencing shame as one experiencing how others are evaluating them. Lewis further asserted that guilt focuses on how one affected another person.

Shame is experienced as negative self-evaluation with avoidance of behaviors that reinforce the emotion (Behrendt & Ben-Ari, 2012). The key component is the aspect of self in relationship to the evaluation of the self (Tangney & Dearing, 2002). Specifically, Tangney and Dearing (2002) stated that the shame-based person feels exposed and yet a guilt-based person experiences only a negative self-evaluation of their behavior and not the self. Similarly, Lewis (1971) discussed that shame is a much more painful emotion than guilt. Additionally, shame is accompanied by feelings of inferiority and a sensation of being physically small (Lewis, 1971; Tangney & Dearing, 2002). This maladaptive nature of shame is centered on global self-perception (Tangney & Dearing, 2002; Wolf et al., 2010; Tangney, 1994).

Wolf et al. (2010) and Tangney (1994) identified that individuals with shame will focus on the perceptions, by intense observation of the other facial expression, related to the behaviors committed by the shame-based person. In other words, the shame-based individual is more concerned with the negative perceptions of others than about the experiences and behaviors of the self (Tangney & Dearing, 2002). Tangney and Dearing (2002) identified this self-awareness or inner-directed attention as a state experience focusing inwardly concerning specific moments. This is a private awareness and not a public one (Tangney & Dearing, 2002). Therefore, the individual is equally concerned with public perceptions about themselves.

Shame and Stigma

Shame and stigma viewed through Bandura's self-regulation model link self-evaluation to moral motivation (Bandura, 2001). The self-awareness of mental illness (such as the shame of sexual trauma) can lead to self-stigma (Hasson-Ohayon et al., 2012). Additionally, Hasson-Ohayon et al. (2012) discussed the effects of stigma on quality of life, self-value, and depression and found that the stigmatized individual has a lower likelihood of rejecting stigma's negative effects (Rusch et al., 2010). Shame proneness is related to one's personal mental health insights

(Hasson-Ohayon et al., 2012). There appears to be a mediation but not moderation between insight and self-stigma (Hasson-Ohayon et al., 2012).

Self-evaluation is the key to the moral motivation of individuals (Rothmund & Baumert, 2014). The stigmatized shame-prone individual will do anything to cover up the exposed self (Dorahy, 2017). Shame reactions to the global moral self-identified by Lewis (1971) and Tangney (2007) are the internalized perceptions of failure experienced via the humiliating exposure of the flawed self to the public (Dorahy, 2017). The individual has continual awareness of the scars of abuse and will perceive that others also see and know what they are aware of themselves (Dorahy, 2017). This is a disintegrative shaming or stigmatization that causes isolation, humiliation, and inability within the individual to experience forgiveness (Tangney et al., 2011).

Shame and Trauma

How does shame develop? The role of trauma and shame has become a well-studied phenomenological aspect of psychology. Lewis (1971), in a landmark work titled *Shame and Guilt in Neurosis*, discussed the usefulness of shame and guilt from a psychodynamic perspective. Lewis stated that shame has negative aspects in the therapeutic relationship. Lewis used the expression of an asphyxiated affect with regards to the effects of shame and guilt on a person. Lewis further added that shame is a primitive emotion that can only occur in the context of a relationship. Shame is developed in close relationships where boundaries are broken and safety is removed by abuse and trauma (Bradshaw, 1988; Van Der Kolk, 2014; Herman, 2015; Chu, 2011).

The reactions of sexual trauma-induced shame include the following: Feelings of paralysis or helpless is common (Herman, 2015). Feeling childish or an object of scorn or contempt and ridicule is almost universal (Van Der Kolk, 2014). A blurring of boundaries

between the self and others in cases of humiliation takes place (Dorahy, 2017; Chu, 2011). Lastly, a focalization of awareness of the self develops (Lewis, 1971) and a fear of being exposed is born and suppression is used (Oktedalen et al., 2014).

The individual may experience physical sensation of pleasure during the traumatic event. Sexual events that cause subcortical arousal and lubrication, as well as orgasm, can and may take place even during a sexual trauma (Levin & Van Berlo, 2004). The self-blame and shame of experiencing sexual pleasure from a moment of sexual abuse/trauma can intensify the general humiliation and shame one experiences. This intensification can, in theory, lead to more coverup and in turn can lead to reduced empathy from the stigma of the event.

Shame and Criminality

Lewis (1971) stated that denial causes a person to have increased difficulty in identifying the cognition or the affective shame reaction. Shame in a criminogenic nexus is so maladaptive that it can prevent honesty and impede empathy (Tangney et al., 2011). Marshall and Marshall (2011) discussed how empathy is a prosocial component of healthy behavior and that a lack of empathy results in aggressive behaviors causing the suffering of others. It is hypothesized that a lack of empathy is due to an abundance of shame that has been branded as criminogenic (Marshall & Marshall, 2011). Criminal behavior of sexual offending is a moral issue (Hasson-Ohayon et al., 2012; Rothmund & Baumert, 2014). The emotion of shame, as previously discussed, when in combination with other aspects may be the cause for the appearance of a narcissistic personality and anti-social disorders often seen in the sex offender population with the presentation of lack of empathy or possessing callousness (Pardini & Loeber, 2008).

Shame and Blame in Criminology

Both shame and guilt are emotions of self-blame (Tangney & Dearing, 2002). Tangney and Dearing (2002) wrote, “They [guilt and shame] are inextricably linked to internal attributions

for negative events (events that are judged to be negative based on our own or others' standards)" (p. 53). These emotions are never more pronounced than during the experience of self-blame, when the awareness of evaluation by others is elevated. The results of shame and blame are avoidance and anger (Tangney, 1996). Often, individuals will express feelings of being treated poorly by others (Tangney & Dearing, 2002).

Shame and Emotional Regulation

Shame and emotional dysregulation are closely related as shame is more difficult to regulate (Elison et al., 2014). Velotti et al. (2017) discussed two ways that shame is regulated: as cognitive reappraisal and expressive suppression, with the latter being more damaging and pathological. Shame specifically was found to be related to increased internalization and expressive suppression (Lanteigne et al., 2014). In other words, shame-prone individuals tend to suppress their emotional expressions and internalize their shame at increased amounts than non-shame-prone individuals.

Guilt, unlike shame, reduces the experience of anger and avoidance (Tangney & Dearing, 2002), but the shame-prone person is reluctant to discuss their anger without hostility. This is related to the empathic reaction the individual experiences when in a place of guilt proneness (Tangney & Dearing, 2002). However, this shift is exceptionally difficult to achieve due to the trait nature of shame identified above that leads to increased emotional dysregulation with its internalization and expressive suppression (Velotti et al., 2017). The offender is asked to expose themselves for all the things they have done as part of their offense to the victim during the assessment and group process. What this means is that the individual is being forced to self-expose to others. This is quite impossible to just simply accomplish. The shame-based person has taken steps to prevent their shame from being exposed to others and even to themselves (Bradshaw, 1988). This leads to the aspect of stigma and specifics therein.

Stigma

Goffman (1963) affirmed that the history of the term *stigma* is Greek and was used to describe one having a mark or character flaw on their person evidenced by a medical deformity or misshaped body. Goffman identified that those under stigma feel that they are no longer whole, but discounted and tainted (Pachankis et al., 2018). Boyd et al. (2003) discussed stigma as the eroding of the individual social standing, network, and self-esteem, all of which impedes recovery in areas such as employment and is involved in isolative practices. Boyd et al. (2003) added that the subjective perspective of the individual will be one of marginalization, secrecy, and withdrawal as part of the self-stigma. The National Alliance for Mental Illness (NAMI) defined stigma as "a mark of disgrace, a negative stereotype" (page or paragraph number needed). Additionally, NAMI confirmed that individuals with a mental illness are often stigmatized (Abderholden, 2020).

Stigma contains three unique and specific qualities. Stigma is a combination of stereotypes, prejudice, and discrimination (Stier & Hinshaw, 2007). Stier and Hinshaw (2007) stated that stereotypes are cognitive, while prejudice is affective, and discrimination is behavioral. Therefore, individuals hold secrets about their conditions to avoid the cognitive, affective, and behavioral responses of perception. Secrecy reduces the us and them responses of stigmatization (Stier & Hinshaw, 2007).

Combining the elements of these definitions deepens one's understanding of stigma as a prejudice of negative stereotype placing [disgrace/shame/humiliation] on an individual, which affects their self-esteem and social network standing and obstructs quality of life conditions, causing isolation and secrecy. The key link between stigma and shame is the negative stereotype that stigma carries with it. The NAMI definition of stigma uses the terminology "mark of disgrace", where the term disgrace is synonymous with shame and humiliation. Hence, the

bracketed [disgrace/shame/humiliation] will be used in the definition for this research. Stigma is the perceived discrimination from the prejudice of negative stereotypes viewed as character flaws that erode an individual's social standing and self-esteem, as well as their quality of life and employment and housing opportunities due to an us and them attitude.

Stigma and Trauma in Mental Health

Persons with a mental illness tend to be more apt to endorse rather than apply negative stereotypes to themselves (Boyd et al., 2003). Self-evaluation is a mechanism used when a person applies a negative stereotype to themselves in a self-stigma (Hasson-Ohayon et al., 2012). Consequently, the identified consumer of mental health services may be more prone to place negative stereotypes on themselves to the point of disgrace and social isolation.

Sex offenders studied for mood disorders in relationship to community restrictions found that 75% of sex offenders have a diagnosable mood disorder after receiving restrictions to life (Jeglic et al., 2012). Negative mood states such as mood disorders are linked to offender recidivism (Jeglic et al., 2012). Additionally, Jeglic et al. linked childhood trauma and sexual offending in adulthood while citing deviant sexual behaviors as a maladaptive coping skill. Moreover, Jeglic et al. developed a self-derogation theory that postulates how childhood trauma victims develop low self-esteem and then engage in self-derogation. The combination of a diagnosable mood disorder with a stigmatized status of a mental health condition in the population of sex offenders is problematic.

Stigma and Sex Offenders

Sex offenders receive the stigma of being an offender after they are convicted and incarcerated and the process of assessment and ongoing supervision has been initiated (Tewksbury, 2012). The public attitude toward offenders is a barrier to recovery as they perceive the offender as being unreformable (Kerr et al., 2018). Tewksbury (2012) reported that sex

offenders know that they are stigmatized the moment they are incarcerated, as many are assaulted or segregated.

In most states, sex offenders are not allowed to reside within 500 to 2,500 feet of where children reside, including homeless shelters (Rolf et al., 2017). Rolfe et al. (2017) stated that due to these laws, many sex offenders violate their registration or become homeless themselves. This adds to the sex offender's social isolation due to negative stereotypes that often increase recidivism risk (Kerr et al., 2018).

Negative internal self-evaluation leads to increased shame reactions when the SO attributes their actions to more stable internalized causes (Rothmund & Baumert, 2014). The most likely onset of stigma-inducing shame proneness ever experienced by the SO is in their own trauma history. Felson and Lane (2009) concluded that sex offenders are at a higher frequency of having been sexually abused as children themselves, which lines up with Bandura's social learning theory of the 1970s. The stigma of being exploited for another's gratification leads the victim to internalize a negative self-evaluation of shame that is in line with the abused abuser theory.

Sex offender self-stigma and shame proneness are linked. The 2011 study by Hasson-Ohayon et al. concluded that the mediation model of shame proneness and insight of illness and self-stigma is supported. In other words, self-awareness of the label mentally ill, or in this case sex offender, mediates shame proneness by way of self-stigmatization. This was upheld by Rothmund and Baumert's (2014) study where they concluded that self-evaluation and moral self-regulation are in line with Bandura's (year) work. Additionally, Rothmund and Baumert stated that shame proneness is related to overly critical self-evaluations in personal transgression. This is compounded by the increased lack of self-forgiveness experienced by shame prone persons (Carpenter et al., 2016).

The stigma of sex offending can be intensified by Megan's Law and the Adam Walsh Child Protection and Safety Act of 2006 following incarceration. Two studies have shown how sex offenders are affected by mandated restrictions of proximity to children's frequented facilities and employment options. Levenson and Cotter (2005) reported that only 10% of sex offenders found mandates on having their housing, employment, and vehicle information published to be unfair. More specifically, negative mood states were reported by more sex offenders in residence restrictions than those in no restrictions (Jeglic et al., 2012). Additional to the feelings of shame and hopelessness, sex offenders are resigned to feelings of depression and sadness over the loss of normalcy in relationships due to restricted opportunities (Tewksbury, 2012).

Lastly there are six dimensions of stigma that include concealability, course, disruptiveness, aesthetics, origin, and peril (Jones et al., 1984). The dimensions of concealability, course, origin, and peril are specific to sex offenders (Pachankis et al., 2018). Concealability is simply the ability of one to keep their stigma secret. Course is the degree to which the stigma persists in time. Origin is the dimension of how the stigma began. Peril is the level of threat that the issue creates to the public. The peril dimension is positively correlated with increased stigma (Pachankis et al., 2018), and in the case of sex offenders the peril is perceived to be greater by the public than is proven empirically (Tewksbury, 2012). Specifically, Panchankis et al. (2018) concluded that sex offender origin of stigma in perceived as self-created and that the threat of the peril dimension is higher than in other origins of stigmas.

Empathy

Defining empathy is not as simple an endeavor as many have proposed; one's behavior toward others must be included (Marshall et al., 1995). The earliest recorded definition of empathy was coined by the Scottish economist Adam Smith in 1759, when Smith paired

understanding of another's perspective with an emotional response (Shirtcliff et al., 2009). This perception led to the psychological study of emotional recognition which Marshall (1995) discussed historically. Titchener translated the word empathy from the German *Einfühlung* in 1909 after the psychologist Lipps used it to describe projecting the feelings of an experience onto another (Oxley, 2011; Barnett & Mann, 2013). Oxley (2011) added that this is the idea of stepping into someone else's shoes. Opposed to Lipps's perspective was Wundt's view that the empathizer assumes the feelings of the victim and does not project their own feelings onto the victim, which is what social psychologists refer to as social contagion (Barnett & Mann, 2013).

Linguistic Difficulties

Problems of language have historical significance concerning empathy. Hanson (2003) described Scheler's forms of empathy that can be expressed in lesser forms, such as *Miteinanderfühlung* (the reaction of two or more persons in a movie theater or play), *Gefühlsansteckung* (the infection spread of emotion in a crowd by social induction), as well as higher forms of empathy such as *Einsfühlung* (complete emotional identification with another), and *Mitgefühl* (conscious recognition of similar experiences that lead to feelings of vulnerability). Schopenhauer may have added another component of compassion with the term *Mitleid* (Roughley & Schramme, 2018). Noticing the Germanic prefix *Mit* [literal translation-with] demonstrates the combined nature of two or more persons engaged in a shared experience as observed in the terms *Miteinanderfühlung* and *Mitgefühl* (Roughley & Schramme, 2018).

Syntactical Differences

The terms empathy and sympathy were used interchangeably until the last few decades when a semantic shift took place (Roughley & Schramme, 2018). Thus, empathy and sympathy must be viewed separately due to the cognitive and emotional aspects involved (Marshall &

Marshall, 2011). First, empathy is not sympathy. Empathy is a complex psychological reaction of matching the emotional condition of another person, where sympathy is not (Pithers, 1999).

Roughley and Schramme (2018) viewed sympathy as a component of one's affective response to the suffering and discomfort of another. More specifically, sympathy is diverse enough that it can also be applied to a positive emotional experience (Roughley & Schramme, 2018). However, Eisenberg (2018) defined sympathy as an emotional response due to only the comprehension of another's feelings. Additionally, sympathy can trigger altruistic reactions that are forms of prosocial behaviors (Eisenberg, 2018). Ultimately, sympathy ends in a compassionate response (Marshall & Marshall, 2011).

The definition of empathy possesses several aspects. These aspects include cognitive and affective components as well as behaviors of communication and relationships (Marshall & Marshall, 2011). A functional definition is needed in this setting. This definition will include cognitive, affective, and behavioral components (Schramme, 2018).

Cognitive Traits. This aspect of empathy is often referred to as projective empathy and requires cognitive skills to imagine another's emotional condition (Slote, 2018). The cognitive aspects of empathy include both the awareness of others' emotional states and the ability to match the emotional state in self (Pithers, 1999). Marshall's (1995) model of empathy suggested stages of recognition, perspective taking, replication of emotion, and response decision in empathy. Oxley (2011) added that the recognition must be accurate and congruent to the emotional state of the perceived. Ward and Durrant (2013) submitted that accurate cognitive recognition includes the freedom from personal bias. This aspect of freedom from personal bias is a possible issue in this study as the SO is often perceived as unable to have cognitive understanding due to a lack of theory of mind ability (Ward & Durrant, 2013).

Affective Traits. So, what are the affective traits of empathy? The affective aspects of empathy are an unconscious process unlike those of the cognitive traits (Chrysikou & Thompson, 2016). Emotional empathy, also known as receptive empathy, requires specific cognitive skills to be in place for the emotions to be experienced (Slote, 2018). Caring and concern about distress or suffering have been proposed as the primary affective aspects of empathy (Roughley & Schramme, 2018). Roughley and Schramme (2018) identified that caring and concern carry with them additional levels of difficulty concerning understanding due to potentially high levels of confusion related to terminological complications.

Emotional empathy is as analogous to listening as listening is to hearing (Slote, 2018). Slote (2018) elaborated that emotional empathy involves hearing of feelings but also the desire or a motivation to respond. Sympathy as superior to empathy would imply that empathy has reduced ability (Eisenberg, 2018). However, Slote held that genuine sympathy is required for emotional or receptive empathy to exist. Slote argued that even psychopaths have the ability of cognitive or projective empathy (Slote, 2018). Roughley and Schramme (2018) stated that empathy involves an emotional transfer, but sympathy is a specific type of emotion. This then means that a relationship is required between persons for empathy to exist.

The state of mood the offender is in at the time of the offense as well as the emotional state the victim is in during the offense (Marshall et al., 1995) coincides with the idea that sympathy and empathy are both required. Pithers (1999) showed that offenders have lower empathy at times of moods the same as when they offended. This would imply a potential recidivism risk is present and the need for therapy evident. Nitschke et al. (2012) found that the affective aspect of empathy <u>was not</u> deficient in only a single subgroup of offenders called sexual sadists. These offenders took pleasure in committing their acts while their victims experienced negative emotional states (Nitschke, et. al., 2012).

Behavioral Traits. The behavior aspects of empathy have been described as prosocial when the empathic response is not aggressive or does not violate the rights of others (Marshall & Marshall, 2011). This is the hope of rehabilitation for the sex offender. Yet Marshal and Marshall (2011) described that there is no general (global) deficit in empathy on the part of sex offenders and that only the victims are recipients of deficient empathic response. This is the gap in the research. Offenders that perform deviant sexual acts with no deficit in empathy on a global level while demonstrating callousness must be studied further.

Empathy and Morality

Empathy is the only possible basis for morality (Schramme, 2018). In 1739, Hume proposed that morality is due to sympathy (Hume, 1960). Roughley and Schramme (2017) abstracted Hume's ideas that people enjoy observing acts of heroism and are distressed by acts of cowardice by themselves and in others. Hume concluded that love of self is not involved in the mental operations people today call empathy, as Hume saw the feeling of sympathy and not reason as the primary element of morality (Roughley & Schramme, 2017). Schopenhauer added to the debate in 1841 and argued that compassion was needed as the basis for morality (Schopenhaauer, 1841; 1915). Oxley (2011) suggested that empathy is mandatory for a moral life, and yet empathy is not fundamentally moral. Discussed previously, *Einfühlung* (empathy) is not the same as *Verstehen* (sympathy), yet in the period from Hume to Schopenhauer to Oxley much development took place in the topic of empathy and sympathy.

The ideas of Hume and Kant were not lost to time. Kennett (2002) discussed the lack of empathy in the psychopath as due to the inability to experience the moral sense that Kant perceived as moral duty. Kennett also shared the perspective of Deigh (1995), who proposed that psychopaths possess conventional constructs of morality but are missing the deeper sophisticated forms of prosocial awareness (Kennett, 2002). The development of empathy for Kennett is one

of constant consistent imaginal simulations that results or concludes in reciprocal awareness of others in place of the self as the creation of moral agency (Kennett, 2002). Persons with more ability to imagine the feelings of others have higher empathy and subsequently more moral motivation of caring for others (Hoffman, 2000; Slote, 2007).

Thus, sympathy does not imply moral obligation but demonstrates moral superiority (Johnstone, 2018). Yet sensations of duty as viewed by Kant (Kennett, 2002; Johnstone, 2018) can create empathy (Barnett & Mann, 2013). The theory of mind posits that it is through empathy and not sympathy that one gains an understanding of others, and in doing so one can make judgments and follow through on chosen behaviors, thereby making empathy an agent of morality (Robinson & Rogers, 2015; Oxley, 2011). Empathy, sympathy, and prosocial living are correlated and identified as needing coexistence (Marshall & Marshall, 2011; Eisenberg, 2018).

But how does one develop these traits? Empathy can only be developed in and through relationships. Tangney and Dearing (2002) shared that Rogers had identified empathy as foundational to relationships. Sympathy, empathy, shame, and guilt work in concert to yield prosocial relational behaviors (Tangney & Dearing, 2002).

Morality. Piaget's work on children's moral development held that children develop morality based on the learnings they obtain from their parentage (Roughley & Schramme, 2018). Kohlberg (1976) developed six stages of moral development, three of which must be addressed in this research because they are applicable to empathy. Stage 1, avoidance of punishment, and stage 2, reciprocal fairness, are preconventional morality of childhood (Kohlberg, 1976). Stage 3, of good intentions to obtain approval, and stage 4, of law and order, are the aspects of convention and tend to relate to the educational years, while stage 5 is the social contract of accepted correct behavior and stage 6 is where the ethical principles of justice and human dignity become the focus of older adulthood (Kohlberg, 1976). Kohlberg stated that expanding empathy creates an

expansion of perspectives and that it is this expansion that defines the six stages. Unlike Piaget, Kohlberg suggested that empathy develops from the growth of a child's life experience.

Eisenberg (2018) added to the discussion of Kohlberg's (year) cognitive moral developmental model and stated that sympathy and prosocial moral judgment is a two-way street. Eisenberg separated sympathy as a disposition or trait-similar prosocial quality and empathy as a stable prosocial personality that is not state dependent, with the difference being observed as spontaneousness of response speed and intensity in empathy as the more superior. Further, Eisenberg proposed that emotional regulation as a cognitive capacity early in age was indicative of one's ability to have increased sympathy and prosocial behaviors.

Empathy and Biology

The role of neurobiology was discussed in the context of a nature or nurture debate in a 2016 adoption study with 561 children conducted by Hyde et al. Hyde et al. concluded that children with antisocial mothers did not predict callousness when high levels of parental positive reinforcement was utilized by either biological parent of adopted parent. Another biological study showed onset of empathy was a learned socio-cultural phenomenon with prenatal foundations (Sonne & Gash, 2018). Sonne and Gash (2018) provided evidence that prenatal development was molded by maternal native languages and that callous-unemotional mothers have an effect on the cognitive development of the prenatal fetus. This supports the findings of Shirtcliff et al. (2009) who reported that during the mother child bonding period, the limbic system undergoes activation, which supported the research of Swain et al. (2007) as well as that of MacLean (1985).

Neurophysiology

Neurobiology research has identified the anterior cingulate cortex (or ACC) to be activated during distress and is referred to as the alarm system (Shirtcliff et al., 2009), while the

anterior insular and anterior mid-cingulate cortex was involved in the formation of empathy (Keysers & Gazzola, 2006). One's own distress and that of others is distinguishable only in intensity as the same anatomical regions are stimulated (Shirtcliff et al., 2009). Sonne and Gash (2018) reported that when observing the distress of another individual, empathy triggers the anterior insula and anterior to midcingulate cortex.

Sonne and Gash (2018) pointed out that specific to the temporal cortical junction amount of grey matter and the activation of the anterior insula is predictive of increased empathy and generosity. Additionally, the right amygdala is smaller in persons with reduced grey matter, and they demonstrate reduced altruistic empathy (Sonne & Gash, 2018). The Sonne and Gash findings added to Shirtcliff et al.'s (2009) research that illustrated criminal pathology in fear conditioning studies demonstrated increased limbic anterior cingulate cortical only in non-pathological controls, meaning that only non-pathological individuals experience the limbic system activation during fear conditioning. Previously, Kiehl (2006) and Singer (2006) referred to this area of the parasympathetic ACC as the empathy circuit.

Biochemically

Shirtcliff et al. (2009) discussed the involvement of the autonomic nervous system with callousness. Shirtcliff et al. presented cognitions to be associated with hormones in an emotional mechanical process, where hormonal functioning is strongly manipulated by the emotions of the individual person. This is seen when the ANS experiences releases of biochemical hormone cortisol as personal distress and to an observation of others in distress (Hastings, Zahn-Waxler, & McShane, 2006). The steps of the release begin in the limbic system with corticotropin releasing hormone (CRH) from the hypothalamus that acts on the pituitary releasing (ACTH) adrenocorticotropic hormone, which ends in the adrenals causing the release of the cortisol (Shirtcliff et al., 2009). Additionally, Shirtcliff et al. maintained the neurological reason for

callousness is due to a blunting of cortisol and a reduced stress response. Shirtcliff et al. associated the action of a mother breastfeeding a child to activate limbic circuitry and thus be related to attachment to peers and the establishment of prosocial behaviors, which are linked to coordinated encoding of distress and shared recognition of pain.

Cortisol. Cortisol research is not definitive, but much research has been conducted that has shown strong indications of a need for certain levels in the body for development of prosocial behavioral responses (Shirtcliff, et al., 2009). The human body normally contains 5% cortisol with 95% bound to proteins; during times of stress, these levels can reach three times the normal amount (Berger et al., 2010). Berger et al. (2010) added that corticoid binding globulin (CBG) is fat soluble and able to cross the blood brain barrier. In times of high stress where the levels are three times the normal amount, a pruning of synaptic contacts takes place in the amount of 16% reduction within the brain (Berger et al., 2010). Child abuse and neglect have been linked to this reduction in brain development (Berger et al., 2010). Additionally, Berger et al. (2010) reported that an eight-hour sleep interval of the circadian rhythm is required to reduce high cortisol levels to normal. Berger et al. (2010) concluded that children need stress as well as sleep to allow healthy brain development but that excessive cortisol levels due to high stress from abuse and neglect cause blunting of the limbic system, as Shirtcliff et al. (year) had predicted one year prior.

Empathy and Criminogenic Nexus

Moral emotions such as empathy (and its opposite—callousness), are closely related (Obradovic et al., 2007). Psychopathic testing includes lack of remorse or guilt, shallow affect, failure to accept responsibility, and lack of empathy (Robinson & Rogers, 2015). Empathy is involved in almost all forms of criminal pathology, yet sex offenders have more higher levels of pathology than non sex offenders (Ahlmeyer et al., 2003).

Specifically, Robinson and Rogers (2015) discussed how psychopaths lack both the cognitive and affective aspects of empathy. A problem exists, however, in that personality disorders have declined in affective empathy but not in cognitive empathy, and alcoholics have reduced affective empathy only while depressed persons have both affective and cognitive empathy reductions (Chrysikou & Thompson, 2016).

The criminogenic aspect of lacking empathy includes a callous interpersonal style of deception and superficiality (Pardini & Loeber, 2008). Pardini and Loeber (2008) suggested that parental relationships are of prime importance in the criminogenic nexus regarding empathy deficits. Furthermore, interpersonal callousness in youth has been found to be stable developmentally from childhood through adolescence (Obradovic et al., 2007). Shirtcliff et al. (2009) held that empathy or callousness is due to a mixing of nature and nurture qualities in the biological process over the time of development.

Empathy and the Offender

Marshall et al. (1995) depicted a four-stage process of empathy involving recognition, perspective taking, replication of emotion, and behavioral response. Empathy deficits can transpire at any or all of these stages. The cognitive requirement of emotional recognition takes the forefront in this cognitive-based paradigm of empathy as the failure to recognize distress means that the rest of the stages never develop (Marshall et al., 1995). Marshall et al. maintained that for a person to have any emotional reactions such as empathy, they must have the cognitive ability to accurately evaluate the emotions of others. Marshall et al.'s work was supported by MacLean (1985), Swain et al. (2007), Shirtcliff et al. (2009), and Sonne and Gash (2018).

However, Marshall and Marshall (2011) discussed how child molester empathy is variable for victims of observed accidents and not for victims of their own perpetration. This calls into question the first stage of Marshall et al.'s (1995) cognitive empathy model. How can

an offender have the cognitive skill to observe distress in one child and not in another? Fernandez and Marshall (2003) suggested that cognitive distortions may be to blame for the offender's decision making in who does and does not receive distress recognition. Kennett (2002) and Hanson (2003) added aspects of personal relationships, adversarial or caring, and personality disorder such as antisocial. Hanson concluded that empathy deficits should not be counted in cases of adversarial or indifference on the part of the offender.

Empathy Deficits. There are several possible reasons for empathy deficits in sex offenders. Empathy deficits are viewed as psychological dispositions and trait factors (Ward & Beech, 2008). These include offence-supportive implicit theories, deficits in theory of mind, and self-focused versus other focused states such as shame proneness (Barnett & Mann, 2013). Such deficits can be problematic for the development of victim sympathy/empathy as several have a chance of causing increases in offender sexual arousal (Hanson, 2003; Rice et al., 1994). There is empirical support that sex offenders as criminal specialists suffer from a deficit in empathy towards their victim or the victim of other sex offenders but not towards everyone in general (Smallbone et al., 2003). Smallbone et al. (2003) stated that lower levels of empathy have been linked to increased blaming of the victim, increased sexual aggression, and increased desire to perform sex offense. This is correlated with Hanson's (2003) research that stated the reason for the relationship may hold the key to the empathy deficit. Some offenders enter into offending as forms of intentionally punishing the victim and as such, the goal of the relationship is hostile in nature (Hanson, 2003).

Offence-Supportive Implicit Theories. Implicit theories of sexual offending include the child as a sexual being, entitlement, nature of harm, dangerous world, and uncontrollable (Ward & Keenan, 1999). These cognitive distortions are viewed as self-made statements that allow the offender to offend (Marziano et al., 2006). Ward and Keenan (1999) held that offenders produce

and test their own predictions about how they view the world, themselves, and their victims. Marziano et al. (2006) identified the reported frequency of use by offenders to be child as a sexual being (28%), uncontrollability (26%), dangerous world (22%), nature of harm (14%), and entitlement (10%).

The first distortion, the child as a sexual being, is the cognitive understanding that the child wanted the sexual encounter (Ward & Keenan, 1999). Marziano et al. (2006) clarified that the offender takes the assumption that children not only need but that they benefit from sexual activity with adults. The argument of the offender would sound like "but she or he wanted sex" (Marziano et al., 2006).

The second distortion, entitlement, holds to the self-made assumption of superiority (Marziano et al., 2006). This superiority gives the offender self-made rights. This cognitive distortion views the victim with contempt, as ineffective, hideous, unintelligent, unworthy, and possibly less than human (Miceli & Castelfranchi, 2018). Miceli and Castelfranchi (2018) indicated that cold indifference of the one with contempt will appear in many forms, including callousness.

The third distortion is the nature of harm. Nature of harm is a reduction of severity (Marziano et al., 2006). The offender will be heard saying things similar to 'It was nothing. It could have been much worse,' or 'We were just having some fun' (Marziano et al., 2006). This distortion of the nature of harm is one of subjective mental state and requires objective factual counter argumentation as discussed separately by Kant, Piaget, and Kohlberg (Goodwin & Darley, 2010).

The fourth distortion, the dangerous world, and the fifth distortion, uncontrollable, can be viewed as similar, with a change in the object reasoning. The offender holding to the dangerous world distortion will believe that they are safer with children as opposed to adults for their sexual

gratification (Marziano et al., 2006). Marziano et al. (2006) pointed out that the final distortion, uncontrollable, maintains the reason for the offense was due to external causes such as alcohol or another substance.

Deficits in Theory of Mind. Some problems exist in the ToM. Mental conditions that include spectrum disorders such as autism and Asperger's disorder have been shown to have an 80% fail rate at false belief stage of understanding (Ruhl, 2020). Ruhl (2020) also pointed out that people with problems related to reality testing such as those with schizophrenia will struggle with the false belief stage. Individuals afflicted with anxiety and depression can struggle with decoding of social contextual settings (Ruhl, 2020). However, before one can understand the deficits of ToM, one must grasp the ToM.

Theory of Mind Development. ToM is a foundational developmental requirement for prosocial relationship development (Dodell-Feder et al., 2014). The growth of ToM begins early in child development and is often observed in the child imagining being another person, such as a doctor or police officer (Ruhl, 2020). More advanced progress includes understanding that others have likes and dislikes as well as the reasons and costs of emotions (Ruhl, 2020). However, without the ability to pay attention to other people, the ToM may fail to develop (Ruhl, 2020). The importance of paying attention was addressed by Rutter et al. (2019), where emotion recognition (ER) was accomplished by children at adult levels in this way: five-years-old for ER of happiness, seven-years-old for ER of fear, nine-years-old for ER of anger, and 11–12 years old for ER of disgust.

Stage requirements for ToM. Ruhl (2020) discussed five requirements needed for ToM to be effective. Understanding of wanting, thinking, seeing leading to knowing, false beliefs, and hidden feelings are the five stages. Wanting is about the ways people act to obtain their wants and desires (Ruhl, 2020). Thinking is the second stage and is focused on the ability people have

to have different thoughts about the same topics (Ruhl, 2020). Having access to knowledge and learning is different from one person to another and is the third stage of understanding Rhul identified. The fourth stage is understanding that some people may have false beliefs, while the final stage people learn that others hide their true feelings (Ruhl, 2020).

ToM requires mental state reasoning or the use of one's ability to predict the mental state of another person (Dodell-Feder et al., 2014). Dodell-Feder et al. (2014) indicated that mental state decoding is the ability to use contextual settings and available information of facial expressions in one's reasoning and that this engages certain regions of the brain. Early research held that children between five and 11 years old developed these skills; however, newer studies are showing that children as young as two can have a fully functioning false belief stage of ToM (Gweon et al., 2012).

Neurobiology of ToM. The regions of involvement include the Medial Prefrontal Cortex (MPFC), temporoparietal junction (TPJ), superior temporal sulcus (STS) , as well as the superior temporal gyrus (STG) and precuneus (PC) (Dodell-Feder et al., 2014). Gweon et al. (2012) concluded that neural regions continue to develop throughout childhood and that there is little to no difference between the quality of adult and child brain imaging of ToM regions. Specifically, the PC and MPFC regions were active in all age groups (Gweon et al., 2012). Mental state reasoning includes the temporal and parietal areas of the ToM network (Mukerji et al., 2019).

Impairments. Dodell-Feder et al. (2014) discussed that persons with clinical high risks such as schizophrenia, major depression, and anxiety disorders have shown behavioral impairment in ToM. Particularly, the aspect of mental state reasoning was identified as being deficient (Dodell-Feder et al., 2014). Dodell-Feder et al. (2014) proposed that neural studies as opposed to behavioral ones were more accurate and most likely to be predictive due to the findings that psychotic disorders in genetically related families showed measurable disruption in

the ToM areas of the brain. However, in healthy adults the ToM brain regions were more active when perspective-taking of other persons emotions were being performed.

Emotional Recognition and Emotional Sensitivity. Emotional recognition (ER) is viewed as basic and necessary for prosocial interactions (Marshall, 1995; Marshal & Marshal, 2011; Hanson, 2003). Rutter et. al. (2019) concluded that ER of happiness is consistent across life span, while anger intensifies in adolescence and female ER and emotional sensitivity (ES) have greater strength than that of males. Furthermore, psychopathology directly affects the ER and ES ability (Rutter, et al., 2019).

ER and ES are connected to impairment of ToM (Rutter et al., 2019). Rutter et al. (2019) discussed how increased cognitive intellectual ability does not replace ability in emotional recognition, such as in the case of high-functioning autism. Hanson (2003) shared that many sex offenders struggle with accurately identifying ER of female signals opposing intimacy while performing sexual coercion, but that this may be due to a general mistrust of women.

Self-Focused Versus Other Focused. A problem exists concerning the motivation of callousness and self-focused traits and states. Self-focused states and traits such as shame can be observed in personality disorders of narcissistic and possibly anti-social personality disorder as related to demonstrable callousness unrelated to autism spectrum disorders (Lewis, 1971; Tangney & Dearing, 2004; Jones & Figueredo, 2013). Furthermore, a key component to what is called the dark triad of personality disorders is that shame is not tied to callousness unless manipulation and deception are actively present (Jones & Figueredo, 2013).

Shame resides in the space existing between the self and others (Jacoby, 2016). Jacoby (2016) maintained that problems with self-esteem/value can often come under the influence of shame and the fear of shame. The development of self-esteem is an unconscious endeavor that is difficult to alter and creates a complication regarding the self-evaluation involved in one's self-

esteem (Jacoby, 2016). The psychogenesis of self-esteem is the evaluation by the child focused on the imaginary self and then compared to the caretaker/parent (Jacoby, 2016). The child's evaluation of self needs to be relatively equal or good enough; otherwise, a cognitive dissonance ensues that leads to reduced self-esteem and fear of shame or shame outright (Jacoby, 2016).

Traits such as shame proneness, as observed in poor self-esteem evaluation, are viewed as a cognitive distortion affecting the evaluation of behavior by the offender (Polaschek, 2003). Tangney et al. (1992) discussed how shame-prone persons are vulnerable to a myriad of psychological disorders but that the effects are devastating and end in a maladaptive and incapacitating functioning of the self. The cognitive distortion of the self-evaluation in relationship to others leads one to the need to cover up the shame experienced with an imaginary world scheme where the needs of the self is more important than the needs of others.

Empathy and Personality Disorders

Due to the forensic nexus component of the study, personality disorders need to be addressed as potentially part of the demographic nature of the participants. Personality disorders have increased levels in psychopathy with 41% demonstrating avoidant personality disorder and 30% dependent personality disorder; clinical syndromes include 30% depressive disorders, 49% anxiety, and 30% dysthymia. Overall, mood disorders have a 73% relevancy followed by anxiety at 47% with sex offender pathology (Ahlmeyer et al., 2003). The psychopathic nature of sex offenders is positively correlated to genetic and environmental qualities in studies of twins children (Tubvald et al., 2017). Thus, the sex offender population has a hereditary quality that cannot be ignored.

Several aspects of psychopathology are found to be comorbid. These include a pattern of affective as well as interpersonal issues that includes but are not limited to lack of remorse, shallow affect, callousness, superficial charm, increased sense of self-worth, and manipulation

skills (Tubvald et al., 2017). Also noted by Tubvald et al. were anti-social, borderline, and substance abuse disorders as noted in the *DSM 5*. These traits are found in 4% of the SO population (Tubvald et al., 2017). Additional diagnostic disorders identified in sex offenders include mood disorders (with a prevalence of 73%), anxiety disorders (with a prevalence of 47%), and substance abuse (with a prevalence of 47%) (Ahlmeyer et al., 2003).

Chapter Summary

There exists a triad of therapeutic engagement in rehabilitation for sex offenders. This triad includes the development of empathy, appropriate prosocial reactions, and the shift from shame to guilt. The development of empathy as an agent for moral prosocial living is composed of cognitive and affective recognition. Shame as an emotional reaction to trauma creates the potential for shame proneness. Additionally, stigma related to having a label such as SO or RSO appears to serve as a discriminatory aspect that diminishes one's value.

Possible impediments exist in the study of SO callousness. Cognitive distortions such as those of offence-supportive implicit theories cause researchers' dilemmas. Also holding to the ToM, the SO will undergo cognitive recognition of the emotions and then make links to affective responses, which may hold some difficulties for the SO. However, the shifting from shame to guilt remains elusive. The ability for a sex offender to apologize to their victim after shifting from shame to guilt with increased empathic ability is the focus of many sex offender treatment programs.

However, how does a labeled and stigmatized SO or RSO make this shift? Additionally, what component is the most influential? Furthermore, the relationship that empathy, stigma, and shame have appears to be complex and requires further investigation.

Hypotheses

The relationship sequencing hypothesis corresponds to Research Question 1. The moderation mediation sequence hypothesis corresponds to Research Question 2. The hypothesis of this study is that there is a domino-like cause effect relationship between shame and empathy strength deficit that is mediated by stigma. SOs experience many forms of abuse in childhood (Jespersen et al., 2009), which reinforces Bowlby's (1944) attachment theory work linking poor childhood parental attachment to juvenile delinquency (McKillop et al., 2012). Grady et al. (2019) added that unhealthy attachment styles led to offender coping strategies. Furthermore, Evans and Fera's (2019) discussion on labeling theory proposed that stigma is a motivator for the SO.

Hypotheses Relationship Sequence

Study Assumptions: Trait shame (X) is a pre-existing condition due to childhood experiences of the sex offender while state shame (W) is experienced by the sex offender after being labeled as an offender.

HR1a: Sex offenders have an increased trait shame/shame proneness that increases the relationship with stigma.

HR1b: Sex offenders have a relationship between trait shame/shame proneness (X) and empathy (Y) that shows an empathy strength reduction observed as callousness.

HR1c: Sex offenders have an increased relationship between stigma (M) and empathy strength (Y).

HR1d: Sex offenders have an increased state shame (W) that increases the relationship with stigma (M).

HR1e: Sex offenders have an increased state shame (W) that increases the relationship with empathy (Y).

HR1f: The combination of state (X) and trait (W) shame increases the relationship with empathy (Y) strength reduction.

HR1g: The combination of state (X) and trait (W) shame increases the relationship with stigma (M).

Hypotheses Mediation Sequence

HR2a: Stigma (M) influences the relationship between trait shame (X) and empathy (Y).

HR2b: Stigma (M) influences the relationship between state shame (W) and empathy (Y).

HR2c: Stigma (M) influences the relationship between trait and state shame (XW) and empathy (Y).

CHAPTER THREE: METHODS

Overview

This study has the purpose of answering the research questions based on the hypotheses and assumptions that shame leads to stigma and that combined, they create reduced empathy strength. Participants will be recruited from Texas and consist of males ages 18 to 99 with and without childhood abuse histories and criminal histories of sex offender status currently residing in the community or in a semi secure housing facility and participating in a treatment program. The measures and instruments that were used include the Test of Self-Conscious Affect - Three, a modified Internalized Stigma of Mental Illness, and the Interpersonal Reactivity Index. The research procedures included the separation of the participants into categorical and non-categorical groupings with manipulation of the sequence of tools used to obtain the needed observations. The statistical tests used included bivariate scatter plots, Pearson's r, ANOVA, Causal Steps pathway analysis, and bootstrapping. Sobel testing was found to be unnecessary. Ethical considerations for this study included discussions on use of prisoners, non-maleficence, informed consent, voluntariness, rights to privacy, and use of deception that was not used.

Research Purpose

The purpose of this study was to observe the cause effect domino relationship of shame, stigma, and empathy in a mediation and moderation design that yielded a better understanding of the impact of stigma on empathy strength. Shame, stigma, and empathy strength was assessed for relationships of a moderated mediation type. The anticipated outcome was demonstrate that stigma negatively influences the relationship between shame and empathy strength, thus showing a reduction in empathy that presents as callousness.

Research Questions and Hypotheses

RQ1a: What is the relationship between shame proneness (trait shame) (X) and stigma (M)?

Hypothesis 1a: Sex offenders have an increased trait shame/shame proneness that increases the relationship with stigma.

Null hypothesis: There is no increase in the relationship between trait shame (X) and stigma (M) in sex offenders.

RQ1b: What is the relationship between trait shame/shame proneness (X) and empathy (Y)?

Hypothesis 1b: Sex offenders have a relationship between trait shame/shame proneness (X) and empathy (Y) that shows an empathy strength reduction observed as callousness.

Null hypothesis*:* There is no empathy (Y) strength reduction or callousness observed in the relationship between trait shame (X) and empathy (Y).

RQ1c: What is the relationship between stigma (M) and empathy (Y)?

Hypothesis 1c: Sex offenders have an increased relationship between stigma (M) and empathy strength (Y).

Null hypothesis: There is no empathy (Y) strength reduction or callousness observed in the relationship between stigma (M) and empathy (Y).

RQ1d: What is the relationship between shame (state shame) (W) and stigma (M)?

Hypothesis 1d: Sex offenders have an increased state shame (W) that increases the relationship with stigma (M).

Null hypothesis*:* There is no state shame (W) that increases the relationship with stigma (M).

RQ1e: What is the relationship between shame (state shame) (W) and empathy (Y)?

Hypothesis 1e: Sex offenders have an increased state shame (W) that increases the relationship with empathy (Y).

Null hypothesis: There is no increase in the relationship between state shame (W) and empathy (Y).

RQ1f: What is the relationship between shame (state shame) combined with trait shame (XW) to empathy (Y)?

Hypothesis 1f: The combination of state (X) and trait (W) shame increases the relationship with empathy (Y) strength reduction.

Null hypothesis*:* State and trait shame (XW) has no effect on empathy (Y).

RQ1g: What is the relationship between shame (state) combined with (trait) (XW) to stigma (M)?

Hypothesis 1g: The combination of state (X) and trait (W) shame increases the relationship with stigma (M).

Null hypothesis*:* There is no effect on stigma (M) from state trait shame (XW).

RQ2a: Does stigma (M) mediate the relationship between trait shame/shame proneness (X) and empathy strength (Y) seen as callousness?

Hypothesis 2a: Stigma (M) influences the relationship between trait shame (X) and empathy (Y).

Null hypothesis: Stigma (M) has no influence on the relationship between trait shame (X) and empathy (Y).

RQ2b: Does stigma (M) mediate the relationship between state shame (W) and empathy strength (Y) seen as callousness?

Hypothesis 2bs: Stigma (M) influences the relationship between state shame (W) and empathy (Y).

Null hypothesis: Stigma (M) has no influence on the relationship between state shame (W) and empathy (Y).

RQ2c: Does stigma (M) mediate the relationship between trait shame and state shame (XW) and empathy strength (Y) seen as callousness?

Hypothesis 2c: Stigma (M) influences the relationship between trait and state shame (XW) and empathy (Y).

Null hypothesis: Stigma (M) does not influence the relationship between trait and state shame (XW) and empathy (Y).

Design

The design in this study was a moderated mediation study design using model 8 (Hayes, 2018). Correlations, causalities, and statistical modeling was used to uncover the interaction between the variables as described by Hayes (2018). This study had the variables of stigma, shame, and empathy. Correlations and bootstrapped moderation mediation was used to find the relationships between the variables to determine the empathy strength of the SO when stigma and shame are manipulated. The purpose was to yield deeper understanding of the SO who experiences shame as actions of the self, stigma of being labeled as a SO, and the common therapeutic modality of increasing empathy to hopefully find better ways to provide counseling.

Participant Selection

The participant pool for this study came from several locations. The study group participation population was identified as post-conviction sex offenders. The population consisted of biological males only who could also self-identify as other than male. No one was compensated for participation. The study population of post-incarcerated sex offenders are considered part of the vulnerable populations as identified by the Collaborative Institute Training

Initiative (CITI) training and the National Institute of Health guidelines concerning vulnerable populations (Collaborative Institure Training Initiative, 2018).

Demographic Information

The population was anticipated to represent the naturally found demographics of Texas and thus provide good generalizability within the state of Texas. The gender of the participants were biological males yet will include those that self-identify as other than male as long as they were born with male genitalia. The age range was 18 to 99 years. The study attempted to reflect the current ethnicity representation of Texas of 78.8% Caucasian, 12.8% Black or African American, 1% Native American, 5.2% Asian, 0.1% Pacific Islander, and 39.6% Hispanic and Latino (US Census Bureau, 2018). Economic breakdown will be addressed as incomes under 12,000, between 12,999 to 24,000, between 24,999 to 50,000, and between 50,999 and 100,000 USD annually. Education was addressed as years of education with total numbers combined, meaning that a high school grad will have had 12 years while a master's student will have had 18 years of education or more. Vocational school was included. Family was included with history of mental illness in the family, substance use or addictions in the family, history of sexual abuse in the family, and birth order. The offenders' official charge(s) was included as part of the demographic breakdown. The number of identified victims and ages of victims was included. Additionally, participant mental health diagnosis will be included (see Appendix D).

Instrumentation

Three tools were used in this study. The intent was to use the three best available instruments that have a validated history of examining the exact qualities that are being looked at in this study. The instruments are listed here.

Internalized Stigma of Mental Illness Inventory (ISMI)

The Internalized Stigma of Mental Illness Inventory or ISMI is a 29-item 4-point Likert self-report questionnaire developed by Boyd that was published in 2003 (Hammer, 2017). ISMI has had multiple validations since 2003 (Chih-Cheng et al., 2014). The ISMI has an internalized consistency of $\alpha = 0.72\text{-}0.90$ with test re-test of $r = 0.68\text{-}0.92$ (Chih-Cheng et al. 2014). Boyd and colleagues used the 127 outpatient participants of the VA to complete the initial research. Five subscales were formed to include alienation, stereotype endorsement, perceived discrimination, social withdrawal, and stigma resistance, which was identified as the weakest of the five (Boyd et al., 2003). The ISMI is useful regardless of actual or perceived discrimination by the participant. The one facet that is important to this study is that the normative population of mental health patients did not score high in internalized stigma (Boyd et al., 2003).

Test of Self-Conscious Affect (TOSCA-3)

The test of self-conscious affect three or TOSCA-3 is a 16-item 5-point Likert scale tool created by Tangney in 1996 focused on situational life scenarios that can yield shame or guilt in one's life. TOSCA-3 differentiates shame from guilt with six subscales: (1) *guilt proneness* as a negative evaluation of personal behavior, (2) *shame proneness* as a negative evaluation of one's self perspective, (3) *externalization* as the measure of blaming applied to others as part of an externalized locus of control, (4) *detachment/unconcern* as a measure of the amount of emotional involvement in the situation(s) and the consequence(s) of the situation(s), (5) *alpha pride* as a measure of the proneness of one's having a positive self-pride, and (6) *beta pride* or the level of pride in a person's immediate behavior. The reliability of the TOSCA-3 was determined to have a Cronbach's Alpha between .76 and .88 for shame and .70 and .83 for guilt measurements. The test-retest scores for TOSCA-3 are .85 after three weeks and .74 after five weeks (Smith, 2011). Hanson (2003) stated that the TOSCA is the best test for shame-based emotions but that the utility with offender populations was yet to be explored until this study.

Interpersonal Reactivity Index (IRI)

The Interpersonal Reactivity Index or IRI was created by Davis in 1980 and is the most widely used tool for empathy (De Corte et al., 2007). The IRI uses a 5-point Likert scale of 28 items. The IRI has four subscales of fantasy, perspective taking, empathic concern, and personal distress (Pulos et al., 2004). Each of the subsections has seven items (Pulos et al., 2004). A validation study performed by Pulos et al. (2004) demonstrated similar findings as the original Davis studies of 1980 and 1996. The only subcategory that stands alone is the personal distress category. The other three were found to support each other and the traditional idea of empathy (Pulos et al., 2004). Chrysikou and Thompson (2016) identified a potential issue related to the two-factor aspect of the IRI. The problem rests in the need to reexamine the psychometric properties of the IRI to ensure that proper clinical decisions are being made on the correct premises (Chrysikou & Thompson, 2016).

Research Procedures

Each participant was screened for appropriateness for this study. Inclusionary elements included adult male post-incarcerated sex offenders attending court mandated treatment who may or may not identify a history of any form of childhood abuse (sexual, emotional, or physical). Participants without a history of sex offender status were not included as part of the study and no normative control groups for comparative purposes were required.

The participants were established in several areas. Categorical aspects of age, race, ethnicity, sex offender charge, and personal child abuse history was accounted for. All participants were biologically male, making gender a constant. Sex offender charges from court data was separated as categorical under the labels of child victim under 13, child victim between 14 and 17, and adult victim. Victim gender was also categorical.

Non-categorical groupings was formed into three groups. Groups were originally thought to be sequential for instrument testing for a traditional mediation study (see Table 1). Group A, consisting of the sequence of TOSCA-3, ISMI, and IRI. This was the precedent foundation that was to allow manipulation of groups B & C to make observation of the A precedent sequence of shame then stigma preceding empathy deficit. This was found to be unnecessary.

Table 1

Group Sequence Table

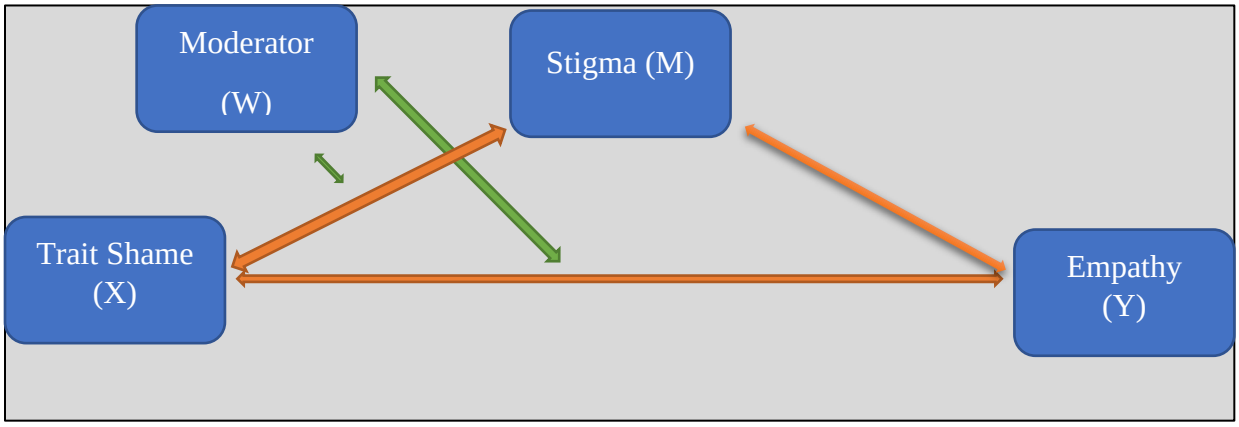
	A	B	C
1st	TOSCA-3	ISMI	IRI
2nd	ISMI	TOSCA-3	ISMI
3rd	IRI	IRI	TOSCA-3

Data Processing and Analysis

IBM SPSS version 28 for Windows was used. Data was screened for missing sets and outlier findings with the use of bivariate scatter plot (Warner, 2013). Errors in data entry were removed from the data set and the scatter plot repeated. If errors in data entry are not at fault, then the outlier will be viewed as a natural variation due to participation size and was included in the study findings section.

Figure 12

Model 8 Diagram



Mediation Analysis

Scatter plot assisted in demonstrating the multiple regression assumption of a linear relationship of the X and Y variables. A linear relationship was anticipated between IV (X) and DV (Y). A Pearson's r was performed to demonstrate the correlational requirements. Pearson's r was used to compare the predictor independent variable (X) to the outcome dependent variable (Y), followed by the independent variable (X) to the mediator (M), and then from the mediator (M) to the dependent variable (Y). ANOVA provided limited testing for the mediation hypothesis (Baron & Kenny, 1986).

***Causal Steps: Pathway** A*

A pathway analysis followed the ANOVA. The pathway analysis used causal steps for the difference in coefficients and product of coefficients (MacKinnon et al., 2007). SPSS performed the equations for the initial analysis to show that the independent variable was influencing the mediator in pathway a1 as well as a2 and a3. Pathway a1 consisted of trait shame (X) to state shame (W). Pathway a2 consists of stigma (M) to state shame (M). Pathway a3 consists of the combined (XW) to (M), which was trait shame (X) with state shame (W) influencing the shame condition of the mediator (M).

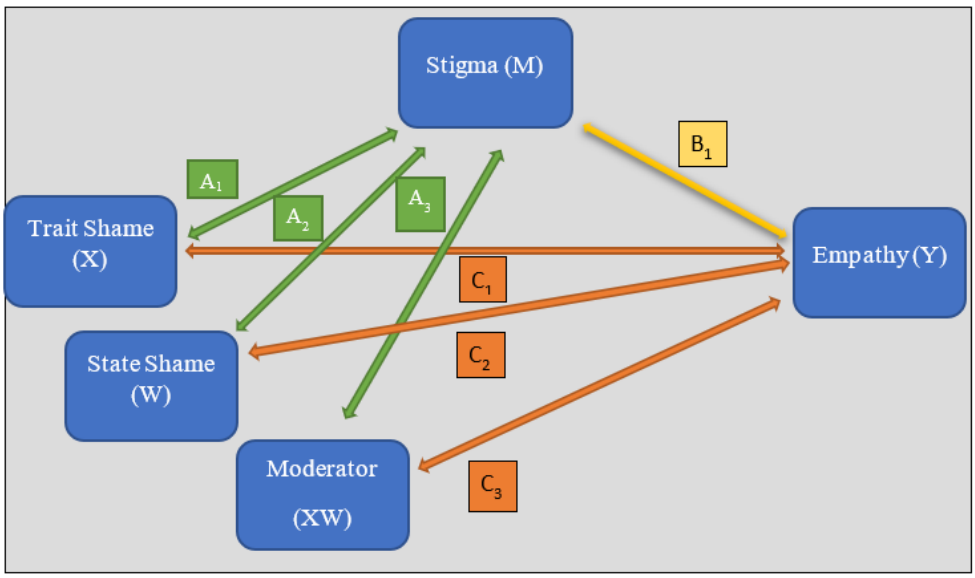
Causal Steps: Pathway B and C

A second pathway analysis was performed in the causal steps equations for the coefficient of (M) to the (DV); b was performed to show that the mediator (M) effects the DV (Y). Lastly, the final pathway of the c pathway was studied. The c1 pathway as a coefficient of the IV (X) to DV (Y) was conducted to show that (X) effects (Y). The c2 was the coefficient of the (W) stigma to the DV (Y) of empathy. The c3 pathway as a coefficient of the combined (XW) of shame proneness and stigma to the DV (Y) empathy was conducted.

Figure 11 depicts the visual representation of the pathway analysis that will be conducted. Baron and Kenny (1986) stated that in a perfect mediation, the IV (X) will have no effect when the (M) is controlled and that (Y) did not cause (M). In other words, this is a one-way ANOVA test that shows that shame leads to stigma, which leads to reduced empathy strength and not the other way around. The causal steps test will be viewed as showing a positive pathway when the coefficients of a and c are less than b ($a < b$, $a < c$, and $b > a + c$).

Figure 11

Statistical Model 8 Diagram (PATHWAY MODEL)



Joint Significance

Next, a joint significance test was performed. This test showed the significance of the mediation by determining the significance of the pathways a and b. The *t* tests from the regression results was used with a desired type 1 error of .05, thus rejecting the null hypothesis.

Inferential Testing

A Sobel test was not deemed necessary to determine the total effect of the total number of participants is large (Hayes, 2018). A sample size of N = 217 was used. Sobel testing is not recommended for use by Hayes due to the superiority of the bootstrapping method (Hayes, 2018). Bootstrapping was used regardless of the total *N* due to the potential that the standard error will not be known, as suggested by Warner (2013). A bootstrapping of 5000 was used with a percentile method for the confidence interval.

Anticipated Outcomes

Based on the hypothesis of this study, the anticipated outcomes was believed to show that empathy strength is correlated to shame and stigma, and that empathy strength is moderated by the effects of stigma upon shame, which intensifies the loss of empathy strength. Thus, individuals with increased TOSCA-3 scores should demonstrate higher stigma and higher IRI scores as well, thereby indicating that there is a positive finding. However, if the opposite happens and the stigma and empathy strength scores were low, thus upholding the null hypothesis, then this study hypothesis would have been rejected.

Ethical Concerns

There are some ethical considerations in this study. Primarily, the participants are part of a group as those not in active custody as prisoners, yet they remain in a setting required by law. Additional ethical concerns include nonmaleficence, justice, informed consent, and

voluntariness, which are closely related to their status as sex offenders (SO). Deception of participants was not necessary for this study as they each were post adjudicated.

One Institutional Review Board, IRB, concern was the use of prisoners. The e-CFR, or electronic code of federal regulations, indicates that participants who are under duress of incarceration must be protected from undue controls. 46.304 composition of the IRB states that a current prisoner or prisoner representative is required to participate in the IRB process for this study (US Department of Health and Human Services, 2020). Additionally, the prisoners themselves received no benefit from pardons, probations, or parole boards for their involvement in the study. No participant was compensated. The participant could have at any time removed themselves from the study. Furthermore, the participant's identity was withheld from the study except for demographics of age, race, ethnicity, and convictions/charges.

Chapter Summary

The research questions determining the relationships between shame, stigma, and empathy strength based on the hypotheses and assumptions that shame and stigma lead to reduced empathy strength were the focus of this study. The recruitment of participants from Texas, males with and without childhood abuse histories and criminal status as a sex offender residing in the community in a treatment program, were utilized. The measurements that were used include the Test of Self-Conscious Affect Three, a modified Internalized Stigma of Mental Illness, and the Interpersonal Reactivity Index. Statistical analysis will consist of bivariate scatter plots, Pearson's r, ANOVA, Causal Steps pathway analysis, and bootstrapping testing but not Sobel was used. Procedures and ethical considerations have been identified and discussed. Findings expected to demonstrate reduced empathy strength due to the mediation of stigma upon shame were found.

Chapter Four: Findings

Overview

The purpose of this study was to investigate the relationships between shame, stigma, and empathy of adult male sex offenders. The study was intended to understand the influence of trait shame, state shame, and stigma upon empathy. Simply stated, the study was originally designed to investigate how sex offenders appear calloused and unempathetic towards victims as evidenced by a classical control and study group design.

Research question 1 had seven parts, while research question two had only three parts. ANOVA was completed on all study survey packets and instrument subcategories to ascertain that there were similarities and differences enough to ensure relationships exist and rule out the null hypothesis of each research question. Pearson's r was used to verify the correlational relationships in RQ1a through RQ1g. Then, a moderation mediation regression analysis was performed for RQ2a to RQ2c. Bootstrapping was utilized. This chapter presents the findings with a summary and the hypotheses and statistical analysis of each of the research questions following the demographic summaries.

Data Screening

600 study packets were sent to the Texas locations in March of 2022. Data screening and analysis were performed using IBM SPSS version 28. Data screening was performed to locate missed values and data. Packets with more than one missing demographic were discarded. Only packets with complete scores were kept for processing and analysis. Over 30 packets with missing data were removed from use. 217 packets were returned that passed screening to create the study sample size. All packets were shredded following data recording into SPSS to protect participant identity. The researcher found several packets with identifying data during the

screening process. Additionally, the researcher found several packets with phone numbers, drawings of phallic symbols, and other sketches.

Retained packets provided descriptive findings of frequency of demographic data and the variable findings of trait shame (X), state shame (W), stigma (M), and empathy (Y). An ANOVA was also performed to show significance in variation. Tukey HSD and Bonferroni were both used to test for significance in the regressions. Lastly, moderation and mediation analysis were performed followed by the causal pathway. Bootstrapping was used to increase the effect size and significance.

Descriptive Statistics

Participant Demographics

217 males over the age of 18 who were part of a state-approved sex offender treatment program opted to participate and provide complete packets. Participants' demographics were separated by age, ethnicity, sexual identity and interest, mental health diagnosis, education, income, career, parental involvement, birth order, family history of addiction (AOD), family history of mental health diagnosis, participants' adverse childhood experience history, participants' beliefs, number of charges, type of charge, victim's age, victim's gender, and relationship to the victim.

Participants' ages were reported in a broad range of responses. Five reported ages under the18 year requirement. These included reports of being (N3 reported being zero years old), (N1 reported being four years old), and (N1 reported being six years old). The oldest participant reported being 79 years old (N2/0.9%). The most common age was 50 years with (N14/6.5%). These findings will be discussed further in the final chapter.

Participants' ethnic backgrounds include Asian (N12/5.5%), Black or AFAM (N31/14.3%), Hispanic nonwhite (N14/6.5%), Hispanic white (N33/15.3%), White (N92/42.4%),

Native American (N1/0.5%), and other ethnicities (N31/14.3%). (N3/1.4%) participants left the ethnicity blank. The ethnic results show strong similarities to the proposal.

Participant sexuality was reported as identity and sexual interest or orientation. (N204 94%) of the participants reported their sexual identity as the male gender. (N6/2.8%) reported being female gender, while (N7/3.2%) reported being other in gender. Sexual interest or orientation consisted of straight (N183/84.3%), homosexual (N4/1.8%), bisexual (N1/0.5%), transexual (N16/7.4%), and other sexual interest (N12/5.5%). One participant did not report his sexual orientation interest.

The diagnosis of mental health was reported with only two missed responses. The most reported was no diagnosis by (N140/64.5%). The remaining reports held a broad range of diagnoses. Major Depressive DO was reported by (N26/12%). Bipolar Do was reported by (N16/7.4%). Psychotic disorders were reported by (N1/0.5%). Anxiety disorders were reported by (N6/2.8%). Personality disorders were reported by (N1/0.5%). Intellectual DO and spectrum disorders were reported by (N9/4.1%). PTSD was reported by (N3/1.4%). ADHD was reported by (N12/5.5%). One participant reported having Klinefelter syndrome and two responses were missing.

Education, career, and income were recorded next. The most common education level was reported as 6th grade, with (N105/48.4%), and was followed by some college at (N64/29.5%). The next levels included undergraduate degree (N19/8.8%), graduate degree (N2/0.9%), then postgraduate degree (N1/0.5%) and doctorate (N4/1.8%). The career field type includes the highest as unemployed and skilled labor at (N44/20.3%) each. Unskilled labor was next at (N38/17.5%). The remainder included professional (N21/9.7%), office and warehouse (N19/8.8%), day labor (N18/8.3%), food/restaurant (N16/7.4%), military (N11/5.1%), and lastly retired (N6/2.8%). This will be discussed further in the final chapter.

Participant self-report of income was an extremely wide range, from $0 to $210,000.00. The majority was reported as $0 with (N69/31.8%). There were only four other numbers that had any frequency. These included $14,000 (N12/5.5%), $24,000 (N11/5.1%), and $35,000 and $50,000 (N10/4.6%) each. The mean average income was $22,374. This will be discussed further in the final chapter.

Family involvement and siblings followed career and income. 217 participants reported a high of (N107/49.3%) as raised by both parents. The next highest included single mothers (N68/31.3%) and foster care system (N25/11.5%). The lowest reported as father only (N11/5.1%), grandparents only (N3/1.4%), and being adopted (N1/0.5%), while (N2/0.9%) were missing responses.

Family of origin demographics continued with a family history of alcohol or other drugs (AOD), mental illness, and birth order reports. Participants reported having a family history of addiction as (N68/31.3%), no history as (N147/67.7%), and two responses were missing. Family history of mental illness was highest with (N177/81.6%) reporting no history. Subsequent reports showed MDDO (N37/17.1%) and then psychotic and personality DOs as (N2/0.9% & N1/0.5%), respectively.

Last in the family of origin demographic was the birth order category. The top six include the birth order of 1st (N66/30.4%), 2nd (N43/19.8%), 3rd (N31/14.3%), 4th (N38/17.5%), only child (N17/7.8%), and 5th (N11/5.1%). The rest ranged from 6th to 13th born, with 1.4% to 0.5% in this category of birth order.

Adverse childhood experiences (ACEs) were also collected in this study. The participants reported the following data. The majority (N124/57.1%) reported having no forms of adverse childhood experiences. The next highest number was reported as any combination of ACEs (N35/16.1%). Some participants reported physical abuse (N20/9.2%), while (N17/7.8%)

identified sexual abuse, and (N12/5.5%) recorded emotional abuse. Neglect was reported with the lowest number of (N9/4.1%).

The spiritual beliefs of the respondents recorded 13 different spiritual or religious beliefs. The highest number was reported as atheists (N64/29.5%). The lowest included Buddhist, Pentecostal, Wiccan, and Hindu, with (N1/0.5%) each. Christian denominational was reported as (N54/24.9%). Jewish was declared by (N26/12.0%). Catholic and non-denominational were identified by (N25/11.5%) each. Lastly, (N7/3.2%) reported Russian Orthodox. This will be discussed further in the final chapter.

The number of sexual offense charges was recorded with a wide range of responses. The most common number of charges was one charge with (N129/59.4%). More than four charges were in second place with (N16/7.4%). Two charges were reported by (N19/8.8%). Three charges were reported by (N12/5.5%). Four charges were identified by (N5/2.3%). The highest number was a report of three hundred charges by (N3/1.4%). Similar numbers were found with 15 counts of sexual charges (N3/1.4%). The remaining reports included numbers of counts from 7 to 275 charges by (N1 or 2/0.5% to 0.9%).

The types of sexual offense charges consisted of seven primary charges reported. The highest charge type was recorded as sexual assault under age 17 by (N50/23.0%). This was followed by indecency with a child (N35/16.1%), child pornography by (N33/15.2%), child sexual assault under 10-years-old (N32/14.7%), sexual assault over 17-years-old by (N25/11.5%), solicitation of a minor by (N18/8.3%), rape by (N13/6.0%), and missing report by (N4/1/8%). Unlawful restraint was reported by (N2/0.9%). The rest include multiple charges, sexual assault of a corpse, exploitation of minors, and human trafficking charges each reported by (N1/0.5%).

Victim age, gender, and relationship to the participant are the final descriptors recorded

in this study. See Table Two for a more detailed victim age report. However, it is important to report the youngest, oldest, and most reported victim age. The youngest victim age was reported as under one year by (N4/1.8%), while the oldest victim was recorded as 70-years-old (N1/0.5%). The most common ages include 15-years-old by (N23/10.6%), 10-years-old by (N20/9.2%), 14- and 12-years-old by (N19/8.8%), nine-years-old by (N15/6.9%), six-years-old by (N13/6.0%), and 22-years-old by (N12/5.5%). The rest can be observed in Table Two.

Female victims were reported by (N172/79.3%) participants, while (N28/12.9%) identified as having male victims. Both genders were reported by (N11/5.1%) participants. Three participants reported denial of the victim's having a gender, making 1.4% of respondents. Two participants reported victim genders with the number four and one reported a gender with the number six.

The victim's relationship to the sex offender participant was also recorded. These details include no relationship or stranger by (N94/w43.3%). The second highest number was friends of the parent of the victim (N65/30%). The third highest was (N33/15.2%) with the parent or stepparent of the victim. The rest included uncles or cousins (N7/3.2%), respectively. Boyfriend of victim by (N6/2.8%), childcare provider (N3/1.4%), and lastly sibling by (N2/0.9%).

Table Two

Participant Demographics

	N	%
Age: Mean = 47.86, Range=79	**217**	**100**
INCOME Mean = $22,374, Range = $210,000	**217**	**100**
Ethnicity		
Asian	12	5.5
Black/AFAM	31	14.3
Hispanic nonwhite	14	6.5

Table Two (continued)

Participant Demographics

	N	%
Ethnicity		
Hispanic White	33	15.2
White **(Most Frequent)**	**92**	**42.4**
Native American	1	0.5
Other	31	14.3
Sexual Identity		
Female	6	2.8
Male **(Most Frequent)**	**204**	**94**
Other	7	3.2
Sexual Interest		
Bisexual	1	3.2
Heterosexual **(Most frequent)**	**183**	**84.3**
Homosexual	4	1.8
Transexual	16	7.4
Other	12	5.5
Birth Order		
Single child	17	7.8
First **(Most Frequent)**	**66**	**30.4**
Third	31	14.3
Fourth	38	17.5
Other	22	10.2
Parental Involvement		
Foster System	25	11.5
Single Mother	68	31.3
Single Father	11	5.1
Both Parents **(Most Frequent)**	**107**	**49.3**

Table Two (continued)

Participant Demographics

	N	%
Parental Involvement		
Adopted	1	0.5
Other	2	0.9
Psychiatric Diagnosis		
Anxiety Do's	6	2.8
NONE **(Most frequent)**	**140**	**64.5**
MDDO	26	12
Bipolar DO	16	7.4
Psychotic DO's	1	0.5
Personality DO's	1	0.5
IDD or Spectrum DO's	9	4.1
PTSD	3	1.4
ADHD	12	5.5
Klinesfelter Syndrome	1	.5
Education		
None	22	10.1
High School **(MOST Frequent)**	**105**	**48.4**
Some College	64	29
Grad Deg.	2	0.9
Post Grad.	1	0.5
Doctoral	4	1.8
Career		
Unemployed	44	20.3
Unskilled Trade	38	17.5

Table Two (Continued)

Participant Demographics

	N	%
Career		
Day Laborer	18	8.3
Food	16	7.4
Office	19	8.8
Military	11	5.1
Skilled Trade **(MOST Frequent)**	44	20.3
Professional	21	9.7
Retired	6	2.8
Family Hx of Addiction		
YES	68	32.3
NO **(Most Frequent)**	**147**	**67.7**
Participants ACE's		
None **(Most Frequent)**	**124**	**57.1**
Physical	20	9.2
Emotional	12	5.5
Sexual	17	7.8
Neglect	9	4.1
Any Combination	35	16.1
Spiritual Beliefs		
Atheist **(Most Frequent)**	**64**	**29.5**
Catholic	25	11.5
Nondenominational	25	11.5
Denominational	54	24.9
Jewish	26	12
Muslim	4	1.8

Table Two (Continued)

Participant Demographics

	N	%
Spiritual Beliefs		
Buddhist	1	0.5
LDS	2	0.9
Pentecostal	1	0.5
Other	3	1.4
Wiccan	4	1.8
Hindu	1	0.5
Russian Orthodox	7	3.2
Number of Sex Charges		
Reported NONE	4	1.8
One **(Most Frequent)**	**129**	**59.4**
Two	19	8.8
Three	12	5.5
Four	5	2.3
>5 but under 100	23	9.8
100 to 300	9	4.2
Legal Charge		
Sexual Assault of > 10 y/o	32	14.7
Sexual Assault of 11-17 y/o **(Most Frequent)**	**50**	**23**
Indecency with Minor	35	16.1
Solicitation of Minor	18	8.3
Child Pornography	33	15.2
Sexual Assault >18 y/o	38	17.5
Human Trafficking/Unlawful restraint	3	1.4
Other sexual charges	8	3.8

Table Two (Continued)

Participant Demographics

	N	%
Victims ages, Range (0 y/o-70 y/o)		
Infant	4	1.8
Under 4 y/o	13	6
5 years	10	4.6
6 years	13	6
7 Years	4	1.8
8 Years	10	4.6
9 years	15	6.9
10 years	20	9.2
11 years	10	4.6
12 years	19	8.8
13 year	11	5.1
14 years	19	8.8
15 years **(Most Frequent)**	23	10.6
16 years	14	6.5
17 years	6	2.8
18 years & over	20	9.2
25 to 70 years	6	3
Victims Gender		
Male	28	12.9
Female **(Most Frequent)**	172	79.3
Both	11	5.1
Unknown	6	2.8

Table Two (Continued)

Participant Demographics

Relationship Victim to Offender		
NONE **(Most Frequent**)	94	43.3
Friend of Family	65	30
	N	**%**
1st Deg. Relative	33	15.2
2nd Deg. Relative	7	3.2
3rd Deg. Relative	7	3.2
Boyfriend of Victim	6	2.8
Child Care Provider	3	1.4
Sibling	2	0.9

Variable Descriptors

The three instruments, TOSCA-3, IRI, and ISMI yielded numerous variable components. Thus, it was necessary to create transformations of the instruments. The transformations will be explained in detail as relating to the needs of the instrument used and the involvement within the study. Furthermore, each instrument will be given details here concerning the manner in which the instrument's components were used.

Reliability

TOSCA-3 Alpha

The TOSCA-3 possessed scoring for shame (X), renamed as trait shame, and guilt (W), renamed as state shame. These both included externalization and detachment scores as part of the overall. The alpha and beta pride scores were not used in the overall evaluation or as part of the transformational variables. The reliability of the TOSCA-3 had a Cronbach's alpha of (.806). The Cronbach's alpha based on standardized items was (.802). This score is deemed "robust", being over the (.800) requirement (Taber, 2018, p. 1278). The total number of items tested was

four, which included the trait shame (X), state shame (W), and the externalization and detachment scores.

ISMI Alpha

The ISMI contained five subcategories. The categories are alienation, stereotype endorsement, discrimination experience, social withdrawal, and stigma resistance. It is important to note that stigma resistance is reverse scored, meaning that a high score means a lower ability to resist the influence of stigma. The reliability testing with Cronbach's alpha for the ISMI was (.776) and for the standardized scores was (.772). This score is deemed "fairly high", being over the (.760) requirement (Taber, 2018, p. 1278).

IRI Alpha

The IRI contained four components in total. These included the fantasy scale, perspective taking, empathic concern, and personal distress scale. These were transformed into an overall empathy score (Y). The four subscales were tested for reliability and produced a Cronbach's alpha of (.685) and a standardized score of (.693). This score is deemed "reasonable", being over the (.670) requirement (Taber, 2018, p. 1278).

Gliem (2003) and Taber (2018) discussed how lower scores for alpha do not always mean that the score is unacceptable. Therefore, low scores of (.450) and above are deemed acceptable. For a more detailed examination the inter-item correlation and inter-item covariance should be reviewed. The simplest way to observe the inter-item correlation and covariance scores is in the matrix formatting.

Analysis of Variance

A one-way single tailed ANOVA was performed to determine the effects of the variables within the TOSCA-3, the IRI, and the ISMI. The observed findings showed that the variances are enough to ensure that the variable can be correlated and that they are different from each other.

Table three for the TOSCA-3 showed that the sig. is <.001, indicating good statistical significance.

Table Three

TOSCA-3 ANOVA

TOSCA-3	Sum of Squares	Df.	Mean Squares	F	Sig.
Between People	321.309	216	1.488		
Within People					
Between Items	179.760	3	59.920	207.149	<.001
Residual	187.440	648	.289		
Total	688.509	867	.794		

Table four shows the results for the ISMI. The significance of the ISMI is also <.001, indicating a good level of statistical significance.

Table Four

ISMI ANOVA

ISMI	Sum of Squares	Df.	Mean Squares	F	Sig.
Between People	288.855	216	1.337		
Within People					
Between Items	151.854	4	37.963	127.790	<.001
Residual	256.674	864	.297		
Total	697.383	1084	.643		

Table five concludes the ANOVA with the IRI. Again, the significance is good (<.001).

Table Five

IRI ANOVA

IRI	Sum of Squares	Df.	Mean Squares	F	Sig.
Between People	188.918	216	.875		
Within People					
Between Items	30.456	3	10.152	38.817	<.001
Residual	178.677	648	.276		
Total	398.051	867	.459		

Normal Distributions and Correlations

P-P and Q-Q plots were used to demonstrate normal probability distributions. The P-P plots for Trait and State shame, Stigma, and Empathy each indicated acceptable normal distribution results. The Q-Q plot for Trait and State shame, Stigma, and Empathy also demonstrates that in each case the variables are on the line, indicating that they follow a normal distribution.

Additionally, histograms were utilized. The histogram for trait shame held a mean of 3.40 and a SD of .569 with N=217. The histogram for state shame presented a mean of 3.14 with SD of .603 on N=217. The histogram for stigma presented a mean of 2.51, SD of .517 on N=217. The histogram for empathy presented a mean of 2.94, SD of .488 on N=217. The histograms for each fell within acceptable parameters of normal distributions.

Observing the correlations in bold in Table Six: TOSCA-3 Inter-Item Correlation and Covariance shows that trait shame is strongly correlated with externalization and detachment,

with results over (.50). Additionally, state shame is not strongly correlated to externalization or detachment, with scores under (.40). Covariance scoring is provided for future research.

Table Six

TOSCA-3 Inter-Item Correlation/Covariance Table

	Trait Shame (X)	State Shame (W)	Externalization	Detachment
Trait Shame (X)	**1.00**	**.498**	**.631**	**.579**
	.579	.244	.406	.353
State Shame (W)	**.498**	**1.00**	**.311**	**.350**
	.244	.416	.170	.181
Externalization	**.631**	**.311**	**1.00**	**.652**
	.406	.170	.717	.442
Detachment	**.579**	**.350**	**.652**	**1.00**
	.353	.181	.442	.643

Observing the correlations in bold in Table Seven: ISMI Inter-Item Correlation and Covariance shows that alienation, social withdrawal, and discrimination are strongly correlated, with results over (.50). Additionally, stereotyping is not strongly correlated with alienation, with scores under (.40). However, resistance is scored inversely, meaning that the lower the score the stronger the correlation. Therefore, resistance is correlated with the rest of the subcategories, especially with stereotyping (.087) and social withdrawal (.175). Lastly, covariance scoring is provided for future research.

Table Seven

ISMI Inter-Item Correlation and Covariance Table

	Alienation	Stereotyping	Discrimination	Social Withdrawal	Resistance
Alienation	**1.00**	**.396**	**.603**	**.600**	**.193**
	.835	.252	.342	.401	.094
Stereotyping	**.396**	**1.00**	**.657**	**.517**	**.087**
	.252	.487	.284	.264	.032
Discrimination	**.603**	**.657**	**1.00**	**.604**	**.208**
	.342	.284	.384	.274	.069
Social Withdrawal	**.600**	**.517**	**.604**	**1.00**	**.175**
	.401	.264	.274	.535	.068
Resistance	**.193**	**.087**	**.208**	**.175**	**1.00**
	.094	.032	.069	.068	.284

Observing the correlations in bold in Table Eight: IRI Inter-Item Correlation and Covariance showed that empathic concern and perspective taking are strongly correlated with results over (.50). Additionally, the other bold scores are only weakly correlated with scores under (.50). This could be an important element for future study. The potential that only two elements are important in sex offender empathy needs further investigation. Lastly, covariance scoring is provided for future research.

Table Eight

IRI Inter-Item Correlation and Covariance Table

	Fantasy	Perspective	Empathic	Distress
Fantasy	**1.00** .451	**.313** .154	**.386** .152	**.335** .137
Perspective	**.313** .154	**1.00** .538	**.525** .225	**.167** .075
Empathic	**.386** .152	**.525** .225	**1.00** .342	**.436** .155
Distress	**.335** .137	**.167** .075	**.436** .155	**1.00** .371

A scatter plot was used to demonstrate correlations between the variables. The variables of trait and state shame can be observed in Appendix D of figure 15 on page 156. The correlation of trait and state shame was represented by an r = 0.877. Shame to empathy correlation is observable in Appendix E of figure 16 and demonstrated an r = 0.088. The scatter plot for stigma to empathy found in Appendix F with figure 17 shows an r = 0.067. The state shame to empathy scatter plot found in Appendix G of figure 18 reveals an r = 0.061. These variables are positively correlated and show a right upward slope. The strongest to weakest correlations are presented here in order.

Results

The results of this study were interesting and possessed several unexpected results. These will be discussed in the following chronological sequence of study design and model evaluation, collinearity confounding concerns, sequencing, assumptions, path analysis, and research questions. A special note regarding the model design was the most unexpected.

Design and Model Evaluation

Hayes model 8 with use of Hayes' SPSS procedure v4 was found to be appropriate for this study. Model 8 allowed for an appropriate test of path analysis as well as null hypothesis testing. Additionally, model 8 performed moderated mediation analysis effectively. There are, however, several issues that were discovered in the processing of the results in this study in relation to the use of classical research concepts of control and research grouping, null hypothesis testing, causal pathways, and collinearity.

First is the verification of a correlational relationship created by the Baron and Kenny (1986) study. Second is the classical research design of having a control and study group format. The third is null hypothesis testing and causal pathways require further scrutiny. Lastly, is the issue of collinearity confounding.

Igartua and Hayes (2021) discussed the classical requirement of establishing correlations as being problematic in the conditional process analysis of mediation studies. The classical construct of a moderated mediation study should definitively show that the effect paths of X and Y are associated significantly (Igartua, 2021). More specifically, if the effect of X on path c is not statistically different from zero, then a mediation study should not be performed (Igartua, 2021). Igartua and Hayes proposed that correlations need not be clearly expressed, stating that a correlation does not indicate that causality is not happening.

There is also an issue with the classical research design construct. Igartua and Hayes (2021) state that the classical modeling of control conditions and study grouping are not required for a moderation mediation study design. The action of creating subgroupings creates problems with the moderation analysis. Igartua and Hayes stated that subgrouping can lead to having one group with larger direct and indirect effects, making one group significant and the other not, thereby creating confusion. The conclusion is that a single continuous moderator is as good as a categorical moderator so an artificial categorization of moderators before analysis is just redundant and confusing (Igartua, 2021).

Third is the problematic nature of the number research hypothesis H0 null where the causal steps and Sobel testing is low in power while simple bootstrapping is more appropriate. As this study was designed to use bootstrapping originally, it remains the primary focus of the causal steps procedure, opposing the causal steps approach of Baron and Kenny (1986) (Hayes, 2009). The effects of X on Y through M have the least amount of detection when using causal pathways statistics (Hayes, 2009). Additionally, the Sobel test assumes that distribution of sampling has a non-zero skewness and kurtosis of the ab pathway with a normal distribution of the indirect effect (Hates, 2009). Furthermore, bootstrapping is more appropriate as it creates a *K value* used in the development of a confidence interval percentile (*ci*%) that is theoretically identical to rejecting the null hypothesis as the actual indirect effect is zero at the 100% *ci* % significance (Hayes, 2009).

The issues of these four items of concern have moved this study to shift away from performing a causal pathways and Sobel test. Bootstrapping will be used for null hypothesis rejection as directed by Hayes (2009). Bootstrapping will also be used as the primary source of testing for the indirect effect of X on Y through M. Furthermore, bootstrapping will also be used

for the mediated moderation construction. Thus, the indirect effect relationship of (X) and (W) on (M) to (Y) will be used conceptually (Hayes, 2009).

Collinearity Confounding Concerns

Aspects of collinearity must now be addressed as a missing part of the original design proposal. Mediation effect reduction occurs as the effect size of (*ab*) increases (Beasley, 2014). The reduced statistical power is a function of the (*a*) coefficient, which is showing the collinearity of (X) and (M) and is a confounding factor by inflating the variance of (*b*) coefficient (Beasley, 2014). This then inflates the standard deviation of the product and then increases the effect size of (*ab*). Nonparametric bootstrapping that does not estimate standard errors will show this decline in statistical power in the (*ab*) as it is affected by the magnitude of (*a*) (Beasley, 2014). This issue has been resolved based on the use of bootstrapping under Hayes' process V4.

Sequencing

The relationship sequencing hypothesis corresponds to Research Question 1. The mediated moderation sequence hypothesis corresponds to Research Question 2. The hypothesis of this study is that there is a domino-like cause-effect relationship between trait shame (X) moderated by state shame (W) and then mediated by stigma (M), causing an empathy strength deficit that is viewed as callousness.

Assumptions

This study holds certain assumptions. Assumption one is that trait shame (X) is a pre-existing condition in sex offenders. State shame (W) is experienced by all sex offenders by being labeled "sex offender" publicly in registration. Due to the complexity and number of research questions proposed, the results will follow the sequencing of the research questions themselves.

Path Analysis

The path analysis in this section is intended to show the moderation and mediation aspects in raw form. Each of the hypotheses will have a figure and a table associated to them. Additional to the table will be the intext parenthetical for immediate observation.

Hypotheses and Research Question Results

This section will provide the results of the pathway analysis as well as the hypothesis for each research question. The scores for pathway data results can be observed in Table Nine. The list of effects and the size/strength can be found in Table 10. The pathways are also available for observation in Figure 12.

Hypothesis One

RQ1a asked, "What is the relationship between shame proneness (trait shame) and stigma?" based on the assumptions that this increases the relationship to stigma. This result is located in the A_1 pathway of (X-M). Model summary for pathway A_1 showed that there is no relationship between trait shame and stigma as shown by effect size (R-sq=.1771), probability of happening under the H0 (P=.0000), measure of error (MSE=.2232), and the heteroskedasticity (F [HC4] = 23.5889); the null hypothesis is rejected. Pathway A_1 was found to have a coefficient of .9781, meaning that the effect shame has on stigma is very large. The confidence intervals for A_1 pathway were (LLCI= .6727) to (ULCI= 1.2708). This *ci* does not cross zero and as such is viewed as being significant with a range of (0.5981). See Table Nine.

Table Nine

Pathway Outcome Data

	Coeff	Se (HC4)	T	P	LLCI	ULCI

A 1	.9718	.1517	6.4053	.0000	.6727	1.2708
A 2	.7611	.1985	3.8353	.0002	.3699	1.1523
A 3	-.2228	.0296	-7.5373	.0000	.3699	1.1523
B 1	.1061	.0865	1.2256	.2217	-.0645	.2767
C 1	.7530	.3482	2.1628	.0317	.0667	1.4394
C 2	.3907	.3328	1.1738	.2418	-.2654	1.0467
C 3	-.1274	.0753	-1.6921	.0921	-.2759	.0210

Hypothesis Two

RQ1b asked, "What is the relationship between trait shame/shame proneness and empathy?" based on the hypothesis that sex offenders' trait shame/shame proneness reduces empathy strength, which presents as callousness. The result of C_1 pathway of (X to Y) in the model summary for pathway C_1 showed the null hypothesis (there is no relationship between trait shame and empathy) is rejected as shown by effect size (R-sq=.1901), probability of happening under the H0 (P=.0304), measure of error (MSE=.1804), and the heteroskedasticity (F [HC4] = 2.7261). Pathway C_1 was found to have a coefficient of (.7530), meaning that the effect shame has on empathy is large. The confidence intervals for C_1 pathway is (LLCI= .0667) to (ULCI= 1.4394). This *ci* does not cross zero and as such is viewed as being significant, with a range of (1.3727). See Table Nine.

Hypothesis Three

RQ1c asked, "What is the relationship between stigma and empathy?" and is based on the hypothesis that sex offenders have an increased relationship between stigma and empathy. This

is located in the B_1 pathway of (M to Y). The result of pathway B_1 (M to Y) in the model summary for pathway B_1 showed the null hypothesis (there is no relationship between stigma and empathy) is rejected as shown by effect size (R-sq=.1901), probability of happening under the H0 (P=.0304), measure of error (MSE=.1804), and the heteroskedasticity (F [HC4]= 2.7261). Pathway B_1 was found to have a coefficient of (.1061), meaning that the effect shame has on empathy is large. The confidence interval for C_1 pathway is (LLCI= -.0645) to (ULCI= .2767). This *ci* does not cross the zero and as such is viewed as being significant with a range of (.2122). See Table Nine.

Hypothesis Four

RQ1d asked the question, "What is the relationship between state shame and stigma?" The hypothesis is that when sex offenders feel state shame, the relationship with stigma is increased. This is in the A_2 pathway of (W to M). Model summary for pathway A2 showed that the null hypothesis (that there is no relationship between state trait shame and stigma) is rejected as shown by effect size (R-sq=.1771), probability of happening under the H0 (P=.0000), measure of error (MSE=.2232), and the heteroskedasticity (F [HC4] = 23.5889). The pathway A_2 was found to have a coefficient of .7611, meaning that the effect state shame has on stigma is large. The confidence intervals for A_2 pathway were (LLCI= .3699) to (ULCI= 1.1523). This *ci* does not cross the zero and as such is viewed as being significant with a range of (0.7824). See Table Nine.

Hypothesis Five

RQ1e asked the question, "What is the relationship between shame (state shame) and empathy?" This is based on the hypothesis that when sex offenders have an increase in state

shame the relationship with empathy is strengthened. This is in the C_2 pathway of (W to Y). The result of pathway C_2 (W to Y) in the model summary for pathway C_1 showed the null hypothesis (there is no relationship between state shame and empathy) is rejected as shown by effect size (R-sq=.1901), probability of happening under the H0 (P=.0304), measure of error (MSE=.1804), and the heteroskedasticity (F [HC4] = 2.7261). Pathway C_2 was found to have a coefficient of (.3907), meaning that the effect state shame has on empathy is substantial. The confidence interval for C_2 pathway is (LLCI= -.2654) to (ULCI= 1.0467). This *ci* crosses zero and as such is viewed as being significant with a range of (.7813). See Table Nine.

Hypothesis Six

RQ1f asked, "What is the relationship between shame (state shame) combined with trait shame to empathy?" The hypothesis is that the combination of state and trait shame increases the reduction in empathy strength. This can be found in pathway C_3 of (XW to Y). The result of pathway C_1 (X to Y) in the model summary for pathway C_3 showed the null hypothesis (there is no relationship between trait and state shame to empathy) is rejected as shown by effect size (R-sq=.1901), probability of happening under the H0 (P=.0304), measure of error (MSE=.1804), and the heteroskedasticity (F [HC4] = 2.7261). The pathway C_3 was found to have a coefficient of (-.1274), meaning that the effect shame has on empathy is small but present. The confidence interval for C_3 pathway is (LLCI= -.2759) to (ULCI= .0210). This *ci* does cross the zero and as such is viewed as being significant with a range of (.2549). See Table Nine.

Hypothesis Seven

RQ1g asked, "What is the relationship between state shame (W) combined with trait shame (X) to stigma (M)?" This question is based on the hypothesis that the combination of state

and trait shame increases the stigma experienced by sex offenders. The pathway is A_3 of (XW to M). Model summary for pathway A_3 showed that the null hypothesis (no relationship between state and trait shame to stigma) is rejected as shown by effect size (R-sq=.1771), probability of happening under the H0 (P=.0000), measure of error (MSE=.2232), and the heteroskedasticity (F [HC4]= 23.5889). Pathway A_3 was found to have a coefficient of -.2228, meaning that the effect state shame has on stigma is small but does exist. The confidence intervals for A_3 pathway were (LLCI= -.2811) to (ULCI= -.1645). This *ci* does not cross the zero and as such is viewed as being mildly significant with a range of (.1166). See Table Nine.

Table 10

Research Question1 and Hypothesis

	RQ1a (Path A1)	RQ1b (Path C1)	RQ1c (Path B1)	RQ1d (Path A2)	RQ1e (Path C2)	RQ1f (Path C3)	RQ1g (Path A3)
Hypothesis	One	Two	Three	Four	Five	Six	Seven
Method	ANOVA	ANOVA	ANOVA	ANOVA	ANOVA	ANOVA	ANOVA
R-sq	.1771	.1901	.1901	.1771	.1901	.1901	.1771
MSE	.2232	.1804	.1804	.2232	.1804	.1804	.2232
F (HC4)	23.5889	2.7261	2.7261	23.5889	2.7261	2.7261	23.5889
df1	3.000	4.000	4.000	3.000	4.000	4.000	3.000
Df2	213.0000	212.000	212.000	213.0000	212.000	212.000	213.0000
P	.0000	.0304	.0304	.0000	.0304	.0304	.0000
	RQ1a (Path A1)	RQ1b (Path C1)	RQ1c (Path B1)	RQ1d (Path A2)	RQ1e (Path C2)	RQ1f (Path C3)	RQ1g (Path A3)

Method	Regressio n	Regressio n	Regressio n	Regressio n	Regressio n	Regressio n	Regressio n
Coeff	.9718	.7530	.1061	.7611	.3907	-.1274	-.2228
Se (HC4)	.1517	.3482	.0865	.1985	.3328	.0753	.0296
T	6.4053	2.1628	1.2256	3.8353	1.1738	-1.6921	-7.5373
P	.0000	.0317	.2217	.0002	.2418	.0921	.0000
LLCI	.6727	.0667	-.0645	.3699	-.2654	-.2795	-.2811
ULCI	1.2708	1.4394	.2767	1.1523	1.0467	.0210	-.1645

Moderated Mediation Sequence Results

Testing of direct and indirect effects of stigma upon the relationships of state shame, trait shame, and empathy were calculated using bootstrapping. The results are described below and presented in tables for each research question by group. Conditional direct effects of X on Y are presented in Table 11.

Table 11

Conditional Direct Effect of X on Y

W1	*Effect*	*Se(HC4)*	*T*	*P*	*LLCI*	*ULCI*
2.5332	*.4303*	*.2013*	*2.1373*	*.0337*	*.0334*	*.8271*
3.1363	*.3534*	*.1790*	*1.9745*	*.0496*	*.0006*	*.7062*
3.7395	*.2766*	*.1664*	*1.6624*	*.0979*	*-.0514*	*.6045*

The conditional indirect effects of X on Y are presented in Table 12.

Table 12

Conditional Indirect Effect of X on Y

W1	*Effect*	*BootSE*	*BootLLCI*	*BootULCI*
2.5332	*.0432*	*.0396*	*-.0189*	*.1361*
3.1363	*.0290*	*.0304*	*-.0123*	*.1048*
3.7395	*.0147*	*.0227*	*-.0157*	*.0742*

The index of moderated mediation is presented in Table 13.

Table 13

Index of Moderated Mediation

	Index	BootSE	BOOTLLCI	BOOTULCI
W1	-.0236	.0181	-.0599	.0118

The results of bootstrapping are presented in Table 14 below.

Table 14

Bootstrap Results for Regression Model Results

OUTCOME VARIABLE: Stigma1 Coeff BootMean BootSE BootLLCI BootULCI
constant -.7361 -.7905 .4271 -1.8057 -.0960
Shame1 .9718 .9866 .1571 .6958 1.3185
W1 .7611 .7735 .1996 .3886 1.1777
Int_1 -.2228 -.2260 .0303 -.2935 -.1715
OUTCOME VARIABLE: Empathy1 Coeff BootMean BootSE BootLLCI BootULCI

constant	.2910	.2310	.6440	-.9321	1.4476
Shame1	.7530	.7709	.2227	.3298	1.1986
Stigma1	.1061	.1044	.0783	-.0523	.2531
W1	.3907	.4050	.2471	-.0879	.8908
Int_1	-.1274	-.1313	.0470	-.2184	-.0389

Hypothesis Eight

RQ2a investigates the question "Does stigma mediate the relationship between trait shame and empathy strength?" This inquiry is based on the hypothesis that stigma (M) influences the relationship between trait shame (X) and empathy (Y). The question here is how much does (M) "move" C_1? The results are found in pathway A_1 (coeff=.9718, P=.0000) and pathway B_1 (coeff=.1061, P=.2217) compared to C_1 (coeff=.7530, P= .0317). C_1 is controlling stigma (M). Thus, A_1B is (coeff= .1031, P= .0000) while C_1 is (coeff=.7530, P= .0317). The effect strength of X to Y is (.7530), indicating a larger positive direct influence with lesser overall significance (P= .0317) than the combined effects of A_1 B. See Table 15.

Table 15

Research Question 2 and Hypothesis

	RQ2a	**RQ2b**	**RQ2c**
Hypothesis	**Eight**	**Nine**	**Ten**
Method	Bootstrap Regression	Bootstrap Regression	Bootstrap Regression
Coeff	.7530	.3907	-.1274

Boot Mean	.7709	.4050	-.1313
Boot Se	.2227	.2471	.0470
Boot LLCI	.3298	-.0879	-.2184
Boot ULCI	1.4476	.8908	-.0389

Hypothesis Nine

RQ2b investigates the question "Does stigma mediate the relationship between state shame and empathy strength?" This inquiry is based on the hypothesis that stigma (M) influences the relationship between state shame (W) and empathy (Y). The question here is how much does (M) "move" C_2? The results are found in pathway A_2 (coeff=.7611, P=.0002) and pathway B_1 (coeff=.1061, P=.2217) compared to C_2, which is controlling stigma (M). Thus, A_2B is (coeff= .0807, P= .0000) while $C_{2\ is}$ (coeff=.3907, P= .2418). The effect strength of W to Y is (.3907), indicating a larger positive direct influence while possessing lesser significance (P= .2418) than the combined effects of A_2B (coeff= .0807, P= .0000). See Table 15.

Table 15

Research Question 2 and Hypothesis

	RQ2a	**RQ2b**	**RQ2c**
Hypothesis	**Eight**	**Nine**	**Ten**
Method	Bootstrap Regression	Bootstrap Regression	Bootstrap Regression
Coeff	.7530	.3907	-.1274
Boot Mean	.7709	.4050	-.1313
Boot Se	.2227	.2471	.0470
Boot LLCI	.3298	-.0879	-.2184

Boot ULCI	1.4476	.8908	-.0389

Hypothesis 10

RQ2c investigates the question "Does stigma mediate the relationship between trait shame and state shame and empathy strength?" This inquiry is based on the hypothesis that stigma (M) influences the relationship between trait shame (X) combined with state shame (W) to empathy (Y). The question here is how much does (M) "move" C_3? The results are found in pathway A_3 (coeff=-.2228, P = .0000) and pathway B (coeff=.1061, P=.2217) compared to C_3, which is controlling (M). Thus, A_3B is (coeff = .0236, P = .0000) while C_3 is (coeff = -.1274, P = .0921). The effect strength of (XW) is (-.1274), indicating a negative influence on (Y) without the influence of (M) and with the influence of (M) (.0236), which is the index of moderated mediation found in Table 13.

Table 13

Index of Moderated Mediation

	Index	BootSE	BOOTLLCI	BOOTULCI
W1	-.0236	.0181	-.0599	.0118

Unanticipated Findings

An inverse relationship was discovered during the analysis of the data. Table 16 shows an interesting and unanticipated result of the relationships of trait shame, state shame, and empathy. Table 16 clearly illustrates the inverse nature of the focal predictor of trait shame upon the moderating variable state shame (W1) regarding its' relationship to the dependent variable stigma. The significance of this will be further elaborated upon in the final chapter.

Table 16

Conditional Effect of Focal Predictor at Values of the Moderator

W1	Effect	se(HC4)	T	p	LLCI	ULCI
1.0873	.6145	.2787	2.2049	.0285	.0651	1.1639
1.3212	.5847	.2647	2.2091	.0282	.0630	1.1064
1.5552	.5549	.2511	2.2097	.0282	.0599	1.0499
1.7891	.5251	.2381	2.2055	.0285	.0558	.9944
2.0230	.4953	.2257	2.1947	.0293	.0504	.9401
2.2569	.4655	.2140	2.1752	.0307	.0436	.8873
2.4909	.4357	.2032	2.1443	.0331	.0352	.8361
2.7248	.4059	.1933	2.0991	.0370	.0247	.7870
2.9587	.3760	.1847	2.0361	.0430	.0120	.7401
3.1448	.3523	.1787	1.9712	.0500	.0000	.7047
3.1926	.3462	.1774	1.9522	.0522	-.0034	.6959
3.4266	.3164	.1715	1.8447	.0665	-.0217	.6546
3.6605	.2866	.1674	1.7126	.0883	-.0433	.6165
3.8944	.2568	.1650	1.5566	.1211	-.0684	.5820
4.1283	.2270	.1645	1.3803	.1690	-.0972	.5512
4.3623	.1972	.1658	1.1892	.2357	-.1297	.5241
4.5962	.1674	.1690	.9904	.3231	-.1658	.5006
4.8301	.1376	.1740	.7910	.4298	-.2053	.4805
5.0640	.1078	.1805	.5972	.5510	-.2480	.4636
5.2980	.0780	.1884	.4139	.6794	-.2934	.4494

	5.5319	.0482	.1976	.2438	.8076	-.3414	.4377
	5.7658	.0184	.2079	.0884	.9297	-.3915	.4282

Summary

The purpose of this research study was to examine the relationship of trait shame and guilt or state shame as moderators of stigma and determine if stigma mediates empathy within the sex offender. Chapter Four focused on the findings of this research. The analysis of the data in this study has shown that there are significant statistical indicators of correlations in the relationships of shame to stigma and empathy in adult male sex offenders. Additionally, a moderated mediation does exist. Furthermore, some unexpected results were found that will need to be unpacked. Lastly, several areas of interest have been identified for future study. Chapter Five will elaborate upon these findings as well as highlight future research possibilities.

CHAPTER FIVE: CONCLUSIONS

Overview

This study examined the moderated mediation conditions of trait shame, state shame, and stigma and the outcome of reduced empathy. The results will be discussed succinctly and will illustrate that the findings are not only significant to the treatment of sex abusers but to counseling issues of shame and stigma in general. The findings of this study add to the research on shame, stigma, and empathy in numerous ways that will also be addressed. Limitations of this study will be discussed to show the potential of future research directions. Spiritual aspects will be addressed in conjunction with possible future research.

Discussion

The variables of this study included trait shame (X), state shame (W), stigma (M), and empathy (Y). The independent variable (X) trait shame was an assumed preexisting condition of sex offenders based on the premise that "hurt people hurt people". The independent variables of trait shame (X) and state shame (W) mediated stigma, which moderated the dependent variable empathy (Y).

Hypothesis One

The relationship of trait shame (X) to stigma (M) was established as a positive correlation observed in Tables Nine and 10. The effect strength in the R squared showed that there is a strong or large linear relationship with an (R-sq = .1771). This relationship shows correlation but does not indicate causality (Warner, 2013). However, when observed with the other variables one can begin to see a clearer picture. Pathway A_1 coefficient score of (.9781) demonstrates that the influence trait shame has on stigma is great as it is so close to a positive 1.

Hypothesis ones' importance as a correlation adds to the existing knowledge in one specific way. Goffman (1963) concluding that a person must be stigmatizable as based on aspects of criminology, mental health, addiction, sexuality, physical or character deformity. This correlation indicates that sex offenders are stigmatizable based on two counts. Sex offenders are stigmatizable in criminological and mental health categories. Stier and Hinshaw (2007) added that shame is damaging and stigmatizable. This invisible combination is part of the imperceptible, yet dehumanizing quality of character flaw discussed by Bos et al. (2013). Thus, this correlation is required for the others to be significant.

Hypothesis Two

The relationship of trait shame (X) to empathy (Y) was also found to have a positive but minimal correlation with an R-sq of (.1901). This relationship of (X) to (Y) shows correlation but not causality yet (Warner, 2013). However, when observed with the other variables one can again see a clearer image. The coefficient of pathway C_1 was (.7530), showing a very strong effect that trait shame placed on empathy. Now that there are two variables showing strong correlations of shame to stigma and shame to empathy, one can expect to see a correlated relationship of stigma to empathy that is shown to be reduced in the moderated mediation to come. This correlation is significant in that it collaborates the findings of attachment theorists. The poorly attached sex offender as a child to parents now is correlated to empathy (Jespersen et al., 2009; Levenson et al., 2016; McKillop et al., 2019; Grady et al., 2019; Leach et al., 2015; Davis & Knight, 2019; Kingston et al., 2017; Spehr et al., 2010; Burton, 2003; Felson & Lane, 2009; Braithwaite, 2015).

Hypothesis Three

The relationship of stigma (M) to empathy (Y) was also found to have a positive but minimal correlation with an R-sq of (.1901). Even though this is a minimal correlation one does exist. This is important as stigma shows to have sizable negative effects on people and society (Goode, 2015; Bos et al., 2013; Denver et al., 2017). This relationship does not indicate causality yet but has demonstrated a correlation (Warner, 2013).

When this correlation is observed with the other variables a better picture develops. Again, the coefficient of pathway B_1 was (.1061), showing a moderate effect that stigma placed on empathy. Now there are three variables showing correlations of shame to stigma, shame to empathy, and stigma to empathy are positive. Therefore, even with a small correlation the influence was seen to be significant.

Hypothesis Four

The relationship of state shame (W) to stigma (M) was also found to have a positive but minimal correlation with an R-sq of (.1771). Recall that state shame and guilt are effectively the same constructs. Self-control theory (Akers, 1990) and social control theory (Goode, 2015) relate that internal and external controls influence choices as a driving notion in the study of deviance. The correlation of state shame to stigma helps to bolster this idea found in self-control and social control theory of crime.

However, this relationship of state shame (W) to stigma (M) alone does not indicate causality but only existence of correlation (Warner, 2013). Yet, when observed with the other variables one can see the puzzle pieces coming together. Pathway A_2 coefficient of (.7611) indicated again that there is a strong effect that state shame has on stigma. Thus, the study has demonstrated that both forms of shame, state and trait, influence stigma.

Hypothesis Five

The relationship of state shame (W) to empathy (Y) was also found to have a positive correlation with an R-sq of (.1901). Pathway C_2 coefficient of (.3907) indicated that state shame has a strong effect on empathy. This correlation and pathway strength is significant in that it reinforces the positions of the crime theories of attachment, self-control, and social control. State shame also viewed as guilt possess the quality of self-awareness of wrong behavioral choices unlike trait shame which is of global internalized wrongness (Brown, B., 2007; Buker, h., 2011; Lewis, H., 1971; Tuvbald et al., 2017; Garofalo et al., 2018).

However, this relationship alone does not indicate causality (Warner, 2013). Yet when observed with the other variables one can see this picture that is developing. One can now observe that correlations of trait shame (X), state shame (W), empathy (Y), and stigma (M) are correlated and that the effects sizes are substantial with significant levels. Additionally, this pathway deserves further scrutiny due to the results found in Table Sixteen, which will be addressed in the unanticipated findings section.

Correlation Summary

The correlations of hypothesis one through five are complete. To this point the study has shown that each variable does in fact correlate to the other. Trait shame and State shame are both correlated to stigma and empathy. Most significant is the pathway A_1 coefficient having a very strong and significant effect observed between trait shame and empathy (r =.1771, A_1 = .9781). The rest have lower correlations of (.1901 and .1771) and yet the pathway coefficients are strong with (C_1 = .7530, B_1 = .1061, A_2 = .7611, C_2 = .3907) indicating that there is correlation and good effect strength combined.

Hypothesis Six

Now that the correlation of each separate variable is complete. It is time to look at some combinations. The relationship of the combined effects of shame (XW) to empathy (Y) can be observed. The pathway C_3 as part of the moderation of the mediator stigma has an (r = .1901) and a coefficient of (-.1274), showing that the correlation and influence are both present. This relationship needs further discussion due to the unanticipated results in Table 16.

Hypothesis Seven

The relationship of combining shame (XW) to stigma (M) in pathway A_3 is seen to exist. The coefficient of this pathway is (.2228) while the R-sq correlation is (.1771), meaning that there is a correlation, and the effect is influential. Again, the unanticipated results have an influence here as well.

Unanticipated Findings

An inverse relationship was discovered during the analysis of this data. Table 16 shows an interesting and unanticipated result of the relationships of trait shame, state shame, and empathy. Table 16 clearly illustrates the inverse nature of the focal predictor of trait shame upon the moderating variable state shame (W1) regarding its' relationship to the dependent variable stigma (M).

A shift in the effect strength is observed taking place in the process of the change of strength of state shame. Table 16_a P values show the following results: P = .0120, .0000, -.0034. Notice that probability (P) value moves from being significant to insignificant as the effect diminishes and the W1 increases (W1 = 2.9587, 3.1448, 3.1926). Specifically, the first line of Table 16 shows a much stronger effect, with a significant P value and a strong range within the upper and lower confidence intervals (LLCI=.0651, ULCI-1.1639). Additionally, the final results

in Table 16 show a complete loss of significance in P value (.9297) and an effect that is imperceptible with the following scores (W1=5.7658, Effect=.0184, se(HC4)= .2079, and LLCI= -.3915, ULCI=.4282).

This unanticipated result shows that the moderating effects of shame on stigma have a few issues that require unpacking. First, the relationships are all correlated but one must remember that state shame and guilt are effectively the same. Second, the assumptions of this study only accounted for the presence of shame proneness (trait shame). What appears to have taken place is that as the sex offenders' state shame (guilt) increased the effect on stigma was reduced. This logically creates a reduction in the effect combined shame has on stigma (M) and subsequently on empathy (Y).

The unanticipated finding is most likely due to the use of bootstrapping. Bootstrapping the regressions created a shift in the N from the original 217 to a much larger number. This was due to the use of 5000 bootstrapping. This means that the N=217 became N=217x5000 sets of 217 for a total of 1,085,000 participants.

Correlation Summary 2

Hypotheses six and seven correlation and pathway analysis are complete. Here an unanticipated finding showed that the influence of state shame (GUILT) has strong influence over the influence of shame proneness as theorized by Sigmund Freud and Helen Lewis in their respective works. Here we find that increasing guilt away from shame does in fact have a countering effect on the influence that shame has on stigma and empathy. So now a moderated mediation explanation begs to be concluded.

Moderated Mediation Sequence Results

The moderating effects of shame need additional scrutiny. The relationship of trait shame to stigma and empathy does in fact show correlations. The moderation of stigma by trait shame is evident in the regression results. Table 10 shows how the regressions of A_1 and A_2 show significance in P values of (.0000) and (.0002), respectively. The coefficients of A_1 and A_2 show significant effects with (.9718) and (.7611) correspondingly. However, looking at regression of A_3, the XW to M path shows an equally significant P of (.0000) but the coefficient is (-.2228), indicating that the effect is mildly significant but that it is in a negative direction from the single paths of trait shame and state shame. So, the null hypothesis is rejected for each of the pathways.

Bootstrapping was used to test the conditional direct and indirect effects of shame, stigma, and empathy seen in Tables 11 and 12 correspondingly, and the index of moderated mediation presented in Table 13 shows that there is a mediation taking place. The expected effect outcome for stigma, however, is dependent upon the effect strength of the shame variable being triggered. The influence that trait shame has on stigma is strong and clear. The influence of state shame on stigma is also equally strong and clear. The combination of trait and state can be viewed as potential confounding agents within this study.

Hypothesis Eight

The question "Does stigma mediate the relationship between trait shame and empathy strength?" was found true stigma does mediate the relationship between trait shame and empathy. The real question now is how much does (M) "move" C_1? The results are found in combining pathways A_1 with B_1 and then comparing them to C_1. Table 15 shows that by controlling for C_1, stigma does in fact cause an increase in the effect on empathy, with (P=.0317, Coeff=.7430). The effect strength was found to be large and positive (.7530), indicating that the strong shame prone emotions do influence empathy.

The effect that trait shame (shame proneness) has upon empathy was predicted from the statements that empathy is involved in all criminal ventures (Robinson & Rogers, 2015) and that sex offenders as criminals have more reductions in empathy (Ahlmeyer et al., 2003). This reduction in empathy discussed by (Pardini & Loeber, 2008; Obradovic et al., 2007; and Shirtcliff et al., 2009) does yield a reduced empathy observed as callousness as evidenced by the correlations and the bootstrapped moderation of pathway C_1.

Hypothesis Nine

The question "Does stigma mediate the relationship between state shame and empathy strength?" was found accurate. Stigma does mediate the relationship of state shame and empathy. How much does (M) "move" C_2? is found in the effect strength of (Coeff = .3907) with (P = .2418), which again shows a strong positive influence on empathy by the mediating effects of stigma. Here, the influence of the unanticipated results discussed above is found. When state shame (guilt) is strong, the influence on stigma is less, which causes a reduction in the influence on empathy. Thus, the mediation of empathy by stigma depends on the amount of guilt to which the sex offender is reacting.

Hypothesis 10

The question is "Does stigma mediate the relationship between trait shame and state shame and empathy strength?" Again, the question here is how much does (M) "move" C_3? The effect size of (M) was (-.1274), meaning that shame does in fact influence the amount of empathy but in a strong, negative direction. This upholds the hypothesis that empathy is reduced by the influence of shame proneness when state shame is combined with stigma, thus mediating the effect on empathy.

Moderated Mediation Sequence Summary

This finding coincides with the statements that a sex offender's empathy is variable (Marshall et al., 1995). The question of how a child molester can have empathy for one child and not another is now found to be related to the amount of mediated effect stigma has on the relationship of state shame (Guilt), Trait shame (shame proneness), and empathy. In other words, if guilt and shame can be managed effectively then empathy is increased and not reduced.

Implications

Implications of this study may be far reaching in the areas of future research as well as in direct interactions with sex offenders by healthcare clinicians, judges, probation, and parole officers, and even the public. Close to 35% of sex offenders will deny some aspect of their involvement in the commission of a sexual offense (Blagden et al., 2014). Denial as correlated to shame and guilt can now be viewed as logically correlated to stigma, which mediates empathy.

But how does this impact therapeutic interactions with sex offenders? When a person of authority such as an LSOTP, while performing an annual risk assessment asks blunt and possibly insensitive questions, they may inadvertently increase the offenders' shame proneness and consequently moderate the mediating effects of stigma upon empathy, causing the offender to appear more calloused, with reduced empathy or outright denial. It is then logical to assume that the sex offender appears more calloused as part of their self-defense mechanism. Therefore, this study has shown that by increasing the shame experienced in sex offenders, they will have an increase in stigma that leads to a reduction in presenting empathy by the offender. However, this leads to a larger dilemma in sex offender work, which is determining likelihood of reoffending.

This study hypothesized that shame trait and state was correlated to stigma and empathy. This study also hypothesized that shame and stigma interact and lead to reduced empathy. These hypotheses were upheld. Shame proneness can combine with momentary shame states which

influence the stigma of being labeled “sex offender”, and that it is this moderated mediation that reduces the empathy experienced by sex offenders that is often viewed as callousness. This accounts for one aspect of the appearance of reduced empathy towards victims.

However, also found was that in certain cases if the state shame is strong, then the negative effect on empathy is reduced and the sex offender will experience more guilt than shame. This means that the mediating effect of stigma is also reduced. This finding maintained the counseling position that guilt needs to be activated for the offender to emotionally connect with the victim.

Reoffending

The problem of risk assessment in sex offender reoffending is the reason for this and other studies like this one. Salter (1988) and Abel et al. (1989) held that denial is a risk factor of reoffending. This study has increased the understanding of shame, guilt, stigma, denial, and empathy. Connecting these variables via correlations as well as a moderated mediation study means that the presentation of callousness or reduced empathy can now be taken into account as part of the risk assessment of sex offenders so as to improve the chances of determining when an offender may reoffend.

Christian and Scriptural Worldview

A Christian perspective in this study is important as it holds to the mission of Liberty University. Implications for this study concerning sex offenders can be challenging to the world, the sex offender, and to Christians. Christians are instructed through Scripture to restore those who have fallen in the faith. This is often done using forgiveness that Christians are instructed to practice (Greer et al., 2014). However, too often there is a discrepancy in this teaching as

concerning sex offenses (Greer et al., 2014). Forgiveness can be difficult with the influence of shame and stigma, which may contribute to the difficulty found of forgiveness by Greer (2014).

Forgiveness

Forgiveness can also be a profound influence of the change that society wants to see. Harris et al. (2017) discussed how forgiveness is a transformative variable in the offender's growth into a new life. This is often accomplished via the formation of faith while serving prison time (Stansfield et al., 2020). In addition to the forgiveness route of faith, new prosocial behaviors are experienced when involved in the newfound religious groups in prison (Stansfield, et al., 2020).

Religious inclusion that faith groups provide is possibly the only source of socialization that sex offenders find (Stansfield et al., 2020). Kewley et al. (2015) addressed the importance of a faith community as both a prosocial mechanism and a continuation environmental mechanism for continued prevention of recidivism. Eshuys and Smallbone (2006) contradicted the idea that faith groups have preventative effect, stating that individuals with belief in supernatural sanctions have more victims than atheists. The possibility of cognitive distortion related to spirituality is an area for future study (Eshuys & Smallbone, 2006; Cranney, 2018).

The consensus is, however, that spirituality and faith are involved through forgiveness and prosocial interaction for the betterment of society and the sex offender. The combination of faith and the severe stigma received by pedophilia has created what is being labeled the virtuous pedophile (Cranney, 2018). Cranney (2018) quoted one study participant who identified his faith being more alive after receiving forgiveness having admitted to being attracted to children. Again, future study is needed.

Scriptural References

Forgiveness and prosocial behavior are located in several places throughout Scripture. Scriptural examples of reasons to work with offenders include Mathew 18:15 and Galatians 6:1. The first example found is where Jesus is talking about dealing with a fallen fellow Christian. Jesus states that the Christian is to go to the fallen one alone (privately) in Mathew 18:15. This action reduces the influence that shame and stigma can cause in open public. The second example can be viewed as relating to confronting a sex offender who has been saved. The apostle Paul states that fallen Christians need to be restored in a spirit of gentleness in Galatians 6:1. Confronting a sex offender will increase the effects of shame and stigma and cause a reduction in empathy as observed in this study. Therefore, it is this researcher's opinion that the sex offender should be approached with kindness, gentleness, and compassion, and not with a position of disgust or revulsion.

Limitations to the Study

There are some limitations to consider in this study. One limitation was predicted with the fear of public awareness and was observed in the sex drawings and obvious blanks of the surveys that were rejected from use in the study. A second limitation was found in the confounding effects of the interaction of trait and state shame upon stigma having an inverse relationship depending on the amount of state shame felt by the sex offender. A third limitation is that this study does not explain the presence of denial so often observed by sex offender treatment providers.

Another limitation identified was the use of the sample itself (Seto, 2018). Seto (2018) discussed this issue, clearly stating that the majority of samples for pedophiles and hebephiles are already in the criminal justice system. This issue was identified as the sample was one of

convenience. Seto talked about the pedophiles who have never offended but remain in the world unidentified due to their stigma of coming public.

The effects of anti-social personality disorder were not accounted for in this study. As such, additional limitations exist due to the criminal justice population possessing higher than usual numbers of anti-social personality disorder (Ahlmeyer et al., 2003). This can influence this study in the use of self-reporting. Deception, minimization, and denial are often found in this population and may be a limitation here (Seto, 2018).

Recommendations for Future Research

Recommendations for further research can include different populations, different testing instrumentation such as the TOSCA-SD for social deviance and the Hare PCL for pathological aspects, demographic-based aspects such as dividing specific ages for offender and for victim, socioeconomic status, education, career, ACEs, and spirituality components, perpetrator's age of awareness of stigma, shame, empathy, perpetrator fantasy life, and non-perpetrator pedophiles.

Altering the study for juveniles as well as female sex offenders could also yield some fascinating results. Seto (2018) identified that many studies do not address this population. Furthermore, the juvenal sexual misconduct offender may be experiencing what Seto referred to as issues of onset sexual identification and may not have aged enough to recognize that they are too old for their sexual partners. Moreover, the perpetrator's age of awareness of stigma, shame, and empathy will require further design development.

Additionally, identifying the pedophile before conviction would be an interesting future study if one can create a design that would gain IRB approval. Identifying non-perpetrator pedophiles may create new sets of problems for possible investigation. Asking people to openly admit to their sexual proclivities for prepubescent children is complicated. In this light, asking

about sexual fantasies of prepubescent persons may also be difficult. Yet asking if sexual fantasies influence stigma and shame in both offender and non-offender populations would be interesting.

Spiritual-specific data would also be fascinating for future research. Ware et al. (2015) reported that non-Caucasian sex offenders are more likely to deny their involvement. Thus, a more detailed examination of the spiritual demographic variable may yield significant results.

Finally, further studies in empathy reduction can include the aspects of denial and other thinking errors (Ward & Beech, 2008). Denial is an aspect of the therapeutic process that is viewed as needing to be overcome for therapeutic work to be successful (Blagden et al., 2014). 25% of child molesters and 28% of mixed sex offenders deny having committed any aspect of a sex offense (Ware et al., 2015). Seto (2018) discussed this aspect of denial as being understandable based on the pending implications of punishment. However, denial is a self-protection strategy (Yalom, 1991) that needs to be viewed as situational and contextual (Ware et al., 2014). There are many reasons for denial. Shame, guilt, and self-identity are correlated to denial (Happel et al., 1995).

Conclusion Summary

The evidence found in this study shows several important qualities. These fall into two categories. Category one is unanticipated and not hypothesized but learned. The second is the categorized and hypothesized aspects that were intentionally studied.

Category One

This category has two specific learned traits. First is that there is no need to control the variables as the Hayes model 8 design does not require it due to bootstrapping in opposition to Baron and Kenny (Hayes, A., 2009). Second is the unanticipated results that as trait shame

(Guilt) increases then state shame decreases which leans towards the treatment paradigm that guilt not shame needs to be experienced for recovery to take place (Tangney, 1988, 1990, 1996; Tangney & Dearing, 2002; Tangney, Stuewig, & Hafez, 2011a; Tangney, Stuewig, Mashek, & Hastings, 2011b; Ward, & Durrant, 2013; Ware, Marshall, & Marshall, 2015; see also Tewksbury, 2012; Velotti, Garofalo, Bottazzi, & Caretti, 2017; von Krafft-Ebing, 2011;)

Category Two

This is the category that was trying to be researched because there were no studies like it. This research has three learned outcomes. The first outcome is that there are in fact correlations between state shame, trait shame, stigma, and empathy. This initial outcome had not been fully developed previously. Shame and stigma were connected by Tangney, (1988, 1990, 1996); Tangney, & Dearing, (2002); Tangney, Stuewig, & Hafez, (2011a); Tangney, Stuewig, Mashek, & Hastings, (2011b). Stigma and shame were connected by Hasson-Ohayon, Ehrlich-Ben Or, Vahab, Amiaz, Weiser, & Roe, (2012) and DeLuca, Vaccaro, Rudnil, Graham, Giannicchi, & Yanos, (2018). Guilt and shame were connected by Carpenter, Tignor, Tsang, & Wilett, (2016).

Second outcome is that there is a moderated mediation effect found by this study. This indicates that shame does moderate the mediating effects of stigma upon empathy. Previously, the only study found of this sort was by Hasson-Ohayon, Ehrlich-Ben Or, Vahab, Amiaz, Weiser, & Roe, (2012). Now, in this study, the effects of mediation and moderation are more fully developed.

Finally, is that empathy is reduced by the moderation of shame upon the mediation of stigma influence over empathy strength. Thus, it can be stated that the callousness of a sex offender is due to a domino like effect of how shame traits and states influences stigma that then influence how empathy is displayed and experienced.

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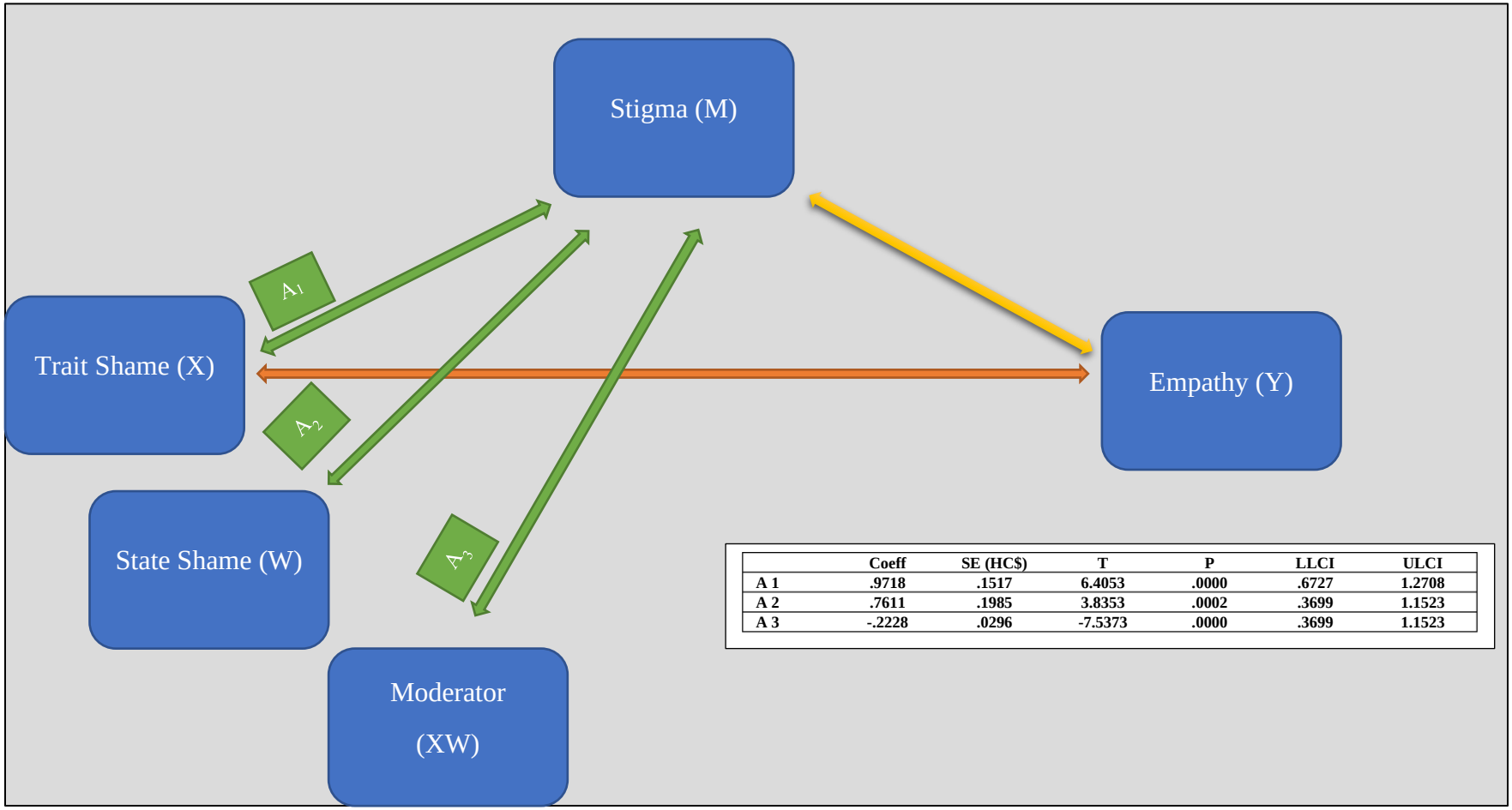
APPENDIX A

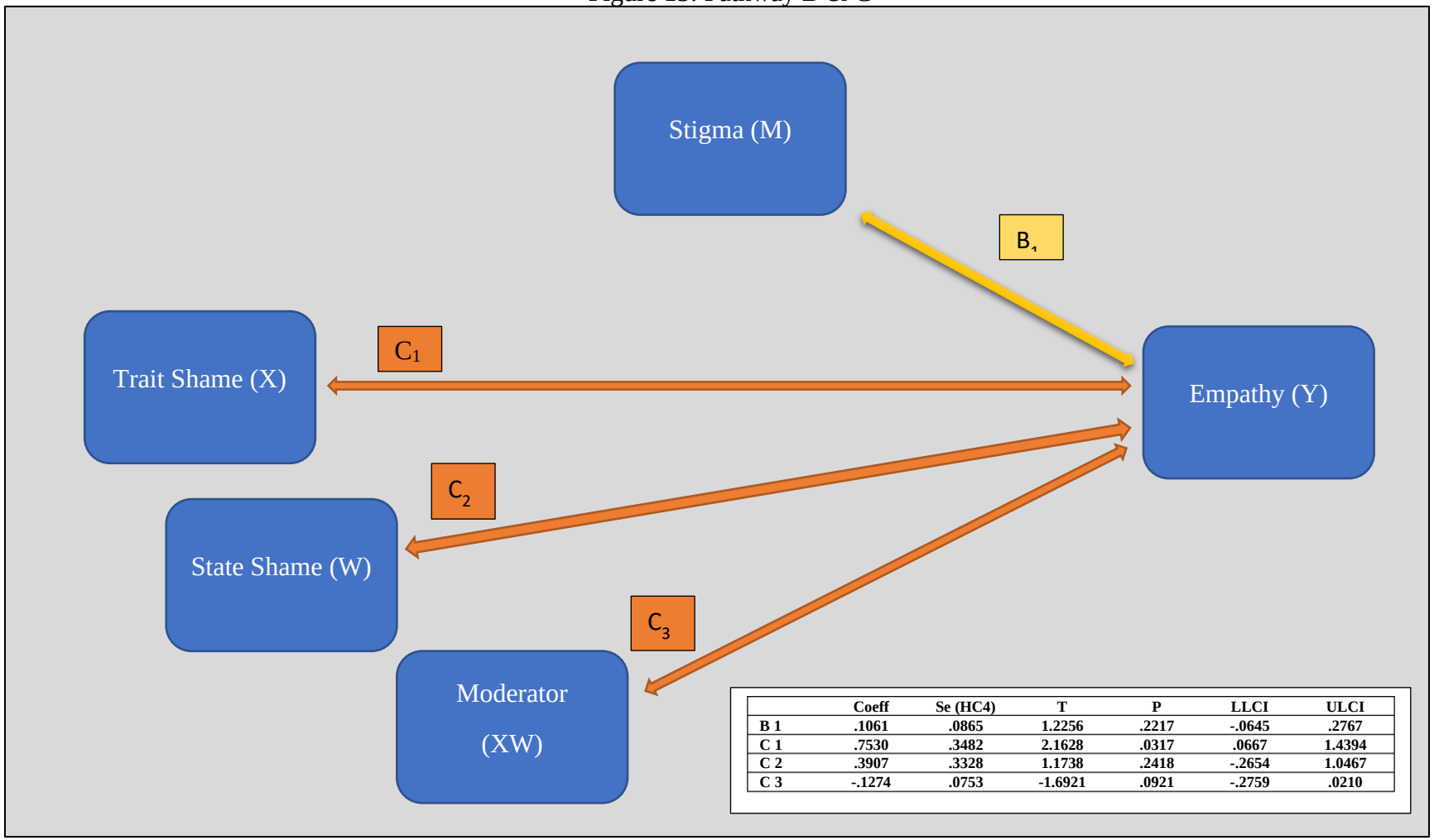
Figure 12: Pathway A



	Coeff	SE (HC$)	T	P	LLCI	ULCI
A 1	.9718	.1517	6.4053	.0000	.6727	1.2708
A 2	.7611	.1985	3.8353	.0002	.3699	1.1523
A 3	-.2228	.0296	-7.5373	.0000	.3699	1.1523

APPENDIX B

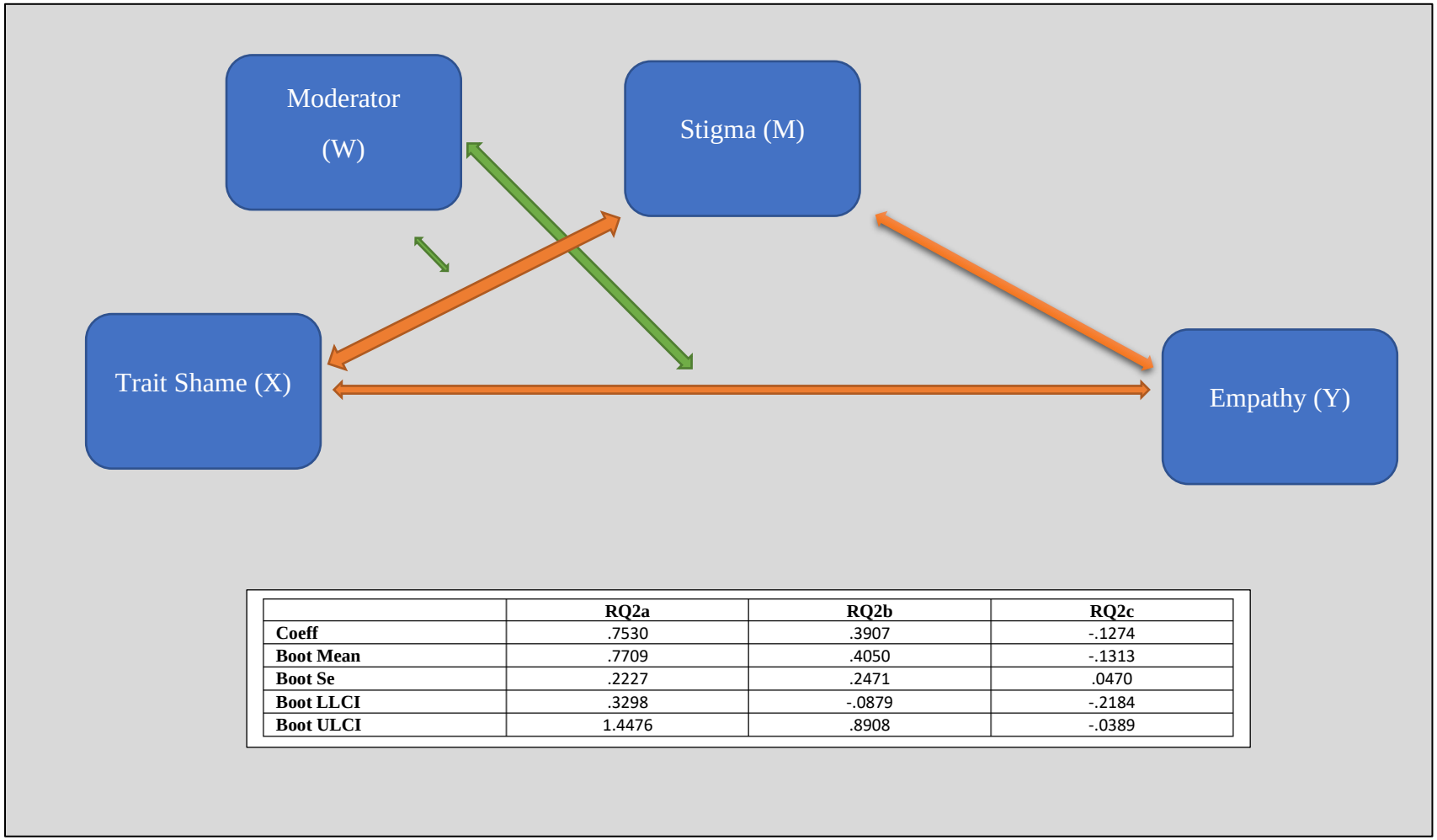
Figure 13: Pathway B & C



	Coeff	Se (HC4)	T	P	LLCI	ULCI
B 1	.1061	.0865	1.2256	.2217	-.0645	.2767
C 1	.7530	.3482	2.1628	.0317	.0667	1.4394
C 2	.3907	.3328	1.1738	.2418	-.2654	1.0467
C 3	-.1274	.0753	-1.6921	.0921	-.2759	.0210

APPENDIX C

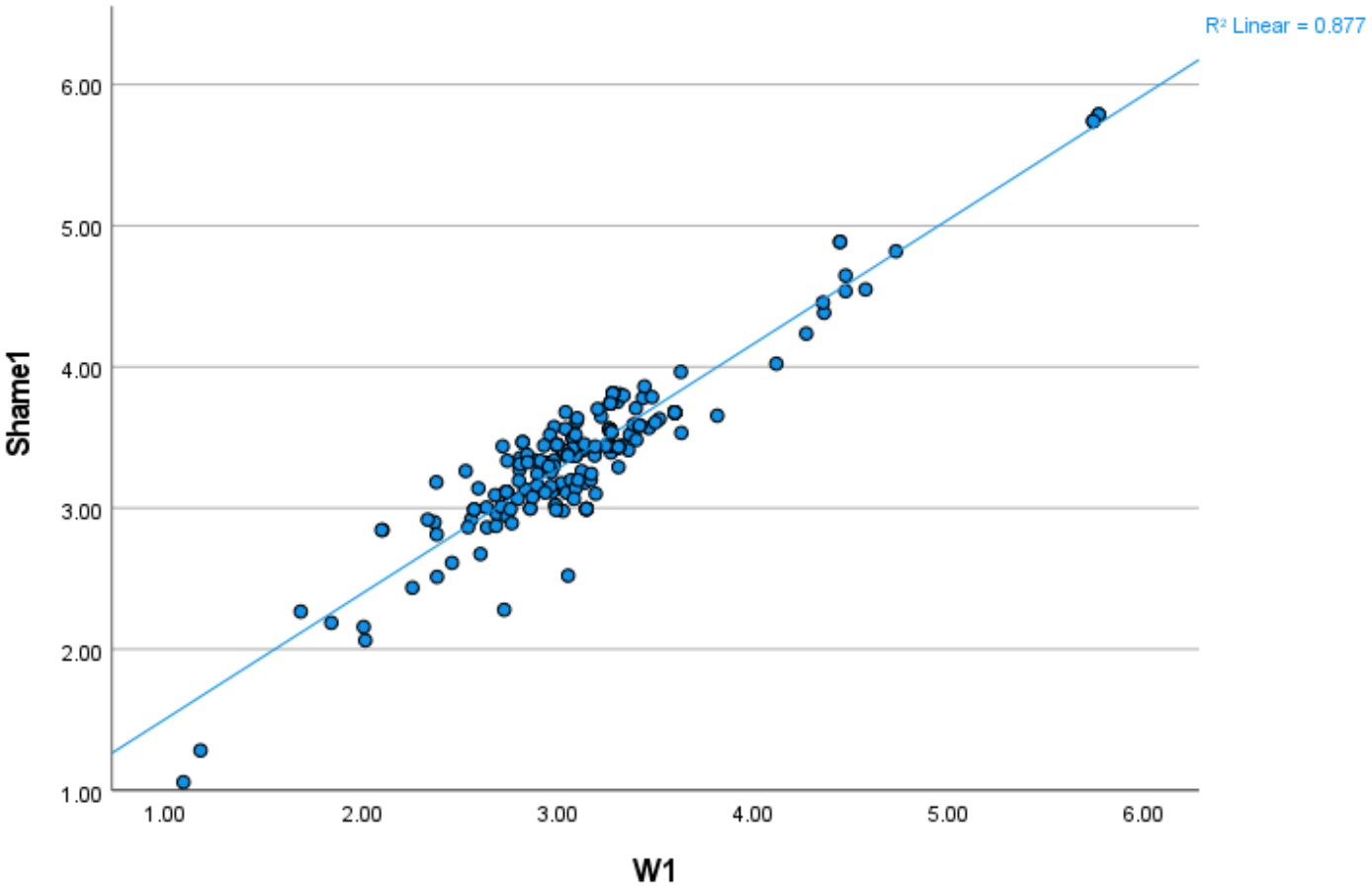
Figure 14: Bootstrap Moderated Mediation



	RQ2a	RQ2b	RQ2c
Coeff	.7530	.3907	-.1274
Boot Mean	.7709	.4050	-.1313
Boot Se	.2227	.2471	.0470
Boot LLCI	.3298	-.0879	-.2184
Boot ULCI	1.4476	.8908	-.0389

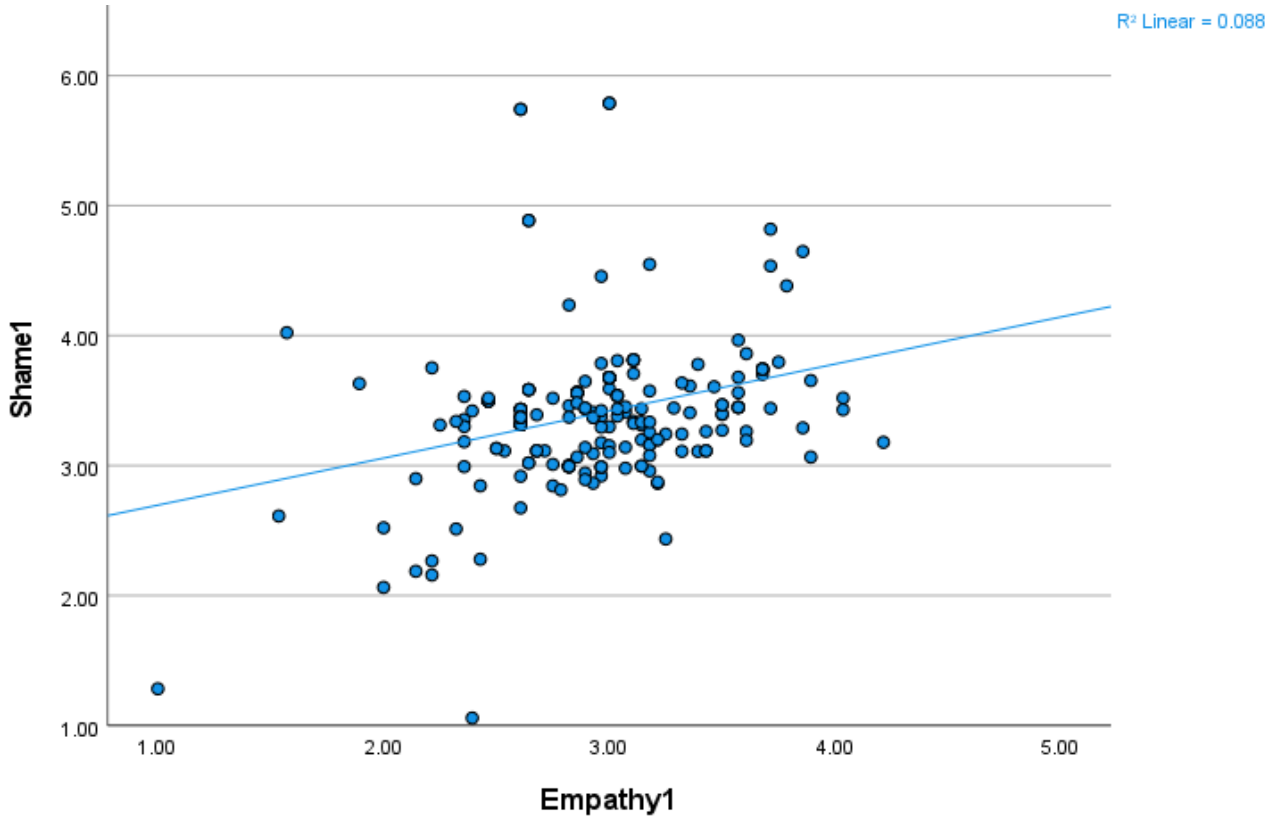
Appendix D

Figure 15: Scatter plot: Correlation of Trait Shame to State Shame



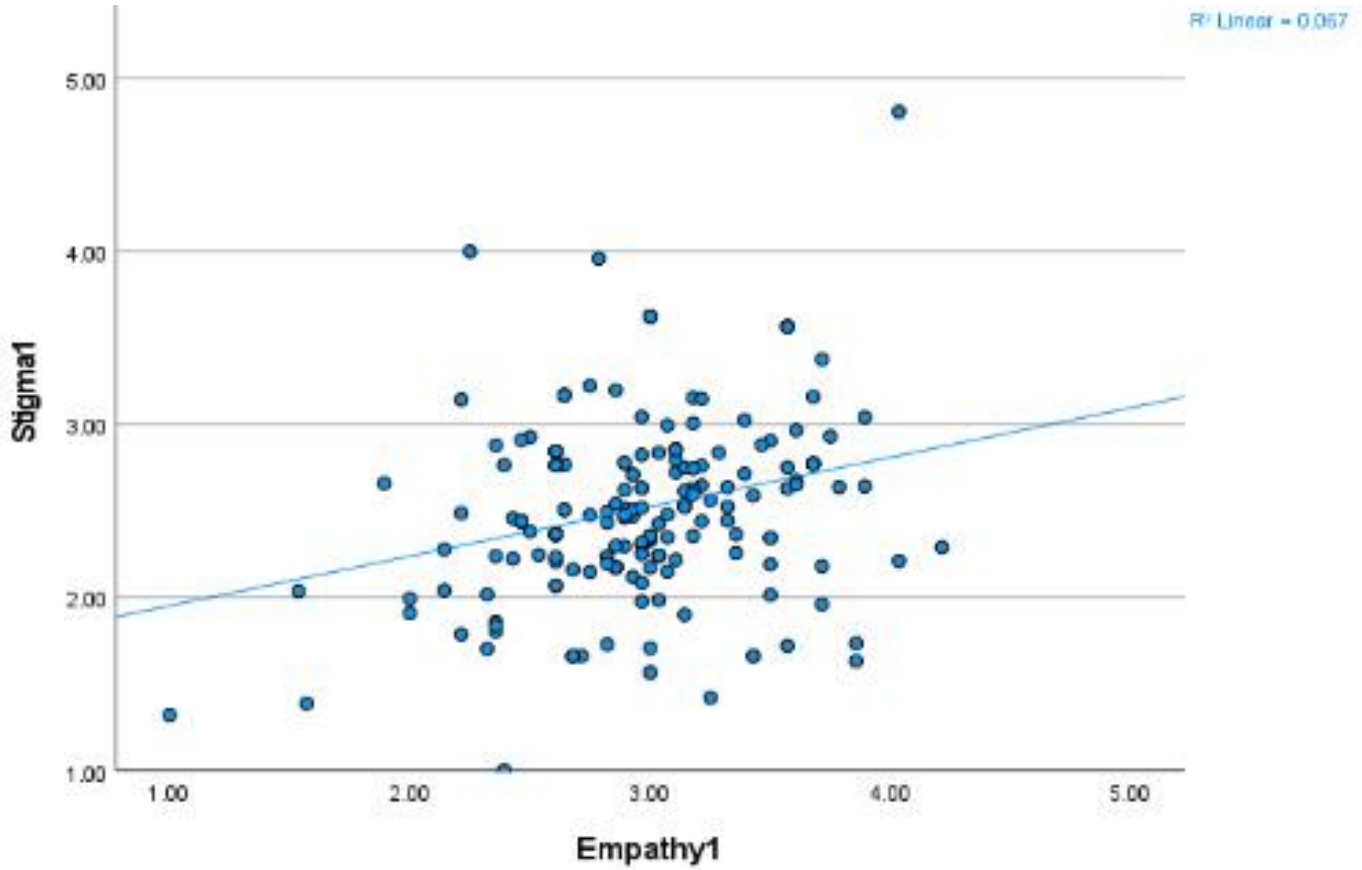
Appendix E

Figure 16: Scatter Plot Correlation of Shame to Empathy



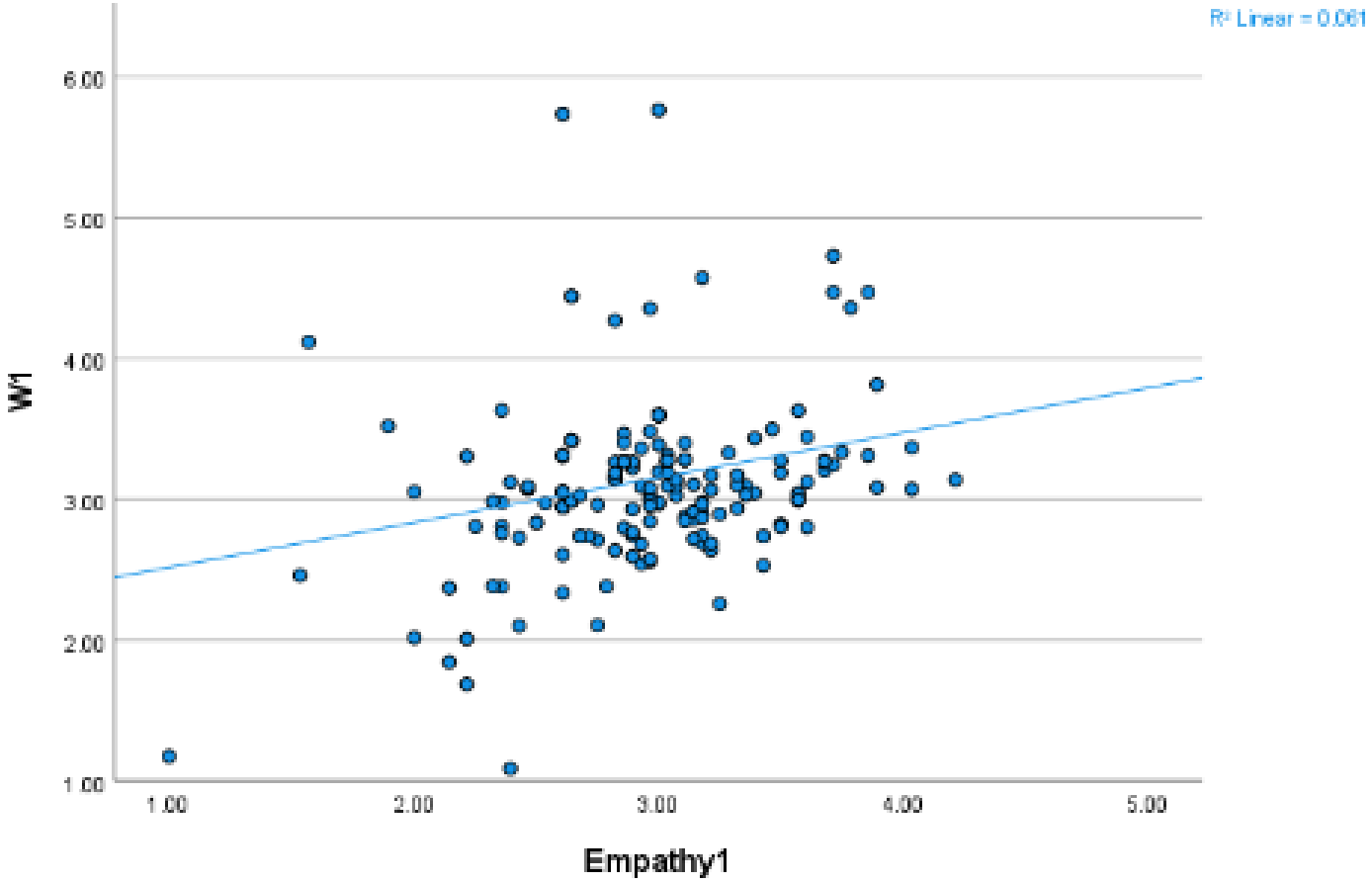
Appendix F

Figure 17: Scatter Plot Correlation of Stigma to Empathy



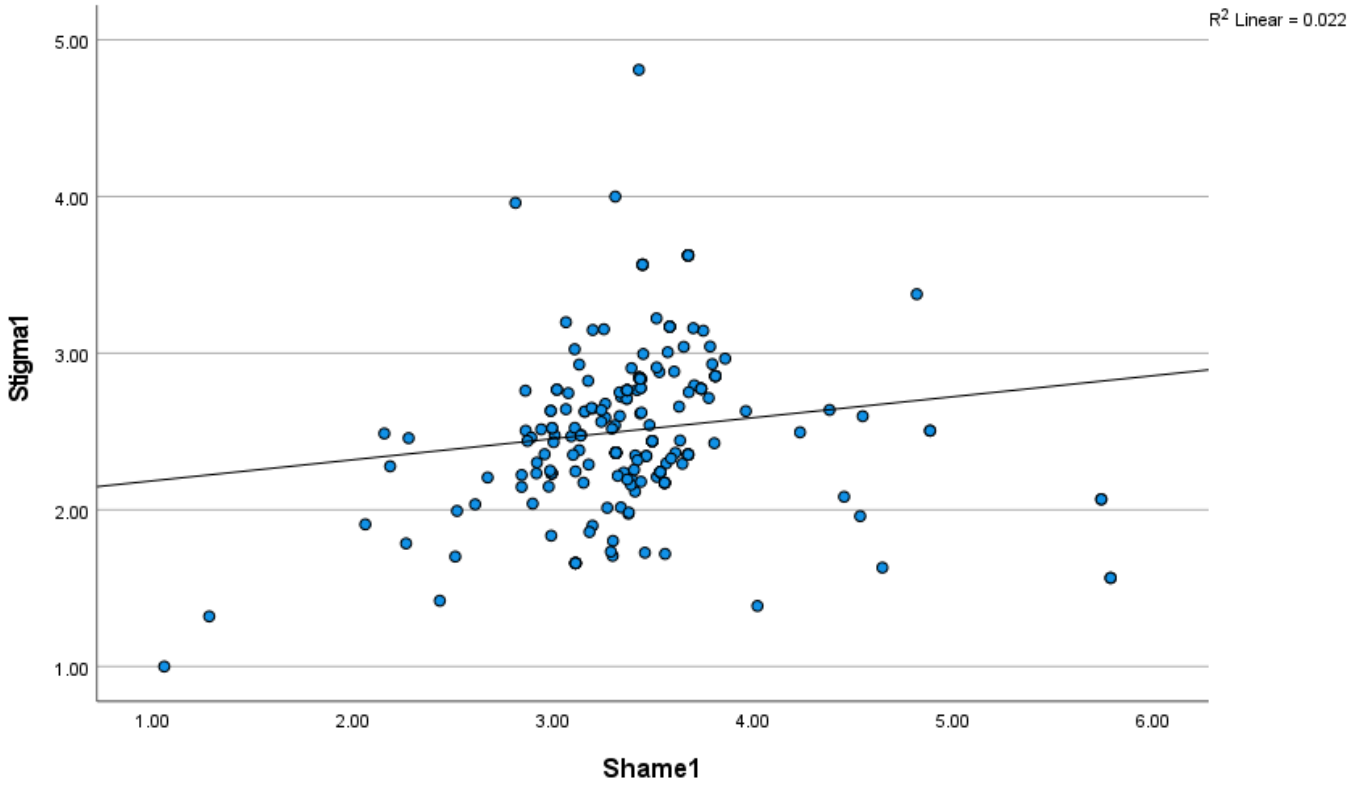
Appendix G

Figure 18: Scatter Plot Correlation of State Shame to Empathy



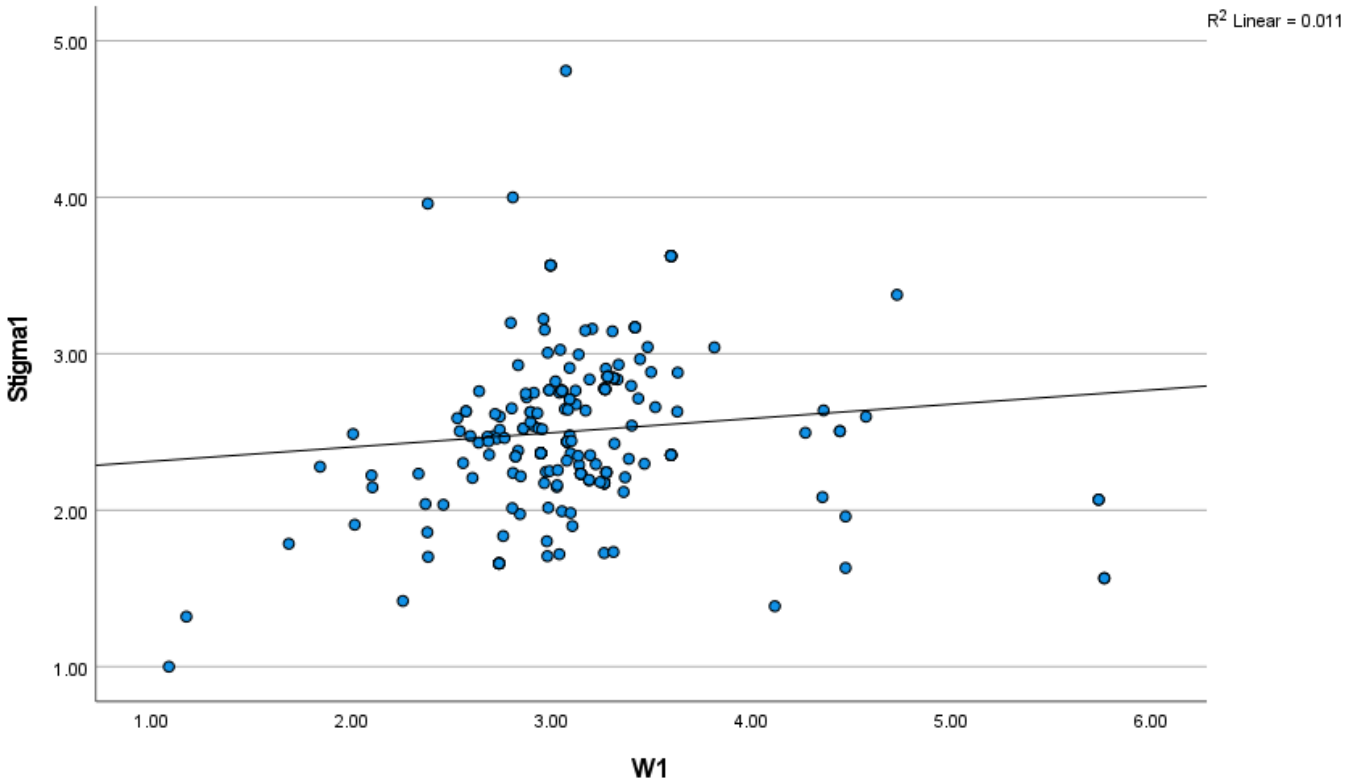
Appendix H

Figure 19: Scatter Plot Correlation of Trait Shame to Stigma



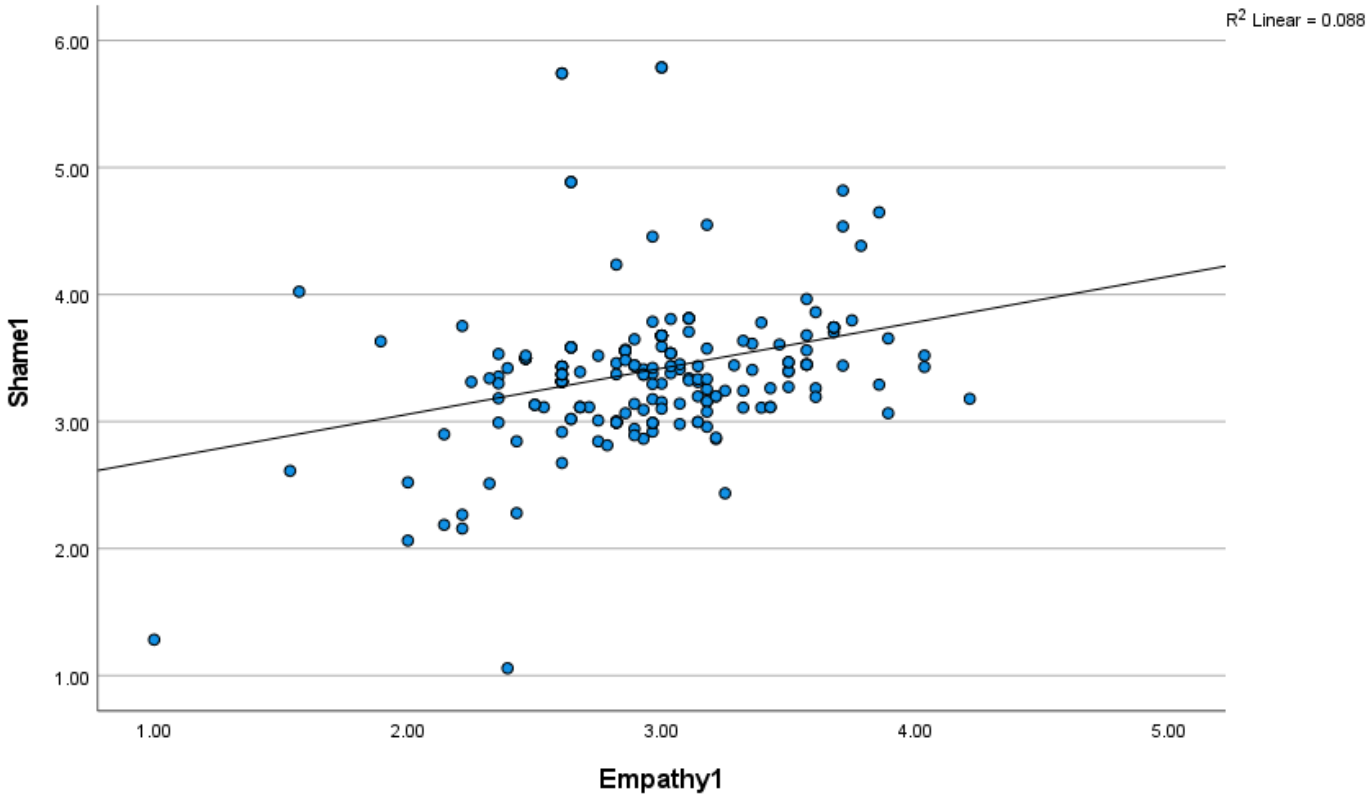
Appendix I

Figure 20: Scatter Plot Correlation of State Shame to Stigma



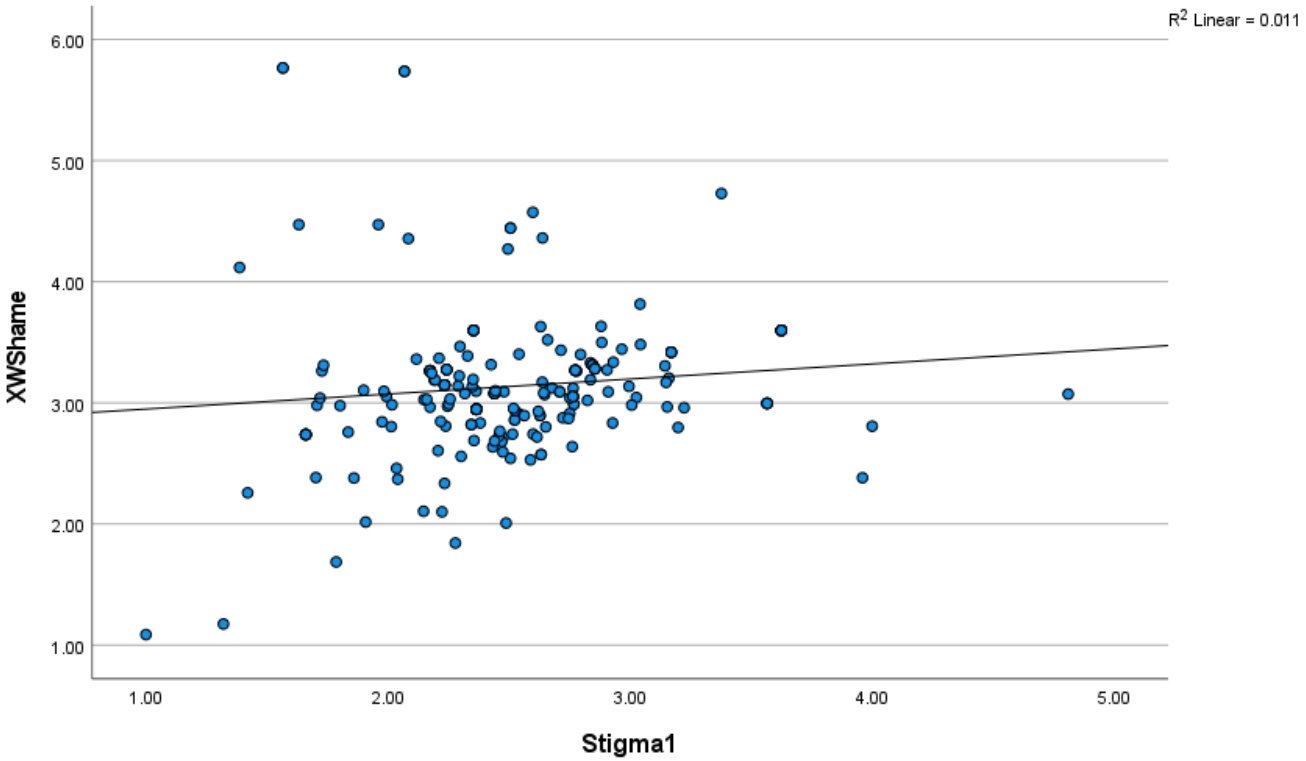
Appendix J

Figure 21: Scatter Plot Correlation of Trait Shame to Empathy



Appendix K

Figure 22: Scatter Plot Correlation of Trait & State Shame to Stigma



APPENDIX L

From: do-not-reply@cayuse.com
Subject: [External] IRB-FY21-22-244 - Initial: Initial - Expedited

Date: February 1, 2022 at 8:52 AM
To: [redacted]

February 1, 2022

Robert Ferow David Shelton

Re: IRB Approval - IRB-FY21-22-244 Shame, stigma, and callousness: A mediation moderation study of sex offender empathy strength

Dear Robert Ferow, David Shelton:

We are pleased to inform you that your study has been approved by the Liberty University Institutional Review Board (IRB). This approval is extended to you for one year from the following date: February 1, 2022. If you need to make changes to the methodology as it pertains to human subjects, you must submit a modification to the IRB. Modifications can be completed through your Cayuse IRB account.

Your study falls under the expedited review category (45 CFR 46.110), which is applicable to specific, minimal risk studies and minor changes to approved studies for the following reason(s):

7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your stamped consent form(s) and final versions of your study documents can be found under the Attachments tab within the Submission Details section of your study on Cayuse IRB. Your stamped consent form(s) should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document(s) should be made available without alteration.

Thank you for your cooperation with the IRB, and we wish you well with your research project.

Sincerely,

G. Michele Baker, MA, CIP

Administrative Chair of Institutional Research

Research Ethics Office

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD