

**Assessing Components of Empathy and Victim Specific
Empathy in Sex-offenders with Intellectual and
Developmental Disabilities**

Sonya Ralfs

**Thesis submitted to the University of Sheffield in partial fulfilment of the
requirements for the Doctorate in Clinical Psychology, August 2008**

Declaration

This thesis has not been submitted for the fulfilment of any other degree or to any other institution

Structure

The literature review and research report have both been prepared in accordance with the guidelines for the *Journal of Applied Research in Intellectual Disabilities* (Appendix 2).

The choice of journal previously received approval from the University of Sheffield (Appendix 1).

Word Counts

Section 1: Literature Review

Article: 7,766

References: 1,688

Total: 9,454

Section 2: Research Report

Article: 9,359

References: 1,410

Total: 10,769

Section 3: Critical Appraisal

Article: 2,609

References: 0

Total: 2,609

Section 4: Appendices

Total: 3,550

Total Word Count (excluding references and appendices): 19,734

Total word count (including references and appendices): 26,382

Thesis Abstract

The focus of this thesis is empathy in sex offenders with intellectual disabilities (ID). The first section reviews components of empathy, based on Marshall et al.'s (1995) model, in sex-offenders with ID. Due to the paucity of research into empathy in sex-offenders with ID, the review establishes what can be learned from studies investigating components of empathy in sex-offenders without disabilities and in people with ID. Evidence is conflicting and no clear conclusions can be made as to whether sex-offenders or people with ID are deficient in components of empathy. Further research is needed into the components of empathy in sex-offenders with ID, motivating the research carried out in section two.

The second section describes a study on components of empathy and victim empathy in sex-offenders with ID. Twenty-one sex-offenders and twenty-one non-offenders with ID were given measures of empathy. In addition the sex-offenders completed a measure of empathy towards their own victim. There were no significant differences between sex-offenders and non-offenders with ID on measures of general or victim empathy, nor on components of empathy. There was no significant relationship between the sex-offenders' scores on empathy towards their own victim and empathy towards non-specific victims of sexual assault. Sex-offenders who had received treatment performed better on some measures of components of empathy than non-offenders. Limitations and clinical implications are discussed. Further research is needed to understand empathy in sex-offenders with ID.

The final section discusses reflections on the research process, including what was learned and areas for future development.

Acknowledgements

First and foremost I would like to thank all the people who took part in my study; for their patience and their time. I enjoyed meeting and working with them.

I would also like to thank all the people who helped me recruit participants, especially team leaders: Dawn and Jeremy, who both made me feel incredibly welcome in their day services. I would also like to thank Michelle Northgraves and Andrew Ducker. Finally I would like to thank Christine Hughes, Alan Lyons and Fiona Johnston, who with their unfaltering enthusiasm and organisational abilities helped me to recruit a large number of my participants with very little time to go.

Many thanks to my research supervisor, Nigel Beail, for his help and advice throughout the research process. His support and flexibility towards the end has been especially appreciated.

I would also like to thank my placement supervisors: James Lang and Louise Clancy, whose flexibility with allowing me to move placement days around helped me with carrying out my interviews.

Finally I would like to thank my friends Christine and Bird for their encouragement throughout the write up, especially the lunches and dinners which helped to break the monotony and kept me sane! I would also like to thank my parents and partner, James, whose help at the end, when I suffered a slipped disc, has made it possible to submit this thesis to the deadline.

List of Contents

| | |
|--|-----------|
| Abstract | iv |
| Acknowledgements | v |
| Section 1: Literature Review | 1 |
| Structured Summary | 2 |
| Introduction | 3 |
| Materials and Methods | 6 |
| Results | 7 |
| Literature Relating to Emotion Recognition | 7 |
| Literature Relating to Perspective Taking | 12 |
| Literature Relating to Emotion Replication and Response Decision | 22 |
| Discussion | 24 |
| References | 289 |
| Section 2: Research Report | 37 |
| Structured Summary | 38 |
| Introduction | 39 |
| Materials and Methods | 47 |
| Results | 54 |
| Discussion | 63 |
| Conclusions | 71 |
| References | 72 |

| | |
|--|-----------|
| Section 3: Critical Reflection on the Research Process | 79 |
| Introduction | 80 |
| Origins of the Project | 80 |
| Implementation: Barriers and Facilitators | 81 |
| Maintaining Motivation | 84 |
| Supervision | 85 |
| Dissemination of Findings | 86 |
| Reflections and CPD | 87 |
| | |
| Section 4: Appendices | 89 |
| Appendix 1: Approval letters of journal for publishing work contained in the thesis | 90 |
| Appendix 2: Author guidelines for <i>JARID</i> | 91 |
| Appendix 3: Ethics approval letters | 97 |
| Appendix 4: Search terms used in literature review | 102 |
| Appendix 5: Information sheets | 103 |
| Appendix 6: Consent forms: | 109 |
| Appendix 7: A-TEP | 112 |
| Appendix 8: Empat | 119 |
| Appendix 9: A-Empat | 124 |
| Appendix 10: A-QVES | 128 |

Section 1: Literature Review

Components of Empathy in Sex-offenders with Intellectual Disabilities

Structured Summary

Introduction

There is a lack of research examining empathy in sex-offenders with intellectual disabilities (ID). With the aim of informing treatment programmes, this paper reviewed studies investigating components of empathy in sex-offenders and in people with ID.

Methods

A systematic search of papers published in peer-reviewed journals, since January 1950 was conducted. The review included studies measuring skills of: emotion recognition, perspective taking, emotion replication or response decision, in either people with ID or sex-offenders.

Results

Thirty-one papers were identified and a further two reviews of emotion recognition in people with ID. Evidence was conflicting; therefore no conclusions can be drawn as to whether sex-offenders or people with ID are deficient in components of empathy.

Conclusions

Further research is needed which investigates empathy in sex-offenders with ID before any recommendations can be made to treatment programmes. Recommendations for the assessment of empathy in sex-offenders with ID were discussed.

Introduction

There has been an increasing interest in research on sex-offenders with intellectual disabilities (ID) and a number of reviews have been published covering aetiology, assessment and treatment (Lindsay, 2002; Lambrick & Glaser, 2004; Courtney & Rose, 2004). Treatment of sex-offenders with ID have historically relied on pharmacological treatments and behavioural interventions (Lindsey, 2002); however more recently, based on interventions commonly used with non disabled sex-offenders, treatments have begun to incorporate empathy training as a component (Rose et al., 2002; Sinclair et al., 2003). Criminologists have hypothesised that both violent and sexual offenders have deficits in empathy which reduces the inhibition to harm others because they are unable to share and/or understand the negative emotional impact their antisocial behaviour has on others (Jolliffe & Farrington, 2004). Research to support this hypothesis in sex-offenders, however, is sparse and contradictory; with some studies demonstrating a lack of empathy in sex-offenders (Rice et al., 1994; Marshall et al., 1993) and some not finding any differences between sex-offenders and non sex-offender controls (Langevin et al., 1988; Marshall & Maric, 1996). Furthermore, due to the paucity of research in this area, drawing any conclusions as to whether sex-offenders with ID have empathy deficits is even more difficult. Literature searches revealed only two papers; however, one study did not use a control group (Doyle, 2004), whereas the other demonstrated that offenders were more skilled in empathy than non-offenders, though unfortunately the study did not distinguish between sex-offenders and other offenders (Proctor & Beail, 2007).

There are several arguments as to the lack of consensus in research findings. Some theorists argue that because many studies on empathy in offenders use self-report measures of general empathy which employ a 'trait-like' view of empathy, they obscure

real differences between sex-offenders and non-offenders due to failure to acknowledge the importance of situational factors or victim characteristics. Marshall and colleagues (1995) go as far as to argue that: “researchers should abandon generalised measures of empathy” in favour of “more person-specific measures that may reveal inability to empathise with their victims” (p.109).

Another argument suggests that the equivocal research findings are due to the lack of consensus regarding the conceptualisation of empathy. Despite a general agreement in the more recent literature that there are cognitive and affective components to empathy (Covell & Scalora, 2002; Jolliffe & Farrington, 2004), it is often measured as a single component or there is a focus on only one aspect of empathy (i.e. the Emotional Empathy Scale, Mehrabian & Epstein, 1972). Following their review of the literature Marshall et al. (1995) attempted to clarify the definition by re-conceptualising empathy as a four-stage process involving: emotion recognition (the ability to recognise another person’s emotion), perspective taking (the ability to see another person’s point of view), emotion replication (the ability to feel the same emotion as another person), and response decision (the ability to make a decision about how to act based on the other stages). Each stage is needed before progression to the next stage can be achieved. This model proposes that individuals can have different empathy deficits, such that one person can be deficient on one factor (e.g. perspective taking) whereas another is deficient in another (e.g. emotion replication). They identify one measure, the Interpersonal Reactivity Index (IRI, Davis, 1980), which attempts to measure empathy from a multidimensional perspective. However, Marshall et al. (1995) argue that because the measure is focused on general empathy (i.e. empathy towards all people, all of the time) it still follows the traditional view that empathy is a trait which is consistent across people and situations.

In an attempt to measure the stages of empathy proposed by their model, Fernandez, Marshall and colleagues designed and tested out two questionnaires to measure emotion recognition, perspective taking and emotion replication in sex-offenders: the Child Molester Empathy Measure (Marshall et al., 1997) and the Rapist Empathy Measure (Fernandez & Marshall, 2003). Respondents were required to read three vignettes describing either a woman (Rapist Empathy Measure) or child (Child Molester Empathy Measure) who has been: (1) permanently disfigured in car crash, (2) sexually assaulted by another offender, or (3) the offender's own victim. They were then required to indicate: their recognition of the victim's distress (the first two stages of Marshall et al.'s model) and their own feelings about the victim (the third stage of the model). A further three studies were carried out using these measures with rapists and child molesters (Fernandez et al., 1999; Marshall et al., 2001; Marshall & Moulden, 2001). The studies demonstrated that the sex-offenders were not generally unempathic towards the accident victim but that they had less empathy for the non-specific victim of sexual assault than non-offenders and the least empathy towards their own victim. However, four out of the five studies report overall empathy scores for each vignette. Only one study analysed the results for recognition of the victim's distress, and their own feelings for the victim separately; demonstrating that sex-offenders were less able to recognise the harm caused than non-offenders, but equally able to feel compassion or concern towards the victim as non-offenders (Marshall et al., 2001). Whilst these results are encouraging, further evidence is required to draw any conclusions about whether sex-offenders have specific deficits in either: emotion recognition, perspective taking or emotion replication.

Aim

To review studies investigating the stages of empathy (proposed by Marshall et al., 1995) in sex-offenders with ID. Due to the paucity of this research in sex-offenders with ID, the review will establish what can be learned from examining the findings relating to non disabled sex-offenders followed by those findings relating to people with intellectual disabilities.

The overall aim is to inform treatment programmes for sex-offenders with ID. By examining the different stages of empathy, specific deficits may be located which in turn will direct treatments as to which empathy skills need to be enhanced.

Materials and Methods

The following databases were searched for articles published between January 1950 and May 2008: Ovid, British Nursing Index, CINAHL, International Bibliography of the Social Sciences, PsychARTICLES, MEDLINE, PsychINFO, and Web of Knowledge databases. Search terms were used to find articles investigating skills of: emotion recognition, perspective taking, emotion replication and response decision in sex-offenders and/or people with ID (for a full list of search terms, see **Appendix 4**). The reference sections of papers identified were scrutinised for any further papers.

The inclusion criteria for papers were as follows: (1) the study sample includes either people with ID or sex-offenders, and a control group, (2) there are measures of: emotion recognition, perspective taking, emotion replication or response decision, (3) the study design assesses differences in skills between either people with ID and/or sex-offenders and the control participants on the aforementioned measures.

The exclusion criteria for papers were as follows: (1) papers not published in peer-reviewed journals, (2) studies not directly investigating the skills of: emotion

recognition, perspective taking, emotion replication, response decision in either sex-offenders and/or people with ID, for instance studies investigating treatments aimed at enhancing any of these skills.

Results

Thirty-one papers were identified and a further two reviews of emotion recognition in people with ID. Literature on each stage will be reviewed in turn, beginning with the first stage: emotion recognition.

Literature Relating to Emotion Recognition

Emotion Recognition Skills in Sex-offenders

One paper investigating emotion recognition skills and three papers investigating the ability to read non-verbal cues in sex-offenders were identified.

Hudson et al. (1993) tested the emotion recognition skills of sex-offenders and child molester, in two studies. The first compared sex-offenders ($n=21$) to other offenders ($n=54$) on emotion recognition using Ekman and Friesen's (1975) Facial Affect Slides. Sex-offenders were the least accurate at identifying emotions. Further analyses revealed that participants commonly rated the fear slides as showing surprise and often rated anger slides as disgust and vice versa. This was done most frequently by the violent offenders and sex-offenders. In the second study, participants (child molesters, $n=20$ and community controls, $n=20$) were compared on their ability to name the emotions depicted in drawings of child and adult faces. Child molesters were less accurate at recognizing emotions in both child and adult faces than community controls. There were no differences in emotional recognition accuracy between the child and adult sets, therefore providing no evidence for the hypothesis that child molesters are less accurate at recognising emotions in children. Interestingly the accuracy of identifying the

children's emotional states were significantly positively correlated to scores on a measure of empathy, the Interpersonal Reactivity Index (Davis, 1983), providing some evidence for Marshall et al.'s (1995) four-stage model of empathy. Unfortunately in their second study, Hudson et al. (1993) did not report the emotions being identified or the errors which were made, so it is not clear whether there were differences in recognition of specific emotions or confusion between negative and positive emotions.

Lipton et al., (1987) developed the Test of Reading Affective Cues (TRAC), which uses video clips of heterosexual couples interacting in various situations, to measure heterosexual cue reading accuracy. They administered the TRAC to rapists ($n=11$) and violent and non-violent offenders ($n=22$). Results indicated that rapists were significantly less accurate at reading the female target cues in the first date situation than violent and non-violent offenders. Furthermore, they were least accurate at reading negative cues, providing some evidence for the researchers' hypothesis that rapists have an information processing bias which predisposes them to misperceive women's negative cues as positive.

In contrast to the previous study, in their study Gianni & Fellows (1986) concluded that rapists ($n=12$) are more accurate in interpreting non verbal cues than student controls ($n=12$). However, the ability to read non verbal cues was based on a task requiring participants to guess the amount confederates won on variable jackpots (ranging from very small to larger amounts) from their non verbal cues; hence measuring the ability to read neutral or positive nonverbal cues and does not provide any clues as to rapists' ability to read negative cues, which are more likely to be salient during an assault. Furthermore, the participants in the rapist group were all self-reported, unconvicted rapists who were being treated for reactive depression attributed to guilt associated with their sexual offences, suggesting they had some insight into the impact of their

behaviour on their victims. It is likely that these participants would differ greatly in empathy skills in comparison to convicted rapists, and indeed unconvicted rapists who do not admit their offences.

The final study indentified (Puglia et al., 2005), used the Mayer Salovey Caruso Emotional Intelligence Test, version 1.1 (MSCEIT, version 1.1, Mayer et al., 1999) to investigate emotional intelligence in sex-offenders ($n=19$), other offenders ($n=18$) and non-offender controls ($n=19$). Results showed that the sex-offenders scored significantly higher on the Perception subscale (measuring emotion perception in landscapes, designs or faces) than other offenders, but not than non-offender controls. However, the study does not report enough detail on how or what emotions are scored; therefore determining which emotions were easier to recognise or indeed whether the sex-offenders high scores was based on seeing emotions in landscapes or designs and not in faces, cannot be established.

Emotion Recognition Skills in People with Intellectual Disabilities

Literature searches revealed two published reviews of studies investigating emotion recognition in people with ID: Rojahn et al. (1995) and Moore (2001), and five controlled studies published since 2001.

Rojahn et al. (1995) reviewed 21 studies published between 1980 and 1992. They concluded that people with ID have difficulties recognising emotions when compared to normally developing individuals and that the ability to decode emotions decreases with declined cognitive function. However, they argue that despite this evidence, the research is unable to establish whether this deficit is a function of the decreased cognitive functioning inherent in people with ID or whether it is emotion specific.

Following on from Rojahn et al.'s (1995) conclusions; Moore (2001) critically analyses the methodology of studies on emotion recognition, to investigate whether there is

evidence for an 'emotion specific deficit' in people with ID. He concludes that only four studies employed appropriate controls (i.e. a control group matched by mental age, and a control task matched to place the same cognitive demands as the emotion recognition task) to rule out the confounding variable of poor information processing abilities (Hobson et al., 1989a, 1989b; Moore et al., 1997; Rojahn et al., 1995). Only one of these studies provided some evidence for the emotion-specificity hypothesis (Hobson et al., 1989a). However, Moore (2001) argued that the control task involved in this study required considerable imaginative abilities and in fact in the second study (Hobson et al., 1989b) which employed a much simpler task, there was no emotion-specific impairment. Moore (2001) provided some recommendations to the methodologies: mental age matched controls; more than one control task with stimuli of varying complexity and abstraction; tasks used to test participants' memory and attention, which can then be used as co-variables in analyses to partial out the role of these factors on emotion perception performance; and stimuli which is ecologically valid, and moving rather than static.

The searches conducted for this review identified five studies published after 2001; out of these, three were published in the same year as Moore's (2001) review and did not employ control tasks (Dyck et al., 2001; Kasari et al., 2001; Owen et al., 2001). Despite not employing appropriate controls, Owen et al. (2001) investigated emotion recognition from a different angle to other studies, which makes it worth considering in more detail here. They investigated whether adults with ID are able to recognise emotions in terms of their underlying dimensions; namely in terms of their valence (pleasure-displeasure) and arousal (excitement-calm). Results demonstrated that although the adults with ID ($n=6$) were less proficient than the adults without ID ($n=6$) at labelling emotion categories expressed in photos of facial expressions and affect-

laden stories, they did not show any deficits in labelling whether an expressed emotion was pleasant or unpleasant in either tasks. However, the participants with ID were significantly impaired in the ability to recognise the emotional dimension of arousal. The authors attributed this to impaired cognitive abilities and the cognitive demands placed on them by having to rate the emotions on two dimensions at the same time. In spite of the many limitations of the study, the results are interesting because they demonstrate that despite being unable to use the correct emotion word to label an emotional expression, adults with ID can discriminate between pleasant and unpleasant emotions, which in turn provides some evidence against the 'emotion specificity hypothesis'.

Only two studies published after 2001 employed appropriate task and participant controls (Williams et al., 2005; Wishart et al., 2007). Both studies used an emotion matching task as the experimental task to measure emotion recognition, and an identity-matching task to control for general face processing. Participants in the experimental group included children with: Down's syndrome, non-specific ID and Fragile X syndrome. These were matched to control participants (normally developing children) by mental age. In both studies the children with Down's syndrome performed significantly lower on the emotion matching task and only in comparison to the typically developing children. Furthermore, there were no significant differences between children with: non-specific ID, Fragile X syndrome and typically developing children, on the emotion matching task. The authors concluded that children with Down's syndrome had specific difficulties in processing facial emotional expressions. However, further analysis revealed the only emotion the children with Down's syndrome scored significantly lower on was fear. This was consistent with the findings of other research which shows that in people with ID, some emotions are more difficult

to recognise than others. Research has shown that happiness is the easiest emotion to decode (i.e. McAlpine et al., 1992), whereas emotions: anger and fear are more difficult (i.e. Kasari et al., 2001, Gioia & Broscole, 1988).

It is also important to note that although there were no significant differences between children with: non-specific ID, Fragile X syndrome and typically developing children on the task of emotion recognition, the overall scores of all three groups of children with ID were lower than the typically developing children's scores. This was despite having much longer experiential histories; participants in the experimental group were on average 8 years older than the typically developing children. Furthermore, as none of the three ID groups were close to ceiling in recognising any expression, except for happy, and increasing age was not associated with increasing scores in any of these groups; it is questionable that the children with ID may have reached their developmental ceiling in emotion recognition. Caution should therefore be taken when attempting to translate the results of studies on emotion recognition in children with ID to adults with ID. This is further backed up by studies using both children and adult research which have reported that adults with ID perform poorly compared to children with ID (i.e. Marcell & Jett, 1985; McAlpine et al., 1991).

Literature Relating to Perspective Taking

Perspective taking skills in sex-offenders

Literature searches revealed that researchers have investigated perspective taking skills in sex-offenders using three broad types of methodologies, including the use of: video vignettes, questionnaire measures and interviews analysed using qualitative methodology.

Four papers were identified which use video scenarios to measure perspective taking ability. Murphy et al. (1986) investigated whether social perception is related to: sexual

arousal to rape stimuli, rape supportive attitudes and self-reported coercive sexual behaviour, in a community sample of males ($n=189$). They measured social perception based on two indices: the participant's ability to discriminate friendly from seductive behaviour ('the seduction discrimination index') and their ability to discriminate assertive from hostile behaviour ('the hostility discrimination index'), in females in male/female interactions. Results indicated that those participants who showed poor discrimination on the 'hostility discrimination index' reported more sexual coercion as well as more arousal to rape depictions, demonstrating a relationship between inaccurately interpreting women's interactions as hostile and sexual aggression. However, results should be interpreted cautiously as the measure of sexual coercion used was based on only four questions (i.e. "How many times have you touched a woman's breasts, when she didn't really want you to?"), which makes it open to individual variability in interpretation.

Extending the research by Murphy et al. (1986), Malamuth and Brown (1994) used the same video scenarios to investigate three hypotheses to explain social perception in sexually aggressive men: over-perception of hostility or seductiveness (the tendency to read a woman's friendly or benign behaviour as revealing more seductiveness or hostility than she intends); negative blindness (an impairment in the ability to recognise a woman's negative reactions, which could result in the persistence in making sexual advances) and suspicious schema (women's communication about sexual interest cannot be trusted as truth). Similarly a community sample ($n=161$) was used and participants were assessed on measures of: sexual arousal to rape, attitudes supporting aggression and sexually aggressive behaviour, in addition to social perception. The results showed that in the hostile scenario, the more sexually aggressive men interpreted the woman's communications as least negative and in the friendly and seductive

scenarios; they interpreted the woman's communications as more hostile than the less sexually aggressive men. The authors concluded that this is evidence for the 'suspicious schema' hypothesis. However, where the study provides some evidence that sexually aggressive men are inaccurate at understanding women's communications about sexual interest, it cannot establish whether this is due to 'suspicious schema', as this hypothesis would suggest that the sexually aggressive men accurately perceived the feelings of the woman but then concluded, through their suspicious schema, that she 'doesn't mean what she is communicating'. In order to investigate this, research would need to measure what the participant thinks the woman is feeling and a separate measure of what he thinks her intentions are.

Two papers used Test of Reading Affective Cues (TRAC, Lipton et al. 1987) to assess perspective taking ability in sex-offenders. In the first study, McDonel & McFall (1991) used the TRAC and the Heterosocial Perception Survey (HPS) which required participants (male college students) to give their opinions as to whether the man in the video scenario should continue to make sexual advances following a negative, unreceptive response from the female in the scenario. This was measured five times, with the man becoming progressively more sexually suggestive, across three different scenarios. Results showed that those participants with higher rape supportive attitudes and self-reported rape proclivity were less accurate at decoding women's negative cues on the TRAC and less conservative in their estimates of a man's justification in continuing to make sexual advances in the face of a woman's negative cues on the HPS. Interestingly, the ability to decode *men's* interpersonal cues was not related to responses on the HPS, rape attitudes or proclivity; suggesting that the decoding deficits were specific rather than general.

In their paper, Stahl & Sacco (1995) compared homosexual and heterosexual child molesters and rapists with non violent and violent non sex-offenders on their responses on the TRAC. In addition to identifying the affective states portrayed by the woman in the video scenarios, participants had to estimate how much sexual activity she desired after the date. In response to the romantic affective responses, the heterosexual molesters rated the woman as desiring significantly less sex after the date than the nonviolent non sex-offenders, the violent non sex-offenders and homosexual child molesters. The authors conclude that this provides evidence for the proposition that paedophiles have social perceptual deficits which predispose them to misinterpret adult woman's romantic interest and underestimate their sexual desire. However, when the heterosexual child molesters' estimates of sexual desire were compared across the five affective states (rejecting, bored, neutral, friendly and romantic) they followed the same pattern as the other groups' responses (i.e. least sexual desire for rejecting, followed by bored and most desire for romantic), which suggests that they were not necessarily inaccurate at reading the woman's affective cues, just more conservative in their estimates of sexual desire than the other groups of participants.

Whilst using video vignettes to investigate perspective taking in sex-offenders has some ecological validity and has shown some insight into this skill in sex-offenders, it has by no means been conclusive. Another way of investigating perspective taking has used questionnaire methods. Although not generally used to specifically assess perspective taking ability, the most commonly utilised measure of empathy in offenders (the Interpersonal Reactivity Index, IRI, Davis, 1980) has a Perspective-Taking (PT) scale. According to Davis, the PT scale 'assesses the tendency to spontaneously adopt the psychological point of view of others' (Davis, 1983, p. 113). Seven papers were identified which used the IRI to compare empathy between sex-offenders and a control,

these are summarised in Table 1. Three out of seven papers did not find any significant differences between sex-offenders and non-offender controls (Hayashino et al., 1995; Lindsay et al., 2001; Moriarty et al.'s, 2001). However, two of these studies used adolescent samples and were poorly controlled (Lindsay et al., 2001; Moriarty et al.'s, 2001). Hayashino et al. (1995) used an adult sample and controlled for age and socially desirable responses; however they unfortunately failed to control for IQ.

The remaining four studies demonstrated sex-offenders scored lower on the PT scale than non-offenders. Three studies used adolescent participants (O'Halloran et al., 2002; Burke 2001; Varker & Devilly 2007). Burke (2001) did not employ any controls in his study, whereas Varker & Devilly (2007) controlled for age and socially desirable responses and O'Halloran et al., (2002) employed the additional control of matching participants on IQ. O'Halloran et al. (2002) also used a clinical control group. Their results demonstrated that there were no differences in perspective taking between adolescent sex-offenders and clinical controls; however both groups scored significantly lower than normal controls. This is interesting because it suggests that adolescents with behaviour problems may also struggle with perspective taking ability. Unfortunately however, this raises an issue in the way perspective taking is investigated in sex-offenders and demonstrates the importance of controlling for the effects of mental health and behaviour difficulties on the ability to take another person's perspective. Finally, Fisher et al. (1999) were the only study to use adult participants. Although they did not find any differences between child molesters and controls on the PT scale, when they compared the scores of child molesters classed as 'high deviancy' (scoring high on pro-offending attitudes and social inadequacy) with non-offenders, they found that 'high

Table 1 – Studies using the IRI to investigate empathy in sex offenders

| Study | Participants | Confounding variables controlled | Results |
|-------------------------|---|--|--|
| Hayashino et al. (1995) | <ul style="list-style-type: none"> - N₁ = 22 incarcerated incestuous child molesters - N₂ = 21 incarcerated extra-familial child molesters - N₃ = 33 incarcerated rapists with no history of child molestation - N₄ = 27 incarcerated offenders with no history of sex offences - N₅ = 26 non offenders (adults enrolled in adult education course) | <p>Age, education level, ethnicity, marital status, socially desirable responses</p> | <ul style="list-style-type: none"> - No significant differences between groups on PT scores |
| Fisher et al. (1999) | <ul style="list-style-type: none"> - N₁ = 140 child molesters - N₂ = 81 non offenders (newly recruited prison officers) | <p>Age (treated as a covariate in analysis), IQ, education, socially desirable responses</p> | <ul style="list-style-type: none"> - No significant differences between child molesters and non offenders on PT - High deviancy child molesters had significantly lower PT scores than non offenders. - Extrafamilial child molesters without children were lower on PT than non offenders without Children |
| Burke (2001) | <ul style="list-style-type: none"> - N₁ = 23 adolescent sex offenders, mean age 15.48 years - N₂ = 23 adolescent non offenders (from one public high school), mean age 16.30 years | <p>None</p> | <ul style="list-style-type: none"> - Sex offenders had significantly lower scores than the non offenders on the PT scale |

Moriarty et al. (2001)

- N₁ = 15 adolescent sex offenders, mean age 16.93 years
 - N₂ = 49 adolescent non offender (from a secondary school), mean age 15.24 years
- None

- No significant differences between sex offenders and non offenders on PT.

Lindsey et al. (2001)

- N₁ = 27 adolescent sex offenders
 - N₂ = 54 adolescent non sexual offenders
 - N₃ = 74 adolescent non offenders (from a university research setting)
- Age matched

- No significant differences between sex offender, non sexual offenders and non offenders on PT

O'Halloran et al. (2002)

- N₁ = 27 adolescent sex offenders, mean age 15.5 years
 - N₂ = 20 clinical controls (adolescents scoring above clinical cut-off on the CBCL), mean age 13.62 years
 - N₃ = 29 non-clinical controls (adolescents scoring in the normal range on the CBCL), mean age 13.79 years
- Age (treated as a covariate in analysis), IQ, socially desirable responses, mental health/behaviour difficulties

- There were no significant differences between sex offenders and clinical controls on PT.
- Both sex offenders and clinical controls scored lower on PT than non-clinical controls.

Varker et al. (2007)

- N₁ = 16 adolescent sex offenders, mean age 16 years
 - N₂ = 16 adolescent non offenders (recruited from a secondary school), mean age 15.73 years
- Age, socially desirable responses

- Sex offenders scored significantly lower than non-offending controls on PT

deviancy' child molesters scored significantly lower on the PT scale than controls. They also found that extra-familial child molesters scored significantly worse on the PT scale than those controls without children. These findings are of particular interest because both high deviancy and extra-familial offenders are more likely to commit more offences and the fact that they are more lacking in perspective taking ability may go some way to explaining this. Unfortunately, the researchers did not describe the measures they used to identify deviancy. Although more of the studies using the IRI found that sex-offenders are lacking in perspective taking ability, these findings need to be interpreted cautiously due to the failure to control for a number of confounding variables, including age, IQ and mental health problems. Furthermore, most of the studies used adolescent participants and therefore whether the findings can be generalised to adult sex-offenders, moreover those with ID, is questionable because it is likely that perspective taking is a developmental skill acquired through socialisation in childhood and adolescence.

Hanson and Scott (1995) further argue that the PT scale from the IRI does not directly assess perspective taking ability but '...measures the respondents' assessment of the extent to which they habitually consider other people's perspective' (Hanson & Scott, 1995, p.262). In response to this criticism, they designed two measures to assess perspective-taking deficits in child molesters (the Child Empathy Test, CE Test) and rapists (the Empathy for Women Test, EFW Test) which require the respondent to read vignettes depicting social/sexual interaction (ranging from non-abusive, ambiguous to abusive) and rate how the child or woman would likely feel in the situation. The researchers compared: rapists, child molesters, non-sexual offenders, community, and student controls on these measures. There were strong differences on the EFW Test, with the rapists making significantly more errors than both non-offender groups and non

sexual offenders. However unfortunately, both tests had poor internal and discriminant validity, and the CE Test was also unable to distinguish between the samples. Further analysis revealed that those offenders who were not known to use overt force or alcohol during offences showed greatest perspective taking deficits. That those sex-offenders who used overt force did not show perspective taking deficits highlights the importance of distinguishing between sadistic and non-sadistic motivations for sexual assaults. It is also interesting that the sex-offenders who used alcohol did not have perspective taking deficits and provides some evidence that perspective taking may not be a stable characteristic. It is likely that other factors, in addition to intoxication, could also temporarily suspend people's perspective judgement, such as lust or rage.

The final paper which uses qualitative methodology to investigate perspective taking in offenders provides further insight into the transient nature of perspective taking and empathy. Scully (1988) interviewed 114 rapists to explore their perceptions of: their crime, themselves and how they thought their victim perceived them. For the purpose of analysis she classified the rapists as admitters and deniers. When asked to think about their perceptions during the rape, admitters' responses indicated either concern for their own well-being or indifference. Their perceptions of how the victim saw them, was of a 'violent, subhuman creature' which terrified their victim and rendered her compliant. Furthermore, although they were aware of the emotional impact on the victim, rather than empathy they took pleasure in the belief they were powerful and their victim was degraded. At the time of the interview fifty-seven per cent of admitters expressed regret for their behaviour and sorrow for their victim. Deniers on the other hand were either unaware of their victim's feeling and did not care how their victim perceived them or believed she would have described them as gentle, desirable and a good lover. Sixty-two per cent continued to report no emotions or regret or they

expressed concern for their own well-being. Scully explained why the men did not experience shame or empathy at the time of the rape by examining the perspective they took towards their victim, which was that the victim did not have any value to play outside the role they were forced to play in the rape. These roles were either as an opponent to be reduced to powerlessness or as a sexual commodity.

Perspective Taking Skills in People with Intellectual Disabilities

Five papers were identified on affective perspective taking, of which only two had a typically developing control group. Bender and Carlson (1982) compared perspective taking as well as pro-social behaviour in normally developing children ($n=14$), children with mild ID ($n=14$) and moderate ID ($n=14$). Tasks were designed to meet the skills required at Piaget's 'preoperational' and 'concrete operational' stages. No differences were found between groups; however this was hardly surprising as the researchers claimed participants were matched according to Piaget's 'preoperational' stage. Unfortunately due to the simplicity of the tasks, it is impossible to make any inferences as to the perspective taking abilities of sex-offenders with ID; as they are unlikely to match the level of perspective taking needed for sex-offenders to understand their victim's point of view.

The second paper (Bliss, 1985) used tasks designed to assess persuasive strategies as a measure of perspective taking ability in children with mild ID and normally developing children, with mental ages of 6, 8, 10 and 12 years. Persuasive strategies are a good indicator of perspective taking ability because in order to make a good persuasive argument the 'persuader' needs to take into account the 'persuadee's' background and attitudes and adapt the message accordingly. Participants were required to detail how they would persuade different people to agree to different requests and persuasive skills were scored in terms of levels of sophistication. The level of sophistication used to

persuade increased with age for both groups; furthermore there were no differences in scores between the ID and normally developing children. However, although failing to reach statistical significance, fewer 10 to 12 year old children with ID used higher level persuasive strategies. It is therefore difficult to generalise these results to adults with ID, as it is unclear whether children with ID reach a developmental plateau in terms of their level of perspective taking ability. Further research is therefore needed with older participants in order to establish this.

Of the studies that did not employ a normally developing control group, two demonstrated that participants with moderate ID performed more poorly on perspective taking tasks than those with mild ID (Oppenheimer & Rempt, 1986; Moffatt et al., 1995) and one indicated that there is age-related developmental growth in perspective taking in children with ID (Bradley & Meredith, 1991). This further demonstrates the importance of controlling for the effects of IQ and age when investigating perspective taking in sex-offenders with ID.

Literature Relating to Emotion Replication and Response Decision

No papers were identified investigating emotion replication in people with LD and /or sex-offenders. However, searches carried out to identify papers investigating response decision found two papers which firstly look at the response to distress in others, in children with ID and then look at whether they make a pro-social response as a result of these distress cues. A further paper was found investigating the psycho-physiological response to distress in others in: children with ID, children with autism and normally developing children, who were matched by mental age (Blair, 1999). In this study, participants were required to watch slides depicting distress and threat cues and neutral images, whilst skin conductance activity was recorded to measure psycho-physiological response. All three groups responded significantly more to distress and threat cues than

to neutral ones, with no differences between groups. This demonstrates that children with ID experience the same level of arousal as normally developing children in response to the distress of others. Where this provides some insight into the internal responses of children to distress of others, it does not allow for any inferences to be made as to whether the children were replicating the same emotion as depicted in the picture or whether the same physiological response would be produced to stimuli depicting positive emotion.

Another study compared the responses of preschool children: with autism, ID and normal development, to the faked distress of an experimenter (Bacon et al, 1998). The results demonstrated that children with ID were equally proficient at recognising distress in others but less able to respond pro-socially than normally developing children. Unfortunately however, it is unclear where the deficit in empathy is located; although the children recognised the distress, it is questionable whether they replicated it and if they didn't it is possible that this accounts for their inability to respond appropriately. Of separate interest in this study were the findings that regardless of groups there was a trend for males to act less pro-socially than females, this difference became significant when language age was used as a covariate in analysis. This is particularly interesting in light of the fact that the vast majority of sex-offenders with ID are male.

Another study by Kasari et al. (2003) used a similar faked distress scenario and an empathy measure using puppets depicting various affective situations. Results showed that children with Down Syndrome performed worse than both the children with non-specific ID and normally developing children at replicating the emotions: happy, sad, angry and fear. Children with non-specific ID performed worse only in the case of feeling 'sad' in comparison to the normally developing children. Furthermore, in the

faked distress situation, children with non-specific ID showed significantly more positive affect than both the normally developing and the Down syndrome children. Whilst these results demonstrate that children with intellectual disabilities may have difficulties replicating emotions, it is important to note that in one of the tasks (the faked distress task) emotion replication was judged by observations made by research assistants and is therefore subjective. In terms of the ability to respond appropriately to the distress of the experimenter, there were no significant differences between groups in the time it took to respond; however, children with Down syndrome were significantly more likely to respond in a pro-social manner than the other two groups of children. There were no differences between the normally developing children and the non-specific ID children. However, these differences may be accounted for by the difference in developmental experience; the normally developing children were approximately 5 years younger than the other children.

Discussion

The review highlights the complete dearth of literature investigating components of empathy in sex-offenders with ID. For this reason the review relied on studies investigating components of empathy in sex-offenders without disabilities and in people with ID in attempt to make inferences about these skills in sex-offenders with ID. Unfortunately however, the findings of these studies are conflicting and the methodologies used have various limitations making it difficult to draw any firm conclusions.

Despite the conflicting results found in research investigating emotion recognition skills in sex-offenders, the studies which demonstrated that sex-offenders are impaired in comparison to non sex-offender controls (Hudson et al., 1993; Lipton et al., 1987) were better designed than the studies which demonstrated there were no differences (Gianni

& Fellows 1986; Puglia et al, 2005). Furthermore, Lipton et al. (1987) used a measure which was ecologically valid and particularly relevant to understanding sex-offenders' comprehension of women's cues in hetero-social interactions. Of particular importance was the finding that rapists were least accurate at reading women's negative cues and therefore may go some way to explaining the unwanted sexual advances and sexual assaults carried out by sex-offenders. Similarly, Hudson et al. (1993) found that sex-offenders confused negative emotions, in particular fear with surprise, and anger with disgust.

Of studies investigating emotion recognition in people with ID, only two were appropriately controlled, according to Moore's (2001) recommendations. They demonstrated that there were no differences between children with non-specific ID and normally developing controls. However, children with Down's syndrome were found to be impaired, but only on 'fear' (Williams et al., 2005; Wishart et al., 2007). Unfortunately, how generalisable these findings are to sex-offenders with ID is questionable and further complicated by the use of child participants; it is possible that children with ID reach a developmental plateau in their ability to recognise emotions and with a lack of studies using adult participants, whether adults with ID are impaired in comparison to adults without ID is still unknown. Interestingly, the findings that fear was most difficult to recognise, supports the findings of research into emotion recognition in sex-offenders; that some emotions, in particular negative emotions, are more difficult to understand than others.

In terms of research investigating perspective taking in sex-offenders, studies using video scenarios have demonstrated that participants rated as more sexually aggressive fail to accurately understand women's cues; for instance interpreting assertive behaviour as hostile (Murphy et al, 1986), and confusing friendly and seductive behaviour with

hostile behaviour (Malamuth & Brown, 1994). Moreover, McDonel and McFall (1991) demonstrated that these deficits were specific to understanding woman's cues and not men's. Unfortunately these studies used community participants, who were given measures of rape supportive attitudes and self reported sexual coercion, and therefore how generalisable the results are to convicted sex-offenders, moreover sex-offenders with ID is questionable.

The results of questionnaire measures are also difficult to interpret, with a similar number of studies using the IRI reporting no differences between sex-offenders and non-offenders (i.e. Moriarty et al., 2001) to studies demonstrating they are deficient in empathy (i.e. Varker & Devilly, 2007). Furthermore, the majority of studies used adolescent participants making it difficult to generalise findings to adult sex-offenders. However, it is perhaps worth considering the findings of two studies: O'Halloran (2002) used a clinical control group, in addition to normal controls, and demonstrated there were similar deficits in children with behavioural problems as adolescent sex-offenders in perspective taking. Fisher et al. (1999), who used an adult sample, interestingly found that only extra-familial child molesters and those classified as 'high deviancy' scored poorly on the PT scale. However, it still remains that the IRI is criticised for measuring respondent's estimates of the extent to which they habitually consider other peoples perspectives rather than perspective taking ability. The final study using questionnaire methodology, demonstrated that rapists made more errors on the EFW Test ((Hanson & Scott, 1995) and interestingly those who reported not using alcohol or force during the sexual assaults had the greatest perspective deficits, demonstrating that perspective taking ability is transient. Unfortunately the EFW Test had poor internal validity so it is questionable whether it actually measured perspective taking ability. However, evidence from Scully's (1988) interviews of sex-offenders, showing that

perspective taking ability was suspended during an assault but not at the time of the interview, provides further support for this.

In terms of studies investigating perspective taking ability in people with ID, these again only used child samples and although they did not show any deficits in perspective taking ability in children with ID (Bender & Carlson, 1982; Bliss, 1985), without evidence from studies using adults with ID or sex-offenders with ID, there is no way of knowing whether adults with ID are impaired in comparison to adults without ID, nor whether sex-offenders with ID have impairments in perspective taking ability.

In terms of emotion replication and response decision skills, there were no studies investigating these skills in sex-offenders and the three studies investigating these skills in people with ID, again only used child samples. The studies demonstrated there were no differences between children with non-specific ID to normally developing children, in their response to distress cues (Blair, 1999; Bacon et al, 1998) or ability to replicate emotions in others, but that children with Down's syndrome were more impaired (Kasari et al., 2003). One study demonstrated that children with ID were less able to respond pro-socially to the distress in others and the other study showed that there were no differences between children with non-specific ID (Bacon et al., 1998) and normally developing children, but that children with Down's syndrome were more likely to respond pro-socially (Kasari et al., 2003).

Clinical Implications

Due to the lack of research investigating components of empathy in sex-offenders with ID, compounded by the limitations in the studies investigating these skills in sex-offenders or people with ID, it is difficult to draw any clear recommendations as to how interventions for sex-offenders with ID should be planned. However, the review highlights some areas which are worth bearing in mind when working with sex-

offenders with ID, in particular during assessment. Until research suggests otherwise, using Marshall et al.'s (1995) model of empathy, the components should be measured separately in order to understand empathy in sex-offenders more clearly. The findings suggest that certain emotions such as fear, anger and distress are more difficult to process than other emotions and therefore it is important to measure the components across various emotions, particularly negative emotions, as deficits with these emotions are more likely to be linked to sexual offending. When investigating perspective taking, it is important to assess the offender's understanding of the victim's perspective during the sexual assault, it is also important to think about factors such as intoxication and violence used during the offences. Particular in depth assessment of empathy should be carried out in offenders who have mental health problems or Down's syndrome or in those offenders who are considered more 'deviant', as it is possible that these offenders will have more impaired skills in components of empathy. Assessment should also be tailored to the individual offender and circumstances of their offences, so for instance if the offender has committed most offences against males, assessment of empathy skills should be focused in more detail on their understanding of males' emotions, perspective and so on.

Future Research

Clearly further research is needed in the area of empathy in sex-offenders with ID. Future research should focus on investigating the components of empathy separately and where possible focus in particular on negative emotions and use methodology which is ecologically valid to sexual assault. The use of video scenarios such as those outlined in Lipton et al.'s (1987) study may be particularly useful for investigating perspective taking. Video scenarios could also be used to investigate the other three components, particularly as using moving displays of emotions seems a more accurate

way of measuring emotion recognition in people with ID (Harwood et al., 1999). Future research should also attempt to include: non-offender with ID, sex-offender without ID and non-offender without ID control groups, thus allowing conclusions to be made about whether empathy deficits, if any, are specific to sex-offenders with ID. Further research is also needed investigating these components in people who have different underlying causes for their ID. Finally qualitative research could be a useful way of gaining rich data into empathy in sex-offenders with ID.

References

- Bacon, A. L., Fein, D., Morris, R., Waterhouse, L. & Allen, A. (1998). The responses of autistic children to the distress of others. *Journal of Autism and Developmental Disorders*, 28, 129-142.
- Bender, N. N. & Carlson, J. S. (1982). Prosocial behaviour and perspective-taking of mentally retarded and nonretarded children. *American Journal of Mental Deficiency*, 86, 361-366.
- Blair, R. J. R. (1999). Psychophysiological responsiveness to the distress of others in children with autism. *Personality and Individual Differences*, 26, 477-485.
- Bliss, L. S. (1985). The development of persuasive strategies by mentally retarded children. *Applied Research in Mental Retardation*, 6, 437-447.
- Bradley, L. J. & Meredith, R. C. (1991). Interpersonal Development: A study with children classified as educable mentally retarded. *Education and Training in Mental Retardation*, 130-141.
- Burke, D. M. (2001). Empathy in sexually offending and nonoffending adolescent males. *Journal of Interpersonal Violence*, 16, 222-233.

- Courtney, J., & Rose, J. (2004). The effectiveness of treatment for male sex offenders with learning disabilities: A review of the literature. *Journal of Sexual Aggression, 10*, 215-236.
- Covell, C. N. & Scalora, M. J. (2002). Empathic deficits in sexual offenders: An integration of affective, social, and cognitive constructs. *Aggression and Violent Behavior, 7*, 251-270.
- Davis, M. H. (1980). A multidimensional approach to individual differences in empathy. *JSAS Catalog of Selected Documents in Psychology, 10*, 85.
- Davis, M. H. (1983). Measuring individual differences in empathy: Evidence for a multidimensional approach. *Journal of Personality and Social Psychology, 44*, 113-126.
- Doyle, M. (2004). Empathy, loneliness and 'theory of mind' in sexually abusive men with intellectual disability. *Journal on Intellectual Disability Research, 48*, 464-464.
- Dyck, M. J., Ferguson, K. & Shochet, I. M. (2001). Do autism spectrum disorders differ from each other and from non-spectrum disorders on emotion recognition tests? *European Child and Adolescent Psychiatry, 10*, 105-116.
- Ekman, P. & Friesen, W. V. (1975). *Unmasking the face*. Englewood Cliffs, NJ: Prentice Hall.
- Fernandez, Y. M. & Marshall, W. L. (2003). Victim Empathy, Social Self-Esteem, and Psychopathy in Rapists. *Sexual Abuse: A Journal of Research and Treatment, 15*, 11-26.
- Fernandez, Y. M., Marshall, W. L., Lightbody, S. & O'Sullivan, C. (1999). The Child Molester Empathy Measure: Description and Examination of Its Reliability and Validity. *Sexual Abuse: A Journal of Research and Treatment, 11*, 17-31.

- Fisher, D., Beech, A. & Browne, K. (1999). Comparison of sex-offenders to non offenders on selected psychological measures. *International Journal of Offender Therapy and Comparative Criminology*, 43, 473-491.
- Gianni, A. J. & Fellows, K. W. (1986). Enhanced Interpretation of Nonverbal Facial Cues in Male Rapists - A Preliminary Study. *Archives of Sexual Behavior*, 15, 153-156.
- Gioia, J. V. & Broscole, L. (1988). Visual and auditory affect recognition in singly diagnosed mentally retarded patients, mentally retarded patients with autism and normal young children. *International Journal of Neuroscience*, 43, 149-163
- Hanson, R. K. & Scott, H. (1995). Assessing perspective-taking among sexual offenders, nonsexual criminals and nonoffenders. *Sexual Abuse: A Journal of Research and Treatment*, 7, 259-276.
- Harwood, N. K., Hall, L. J. & Shinkfield, A. J. (1999). Recognition of facial emotional expressions from moving and static displays by individuals with mental retardation. *American Journal on Mental retardation*, 104, 270-278.
- Hayashino, D. E., Wurtele, S. K. & Klebe, K. J. (1995). Child molesters: an examination of the cognitive factors. *Journal of Interpersonal Violence*, 10, 106-116.
- Hobson, R. P., Ouston, J. & Lee, A. (1989a). Naming emotion in faces and voices: Abilities and disabilities in autism and mental retardation. *British Journal of Developmental Psychology*, 7, 237-250.
- Hobson, R. P., Ouston, J. & Lee, A. (1989b). Recognition of emotion by mentally retarded adolescents and young adults. *American Journal on Mental Retardation*, 93, 434-443.

- Hudson, S. M., Marshall, W. L., Wales, D., McDonald, E., Bakker, L. W. & McLean, A. (1993). Emotional recognition skills in sex-offenders. *Annals of Sex Research, 6*, 199-211.
- Jolliffe, D., & Farrington, D. P. (2004). Empathy and offending: A systematic review and meta-analysis. *Aggression and Violent Behavior, 9*, 441-476.
- Kasari, C., Freeman, S. F. N. & Bass, W. (2003). Empathy and response to distress in children with Down syndrome. *Journal of Child Psychology and Psychiatry, 44*, 424-431.
- Kasari, C., Freeman, S. F. N. & Hughes, M. A. (2001). Emotion recognition by children with Down Syndrome. *American Journal on mental Retardation, 106*, 59-72.
- Lambrick, F. & Glaser, W. (2004) Sex-offenders with an intellectual disability. *Sexual Abuse: A Journal of Research and Treatment, 16*, 381-392.
- Langevin, R., Write, P. & Handy, L. (1988). Empathy, assertiveness, and defensiveness among sex-offenders. *Annals of Sex Research, 1*, 533-547.
- Lindsay, W. R. (2002). Research and literature on sex-offenders with intellectual and developmental disabilities. *Journal of Intellectual Disability Research, 46* (Suppl. 1), 74-85.
- Lindsey, R. E., Carlozzi, A. F. & Eells, G. T. (2001). Differences in the dispositional empathy of juvenile sex-offenders, non-sex-offending delinquent juveniles, and nondelinquent juveniles. *Journal of Interpersonal Violence, 16*, 510-522.
- Lipton, D.N., McDonel, E.C. & McFall, R.M. (1987). Heterosocial Perception in Rapists. *Journal of Consulting and Clinical Psychology, 55*, 17-21.

- Malamuth, M. & Brown, L. M. (1994). Sexually aggressive men's perception of women's communications: testing three explanations. *Journal of Personality and Social Psychology*, 67, 699-712.
- Marcell, M. M. & Jett, D. A. (1985). Identification of vocally expressed emotions by mentally retarded and non-retarded individuals. *American Journal of Mental Deficiency*, 89, 537-545.
- Marshall, W. L. & Moulden, H. (2001). Hostility toward women and victim empathy in rapists. *Sexual Abuse: A Journal of Research and Treatment*, 13, 249-255.
- Marshall, W. L., Champagne, F., Brown, C. & Miller, S. (1997). Empathy, intimacy, loneliness and self-esteem in non-familial child molesters: A brief report. *Journal of Child Sexual Abuse*, 6, 87-98.
- Marshall, W. L., Hudson, S. M., Jones, R. & Fernandez, Y. M. (1995). Empathy in sex offenders. *Clinical Psychology Review*, 15, 99-115.
- Marshall, W. L., Jones, R., Hudson, S.M. & McDonald, E. (1993). Generalised empathy in child molesters. *Journal of Child Sexual Abuse*, 2, 61-68.
- Marshall, W.L. & Maric, A. (1996). Cognitive and emotional components of generalised empathy deficits in child molesters. *Journal of Child Sexual Abuse*, 5, 101-110.
- Marshall, W.L., Hamilton, K. & Fernandez, Y. (2001). Empathy deficits and cognitive distortions in child molesters. *Sexual Abuse: A Journal of Research and Treatment*, 13, 123-130.
- Mayer, J., Salovey, P. Caruso, D. (1999). *MSCEIT (Research Version 1.1)*. Toronto Canada: Multi-Health Systems.

- McAlpine, C., Kendall, K. A. & Singh, N. N. (1991). Recognition of facial expressions of emotion by persons with mental retardation. *American Journal on Mental Retardation, 96*, 29-36.
- McAlpine, C., Singh, N. N., Kendall, K. A. & Ellis, C. (1992). Recognition of facial expressions of emotion by persons with mental retardation: A matched comparison study. *Behavior Modification, 16*, 543-558.
- McDonel, E. C. & McFall, R. M. (1991). Construct validity of two heterosocial perception skill measures for assessing rape proclivity. *Violence and Victims, 6*, 17-30.
- Mehrabian, A. & Epstein, N. (1972). A measure of emotional empathy. *Journal of Personality, 40*, 525-543.
- Moffatt, C. W., Hanley-Maxwell, C. & Donnellan, A. D. (1995). Discrimination of emotion, affective perspective-taking and empathy in individuals with mental retardation. *Education and Training in Mental Retardation and Developmental Disabilities, 30*, 76-85
- Moore, D. G. (2001). Reassessing emotion recognition performance in people with mental retardation: a review. *American Journal on Mental Retardation, 106*, 481-501.
- Moore, D. G., Hobson, R. P., & Lee, A. (1997). Components of person-perception: An investigation with autistic, nonautistic retarded and typically developing children and adolescents. *British Journal of Developmental Psychology, 15*, 401-423.
- Moriarty, N., Stough, C., Tidmarsh, P., Eger, D. & Dennison, S. (2001). Deficits in emotional intelligence underlying adolescent sex offending. *Journal of Adolescence, 24*, 743-741.

- Murphy, W. D., Coleman, E. M. & Haynes, M. R. (1986). Factors related to coercive sexual behaviour in a nonclinical sample of males. *Violence and Victims, 1*, 255-278.
- O'Halloran, M., Carr, A., O'Reilly, G., Sheerin, D., Cherry, J., Turner, R., Beckett, R. & Brown, S. (2002). Psychological profiles of sexually abusive adolescents in Ireland. *Child Abuse and Neglect, 26*, 349-370.
- Oppenheimer, L. & Rempt, E. (1986). Social cognitive development with moderately and severely retarded children. *Journal of Applied Developmental Psychology, 7*, 237-249.
- Owen, A., Browning, M. & Jones, R. S. P. (2001). Emotion recognition in adults with mild-moderate learning disabilities. An exploratory study. *Journal of Learning Disabilities, 5*, 267-281.
- Proctor, T. & Beail, N. (2007). Empathy and theory of mind in offenders with intellectual disability. *Journal of Intellectual and Developmental Disability, 32*, 82-93.
- Puglia, M. L., Stough, C., Carter, J. D. & Joseph, M. (2005). The emotional intelligence of adult sex-offenders: ability based EI assessment. *Journal of Sexual Aggression, 11*, 249-258.
- Rice, M.E., Chaplin, T.C., Harris, G.T., & Coutts, J. (1994). Empathy for the victim and sexual arousal among rapists and non rapists. *Journal of Interpersonal Violence, 9*, 435-449.
- Rojahn, J., Lederer, M. & Tassé, M. J. (1995). Facial emotion recognition by persons with mental retardation: a review of the experimental literature. *Research in Developmental Disabilities, 16*, 393-414.

- Rojahn, J., Rabold, D. & Schneider, F. (1995). Emotion Specificity in mental retardation. *American Journal of Mental Retardation*, 99, 477-486.
- Rose, J., Jenkins, R., O'Connor, C., Jones, C. & Felce, D. (2002). A group treatment for men with intellectual disabilities who sexually offend or abuse. *Journal of Applied Research in Intellectual Disabilities*, 15, 138-150.
- Scully, D. (1988). Convicted rapists' perceptions of self and victim: role taking and emotions. *Gender and Society*, 2, 200-213.
- Sinclair, N., Murphy, G., Mercer, K. & Hays, S.J. (2003). Cognitive behavioural treatment for men with an intellectual disability at risk of sexual offending. Paper presented at the Division of Forensic Psychology 12th Annual Conference, Cambridge, UK, 26-28 March.
- Stahl, S. S. & Sacco, W.P. (1995). Heterosocial perception in child molesters and rapists. *Cognitive Therapy and Research*, 19, 695-706.
- Varker, T. & Devilly, G. J. (2007). Types of empathy and adolescent sexual offenders. *Journal of Sexual Aggression*, 13, 139-149.
- Williams, K. R., Wishart, J. G., Pitcairn, T. K. & Willis D. S. (2005). Emotion recognition by children with Down syndrome: Investigation of specific impairments and errors patterns. *American Journal on Mental Retardation*, 110, 378-392.
- Wishart, J. G., Cebula, D. S., Willis, D. S. & Pitcairn, T. K. (2007). Understanding of facial expressions of emotion by children with intellectual disabilities of differing aetiology. *Journal of Intellectual Disability Research*, 51, 551-563.

Section 2: Research Report

Assessing Components of Empathy and Victim Specific Empathy in Sex-offenders with Intellectual and Developmental Disabilities

Structured Summary

Objectives

Due to lack of research investigating empathy in sex-offenders with intellectual disabilities (ID), this study explored empathy in sex-offenders and non-offenders with ID. Specific aims were to explore differences between these groups on measures of: components of empathy, general and victim empathy, and if there was any relationship between the sex-offenders' scores on empathy towards non-specific victims of sexual assault and their empathy towards their own victim.

Methods

The scores of twenty-one sex-offenders and twenty-one non-offenders with ID, matched by age, gender and IQ, were compared on three measures of empathy. The sex offenders' scores on a measure of empathy towards their own victim were compared to their scores on the measure of empathy towards non-specific victims of sexual assault.

Results

There were no significant differences between sex-offenders and non-offenders with ID on measures of general or victim empathy, nor on measures of components of empathy. There was no significant relationship between sex-offenders scores on empathy towards their own victim and their empathy towards non-specific victims of sexual assault. Sex-offenders who had received treatment performed better on tasks of emotion recognition, emotion replication and response decision than the non-offenders.

Conclusions

Sex-offenders with ID who have received treatment performed better than non-offenders with ID on some components of empathy; however further research is needed to understand these differences and to further understand empathy in sex-offenders with ID, before any recommendations can be made to treatment programmes.

Introduction

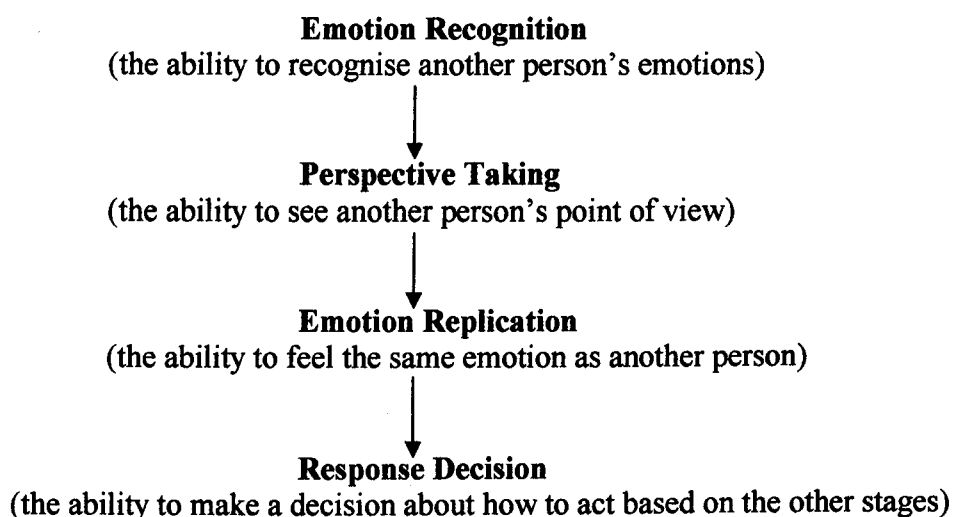
The notion that sex-offenders have deficits in empathy, which reduces their inhibition to harm others because they are unable to understand the negative impact their behaviour has, is one which is shared by many criminologists and lay people alike. In fact empathy training is a common component of the treatment of sex-offenders and forms part of the UK Prison Sex-offender Treatment Programme (SOTP) (Beech et al., 1998). Historically sex-offenders with intellectual disabilities (ID) have been excluded from these treatment programmes; undergoing treatments favouring pharmacological and behavioural interventions instead (Lindsay, 2002). It is only recently that empathy training has been incorporated into the treatment of sex-offenders with ID, with the development of the Adapted Sex-offender Treatment Programme (A-SOTP) and adapted cognitive-behavioural treatments (Rose et al., 2002)

Despite the general agreement that sex-offenders lack empathy, research linking empathy deficits with sex-offenders is sparse and contradictory; with some studies demonstrating a lack of empathy in sex-offenders (Rice et al., 1994; Marshall et al., 1993) and some not finding any differences between sex-offenders and non-sex-offender controls (Langevin et al., 1988; Marshall & Maric, 1996). Furthermore, establishing whether sex-offenders with ID have empathy deficits is even more problematic due to the paucity of research. Only two papers have been published investigating empathy in offenders with ID, of which one does not distinguish sex-offenders from offenders (Proctor & Beail, 2007) and the other does not employ a control group (Doyle, 2004).

There have been a number of arguments as to the lack of consensus in research findings. Marshall et al. (1995) argue that because many studies employ a 'trait-like' view of empathy through the use of *general* empathy measures (i.e. Hogan's Empathy Scale,

Hogan, 1969), they obscure real difference between sex-offenders and non-offenders through failure to acknowledge the importance of victim characteristics and situational factors. They go as far to say that “...researchers should abandon generalised measures of empathy...to develop more person-specific measures that may reveal inability to empathise with their victims...” (Marshall et al., 1995, p. 109).

A second argument suggests that the lack of consensus regarding the conceptualisation of empathy is to blame for the equivocal research findings. Marshall et al. (1995) have attempted to clarify the definition by re-conceptualising empathy as a four-stage process, with each stage needed before progression to the next stage:



This model proposes that individuals can have deficits at different stages, such that one person can be deficient in ‘perspective taking’ and another deficient in ‘emotion replication’, each leading to a deficit in the overall ability to empathise with another person. They identify one measure, the Interpersonal Reactivity Index (IRI, Davis, 1983), which attempts to measure empathy from a multidimensional perspective. However, Marshall et al. (1995) argue that it does not identify any individual or group

characteristics and hence follows the traditional view that empathy is a trait which is consistent across people and situations.

Due to the lack of research, this study aimed to examine empathy in sex-offenders with ID. By focusing on the components of empathy, as outlined in Marshall et al.'s (1995) model, and by measuring victim empathy, it aimed to avoid the pitfalls of other studies in the mainstream literature. Firstly it is worth examining what can be learned from research into the individual components of empathy, as well as victim empathy, in sex-offenders (with or without ID).

Emotion Recognition

Reflecting the dearth of literature on empathy in sex-offenders with ID, no studies were identified investigating emotion recognition skills in sex-offenders with ID. Research examining emotion recognition in sex-offenders without ID is conflicting. In two studies, Hudson et al. (1993) demonstrated that sex-offenders were less accurate at identifying emotions in pictures of faces than other non sexual offenders and community controls. Furthermore, sex-offenders commonly rated the fear slides as showing surprise, and confused anger and disgust. Another study (Lipton et al., 1987) also demonstrated sex-offenders were less accurate at reading hetero-social cues than other offenders; moreover, they were least accurate at reading negative cues.

On the other hand two studies demonstrate that sex-offenders are more skilled at emotional perception than non offending controls (Gianni & Fellows, 1986; Puglia et al., 2005). However, both studies have a large number of flaws which suggests interpretation of the results should be done with caution.

Despite the abundance of studies demonstrating that people with ID perform poorly on emotion recognition tasks (McAlpine et al., 1992; Rojahn et al., 1995) the vast majority do not employ sufficient controls to establish whether this is actually due to poor

emotion recognition skills or the result of decreased cognitive functioning, inherent in people with ID, which impacts on their performance on such tasks. Of those studies which employ appropriate control tasks and controls subjects (Williams et al., 2005; Wishart et al., 2007), both demonstrate that only those children with Down's Syndrome perform poorly on emotion recognition, relative to children with non-specific ID and typically developing controls. However, further analysis revealed that the only emotion participants with Down's syndrome scored significantly lower on was fear. It should also be noted that no, appropriately controlled, studies have examined emotion recognition skills in adults with ID and therefore it is difficult to know how much the findings can be generalised to adults with ID.

Perspective Taking

Again, no studies exist in the literature relating to perspective taking abilities in sex-offenders with ID. In sex-offenders without ID, perspective taking has been measured in a variety of ways using: video vignettes, self-report measures and interviews. Whilst the use of video vignettes has provided some evidence that sexually aggressive males are more likely to inaccurately interpret women's perspectives (Murphy et al., 1986; Malamuth & Brown, 1994; McDonel & McFall, 1991), these studies used community volunteers who were assessed on measures of: sexual arousal to rape and rape supportive attitudes, to establish levels of sexual aggression. The participants had not actually been convicted of any sexual offences and for that reason are likely to differ from convicted sex-offenders.

Research using self-report measures is further difficult to draw any firm conclusions from. An almost equal numbers of studies demonstrate that sex-offenders have deficits in perspective taking ability relative to non-offenders (Fisher et al., 1999; O'Halloran et al., 2002), to studies demonstrating sex-offenders do not have any perspective taking

deficits (Lindsay et al., 2001; Moriarty et al., 2001). The majority of studies also use an adolescent sample, making generalisability to adult sex-offenders questionable, especially as it is likely that perspective taking ability develops through adolescence. Finally one study was identified using interviews of adult sex-offenders (Scully, 1988). The findings demonstrated that although some sex-offenders were able to understand the victim's perspective after the sexual assault, the majority of sex-offenders seemed unable to understand the victim's perspective at the time of the assault; providing some evidence that perspective taking ability is state specific.

Perspective taking ability in people with ID has again only been investigated in children with ID; furthermore only two studies were identified which employed a normally developing control group. Both studies demonstrated there were no differences in perspective taking ability between normally developing children and children with ID. However, one study used very simple tasks unlikely to match the level of perspective taking level needed for sex-offenders to understand their victim's point of view (Bender & Carlson, 1982). Furthermore, despite not finding any differences between normally developing children and children with ID (Bliss, 1985), fewer 10-12 year olds with ID were able to demonstrate higher level perspective taking ability; begging the question that children with ID reach a developmental plateau in their perspective taking ability.

Emotion Replication and Response Decision

No studies investigating emotion replication in people with ID and/or sex-offenders were identified. One paper was identified which examined the psycho-physiological response to distress in others, in children with ID (Blair, 1999). The results demonstrated that there were no differences in the levels of arousal to distress in others, between children with ID and normally developing children. Where this goes some way to explaining the physiological response to distress in children with ID, it does not

provide insight into whether children were replicating the same emotions depicted or whether the physiological response would be the same to stimuli depicting positive emotions. Furthermore, how generalisable these findings are to sex-offenders with ID is questionable.

Two studies were identified which investigated both responses to distress and pro-social behaviour in children with ID. The first demonstrated that children with ID were equally proficient at recognising distress in others but less able to respond pro-socially than normally developing children (Bacon et al., 1998); furthermore, in both groups males were less able to act pro-socially. Unfortunately, it is unclear where the empathy deficit is located; although the children recognised the distress, it could be that they were unable to replicate it and as a result of this were unable to respond appropriately. The second study (Kasari et al., 2003) showed that children with Down's syndrome performed the worst at replicating the emotions: happy, sad, anger, and fear, than children with non-specific ID and normally developing children; whereas children with non-specific ID performed worse at replicating sad than normally developing children. In terms of response decision, the Down's syndrome children were significantly better at responding pro-socially and there were no differences between children with non-specific ID and normally developing children. However, the differences in response decision may be due to developmental experience as the normally developing children were significantly younger (approx 5 years) than the children with non-specific ID and the children with Down's syndrome.

Victim Empathy

Research into victim empathy in sex-offenders is somewhat conflicting, even within research using the same measures. Marshall et al. (1995) have conducted five studies using the Rapist/Child Molester Empathy Measure, which measure empathy towards: a

non-specific victim of sexual assault/child sexual abuse, the offender's own victim, and an accident victim (general empathy). Three studies demonstrated sex-offenders scored significantly lower on empathy towards a non-specific victim of sexual assault than non-offenders (Marshall et al., 1997; Fernandez et al., 1999; Marshall & Moulden, 2001), one demonstrated there were no differences in empathy towards the non-specific victim of sexual assault (Fernandez & Marshall, 2003), and the fourth study demonstrated there were only differences between sex-offenders and non-offenders recognition of harm to victims of sexual assault, not in their feelings of compassion or concern towards the victim; with sex-offenders being less able to recognise the harm caused than non-offenders (Marshall, Hamilton & Fernandez, 2001). However, there was agreement between studies on the sex-offenders' empathy towards their own victim; in all four studies the sex-offenders showed the least empathy towards their own victim than the accident victim and the non-specific victim of sexual assault. There was also agreement that there are no differences in scores on general empathy between sex-offenders and non-offender controls.

A further two studies were identified which used the Empat (McGrath, Cann and Konopasky, 1998); a measure of general empathy (Empat-G) and empathy towards non-specific victims of sexual assault (Empat-A). Tierney and McCabe (2001) demonstrated that child molesters had significantly lower empathy on the Empat-Child (a version of the Empat-A, specific to measuring empathy towards victims of child sexual abuse) than both adult sex-offenders and non-offenders. There were no differences in scores on general empathy between groups; providing further evidence for the hypothesis that empathy is person specific. Wood and Riggs (2008) demonstrated that low levels of empathy on the Empat-A, but *high* levels of empathy on the Empat-G were associated with sex-offender status, using a regression analysis.

Finally, in the remaining study identified the conclusions are less clear. Whittaker et al. (2006) found that sex-offenders performed higher on empathy distortions on one vignette describing a sexual assault and equally to non-offenders on the second vignette (using vignettes from The Victim Empathy Scale, Beckett & Fisher, 1991).

Components of Empathy in Offenders with ID

One study was identified which investigated three components of empathy (emotion recognition, emotion replication and response decision) in offenders with ID, using the Test of Emotional Perception (TEP, Negri-Shoultz & Donnellan 1989). Proctor and Beail (2007) found that offenders with ID performed significantly better on emotion recognition tasks and showed empathic responses to the 'happy' scenario more frequently than non-offenders. Although this provides some insight into the components of empathy in offenders with ID, it is difficult to know whether these findings will be replicated in sex-offenders with ID. Non sexual offenders have been frequently used as control subjects in research into components of empathy in sex-offenders without ID, often demonstrating that in comparison to non sexual offenders, sex-offenders perform worse on empathy measures (i.e. Hudson et al., 1993).

Aims

Due to the lack of research in this area, the aim of the present study was to explore empathy in sex-offenders with ID. By comparing scores on empathy measures between sex-offenders and non-offenders with ID, the following areas were explored:

Components of Empathy

Following Marshall et al.'s (1995) model, empathy was conceptualised as a multi-component concept. The Test of Emotional Perception (Negri-Shoultz & Donnellan, 1989) was selected to measure its component parts and to explore whether there were

differences between sex-offenders and non-offenders on skills of: emotion recognition, perspective taking, emotion replication, and response decision.

General Empathy and Empathy towards Non-specific Victims of Sexual Assault

Using the Empat (McGrath et al., 1998), which includes a measure of general empathy (Empat-G) and empathy towards non-specific victims of sexual assault (Empat-A); whether there were differences between sex-offenders and non-offenders with ID on general empathy and empathy towards non-specific victims of sexual assault was explored.

Comparisons between the Sex-offenders' General Empathy, Empathy towards Non-specific Victims of Sexual Assault and Empathy towards their Own Victim

By using a questionnaire which measures the sex-offenders' empathy towards their own victim (The Victim Empathy Distortion Scale, Beckett & Fisher, 1994), this allowed for exploration of whether there is any relationships between sex offenders' empathy towards their own victim and their empathy towards other victims of sexual assault, as measured by the Empat-A. Using scores from the Empat-G, this allowed for exploration of relationships between the sex-offenders' scores on general empathy, empathy towards their own victim and empathy towards other victims of sexual assault.

Materials and Methods

Ethics Procedures

The study was approved by the North Sheffield Local Research Ethics Committee (**Appendix 3**). Recruitment took place with the support of service managers and key workers, who were provided with a detailed information sheet about the study. They approached service users at least a week prior to testing, to allow the time for participants to think about the information. At the beginning of each interview, the

participant information sheet was explained again by the researcher, usually in the presence of a staff member, to ensure the participant gave informed consent (see **Appendix 5** for information sheets). Participants were advised that the information they gave during the study would remain confidential and that they could cease to participate at any time without any negative consequences (see **Appendix 6** for consent forms). Those who were not deemed to have the capacity to consent were excluded from the study.

Participants

Power Analysis

A power calculation using G*Power was used to determine the number of participants in each group. Only one study was found using the same measures with offenders with ID (the TEP) (Proctor & Beail, 2007). In order to calculate power for a repeated measures 2 by 3 design one requires the effect sizes produced by the study and average correlations between repeated measures. However, as these were not reported in the study, the power calculation for this study had to use an estimate of effect size and average correlations between repeated measures. Based on using ANOVA analyses on the data, producing an estimated medium effect size ($f = .25$) and correlation between repeated measures = .5, this resulted in a sample size of 14 per group to detect a significant difference ($\alpha = .05$, power = .80). However, as this was based on estimates as well as using ANOVA tests, as opposed to RANOVA, the non-parametric and less powerful version of ANOVA, which would be used to analyse the data from the TEP in this study, it was therefore aimed to recruit more participants at around 20 per group.

Experimental Group

Participants in the experimental group were 21 male sex-offenders with intellectual or developmental disability. Approximately 25 sex-offenders were approached to take part; however two were deemed unable to consent and two declined, resulting in a recruitment rate of around 84%. Participants were recruited from: secure units for offenders with ID; probation teams; and clinical psychology services for adults with ID, across two counties in the UK. The age range of the offenders at the time of assessment was 22-68 years, with a mean age of 39.6 years (SD = 3.42). IQ ranged from 49-76 (mean = 62.05, SD = 6.69). The offences committed by these participants included: indecent exposure (28%), indecent assault (46.4%, 62.5% of these were committed against a minor), attempted rape (7.2%), and rape (21.4%, 33.3% were committed against a minor). Out of these participants, 10 had received some form of treatment; and empathy training formed part of the treatment of 5 of these participants.

Control Group

The control group comprised 21 male participants, recruited from community day services for adults with ID, matched to the experimental group on the basis of age, gender and IQ. A further 3 service users were approached to take part; however one declined and two had to be excluded as they did not understand any of the measures, resulting in a recruitment rate of 87.5%. Ages ranged from 21-66 years (mean = 44.95, SD = 13.95) and IQ's ranged from 53-77 (mean = 63.40, SD = 8.76). Age and IQ scores of the groups, analysed using non parametric statistics, due to skewness, did not differ significantly ($U(N_1=20, N_2=21) = 162.5, p = .215$; $U(N_1=20, N_2=21) = 185.5, p = .693$; respectively).

Participants who had autism or serious mental health problems were excluded from the study, as these conditions may account for poorer empathy skills. The vast majority of participants in both groups had ID of unspecified cause,

Measures

Demographics

The following demographic information was gathered from participants (and/or from their key worker, with consent): age, gender, IQ score (if this data was not available, the Weschler Abbreviated Scale of Intelligence, WASI: Weschler, 1999, was administered), day activities, diagnosis of autistic spectrum disorder, history of mental health issues, history of sexual offences. For participants in the experimental group, brief details of the offences committed were gathered by key workers from their files.

Test of Emotional Perception (TEP) (Negri-Shoultz & Donnellan 1989, cited in Moffatt et al., 1995)

This test was chosen because it is the only empathy measure found in the literature that attempts to objectively measure concrete components of empathy in people with ID. The components it measures include: Emotion Recognition, Emotion Replication and Response Decision.

Internal reliability data was not available for this test; however, the test has good face validity and is particularly suitable for people with ID because it uses video-tapes of emotions being expressed in a natural way rather than photographs, words or symbols. Previous research has demonstrated that moving displays of emotion rather than static displays of emotion are a more accurate measure of emotion recognition in people with ID (Harwood, Hall and Shinkfield, 1999).

The test consists of six video vignettes (plus a training video) depicting a main character and a friend playing a game, each lasting approximately 30 seconds. Firstly participants

were shown the training video, to ensure they understand the question: “What happens next?”, in terms of selecting from a number of photographic options. Next participants are shown the six vignettes (in random order) in which the main character receives some news, either via telephone or by letter (the details of which are not shown to the viewer). Two vignettes depict the main character receiving happy news, two sad news and two depict news that made the character angry. To measure **Emotion Recognition**, at the end of each video clip, the participant was asked “What did you see?”. If their response did not elicit an emotional response, a vague response (“Anything else?”) was given up to two times, followed by a more precise prompt (“What happened after he/she opened the letter/answered the phone?”), and then if necessary, the participant was finally asked “How did he/she feel?”. The emotion given was scored as either correct (1 point) or incorrect/no response (0 point) and the number of prompts were recorded.

To measure **Response Decision**, participants were presented with three photographs and asked to choose the one showing what might happen next. The selection was scored as either correct (1 point) or incorrect (0 point), and the time taken to select a photograph was recorded using a stopwatch. To measure **Emotion Replication**, participants were asked: “How would you feel if one of your friends received a phone call/letter like the one in the video?”. Again the response was scored as correct (1 point) if it was congruous with the emotion depicted in the scenario, (i.e. happy or excited for the happy scenario) or if it showed a concerned response to the angry or sad scenario, and incorrect (0 point) if the response was incongruous or no response was given.

Adapted-TEP (A-TEP)

Finally, a number of extra questions were added to the original measure. To measure **Perspective Taking** the participant was asked “How do you think the friend was feeling” (no indication of this was given in the video). Responses were scored correct

(1 point) if they were congruous to the emotion depicted in the video or showed a concerned response to the sad or angry situation; incongruous/no responses were scored 0 point. As an additional measure of **Response Decision**, participants were asked “What do you think the friend will do next?”, responses were scored correct (1 point) if they showed a pro-social response that was congruous to the scenario (i.e. find out what was in the letter, give a hug, offer a tissue, celebrate) and 0 point if the response was incongruous or focused on the participant’s feelings (i.e. cry, shout at them).

(For A-TEP see **Appendix 7**).

The Empat (McGrath, Cann and Konopasky, 1998)

The Empat was chosen because it measures empathy for non-specific victims of sexual assault, and can be used with both sex-offenders and non-offenders. The Empat is divided into two scales (each using a 5-point Likert scale): the Empat-A, containing 34 items measuring empathy for non-specific victims of sexual abuse and the Empat-G, containing 18 items measuring general empathy. The scales have been demonstrated to have sufficient test-retest reliability ($r = .58$, $r = .82$, Empat-A and Empat-G respectively) and internal reliabilities (alpha levels $.89-.93$, $.69-.84$, Empat-A and Empat-G respectively) (Tierney et al. 2001). (See **Appendix 8** for Empat).

Adapted Empat (A-Empat)

For the purpose of this study, the Empat was adapted to make it more suitable for an ID population. This followed guidelines outlined by Keeling, Rose and Beech (2007). The adaptation procedure involved consultation between two clinicians to identify potential difficulties. The sentence length of questions were shortened, vocabulary simplified and ambiguities removed. Readability statistics were obtained from Microsoft Word XP Grammar Check using the Flesch reading ease, which rates text on a 100-point scale, with a score closer to 100 indicating ease of reading. Keeling et al. (2007)

recommended an acceptable standard as 60-70. Items were adapted in order to meet a minimum score of 60 on the Flesch reading ease. Reading ease ranges from 68.6 to 100 on the A-Empat-G and 71.4 to 96 on the A-Empat-A. .

Some further adaptations were made: items specific to victims of child sexual abuse were changed so they relate to all victims of sexual assault; to make it more suitable for the sex-offender group. Items deemed culturally inappropriate (i.e. “A lot of war veterans exaggerate their problems to get money from the government”) and items deemed racist (i.e. “Individuals who have moved to Canada from other countries are being given jobs that rightfully belong to Canadians”) were removed. Finally, a number of items were removed to reduce repetition of ideas. Items chosen to remain in the questionnaire were those scoring highest on readability scores, which resulted in a final questionnaire of 10 items measuring general empathy and 10 items measuring empathy for non-specific victims of sexual assault. As with the original, the questionnaire uses a 5-point Likert scale (strongly agree, agree, neutral, disagree, strongly disagree); however, these are accompanied by visual aids. The test is scored as with the original: a high score indicates a high level of empathy, whereas a low score, a low level of empathy. (See **Appendix 9** for A-Empat).

The Victim Empathy Distortion Scale (QVES, Beckett & Fisher, 1994).

The QVES measures victim empathy specific to the individual’s offending and can only be used with the sex-offender group. This study used the A-QVES (Keeling et al., 2007) version which is an adapted version of the QVES for the use with people with ID. It contains 30 items on a 4-point Likert scale (see **Appendix 10**). A high score indicates a low level of empathy towards the victim. According to Keeling et al. (2007) the A-QVES was significantly correlated with the original version (QVES, $\rho = .631$, $p < 0.01$, two-tailed), it had a high internal consistency ($\alpha = .88$). They also reported high test-

retest reliability and a high correlation with the Empat-A scale, although they did not report the exact values.

Procedure

Participants were interviewed individually. Once consent was gained, the measures were given in random order; both the A-Empat and A-QVES were read out to participants. Testing took between 45-90 minutes, depending on the ability of the individual participant. A number of participants struggled on some of the items in the A-Empat and for this reason, the wording was not stuck to rigidly but questions were reworded, until the participant understood, without losing the essence of the question (i.e. Question 5: “Sex-offenders should not be given long sentences; it’s not as if they killed anyone”, was changed to “Sex-offenders should not be sent to prison for a long time, they haven’t murdered anyone”; Question 1: “There is no reason for so many overweight people. They should stop eating so much”, to “The only reason people are fat is because they eat too much”). At the end of testing, participants were asked if they had any questions and given a chance to talk about the measures.

Results

Internal Consistency Analysis

Prior to conducting analyses on the empathy measures it was necessary to determine the internal consistencies of the measures (see Table 1). This was particularly important for the A-Empat which was adapted for the use with an ID population.

Table 1 Cronbach Alphas* for the A-Empat and A-QVES

| | A-EmpatA | A-EmpatG | A-QVES |
|---------------|---------------|---------------|---------------|
| Sex-offenders | .68 (N=19) | .55 (N=19) | .49 (N=13) |
| Non-offenders | .28 (N=17) | .06 (N=21) | |
| Whole Sample | .57 (N=36) | .37 (n=39) | |

*A Cronbach’s Alpha of $> .7$ is considered acceptable (George and Mallery, 2003)

The A-EmpatA had a marginal-poor internal consistency for the whole sample, and just below acceptable for the sex-offender group; however the internal consistency was poor for the non-offender group. The A-EmpatG had a marginal-poor internal consistency for sex-offender group; however the internal consistency was poor for the whole sample and very poor for the non-offender group. Both scales had much lower internal consistencies than those reported for the original scale by Tierney et al. (2001) (EmpatA, $\alpha = .92$ for sex-offenders, $\alpha = .89$ for community controls; EmpatG, $\alpha = .68$ for sex-offenders, $\alpha = .84$ for community controls).

The A-QVES had fairly poor internal consistency and was much lower compared to the internal consistency ($\alpha = .771$) reported by Keeling et al. (2007). It is likely that the internal consistency of the A-QVES reported in this study was affected by the small number of sex-offenders who completed the scale ($N=13$) compared to ($N=69$) in Keeling et al.'s (2007) study. Furthermore, out of those who completed the A-QVES all of them admitted their offences, whereas five out of the remaining eight sex-offenders, who did not complete, refused because they denied their offences and therefore did not see the scale as relevant¹. Moreover, of the sex-offenders who completed the A-QVES, 69% had received treatment, whereas 0% of the 'refusers' had received any treatment. This was reflected in the overall scores on the A-QVES which ranged from 7-42%, (mean = 23.54%) and the large number of items which had zero variance due to all participants scoring 0; demonstrating the offenders had moderate-high empathy for their victim/s, and further affecting the internal consistency of the scale.

¹ The remaining three sex-offenders failed to complete the A-QVES fully and were therefore eliminated from the analysis.

General and Victim Empathy

To investigate differences between the sex-offenders' and non-offenders' scores on general and victim empathy, Mann Whitney U tests were used to compare scores on the A-EmpatA and A-EmpatG. A non parametric test was chosen as the data violated the assumptions of parametric tests. Two participants in the sex-offender group and one person in the non-offender group failed to complete the A-Empat. A further three participants in the non-offender group failed to complete the A-EmpatA scale; this was due to not understanding the concepts of sexual abuse and related terms.

There were no differences between sex-offenders and non-offenders on general empathy (measured by A-EmpatG): $U(N_1 = 19; N_2 = 20) = 189.5, p = .989$.

There was also no difference between group scores on the A-EmpatA: $U(N_1=19, N_2=17) = 125.5, p = .214$. Both findings should be interpreted with caution, as it is likely that the sample sizes were too small to find a significant difference. In fact a post-hoc power analysis using G*Power revealed that using the effect size produced by the study ($d = .53$), $\alpha = .05$, the sample size ($N_1=19, N_2=17$) provides 34% power and therefore a much larger sample size is required to detect whether there is a difference. Further caution should be taken when interpreting the results due to the poor internal consistencies reported for the A-EmpatA & G.

Correlational Analyses

Separate Spearman's rho correlations were calculated for each group between measures. There was no significant relationship between the non-offender's scores on the A-EmpatA and A-EmpatG ($\rho = .369, N = 17, p = .15$).

The sex-offenders' scores on general empathy (A-EmpatG) were unrelated to their scores on empathy towards non-specific victims of sexual assault (A-EmpatA) ($\rho = 0.271, N = 19, p = .26$) and unrelated to their scores on empathy towards their own victim

(A-QVES) ($\rho=0.293$, $N=13$, $p=.36$). Furthermore, there was no significant relationship between the sex-offenders' scores on empathy towards non-specific victims of sexual assault and their scores on empathy towards their own victim ($\rho= .046$, $N=13$, $p=.89$). As mentioned previously, these results should be interpreted cautiously due to the low internal consistency of the A-EmpatA. Furthermore it should be noted that 69% of those sex-offenders who completed the A-QVES had completed some form of treatment and so their scores on this measure will not be representative of the scores of sex-offenders with ID who have not received any treatment.

Components of Empathy

To analyse differences in scores on components of empathy between groups, separate analyses were performed for each component of the A-TEP. As there were both between variables (groups: sex-offender/non-offender) and within variables (emotions: happy/sad/angry), the design requires a 2x3 analysis of variance; however much of the data provided by the variables was non-continuous and did not meet the criteria for parametric analysis. Therefore a 'randomisation analysis of variance' (RANOVA) was chosen to analyse the data. The RANOVA is a powerful, non-parametric equivalent of ANOVA in which significance is assessed in terms of random permutations rather than the F distribution. It is also the only non-parametric test able to analyse two-way designs. The only requirement of the RANOVA is that observations within each sample are independent of one another. All RANOVA tests were carried out using 5000 permutations of the data. Two participants in the sex-offender group and one participant in the non-offender group failed to complete the A-TEP fully and therefore had to be excluded from the analyses. Mean scores and standard deviations are displayed in Table 2. Scores can range between 0-2 on all variables for each emotion (happy, sad, angry), with low scores indicating poorer ability; except for number of

prompts and response time. Scores for number of prompts for each emotion can range 0-8, with higher scores indicating poorer ability. There is no maximum score for response time and a high response time indicates poorer ability. RANOVA F values are displayed in Table 3.

Table 2. A-TEP Means (SD)

| Variable | Group | N | Happy | Sad | Angry |
|---------------------|-------|-----|---------------|---------------|---------------|
| Emotion Recognition | S.O. | 19 | 1.95 (.23) | 1.68 (.58) | 1.37 (.76) |
| | N.O. | 20 | 2.00 (.00) | 1.30 (.73) | 1.05 (.83) |
| No. of Prompts | S.O. | 19 | 1.89 (2.40) | 2.63 (2.48) | 1.37 (2.14) |
| | N.O. | 20 | 2.45 (3.00) | 2.85 (2.23) | 4.00 (3.36) |
| Perspective Taking | S.O. | 19 | 1.26 (.87) | 1.26 (.73) | .74 (.73) |
| | N.O. | 20 | 1.55 (.61) | .85 (.81) | .40 (.60) |
| Emotion Replication | S.O. | 19 | 1.53 (.77) | 1.42 (.77) | .79 (.86) |
| | N.O. | 20 | 1.65 (.67) | .85 (.88) | .35 (.59) |
| Response Decision | S.O. | 19 | .89 (.94) | .84 (.96) | .63 (.76) |
| | N.O. | 20 | .25 (.55) | .65 (.88) | .30 (.57) |
| Picture Selection | S.O. | 19 | 1.47 (.61) | 1.26 (.65) | 1.16 (.83) |
| | N.O. | 20 | 1.30 (.66) | .90 (.79) | 1.05 (.69) |
| Response Time | S.O. | 19 | 26.65 (24.04) | 26.74 (24.82) | 29.74 (31.73) |
| | N.O. | 20 | 31.70 (31.13) | 35.80 (26.36) | 31.95 (31.28) |

Table 3. RANOVA Results for A-TEP

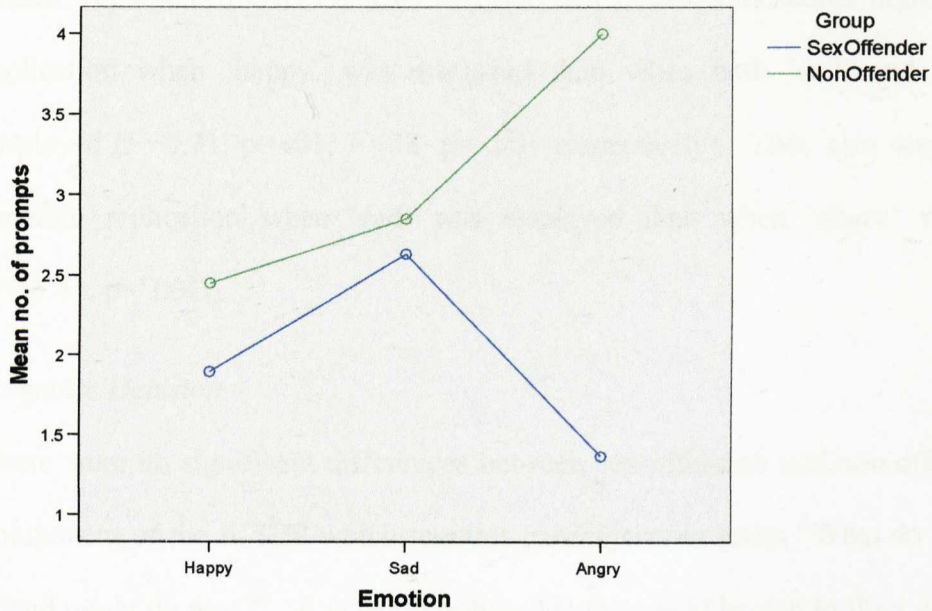
| Variable | Main Effects | | Interaction |
|---------------------|--------------------|----------------------|--------------------|
| | Group | Emotion | Group*Emotion |
| Emotion Recognition | F = 3.58, p = .09 | F = 16.53, p = .001* | F = 1.51, p = .23 |
| No. of Prompts | F = 3.59, p = .06 | F = .75, p = .47 | F = 3.17, p = .05* |
| Perspective Taking | F = 1.06, p = .30 | F = 14.85, p = .001* | F = 3.03, p = .06 |
| Emotion Replication | F = 3.01, p = 0.08 | F = 23.24, p = .001* | F = 2.99, p = .06 |
| Response Decision | F = 3.58, p = .08 | F = 2.52, p = .08 | F = 1.66, p = .20 |
| Picture Selection | F = 2.52, p = .13 | F = 2.33, p = .10 | F = 0.35, p = .70 |
| Response Time | F = .56, p = .47 | F = 0.11, p = .88 | F = 0.27, p = .78 |

Emotion Recognition

There were no significant differences between sex-offender and non-offender scores on the emotion recognition component of the A-TEP. There were also no significant differences between groups on the number of prompts needed to provide an emotion descriptor. However, there was a significant group x emotion interaction on the number of prompts needed. The sex-offenders required least prompts to provide an emotion descriptor in the 'angry' scenario, whereas the non-offenders required the most prompts in the 'angry' scenario and the least prompts in the 'happy' scenario (see Figure 1); there was a significant difference between groups in the number of prompts they needed to provide an emotion descriptor in the 'angry' scenario ($F=8.423, p=.008$). There was also a significant main effect of the type of emotion displayed on the emotion

recognition scores. Post-hoc RANOVA tests (with Bonferroni correction, $p < .0167$) showed that 'happy' was correctly recognised significantly more often than 'sad' or 'angry' ($F = 18.79$, $p = .001$; $F = 34.62$, $p = .001$ respectively).

Figure 1 - Pattern of Mean No. of Prompts Required to Recognise an Emotion



Perspective Taking

There were no significant differences between sex-offenders and non-offenders on the perspective taking component of the A-TEP (scores on the question: "How do you think the friend was feeling?"). However, there was a significant main effect of the type of emotion displayed on the perspective taking scores. Post-hoc RANOVA tests showed that participants scored lower on perspective taking when 'angry' was displayed, than when both 'sad' and 'happy' were displayed ($F = 8.48$, $p = .006$; $F = 27.19$, $p = .001$ respectively).

Emotion Replication

There were no significant differences between sex-offenders and non-offenders on the emotion replication component of the A-TEP (scores on the question: “How would you feel if your friend received a letter/phone call like that?”). There was, however, a significant main effect of the type of emotion displayed on the emotion replication scores. Post-hoc RANOVA tests revealed that participants scored higher on emotion replication when ‘happy’ was displayed than when both ‘sad’ and ‘angry’ were displayed ($F=6.71$, $p=.01$; $F=38$, $p=.001$ respectively). They also scored higher on emotion replication when ‘sad’ was displayed than when ‘angry’ was displayed ($F=9.44$, $p=.004$).

Response Decision

There were no significant differences between sex-offenders and non-offenders on the component of the A-TEP which requires participants to guess “What do you think the friend might do next?”. It is worth noting that this could be due to floor effects; overall participants scored low on this component and, depending on the emotion displayed in the scenario, up to half of the participants answered with “don’t know” responses. There were also no significant differences on the picture selection task or on the time it took to make a picture selection. Furthermore, no main effects of emotion displayed or emotion \times group interaction were found.

Post-hoc power analysis

As the a priori power analysis was based on an estimate of effect size, a post-hoc power analysis was done based on the effect sizes produced by this study. Based on using ANOVA analysis, an average effect size ($f=.313$), $\alpha=.05$, total $N=39$, average correlation between repeated measures = .239, this provides 93.5% power;

demonstrating that the sample size was large enough to detect a difference between and within groups on the measures of the A-TEP.

Additional Analyses

Additional analyses were performed to investigate whether there were any differences between those sex-offenders who had received treatment, those who had not received treatment, and non-offenders on measures of empathy.

A-Empat

Using Kruskal-Wallis analysis, no significant differences were found between the three groups on scores on the A-EmpatA or the A-EmpatG ($\chi^2(2) = 2.6, p=.73$; $\chi^2(2) = .54, p=.76$ respectively).

A-TEP

Separate RANOVAs were used to analyse differences between the three groups on scores of: emotion recognition, perspective taking, emotion replication and response decision.

Emotion Recognition

A significant difference was found between groups on scores of emotion recognition ($F=16.41, p=.019$). Post-hoc RANOVAs (using Bonferroni correction, $p=.0167$) revealed that sex-offenders who had received treatment scored significantly higher on emotion recognition than non-offenders ($F=9.83, p=.007$). No significant differences were found between sex-offenders who had not received treatment and sex-offenders who had, or non-offenders.

Perspective Taking

No significant difference was found between groups on scores of perspective taking ($F=2.95, p=.069$).

Emotion Replication

A significant difference was found between groups on scores of emotion replication ($F=23.20$, $p=.011$). Post-hoc RANOVAs revealed that sex-offenders who had received treatment scored significantly higher than both sex-offenders who had not received treatment and non-offenders ($F=7.20$, $p=.014$; $F=9.45$, $p=.007$ respectively). There was no difference between sex-offenders not receiving treatment and non-offenders.

Response Decision

A significant difference was found between the group scores on the question: “What do you think the friend might do next?” ($F=6.08$, $p=.007$). Post-Hoc RANOVAs revealed that the sex-offenders who had received treatment scored significantly higher than the non-offenders ($F=11.97$, $p=.004$). No significant differences were found between sex-offenders who had not received treatment and those who had received treatment or non-offenders.

Discussion

The present study examined empathy in sex-offenders with intellectual and developmental disabilities. Empathy was conceptualised as a multi-component concept and tests were selected in order to measure its component parts based on the model proposed by Marshall et al.’s (1995). Further tests were also chosen to measure person specific empathy; namely empathy towards non-specific victims of sexual assault and empathy towards the offender’s own victim.

General and Victim Empathy

No significant differences were found between sex-offenders and non-offenders with ID on measures of general empathy (A-EmpatG) and empathy towards non-specific victims of sexual assault (A-EmpatA). Given the low internal consistency of the scales and the

small sample size, these findings should be interpreted with caution. Furthermore, the low internal consistency raises the question whether the constructs of general empathy and empathy towards non-specific victims of sexual assault were measured at all. Unfortunately this does not help further our understanding of general and victim empathy in sex-offenders with ID. Whereas studies using the Empat with sex-offenders without ID have found that sex-offenders are less empathic towards non-specific victims of sexual assault than non-offending controls (Tierney & McCabe 2001), as yet no studies have been published which investigate these concepts in sex-offenders with ID. Clearly, further research is needed to clarify whether the same differences exist in sex-offenders with ID.

When investigating the relationships between the sex-offenders' scores on: general empathy, empathy towards non-specific victims of sexual assault, and empathy towards the offenders' own victims, no significant relationships were found. This was in line with previous research in sex-offenders without ID (Fernandez & Marshall, 2003). No relationship was found between sex-offenders' scores on empathy towards their own victim and towards non-specific victims of sexual assault. This was against the findings of Keeling et al.'s (2007). Where it is possible that the poor internal consistency of the A-Empat, and the poor internal consistency of the A-QVES (found in this study) goes some way to explaining this lack of relationship; it is likely that scores on the A-QVES were affected by the large proportion of those offenders completing it having received some treatment. This was reflected in their scores which demonstrated moderate-high levels of empathy towards their own victims and in turn may also explain the lack of relationship between scores on empathy towards non-specific victims of sexual assault and scores on empathy towards their own victim/s. The majority of the participants completing the A-QVES were also familiar with it, having completed it as part of the

treatment process. Furthermore, all the sex-offenders completing the A-QVES admitted their offences, whereas those who refused did so because they denied their offences. As it is possible that there are differences in empathy between these subgroups, this is an area worth pursuing in future research. A measure of socially desirable responses should be included in this research.

Further research should also focus on designing or adapting a suitable measure of general empathy and empathy towards non-specific victims of sexual assault for use with sex-offenders with ID. The adapted Empat used in this study was very difficult for participants to understand and it is likely that not sticking to the exact wording of every question, with every participant, was a factor which resulted in its poor internal consistency. This has highlighted the importance of piloting and validating measures before they are put to formal use in research. It would additionally be useful to develop a scale which measures all three concepts in one (general, non-specific victim empathy and empathy towards the offender's own victim), so that more accurate comparisons between the sex-offenders' scores on these measures can be made. One such measure, the Rapist Empathy Measure (Fernandez & Marshall, 2003), has been developed for use with sex-offenders without disabilities. Whilst it was thought that this measure would be too difficult for people with ID, due to the use of written vignettes which requires respondents to hold a lot of information in mind while answering a large number of questions; future research could investigate the utility of this measure with sex-offenders with ID. The use of video vignettes may be one way of adapting this; although the 'vignette' describing the offender's own victim would have to rely on the offender's memory of the events instead, which is what the A-QVES already does.

Components of Empathy

There were no significant differences between sex-offenders and non-offenders with ID on any of the components of empathy: emotion recognition, perspective taking, emotion replication, response decision; as measured by the A-TEP. However interestingly, further analyses revealed that when the sex-offender group was divided into: those who had received treatment and those who had not and then compared to the non-offender group; the sex-offenders who had received treatment performed better than the non-offenders on emotion recognition and response decision, as well as better than both the non-offenders and those sex-offenders who had not received treatment on emotion replication.

The TEP was chosen for use in this study because it was designed for use with people with ID. The emotion recognition measure is particularly suitable because it uses video scenarios of emotions being expressed in a natural way, which has been found to be a more accurate way of measuring emotion recognition in people with ID than using photographs, words or symbols to represent emotions (Harwood, Hall & Shrinkfield, 1999). Therefore taken at face value, the results of this study demonstrate that sex-offenders with ID do not perform any more poorly than non-offenders with ID on recognising the emotions: happy, sad or angry; however those sex-offenders who had received some treatment performed *better* than non-offenders. Whilst these findings are promising, they do not provide us with any insight into whether sex-offenders with ID have difficulties recognising emotions such as fear or disgust; emotions which are likely to be salient in victims during a sexual assault. Furthermore, whilst it may be true that sex-offenders are able to recognise emotions demonstrated in simple video scenarios, we can still not be sure how sex-offenders interpret emotions in more complex hetero-

social interactions. Further research should investigate this; a useful way may be to use video scenarios similar to those developed by Lipton et al. (1987).

The finding that sex-offenders with ID did not perform any differently to non-offenders with ID on the measure of perspective taking is also difficult to interpret. The question: "How do you think the friend was feeling?" was added to the original TEP in an attempt to measure perspective taking. However, where it suggests that participants were equally able to understand that the person in the video was likely to feel the same as their friend who received the news, it does not shed any light on whether sex-offenders can understand the victim's perspective before or during the assault. Further use of video scenarios could help to clarify this.

Similar problems are present when attempting to interpret the scores on measures of emotion replication and response decision. Emotion replication was again measured by one question: "How would you feel if your friend received a letter/phone call like that?". Where the scores suggest that sex-offenders who had received treatment were more likely to report feeling similar emotions to their friend, in an emotional situation, than non-offenders and those sex-offenders who had not received treatment; using a single question about a hypothetical situation to measure this concept is unconvincing. Similar difficulties are present when using the question: "What do you think the friend might do next?", to assess response decision skills. This question also proved difficult for a number of participants to answer, perhaps due to its vagueness. However, it seemed important to add another measure of response decision due to doubts about the utility of using photographs of the friend's responses to measure response decision. It seemed more likely that this measured the participant's ability to match the emotions in the photographs to that shown in the video, and this was indeed the answer most participants gave when asked why they chose a particular picture. It could also be

argued that the time taken to pick a photograph provides a more meaningful measure of the participant's processing speed, than it does the time it would take them to make a decision on what response to take. Although it appears that sex-offenders who had received treatment performed better on answering the question: "What do you think the friend might do next?"; further investigation of response decision skills in sex-offenders with ID is warranted. A more meaningful way of measuring the concept of response decision could be to use a series of questions measuring sex-offenders' perceived responses to different scenarios (may be video scenarios) including scenarios which could be interpreted as leading to sexual assault.

Finally in order to investigate whether some emotions were processed or responded to more easily, results for the different emotions were compared. These analyses revealed that participants: recognised happy significantly more often than sad and angry; were more able to take the 'friend's' perspective when the person in the video showed the emotions happy or sad, than when the person displayed anger; and were more able to replicate the same emotion when happy was displayed than both sad or angry, sad was also easier to replicate than angry. This is in line with previous research showing that happiness is the easiest emotion for people with ID to decode (McAlpine et al., 1992), whereas emotions: anger and fear are more difficult (Kasari et al., 2001; Gioia & Broscole, 1988). These findings support the idea that empathy skills may vary across emotions, further supporting the idea that empathy is not a 'trait' but a skill which is affected by many factors. Therefore performance on components of empathy should not only be measured across a wide range of emotions, but across different situations and towards different people.

Given the paucity of research into the components of empathy in sex-offenders with ID, it is impossible to make any direct comparisons with previous research. Furthermore,

although literature exists on these components in sex-offenders and in children with ID, the findings are conflicting. Moreover, the inherent differences between these groups and sex-offenders with ID, makes their findings difficult to compare to the results in this study; particularly as including sex-offender and non-offender without ID control groups, was beyond the scope of this study. It should be noted that without these additional controls, the results from this study cannot establish whether the participants in this study would have poorer empathy skills than non-offenders or indeed sex-offenders without ID.

The only study which allows some comparisons to be made was carried out by Proctor & Beail (2007), who compared the skills of offenders and non-offenders with ID on three components of empathy: emotion recognition, emotion replication and response decision. Although the study also found very few differences between offenders and non-offenders with ID, it was reported that offenders performed significantly *better* on the emotion recognition task and gave empathic responses significantly more often when 'happy' was displayed, than non-offenders. Given the findings of the present study, it is possible that only the offenders in Proctor and Beail's (2007) study who had received some treatment account for the higher scores on emotion recognition and response decision; however as these analyses were not carried out, conclusions about this cannot be made. Finally, without the existence of previous studies investigating sex-offenders who have received treatment and those who have not, it is difficult to know how to interpret the findings in this study. Although it is possible that the sex-offenders who had treatment were better at the skills of emotion recognition, emotion replication and response decision as a result of treatment, it could equally be possible that the sex-offenders were chosen for treatment because they were better at some of these skills and hence would better understand the 'language' or components used in

treatment programmes. Until further research is conducted to clarify these issues, all that can be concluded is that sex-offenders with ID who have received treatment perform better than non-offenders with ID on emotion recognition, emotion replication and response decision, as measured by the A-TEP.

Clinical Implications

Without further research into empathy in sex-offenders with ID, it is difficult to draw any firm conclusions about how important empathy training is in the treatment of sex-offenders with ID, nor whether empathy training should focus on developing specific components of empathy. Whilst the findings in this study show that sex-offenders were equal in their skills of perspective taking to non-offenders with ID, they also demonstrated that those sex-offenders who had received treatment were more skilled than non-offenders with ID on: emotion recognition, perspective taking and response decision skills. It is possible that the sex-offenders who had treatment had more advanced skills than non-offenders as a result of this treatment; however it is equally likely that they were selected for treatment programmes because they had a better understanding of some of these concepts and hence may have been viewed as more 'treatable'. Moreover, without the inclusion of sex-offender and non-offender without ID control groups, it is impossible to establish whether sex-offenders have empathy deficits relative to people without ID. However, despite the many limitations of the present study, it highlights the complexity of investigating causes of sexual offending in people with ID. The aetiology of sexual offending in people with ID is likely to be multi-factorial and is likely to differ from individual to individual; as a result thorough assessment and formulation is required, so that treatment can meet each individual's needs. Finally, whilst recommendations cannot be made from this study to the treatment of sex-offenders with ID, in the spirit of thorough assessment and formulation

of the individual sex-offender's needs, deficits in empathy should still be assessed for. In line with Marshall et al.'s (1995) model, an assessment of the separate components of empathy may be useful in locating deficits. Assessment of empathy should also consider empathy across different situations, different people and different emotions, in particular negative emotions, such as anger and fear.

Conclusions

Sex-offenders and non-offenders with ID performed the same on measures of general empathy and empathy towards non-specific victims of sexual assault. There was no relationship between the sex-offenders' scores on empathy towards non-specific victims of sexual assault and empathy towards their own victim. However these results need to be interpreted cautiously due to the low internal consistencies of the measures, reported in this study.

There were no significant differences between sex-offenders and non-offenders on the components of empathy: emotion recognition, perspective taking, emotion replication, response decision. However, when the sex-offender group was sub-divided into those who had received treatment and those who had not, the sex-offenders who had received treatment performed better on tasks of emotion recognition, emotion replication and response decision than the non-offenders. These findings are difficult to interpret without further research. Future research should focus on developing measures of general and victim specific empathy which are suitable for use with sex-offenders with ID. Further research into the components of empathy in sex-offenders with ID needs to develop measures which are more relevant to sexual offending.

Finally separate analyses revealed that happy is easier to process than angry and sad, this supports the idea that components of empathy should be measured across different emotions.

References

- Bacon, A. L., Fein, D., Morris, R., Waterhouse, L. & Allen, A. (1998). The responses of autistic children to the distress of others. *Journal of Autism and Developmental Disorders*, 28, 129-142.
- Beckett, R. & Fisher, D. (1991). Victim Empathy Scale (Unpublished), cited in M. K. Whittaker, J. Brown, R. Beckett & C. Gerhold. (2006). Sexual knowledge and empathy: A comparison of adolescent child molesters and non-offending adolescents. *Journal of Sexual Aggression*, 12, 143-154.
- Beckett, R. C. & Fisher, D. (1994). *Assessing Victim Empathy: A New Measure*. Paper presented at the 13th Annual Conference of the Association for the Treatment of Sexual Abusers, San Francisco.
- Beech, A., Fisher, D. & Beckett, R. (1998). *STEP 3: An Evaluation of the Prison Sex Offender Treatment Programme*. London: Home Office Publication group.
- Bender, N. N. & Carlson, J. S. (1982). Prosocial behaviour and perspective-taking of mentally retarded and nonretarded children. *American Journal of Mental Deficiency*, 86, 361-366.
- Blair, R. J. R. (1999). Psycho physiological responsiveness to the distress of others in children with autism. *Personality and Individual Differences*, 26, 477-485.
- Bliss, L. S. (1985). The development of persuasive strategies by mentally retarded children. *Applied Research in Mental Retardation*, 6, 437-447.
- Davis, M. H. (1983). Measuring individual differences in empathy: Evidence for a multidimensional approach. *Journal of Personality and Social Psychology*, 44, 113-126.

- Doyle, M. (2004). Empathy, loneliness and 'theory of mind' in sexually abusive men with intellectual disability. *Journal of Intellectual Disability Research, 48*, 464-464.
- Fernandez, Y. M. & Marshal, W. L. (2003). Victim empathy, social self-esteem, and psychopathy in rapists. *Sexual Abuse: A Journal of Research and Treatment, 15*, 11-25.
- Fernandez, Y. M., Marshall, W. L., Lightbody, S. & O'Sullivan, C. (1999). The Child Molester Empathy Measure: Description and Examination of Its Reliability and Validity. *Sexual Abuse: A Journal of Research and Treatment, 11*, 17-31.
- Fisher, D., Beech, A. & Browne, K. (1999). Comparison of sex-offenders to non offenders on selected psychological measures. *International Journal of Offender Therapy and Comparative Criminology, 43*, 473-491.
- George, D., & Mallery, P. (2003). *SPSS for Windows step by step: A simple guide and reference. 11.0 update* (4th ed.). Boston: Allyn & Bacon.
- Gianni, A. J. & Fellows, K. W. (1986). Enhanced Interpretation of Nonverbal Facial Cues in Male Rapists - A Preliminary Study. *Archives of Sexual Behavior, 15*, 153-156.
- Gioia, J. V. & Broscole, L. (1988). Visual and auditory affect recognition in singly diagnosed mentally retarded patients, mentally retarded patients with autism and normal young children. *International Journal of Neuroscience, 43*, 149-163.
- Harwood, N. K., Hall, L. J. & Shinkfield, A. J. (1999). Recognition of facial emotional expressions from moving and static displays by individuals with mental retardation. *American Journal on Mental retardation, 104*, 270-278.
- Hogan, R. (1969). Development of an empathy scale. *Journal of Consulting and Clinical Psychology, 33*, 307-316.

- Hudson, S. M., Marshall, W. L., Wales, D., McDonald, E., Bakker, L. W. & McLean, A. (1993). Emotional recognition skills in sex-offenders. *Annals of Sex Research, 6*, 199-211.
- Kasari, C., Freeman, S. F. N. & Bass, W. (2003). Empathy and response to distress in children with Down syndrome. *Journal of Child Psychology and Psychiatry, 44*, 424-431.
- Kasari, C., Freeman, S. F. N. & Hughes, M. A. (2001). Emotion recognition by children with Down Syndrome. *American Journal on mental Retardation, 106*, 59-72.
- Keeling, J. A., Rose, J. I. & Beech, A. R. (2007). A Preliminary Evaluation of the Adaptation of Four Assessments for Offenders with Special Needs. *Journal of Intellectual & Developmental Disability, 32*, 61-73.
- Langevin, R., Write, P. & Handy, L. (1988). Empathy, assertiveness, and defensiveness among sex-offenders. *Annals of Sex Research, 1*, 533-547.
- Lindsay, W. R. (2002). Research and literature on sex-offenders with intellectual and developmental disabilities. *Journal of Intellectual Disability Research, 46* (Suppl.1), 74- 85.
- Lindsey, R. E., Carlozzi, A. F. & Eells, G. T. (2001). Differences in the dispositional empathy of juvenile sex-offenders, non-sex-offending delinquent juveniles, and nondelinquent juveniles. *Journal of Interpersonal Violence, 16*, 510-522.
- Lipton, D.N., McDonel, E.C. & McFall, R.M. (1987). Heterosocial Perception in Rapists. *Journal of Consulting and Clinical Psychology, 55*, 17-21.
- Malamuth, M. & Brown, L. M. (1994). Sexually aggressive men's perception of women's communications: testing three explanations. *Journal of Personality and Social Psychology, 67*, 699-712.

- Marshall, W. L. & Maric, A. (1996). Cognitive and emotional components of generalised empathy deficits in child molesters. *Journal of Child Sexual Abuse*, 5, 101-110.
- Marshall, W. L. & Moulden, H. (2001). Hostility toward woman and victim empathy in rapists. *Sexual Abuse: A Journal of Research and Treatment*, 13, 249-255.
- Marshall, W. L., Champagne, F., Brown, C. & Miller, S. (1997). Empathy, intimacy, loneliness, and self-esteem in nonfamilial child molesters: A brief report. *Journal of Child Sexual Abuse*, 6, 87-98.
- Marshall, W. L., Hamilton, K. & Fernandez, Y. (2001). Empathy deficits and cognitive distortions in child molesters. *Sexual Abuse: A Journal of Research and Treatment*, 13, 123-130.
- Marshall, W. L., Hudson, S. M., Jones, R. & Fernandez, Y. M. (1995). Empathy in sex offenders. *Clinical Psychology Review*, 15, 99-115.
- Marshall, W. L., Jones, R., Hudson, S. M., & McDonald, E. (1993). Generalised empathy in child molesters. *Journal of Child Sexual Abuse*, 2, 61-68.
- McAlpine, C., Singh, N. N., Kendall, K. A. & Ellis, C. (1992). Recognition of facial expressions of emotion by persons with mental retardation: A matched comparison study. *Behavior Modification*, 16, 543-558.
- McDonel, E. C. & McFall, R. M. (1991). Construct validity of two heterosocial perception skill measures for assessing rape proclivity. *Violence and Victims*, 6, 17-30.
- McGrath, M., Cann, S. & Konopasky, R. (1998). New measures of defensiveness, empathy and cognitive distortions for sexual offenders against children. *Sexual Abuse: A Journal of Research and Treatment*, 10, 25-36.

- Moffatt, C. W., Hanley-Maxwell, C. & Donnellan, A. D. (1995). Discrimination of emotion, affective perspective-taking and empathy in individuals with mental retardation. *Education and Training in Mental Retardation and Developmental Disabilities, 30*, 76-85
- Moriarty, N., Stough, C., Tidmarsh, P., Eger, D. & Dennison, S. (2001). Deficits in emotional intelligence underlying adolescent sex offending. *Journal of Adolescence, 24*, 743-741.
- Murphy, W. D., Coleman, E. M. & Haynes, M. R. (1986). Factors related to coercive sexual behaviour in a nonclinical sample of males. *Violence and Victims, 1*, 255-278.
- Negri-Shoultz, N. & Donnellan, A. M. (1989). *The Test of Emotional Perception*. Unpublished manuscript. University of Wisconsin. In C.W. Moffatt, C. Hanley-Maxwell & A. M. Donnellan. Discrimination of emotion, affective perspective-taking and empathy in individuals with mental retardation. *Education and Training in mental Retardation and Developmental Disabilities, 30*, 76-85.
- O'Halloran, M., Carr, A., O'Reilly, G., Sheerin, D., Cherry, J., Turner, R., Beckett, R. & Brown, S. (2002). Psychological profiles of sexually abusive adolescents in Ireland. *Child Abuse and Neglect, 26*, 349-370.
- Proctor, T. & Beail, N. (2007). Empathy and theory of mind in offenders with intellectual disabilities. *Journal of Intellectual & Developmental Disability, 32*, 82-93.
- Puglia, M. L., Stough, C., Carter, J. D. & Joseph, M. (2005). The emotional intelligence of adult sex-offenders: ability based EI assessment. *Journal of Sexual Aggression, 11*, 249-258.

- Rice, M. E., Chaplin, T. C., Harris, G. T. & Coutts, J. (1994). Empathy for the victim and sexual arousal among rapists and non rapists. *Journal of Interpersonal Violence, 9*, 435-449.
- Rojahn, J., Rabold, D. & Schneider, F. (1995). Emotion specificity in mental retardation. *American Journal of Mental retardation, 99*, 477-486.
- Rose, J., Jenkins, R., O'Connor, C., Jones, C. & Felce, D. (2002). A group treatment for men with intellectual disabilities who sexually offend or abuse. *Journal of Applied Research in Intellectual Disabilities, 15*, 138-150.
- Scully, D. (1988). Convicted rapists' perceptions of self and victim: role taking and emotions. *Gender and Society, 2*, 200-213.
- Tierney, D.W. and McCabe, M.P. (2001). An Evaluation of Self-Report Measures of Cognitive Distortions and Empathy Among Australian Sex-offenders. *Archives of Sexual Behavior, 30*, 495-519.
- Whittaker, M. K., Brown, J., Beckett, R. & Gerhold, C. (2006). Sexual knowledge and empathy: A comparison of adolescent child molesters and non-offending adolescents. *Journal of Sexual Aggression, 12*, 143-154.
- Williams, K. R., Wishart, J. G., Pitcairn, T. K. & Willis D. S. (2005). Emotion recognition by children with Down syndrome: Investigation of specific impairments and errors patterns. *American Journal on Mental Retardation, 110*, 378-392.
- Wishart, J. G., Cebula, D. S., Willis, D. S. & Pitcairn, T. K. (2007). Understanding of facial expressions of emotion by children with intellectual disabilities of differing aetiology. *Journal of Intellectual Disability Research, 51*, 551-563.

Wood, E. & Riggs, S. (2008). Predictors of child molestation: adult attachment, cognitive distortions and empathy. *Journal of Interpersonal Violence, 23*, 259-275.

Section 3: Critical Reflection of the Research Process

Introduction

In this section I will reflect on the process of implementing and planning the research and what I learned through this process.

Origins of the project

Since completing a project on risk factors associated with juvenile offending during my first degree, I have had an interest in understanding causes of offending behaviour. When I started the clinical psychology doctorate I had hoped I would develop ideas for my research by identifying gaps in research during my placements, however as this did not happen, I was keen for ideas from potential supervisors at the research fair. The project which most caught my eye was a project following on from a previous trainee's thesis; looking at theory of mind and empathy in sex-offenders with intellectual disabilities (ID). This felt ideal to me; it was not only an area I was interested in, which I felt was of utmost importance if I was to remain enthusiastic and motivated for the best part of two years, but also somewhat 'safer' as it was developing on from a project which had successfully been through the ethics procedures and my supervisor would have all the relevant contacts for participants.

Despite wanting a project that I thought could be relatively straight forward; I wanted to feel that I could develop it with my own ideas. Firstly, I read the project it was going to be based upon and looked for limitations I could improve on. My supervisor was keen for me to look at both theory of mind (ToM) and empathy in sex-offenders with ID; however after reading the previous project it seemed that there had been a number of problems with the ToM measures used and other ToM measures in published research are either not validated with, or are not suitable for an ID population. Furthermore, after meeting with the trainee whose project I was following on from, she not only highlighted the problems she had with recruitment but also her empathy

measure (the IRI). After this meeting, I was convinced that I should focus on empathy only as this would reduce the time I would need to spend with participants and make recruitment easier. Through reviewing the literature, I also thought it would be more relevant to focus on victim empathy and not only general empathy, as had been the focus of the previous project. I put my ideas to my supervisor and he was happy to support me.

Implementation: Barriers and Facilitators

Despite thinking I had picked a 'safe' option, I was met by hurdle after hurdle in the implementation and then write up of this project. However regardless of this, my enthusiasm has hardly waned. I will reflect on this process and what facilitated me to remain motivated, when at so many times the odds seemed stacked against me.

Recruitment

Due to the relatively small number of sex-offenders with ID in any one region, I intended to begin recruitment by September 2007; however a large number of factors prevented this from happening. To increase my chances of recruiting the desired number of participants, I planned to recruit from and approached contacts in four NHS trusts, and a private hospital. I was assured that obtaining ethical approval for a multi-site study was simpler than it had previously been, due to changes in the ethics procedures. However, with the recent changes, came confusion over which procedures I needed to follow, both for obtaining ethical approval and governance approval. I was given conflicting advice as to which Ethics board I needed to submit my research to, which delayed the ethics process.

After obtaining ethical clearance at the end November 2007, I began the process of applying for research governance but again I found it very difficult to find the advice I needed to complete governance approval. When it was finally confirmed I needed to

complete separate governance procedures for each site, it was then not until after I have submitted the forms that I was informed I needed to complete separate CRB checks for two sites where I planned to recruit participants to the sex-offender group. CRB clearance took 3-4 months and I did not receive governance clearance to begin recruiting participants to the sex-offender groups until May and June 2008. To further add my frustration, it took me 15 months of persistent emails to the author in America to obtain a copy of the Test of Emotional Perception.

I began recruitment of participants to the non-offender group first, in April 2008. It was not ideal to recruit these participants first as I planned to match these to the participants in the sex-offender group. Recruitment was slow due to the first day service only being open on Fridays and most clients left after lunch which left me with 3 hours; enough time to interview 2-3 participants. However, I found the service manager and staff incredibly helpful and the majority of clients were keen to take part.

In terms of recruiting participants to the sex-offender group, I planned to obtain half of the participants in the private hospital. Through prior liaison with the consultant psychologist, I had initial consent from twelve patients that they would take part. However, in the time it took to obtain my CRB clearance, the consultant had left the service and due to various political reasons a large number of patients had been moved. I was left with four patients to interview. Furthermore, despite being promised that the details of my project had been passed to the new consultant, this was the case. When I finally got in touch with him, he was concerned about my consent procedures and insisted I change my consent forms; this resulted in further delays due to having to submit an amendment to the Ethics board. The new consultant was also not very keen for the assistant psychologist's time to be used up escorting me with patients. With

some negotiation he agreed, however, it was difficult to book in times with the assistant and as a result I had to make three 120 mile round trips to interview four participants.

Recruiting participants continued to be a challenge, despite approaching and presenting my research at many different organisations for people with learning disabilities, three out of seven organisations I approached either would not consent to me approaching their clients or could not find clients who would consent. A further organisation agreed on the grounds that I sent a letter to parents and carers first to gain their consent. However, after leaving copies of the letter with the service manager to send to parents, I was unable to get back in touch with her in time to pursue recruitment. This was frustrating as it took up valuable time which I could have been using to interview participants. To try and problem solve the difficulties with recruitment, I approached contacts in the Midlands and West Yorkshire, but without luck.

At the end of May and June 2008 I struck some luck. A new consultant psychologist had been appointed in a secure hospital for offenders with learning disabilities. He was very interested in the project and agreed to support me with recruitment as quickly as possible. I further received enthusiastic support from the head of a regional probation service and the manager of another day service for people with learning disabilities. I finished recruitment with fewer participants than I had hoped for, in the first week of July 2008; however I had exhausted all of my resources.

Measures

Due to delays receiving the TEP from America, I felt that I did not have the time to pilot the measures prior to starting the research. I was also unsure whether I required Ethics approval before I could start piloting, although admittedly I did not check this out. The A-Empat proved very difficult for a number of participants to understand, and it took some time and explaining with the first few participants to understand the questions. It

was helpful having client's key workers present, as they were able to point out when they thought the client did not understand, which was not always obvious, they were also helpful with explaining in a way they thought the client would understand. Once I had established which questions were most difficult and which wording explained the questions so that participants could understand, I made notes of this and tried to stick to similar wording with other participants. However, it is likely that the complexity of this measure and not sticking to the exact same wording with each participant affected the internal consistency of this test. I would certainly make piloting of measures a priority with research in the future.

Writing up

The focus of all my study days up until I had finished interviewing was on recruiting participants. This left all the scoring of the questionnaires, analysis and write up of the research report to be completed in July 2008. Unfortunately, I began to struggle with chronic neck and shoulder pain in the months leading up to July and although I was given a two week extension, during this time I suffered with a slipped disc and had to manage my pain whilst trying to finish the write up. The write up has been a struggle but I was determined to complete it.

Maintaining Motivation

Despite all the complications with my study, I maintained motivation throughout. There were times when I questioned whether I should give up and start a new project; however I was reluctant to start something new after all the effort that had gone in and resigned myself to complete the project even if it meant having to submit at a later date. This decision, as well as my continued interest in the topic kept me motivated. Another factor which helped was that once I started the interviews I really enjoyed it. I enjoyed meeting the diverse participants and I also enjoyed the opportunity to spend time in

many different organisations, gaining insight into how they work and learning from the staff I met.

Supervision

At the beginning of the project I worked quite autonomously, only contacting my university supervisor when I needed to check things out. I initially relied on him for research contacts and whilst I liaised with all the NHS and local authority managers/consultant psychologists, he agreed to liaise with the consultant psychologist at the private hospital. Although my university supervisor informed me that the consultant psychologist at the private hospital would be my 'field' supervisor, this was never formally discussed between the three of us and by the time I had ethical clearance for the project and met him, he informed me that he was leaving the service. Neither my university supervisor nor I had any prior warning of this. As a result, I have been supported by my university supervisor alone, who despite being very supportive, was outside the majority of organisations I was recruiting from and therefore unaware of all the organisational issues which might affect my study. On reflection I wonder whether I should have been more active at developing a relationship with the consultant psychologist, which may have resulted in an earlier start with recruitment and more participants.

My relationship with my supervisor developed most towards the end of the study, where I became to rely on him more for support. I am incredibly grateful to him for his flexibility, in particular during the writing up stage. Overall, I think our personal styles complemented each other well. We both have a laid back style, taking things in our stride but getting on with things at the same time; this was very helpful in light of the many factors affecting recruitment that were out of our control. Had he taken a stricter

approach, particularly with setting deadlines, I would have struggled to keep my head above water.

Dissemination of Findings

Both the literature review and the research report will be submitted to the *Journal of Applied Research in Intellectual Disabilities (JARID)* for publication. In addition the research will be presented at the *BPS Faculty for Learning Disabilities Annual Conference* and the *7th Congress of European Association for Mental Health in Intellectual Disabilities*.

I plan to feedback to the participating organisations verbally and discuss with managers/consultant psychologists how to disseminate the findings to participants. A brief end of study report will also be sent to all participating organisations. For full details of dissemination please see Table 1 below.

Table 1. Timetable for dissemination of findings

| | Planned Time for Completion |
|---|---|
| Verbal feedback to participating organisations | August 2008 |
| Send out brief summary report to participating organisations | September 2008 |
| Submit research report to JARID | November 2008 |
| Submit literature review to JARID | November 2008 |
| Present at BPS Faculty for Learning Disabilities Annual Conference | 27 th -29 th April 2009 |
| Present at the 7th Congress of European Association for Mental Health in Intellectual Disabilities. | 2009 (date to be confirmed) |

Reflections and CPD

When I embarked on the clinical psychology doctorate, I was least looking forward to the research component of the course, favouring myself more as a 'clinician', rather than a 'researcher'. However, having carried a clinically relevant project through from beginning to end, I thoroughly enjoyed this aspect of the course and have become to value the role of researcher and how this role should go hand in hand with being a clinician, allowing clinical psychology to continually develop.

Through the many challenges I have faced implementing this project I have learned a great deal. The entire running of the project relied on the cooperation and coordination of many different professionals and when I started, being so dependent on others was not a position I was used to. I have learned to develop my assertiveness, negotiation and diplomacy skills, which were paramount to seeing the project through to the end. These skills will also be vital when working in multi-professional teams in my future.

I also learned the balancing of roles as researcher and clinician on two demanding placements. However, I still feel that this is an area for continued development. I am incredibly enthusiastic and optimistic, which often results in taking on too much. Although I successfully finished recruitment and write-up, it did not come without negative consequences, in particular stress which was probably a factor in my back pain. In hindsight, I feel that the project was maybe overly ambitious, particularly as it relied on so many different services across a large area and had to be completed in a relatively short period of time. Although I was able to remain motivated, this was in part due to knowing that the stress would be short term; however, I have learned my limitations and know that I would not have been able to sustain the continued pressure for a long period of time, without it affecting my other responsibilities. I am very keen to continue research in the future; however, I hope I have learned to plan projects more

carefully, in particular in terms of what is realistic to achieve in the allocated time I have for research. I would also to be keen to carry out projects within the service I work in, so that I have more control over the planning and implementation of the project.

Finally, due to the short time period the research had to be completed, I did not have the opportunity to involve service users in the planning process; this is definitely an area I would like to develop in the future. I would also like to develop my skills using qualitative techniques as I felt, through my interviews with participants, that a lot of the richness of data was missed through the use of quantitative measures.

Section 4: Appendices

Appendix 1



Department Of Psychology. Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training
& consultancy.

**Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP UK**

Telephone: 0114 2226550
Fax: 0114 2226610
Email: c.harrison@sheffield.ac.uk

18 July 2008

Sonya Raifs
Third year trainee
Clinical Psychology Unit
University of Sheffield

Dear Sonya

I am writing to indicate our approval of the journal(s) you have nominated for publishing work contained in your research thesis.

Literature Review: Journal of Applied Research in Intellectual Disabilities

Research Report: Journal of Applied Research in Intellectual Disabilities

Please ensure that you bind this letter and copies of the relevant instructions to Authors into an appendix in your thesis.

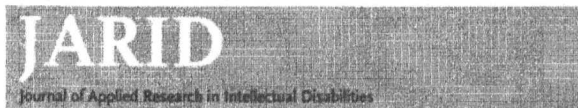
Yours sincerely

Dr Andrew Thompson

Appendix 2

Journal of Applied Research in Intellectual Disabilities – Journal Information

14/01/2008 10:3



bild

Published for the British Institute of Learning Disabilities

Journal of Applied Research in Intellectual Disabilities

Journal of the British Institute of Learning Disabilities

Edited by:

David Felce and Glynis Murphy

Print ISSN: 1360-2322

Online ISSN: 1468-3148

Frequency: Bi-monthly

Current Volume: 20 / 2007

ISI Journal Citation Reports® Ranking: 2006: 9/39 (Psychology, Educational); 4/49 (Rehabilitation)

Impact Factor: 1.657



Latest issue

Author Guidelines

1. GENERAL

The *Journal of Applied Research in Intellectual Disabilities* is an international, peer-reviewed journal which draws together findings derived from original applied research in intellectual disabilities. The journal is an important forum for the dissemination of ideas to promote valued lifestyles for people with intellectual disabilities. It reports on research from the UK and overseas by authors from all relevant professional disciplines. It is aimed at an international, multi-disciplinary readership.

The topics it covers include community living, quality of life, challenging behaviour, communication, sexuality, medication, ageing, supported employment, family issues, mental health, physical health, autism, economic issues, social networks, staff stress, staff training, epidemiology and service provision. Theoretical papers are also considered provided the implications for therapeutic action or enhancing quality of life are clear. Both quantitative and qualitative methodologies are welcomed. All original and review articles continue to undergo a rigorous, peer-refereeing process.

Please read the instructions below carefully for details on submission of manuscripts, the journal's requirements and standards as well as information concerning the procedure after a manuscript has been accepted for publication. Authors are encouraged to visit www.blackwellpublishing.com/bauthor for further information on the preparation and submission of articles.

2. ETHICAL GUIDELINES

The *Journal of Applied Research in Intellectual Disabilities* adheres to the below ethical guidelines for publication and research.

2.1 Authorship and Acknowledgements

Authorship: Authors submitting a paper do so on the understanding that the manuscript has been read and approved by all authors and that all authors agree to the submission of the manuscript to the journal. ALL named authors must have made an active contribution to the conception and design and/or analysis and interpretation of the data and/or the drafting of the paper and ALL authors must have critically reviewed its content and have approved the final version submitted for publication.

Participation solely in the acquisition of funding or the collection of data does not justify authorship.

It is a requirement that all authors have been accredited as appropriate under submission of the manuscript. Contributors who do not qualify as authors should be mentioned under Acknowledgements.

Acknowledgements: Under Acknowledgements please specify contributors to the article other than the authors accredited. Please also include specifications of the source of funding for the study and any potential conflict of interest if appropriate. Suppliers of materials should be named and their location (town, state/county, country) included.

2.2 Conflict of Interest and Source of Funding

Conflict of Interest: Authors are required to disclose any possible conflict of interest. These include financial (for example patent ownership, stock ownership, consultancies, speaker's fee). Author's conflict of interest (or information specifying the absence of conflict of interest) will be published under a separate heading.

The *Journal of Applied Research in Intellectual Disabilities* requires that sources of institutional, private and corporate financial support for the work within the manuscript must be fully acknowledged, and any potential conflict of interest noted. As of 1st March 2007, this information is a requirement for all manuscripts submitted to the journal and will be published in a highlighted box on the title page of the article. Please include this information under the separate headings of "Source of Funding" and "Conflict of Interest" at the end of the manuscript.

If the author does not include a conflict of interest statement in the manuscript, then the following statement will be included by default: "No conflict of interest has been declared".

Source of Funding: Authors are required to specify the source of funding for their research when submitting a paper. Suppliers of materials should be named and their location (town, state/county, country) included. The information will be disclosed in the published article.

2.3 Permissions

If all or parts of previously published illustrations are used, permission must be obtained from the copyright holder concerned. It is the author's responsibility to obtain these in writing and provide copies to the Publishers.

2.4 Copyright Assignment

Authors submitting a paper do so on the understanding that the work and its essential substance have not been published before and is not being considered for publication elsewhere. The submission of the manuscript by the authors means that the authors automatically agree to assign exclusive licence to Blackwell Publishing if and when the manuscript is accepted for publication. The work shall not be published elsewhere in any language without the written consent of the Publisher. The articles published in this journal are protected by copyright, which covers translation rights and the exclusive right to reproduce and distribute all of the articles printed in the journal. No material published in the journal may be stored on microfilm or videocassettes, in electronic databases and the like, or reproduced photographically without the prior written permission of the Publisher.

Correspondence to the journal is accepted on the understanding that the contributing author licences the Publisher to publish the letter as part of the journal or separately from it, in the exercise of any subsidiary rights relating to the journal and its contents.

Upon acceptance of a paper, authors are required to assign exclusive licence to publish their paper to Blackwell Publishing. Assignment of the exclusive licence is a condition of publication and papers will not be passed to the Publisher for production unless licence has been assigned. (Papers subject to government or Crown copyright are exempt from this requirement; however, the form still has to be signed). A completed Exclusive Licence Form must be sent to the address specified on the form, before any manuscript can be published. Authors must send the completed

original Exclusive Licence Form by regular mail upon receiving notice of manuscript acceptance, i.e. do not send the form at submission. Faxing or e-mailing the form does not meet requirements.

3. SUBMISSION OF MANUSCRIPTS

Manuscripts should be submitted via email to patcleveland@wightcablenorth.net and copy it to both felce@cf.ac.uk and g.h.murphy@kent.ac.uk

3.1 Manuscript Files Accepted

Manuscripts should be uploaded as Word (.doc) or Rich Text Format (.rtf) files (not write-protected) plus separate figure files. GIF, JPEG, PICT or Bitmap files are acceptable for submission, but only high-resolution TIF or EPS files are suitable for printing. The files will be automatically converted to HTML and PDF on upload and will be used for the review process. The text file must contain the entire manuscript including title page, abstract, text, references, tables, and figure legends, but no embedded figures. Figure tags should be included in the file. Manuscripts should be formatted as described in the Author Guidelines below.

Please note that any manuscripts uploaded as Word 2007 (.docx) will be automatically rejected. Please save any .docx files as .doc before uploading.

3.2 Blinded Review

All articles submitted to the journal are assessed by at least two anonymous reviewers with expertise in that field. The Editors reserve the right to edit any contribution to ensure that it conforms with the requirements of the journal.

4. MANUSCRIPT TYPES ACCEPTED

Original Articles, Review Articles, Brief Reports, Book Reviews and **Letters to the Editor** are accepted. **Theoretical Papers** are also considered provided the implications for therapeutic action or enhancing quality of life are clear. Both quantitative and qualitative methodologies are welcomed. Articles are accepted for publication only at the discretion of the Editor. Articles should not exceed 7000 words. Brief Reports should not normally exceed 2000 words. Submissions for the Letters to the Editor section should be no more than 750 words in length.

5. MANUSCRIPT FORMAT AND STRUCTURE

5.1 Format

Language: The language of publication is English. Authors for whom English is a second language must have their manuscript professionally edited by an English speaking person before submission to make sure the English is of high quality. It is preferred that manuscripts are professionally edited. A list of independent suppliers of editing services can be found at www.blackwellpublishing.com/bauthor/english_language.asp. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

5.2 Structure

All manuscripts submitted to the *Journal of Applied Research in Intellectual Disabilities* should include:

Cover Page: A cover page should contain only the title, thereby facilitating anonymous reviewing. The authors' details should be supplied on a separate page and the author for correspondence should be identified clearly, along with full contact details, including e-mail address.

Running Title: A short title of not more than fifty characters, including spaces, should be provided.

Keywords: Up to six key words to aid indexing should also be provided.

Main Text: All papers should be divided into a structured summary (150 words) and the main text with appropriate sub headings. A structured summary should be given at the beginning of each article, incorporating the following headings: Background, Materials and Methods, Results, Conclusions. These should outline the questions investigated, the design, essential findings and main conclusions of the study. The text should proceed through sections of Abstract, Introduction, Materials and Methods,

Results and Discussion, and finally Tables. Figures should be submitted as a separate file.

Style: Manuscripts should be formatted with a wide margin and double spaced. Include all parts of the text of the paper in a single file, but do not embed figures. Please note the following points which will help us to process your manuscript successfully:

- Include all figure legends, and tables with their legends if available.
- Do not use the carriage return (enter) at the end of lines within a paragraph.
- Turn the hyphenation option off.
- In the cover email, specify any special characters used to represent non-keyboard characters.
- Take care not to use l (ell) for 1 (one), O (capital o) for 0 (zero) or ß (German esszett) for (beta).
- Use a tab, not spaces, to separate data points in tables.
- If you use a table editor function, ensure that each data point is contained within a unique cell, i.e. do not use carriage returns within cells.

Spelling should conform to *The Concise Oxford Dictionary of Current English* and units of measurements, symbols and abbreviations with those in *Units, Symbols and Abbreviations* (1977) published and supplied by the Royal Society of Medicine, 1 Wimpole Street, London W1M 8AE. This specifies the use of S.I. units.

5.3 References

The reference list should be in alphabetic order thus:

- Emerson E. (1995) *Challenging Behaviour: Analysis and Intervention in People with Learning Disabilities*. Cambridge University Press, Cambridge.
- McGill P. & Toogood A. (1993) Organising community placements. In: *Severe Learning Disabilities and Challenging Behaviours: Designing High Quality Services* (Eds E. Emerson, P. McGill & J. Mansell), pp. 232-259. Chapman and Hall, London.
- Qureshi H. & Alborz A. (1992) Epidemiology of challenging behaviour. *Mental Handicap Research* 5, 130-145

Journal titles should be in full. References in text with more than two authors should be abbreviated to (Brown *et al.* 1977). Authors are responsible for the accuracy of their references.

We recommend the use of a tool such as EndNote or Reference Manager for reference management and formatting.

EndNote reference styles can be searched for here:

<http://www.endnote.com/support/enstyles.asp>

Reference Manager reference styles can be searched for here:

<http://www.refman.com/support/rmstyles.asp>

The Editor and Publisher recommend that citation of online published papers and other material should be done via a DOI (digital object identifier), which all reputable online published material should have - see www.doi.org/ for more information. If an author cites anything which does not have a DOI they run the risk of the cited material not being traceable.

5.4 Tables, Figures and Figure Legends

Tables should include only essential data. Each table must be typewritten on a separate sheet and should be numbered consecutively with Arabic numerals, e.g. Table 1, and given a short caption.

Figures should be referred to in the text as Figures using Arabic numbers, e.g. Fig.1, Fig.2 etc, in order of appearance. Figures should be clearly labelled with the name of the first author, and the appropriate number. Each figure should have a separate legend; these should be grouped on a separate page at the end of the manuscript. All symbols and abbreviations should be clearly explained. In the full-text online edition of the journal, figure legends may be truncated in abbreviated links to the full screen version. Therefore, the first 100 characters of any legend should inform the reader of key aspects of the figure.

Preparation of Electronic Figures for Publication

Although low quality images are adequate for review purposes, print publication requires high quality images to prevent the final product being blurred or fuzzy. Submit EPS (line art) or TIFF (halftone/photographs) files

only. MS PowerPoint and Word Graphics are unsuitable for printed pictures. Do not use pixel-oriented programmes. Scans (TIFF only) should have a resolution of at least 300 dpi (halftone) or 600 to 1200 dpi (line drawings) in relation to the reproduction size. Please submit the data for figures in black and white or submit a Colour Work Agreement Form. EPS files should be saved with fonts embedded (and with a TIFF preview if possible).

Further information can be obtained at Blackwell Publishing's guidelines for figures: www.blackwellpublishing.com/bauthor/illustration.asp

Check your electronic artwork before submitting it:
www.blackwellpublishing.com/bauthor/eacchecklist.asp

Permissions: If all or parts of previously published illustrations are used, permission must be obtained from the copyright holder concerned. It is the author's responsibility to obtain these in writing and provide copies to the Publisher.

Colour Charges: It is the policy of the *Journal of Applied Research in Intellectual Disabilities* for authors to pay the full cost for the reproduction of their colour artwork
http://www.blackwellpublishing.com/pdf/SN_Sub2000_X_CoW.pdf

6. AFTER ACCEPTANCE

Upon acceptance of a paper for publication, the manuscript will be forwarded to the Production Editor who is responsible for the production of the journal.

6.1 Proof Corrections

The corresponding author will receive an e-mail alert containing a link to a website. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF file from this site.

Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following website:
www.adobe.com/products/acrobat/readstep2.html

This will enable the file to be opened, read on screen, and printed out in order for any corrections to be added. Further instructions will be sent with the proof. Proofs will be posted if no e-mail address is available; in your absence, please arrange for a colleague to access your e-mail to retrieve the proofs.

Proofs must be returned to the Production Editor within 3 days of receipt.

As changes to proofs are costly, we ask that you only correct typesetting errors. Excessive changes made by the author in the proofs, excluding typesetting errors, will be charged separately. Other than in exceptional circumstances, all illustrations are retained by the Publisher. Please note that the author is responsible for all statements made in their work, including changes made by the copy editor.

6.2 OnlineEarly (Publication Prior to Print)

The *Journal of Applied Research in Intellectual Disabilities* is covered by Blackwell Publishing's OnlineEarly service. OnlineEarly articles are complete full-text articles published online in advance of their publication in a printed issue. OnlineEarly articles are complete and final. They have been fully reviewed, revised and edited for publication, and the authors' final corrections have been incorporated. Because they are in final form, no changes can be made after online publication. The nature of OnlineEarly articles means that they do not yet have a volume, issue or page number, so OnlineEarly articles cannot be cited in the traditional way. They are therefore given a DOI (digital object identifier) which allows the article to be cited and tracked before it is allocated to an issue. After print publication, the DOI remains valid and can continue to be used to cite and access the article.

6.3 Author Services

Online production tracking is available for your article through Blackwell's Author Services. Author Services enables authors to track their article -

once it has been accepted - through the production process to publication online and in print. Authors can check the status of their articles online and choose to receive automated e-mails at key stages of production. The author will receive an e-mail with a unique link that enables them to register and have their article automatically added to the system. Please ensure that a complete e-mail address is provided when submitting the manuscript. Visit www.blackwellpublishing.com/bauthor for more details on online production tracking and for a wealth of resources include FAQs and tips on article preparation, submission and more.

For more substantial information on the services provided for authors, please see Blackwell Publishing Author Services.

6.4 Author Material Archive Policy

Please note that unless specifically requested, Blackwell Publishing will dispose of all hardcopy or electronic material submitted two issues after publication. If you require the return of any material submitted, please inform the editorial office or Production Editor as soon as possible.

6.5 Offprints and Extra Copies

A PDF offprint of the online published article will be provided free of charge to the corresponding author, and may be distributed subject to the Publisher's terms and conditions. Additional paper offprints may be ordered online. Please click on the following link, fill in the necessary details and ensure that you type information in all of the required fields:
offprint.cosprinters.com/cos/bw/main.jsp?SITE_ID=bw&FID=USER_HOME_PG

If you have queries about offprints please email offprint@cosprinters.com

Top 

Appendix 3



National Research Ethics Service

North Sheffield Local Research Ethics Committee

1st Floor Vickers Corridor
Northern General Hospital
Herries Road
Sheffield
S5 7AU

Telephone: 0114 271 4011
Facsimile: 0114 256 2469

20 November 2007

Miss Sonya Rachel Raifs
Trainee Clinical Psychologist
University of Sheffield
Clinical Psychology Unit
University of Sheffield
Western Bank
S10 2TP

Dear Miss Raifs

Full title of study: Assessing Components of Empathy and Victim Specific Empathy in Sex Offenders with Intellectual Disabilities.
REC reference number: 07/H1308/115

Thank you for your letter of 5th November 2007, responding to the Committee's request for further information on the above research [and submitting revised documentation].

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation [as revised].

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

| Document | Version | Date |
|-------------|---------|----------------|
| Application | | 07 August 2007 |

| | | |
|--|-------------------------|-------------------|
| Investigator CV | | |
| Investigator CV | Supervisor | |
| Protocol | 3 | |
| Letter from Sponsor | | 26 July 2007 |
| Peer Review | Evidence of peer review | 05 July 2007 |
| Questionnaire: A-Empat | | |
| Questionnaire: Emotional perception | | |
| Questionnaire: Demographics | | |
| Participant Information Sheet: Non offenders | 2 | 04 September 2007 |
| Participant Information Sheet: Offenders | 2 | 04 September 2007 |
| Participant Information Sheet: staff | 3 | 19 November 2007 |
| Participant Consent Form: participant | 3 | 19 November 2007 |
| Participant Consent Form: Staff | 3 | 19 November 2007 |
| Response to Request for Further Information | | 05 November 2007 |
| Certificate of insurances | | 02 August 2007 |

R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.

Guidance on applying for R&D approval is available from <http://www.rdforum.nhs.uk/rdform.htm>.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

Here you will find links to the following

- a) Providing feedback. You are invited to give your view of the service that you have received from the National Research Ethics Service on the application procedure. If you wish to make your views known please use the feedback form available on the website.
- b) Progress Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
- c) Safety Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
- d) Amendments. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
- e) End of Study/Project. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

This Research Ethics Committee is an advisory committee to Yorkshire and The Humber Strategic Health Authority

The National Research Ethics Service (NRES) represents the NRES directorate within The National Patient Safety Agency and Research Ethics Committees in England

07/H1308/115

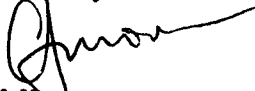
Page 3

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencgroup@nationalres.org.uk .

07/H1308/115**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely



Dr C A Moore
Chair

Email: april.dagnall@sth.nhs.uk

Enclosures: *Standard approval conditions [SL-AC1 for CTIMPs, SL-AC2 for other studies]*

Copy to: **Mr Richard Hudson, The University of Sheffield (sponsor)**

This Research Ethics Committee is an advisory committee to Yorkshire and The Humber Strategic Health Authority

*The National Research Ethics Service (NRES) represents the NRES directorate within
The National Patient Safety Agency and Research Ethics Committees in England*



National Research Ethics Service

North Sheffield Local Research Ethics Committee

1st Floor Vickers Corridor
Northern General Hospital
Herries Road
Sheffield
S5 7AU
Tel: 0114 271 4011
Fax: 0114 256 2469

06 May 2008

Miss Sonya Rachel Ralfs
Trainee Clinical Psychologist
Clinical Psychology Unit
University of Sheffield
Western Bank
S10 2TP

Dear Miss Ralfs

Study title: Assessing Components of Empathy and Victim Specific Empathy in Sex Offenders with Intellectual Disabilities.
REC reference: 07/H1308/115
Protocol number: 3
Amendment number: Minor Amendment 1
Amendment date: 29 April 2008

Thank you for your e-mail letter of 29 April 2008, notifying the Committee of the above amendment.

The amendment has been considered by the Chair.

The Committee does not consider this to be a "substantial amendment" as defined in the Standard Operating Procedures for Research Ethics Committees. The amendment does not therefore require an ethical opinion from the Committee and may be implemented immediately, provided that it does not affect the approval for the research given by the R&D office for the relevant NHS care organisation.

Documents received

The documents received were as follows:

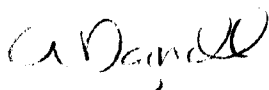
| Document | Version | Date |
|-----------------------------------|-----------------------------|---------------|
| Participant Consent Form | 4 (for use at Linden House) | 21 April 2008 |
| Notification of a Minor Amendment | | 29 April 2008 |

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

07/H1308/115:**Please quote this number on all correspondence**

Yours sincerely



Mrs April Dagnall
Committee Co-ordinator

E-mail: april.dagnall@sth.nhs.ukCopy to: *University R & D (sponsor)*

Appendix 4

Search terms for sex-offenders:

'sex* offend*', 'pedophil*', 'paedophile*', 'rapist*', 'child molest*', 'sex* criminal*', 'perpetrator*', 'sex* assault*', 'abuser*'

Search terms for people with ID:

'mental* handicap*', 'mental* retard*', 'learning disab*', 'learning diff*', 'intellect* disab*', 'dev* disab*', 'mental* impair*'

The above search terms were then combined separately with the following:

Search terms for emotion recognition:

'emo* recog*', 'emo* perce*', 'recog* feeling*', 'expression*', 'understand* emo*', 'affect*', 'discrim* emo*', 'emo* intell*'

Search terms for perspective taking:

'perception', 'perspective taking', 'understand other perspective', 'point of view'

Search terms used for emotion replication:

'emo* experience*', 'emo* & replicat*', 'feeling emo*', replicat* feeling*'

Search terms for response decision:

'compassion*', 'empath* respon*', 'help* other*', 'pro social*', 'response decision'

Appendix 5



Department Of Psychology. Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training
& consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP UK

Telephone: 0114 2226570
Fax: 0114 2226610
Email: dclinpsy@sheffield.ac.uk

Assessing Empathy in Sex Offenders with Intellectual Disabilities

INFORMATION SHEET- For Staff

Service users from your organisation are invited to take part in an educational study. Before they decide it is important for them to understand why the research is being done and what it will involve. It is also important for you, as a member of care staff, to understand what they will be asked to do, so that you can support them in their decision of whether to take part.

What is the purpose of the study?

This is an educational study looking at whether sex offenders with intellectual disabilities have difficulties empathising with other people. Improving our understanding of empathy in sex offenders with intellectual disabilities is important as it may help to improve treatment programmes for sex offenders with intellectual disabilities.

Who will be doing the research?

The research will be carried out by Sonya Ralfs, a Trainee Clinical Psychologist, as part of her doctorate in Clinical Psychology. She will be supervised by Professor Nigel Beail at the Department of Clinical Psychology, University of Sheffield.

Why have service users from your organisation been invited to take part?

In order to find out whether sex offenders with intellectual disabilities have difficulties empathising with other people it is necessary to compare empathy in sex offenders and non offenders with intellectual disabilities. We are therefore asking service users from day centres and from organisations providing support to offenders to take part in the study. Approximately 80 (40 sex offenders and 40 non sex offenders) will be recruited to take part in the study. Service users with a diagnosis of Autistic Spectrum Disorder or serious mental health illness are excluded from the study.

How will you be involved in the study?

Your involvement in this study is entirely voluntary and should you not wish to be involved your employment with your organisation will not be affected. We would like you to ask service users whether they would like to take part in the study. More details about what will be required of service users is provided below. You will be given participant information sheets which you should read out to the service user. When a service user has agreed to take part in the study, you should notify Sonya Ralfs who will arrange a convenient time for your both to interview the service user. Sonya will go through the information sheet with you and the service user again at the beginning of the interview and ask them to complete a consent form to say that they understand the study and agree to take part. You will also be required to complete a consent form to say that you understand and agree to your involvement in this study. It is important for you to assess whether the service user poses any risk to the researcher and that arrangements are discussed prior to the interview. For instance, whether it is necessary for a member of staff to stay in the room whilst the interview takes place and whether this affects the service user's wish to take part. Prior to the interview, the researcher will also require some information from the service user's file, including whether they have received a formal assessment of IQ and if so, their IQ score and in the cases of those service users who have a history of sexual offences, their index offence. It is important that service users are aware that this information will be given if they agree to take part in the study.

Do service users have to take part?

Taking part in the study is entirely voluntary and participants can decide at any point to withdraw from the study without giving a reason.

What will service users be asked to do if they agree to take part?

Participants will be asked to complete two questionnaires (three if they have a history of sexual offences). One questionnaire will involve the use of short video clips followed by a series of questions. The other questionnaires will require participants to respond to a number of statements. All questionnaires will be read through with participants. It is anticipated that the questionnaires will take 30-60 minutes to complete. For those participants who have not had any formal assessment of IQ, they will be given a short IQ assessment involving a number of questions and puzzles. This will take 15-30 minutes to complete.

Confidentiality

The information given by participants will be kept strictly confidential and will not be shared with members of staff. Confidentiality will only be broken if participants request that information is shared with staff or if there are worries about participant's or others' safety. Participant questionnaires will be coded with a number to keep all information anonymous. Any names, places or information that could identify the service user or yourself will be removed. The questionnaires will be stored in a locked cabinet and data will be kept securely at the University of Sheffield for five years and will then be destroyed.

What are the possible disadvantages or risks for service users taking part?

It is possible that some of the questions may be upsetting for some service users. Service users are reminded that they can stop at any point. They are also given time at the end to discuss any worries. Service users will be advised that they can talk to you and other members of staff if they are worried about anything as a result of the study. Should you wish to discuss your worries about a service user, you can contact either Sonya Ralfs or Nigel Beail on 0114 2226570. Further support for clients can be received from the Psychology Service local to your organisation.

What if there is a problem?

If you have any concerns about how a service user was treated in this study you should ask to speak to the researcher, Sonya Ralfs or Professor Nigel Beail on 0114 2226570. If you wish to make a formal complaint, please contact Dr David Fletcher (University Registrar and Secretary) on: 0114 2221100.

What will happen to the results of the study?

It is hoped that the results will be published in academic journals and presented at conferences. A brief end of study report will also be sent to your organisation. No participants will be identified in any reports or summaries of findings.

Who is organising and funding the research?

The University of Sheffield has agreed to sponsor and fund this research.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee to protect the participants' safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by North Sheffield Local Research Ethics Committee.

If you have any queries or concerns about this research, please contact Sonya Ralfs or Professor Nigel Beail at the Clinical Psychology Unit, University of Sheffield on 0114 2226570.

You will be given a copy of this information sheet as well as the signed consent form to keep. Thank you for your help with this research.



Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training
& consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP UK

Telephone: 0114 2226570
Fax: 0114 2226610
Email: dclinpsy@sheffield.ac.uk

Assessing Empathy in Sex Offenders with Intellectual Disabilities

INFORMATION SHEET

My name is Sonya Ralfs and I am doing a study as part of a university course. I would like to find out if you want to take part in my study. Before you decide, it is important you understand what the study is about and what you will have to do.

What is the study about?

- I am trying to find out if sex offenders think about people differently to other people.
- The study will be asking people with a learning disability to take part.
- This may help us to treat sex offenders better in the future.

Why have you been chosen?

- We need to find out how non offenders think about people to find out if sex offenders think differently.
- You have been asked to take part because you have a learning disability but you have not been in trouble with the police.
- You will be asked the same questions as the sex offenders and then we will see whether your answers are different.
- You may be asked to do an IQ test. An IQ test measures what you can and cannot understand. This is to make sure that you and the sex offenders can understand the same things.
- I will be asking about 40 non offenders and 40 sex offenders to do this study.

Do you have to take part?

- You don't have to do this study if you don't want to.
- You will not be affected in any way if you decide not to take part.
- If you take part but later change your mind, let me know and your answers will be destroyed.

What will you have to do?

- You will meet with me in a room at West Bank day centre
- I may ask your key worker to sit in the room with us.
- I will show you some videos and ask you some questions.
- This will take between 30-60 minutes.

- I will ask your key worker some questions about you. Your key worker may have to look at your file to answer these questions.
- I will ask them if you have ever done an IQ test and what this showed. If you have not done an IQ test before, I will ask you to do some puzzles. This will take between 15-30 minutes.
- You will be able to talk about your answers if you want to.

Are there any risks if you do this study?

- Some questions may upset some people
- If you get upset during the study you can ask to stop at any time. We can talk about this if you want to.
- If you get upset after the study you can talk to your key-worker or another member of staff.

Confidentiality

- Your name will not be written anywhere on your answers. You will be given a number so that nobody knows which answers are yours.
- The form you sign will be kept separate from your answers.
- Your answers will be kept safely locked away.
- Your answers will not be shared with staff unless you ask me to.
- I will have to talk to staff if you tell me something which makes me worry about your safety or the safety of others.

Complaints

- If you want to complain about how you were treated in this study, please contact Sonya Ralfs or Nigel Beail on 0114 2226570.
- Or you can contact David Fletcher (University Registrar and Secretary) on: 0114 2221100.
- You can ask your key-worker or a member of staff to help you with this.

What happens next?

- If you decide you want to do the study you should let your key-worker know
- I will meet with you and your key-worker and check you understand what you have to do
- I will then ask you to sign a form to say you understand and agree to do this study.
- You will get to keep a copy of this form and the form you sign.

If you have any more questions about this study please contact Sonya Ralfs or Nigel Beail on 0114 2226570. You can ask your key worker to help you with this.

Thank you for your help with this study.



Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
 Clinical supervision training and NHS research training
 & consultancy.

**Clinical Psychology Unit
 Department of Psychology
 University of Sheffield
 Western Bank
 Sheffield S10 2TP UK**

Telephone: 0114 2226570
 Fax: 0114 2226610
 Email: dclinpsy@sheffield.ac.uk

Assessing Empathy in Sex Offenders with Intellectual Disabilities

INFORMATION SHEET

My name is Sonya Ralfs and I am doing a study as part of a university course. I would like to find out if you want to take part in my study. Before you decide, it is important you understand what the study is about and what you will have to do.

What is the study about?

- I am trying to find out if sex offenders think about people differently to other people.
- The study will be asking people with a learning disability to take part.
- This may help us to treat sex offenders better in the future.

Why have you been chosen?

- You have been chosen to take part because you have been in trouble for a sexual offence.
- We will be asking about 40 sex offenders the same questions.
- We will then ask 40 non offenders the same questions to see if their answers are different.
- You may be asked to do an IQ test. An IQ test measures what you can and cannot understand. This is to make sure that you and the non offenders can understand the same things.

Do you have to take part?

- You don't have to do this study if you don't want to.
- You will not be affected in any way if you decide not to take part.
- If you take part but later change your mind, let me know and your answers will be destroyed.

What will you have to do?

- You will meet with me in a room at Linden House.
- I may ask your key worker to sit in the room with us.
- I will show you some videos and ask you some questions.
- This will take between 30-60 minutes.
- I will ask your key worker some questions about you. Your key worker may have to look at your file to answer these questions.
- I will ask them if you have ever done an IQ test and what this showed. If you have not done an IQ test before, I will ask you to do some puzzles. This will take between 15-30 minutes.
- You will be able to talk about your answers if you want to.

Are there any risks if you do this study?

- Some questions may upset some people
- If you get upset during the study you can ask to stop at any time. We can talk about this if you want to.
- If you get upset after the study you can talk to your key-worker or another member of staff.

Confidentiality

- Your name will not be written anywhere on your answers. You will be given a number so that nobody knows which answers are yours.
- The form you sign will be kept separate from your answers.
- Your answers will be kept safely locked away.
- Your answers will not be shared with staff unless you ask me to.
- I will have to talk to staff if you tell me something which makes me worry about your safety or the safety of others.

Complaints

- If you want to complain about how you were treated in this study, please contact Sonya Ralfs or Nigel Beail on 0114 2226570.
- Or you can contact David Fletcher (University Registrar and Secretary) on: 0114 2221100.
- You can ask your key-worker or a member of staff to help you with this.

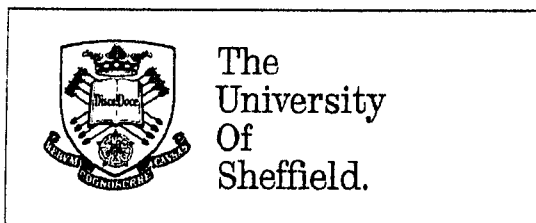
What happens next?

- If you decide you want to do the study you should let your key-worker know
- I will meet with you and your key-worker and check you understand what you have to do
- I will then ask you to sign a form to say you understand and agree to do this study.
- You will get to keep a copy of this form and the form you sign.

If you have any more questions about this study please contact Sonya Ralfs or Nigel Beail on 0114 2226570. You can ask your key worker to help you with this.

Thank you for your help with this study.

Appendix 6



Department Of Psychology. Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training
& consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP UK

Telephone: 0114 2226570
Fax: 0114 2226610
Email: dclinpsy@sheffield.ac.uk

CONSENT FORM – For Staff Involvement

Title of Project: Assessing Empathy in Sex Offenders with Intellectual Disabilities

Name of Researcher: Sonya Ralfs

Please initial box:

1. I confirm that I have read and understand the information sheet dated 19/11/07 (version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my involvement in the recruitment of service users is voluntary and that I am free to withdraw at any time without giving any reason, without my employment or legal rights being affected.
3. I understand what will be required of the service users that I will be recruiting to participate in this study.
4. I understand that data collected during the study, including this consent form, may be looked at by individuals from regulatory authorities, the University of Sheffield or from the NHS Trust, where it is relevant to my taking part in the study.
5. I agree to take part in the above study.

Name of Staff Member

Date

Signature

Name of Researcher

Date

Signature



Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
 Clinical supervision training and NHS research
 training & consultancy.

Clinical Psychology Unit
 Department of Psychology
 University of Sheffield
 Western Bank
 Sheffield S10 2TP UK

Telephone: 0114 2226570
 Fax: 0114 2226610
 Email: dclinpsy@sheffield.ac.uk

CONSENT FORM – For Participant Involvement

Title of Project: Assessing Empathy in Sex Offenders with Intellectual Disabilities

Name of Researcher: Sonya Ralfs

Participant Number:

Please initial box:

1. The information sheet (dated **4/9/07**, version 2) for the above study has been explained to me by my key worker as well as by Sonya Ralfs.
2. I have had time to think about the information and ask questions. I am happy with the answers to my questions.
3. I know that I don't have to do this study if I don't want to. I know I can stop at any time and this will not affect me.
4. I agree that my key worker can be there during the study.
5. I know that Sonya Ralfs may ask my key worker questions about me. I agree that my key worker can look at my file to answer these questions if she/he needs to.
6. I know that people from the University of Sheffield or the NHS Trust may look at the answers I give during the study and this consent form. I know that no one will know which answers are mine
7. I agree to do the above study.

| |
|--|
| |
| |
| |
| |
| |
| |
| |
| |

 Name of Participant

 Date

 Signature

 Name of Researcher

 Date

 Signature



Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research
training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP UK

Telephone: 0114 2226570
Fax: 0114 2226610
Email: dclnpsy@sheffield.ac.uk

CONSENT FORM – For Participant Involvement

Title of Project: Assessing Empathy in Sex Offenders with Intellectual Disabilities

Name of Researcher: Sonya Ralfs

Participant Number:

Please initial box:

1. The information sheet (dated **4/9/07**, version 2) for the above study has been explained to me by my key worker as well as by Sonya Ralfs.
2. I have had time to think about the information and ask questions. I am happy with the answers to my questions.
3. I know that I don't have to do this study if I don't want to. I know I can stop at any time and this will not affect me.
4. I agree that my key worker can be there during the study.
5. I know that Sonya Ralfs may ask my key worker questions about me. I agree that my key worker can look at my file to answer these questions if she/he needs to.
6. I know that people from the University of Sheffield or the NHS Trust may look at the answers I give during the study and this consent form. I know that no one will know which answers are mine
7. I agree to do the above study.

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

Appendix 7

Test of Emotional Perception

Participant No.: _____ Sequence

No.: _____

(For each section write exactly what the participants says as they will be scored for number of propositions they come up with)

(Inform Participants that they will be able to see each tape twice if they need to)

Training tape

1. Ask participant to tell you what they saw:

2. Show the 3 pictures and ask which one shows what comes next:

Correct: Incorrect: Time Taken: _____

Show 1 (Condition: _____)

3. Ask participant to tell you what they saw:

4. If no emotional content to answer say 'anything else?' or 'what else did you see?' (give this prompt twice):

No prompt needed: Prompt given once: Prompt given twice:

5. If still no emotional content say 'what happened in the tape after s/he answered the phone/opened the letter?' and if still no then say 'how did the woman/man feel?':

No prompt needed: Prompt given once: Prompt given twice:

6. If still no emotional content show the tape again (last time):

Tape shown once: Tape showed twice:

7. Ask how they think the friend feels:

8. Ask what they think the friend will do next:

9. Show the 3 pictures and ask which one shows what comes next:

Correct: Incorrect: Time Taken: _____

10. Ask participant how they would feel if one of their friends received a letter/phone call like that:

Show 2 (Condition: _____)

11. Ask participant to tell you what they saw:

12. If no emotional content to answer say 'anything else?' or 'what else did you see?' (give this prompt twice):

No prompt needed: Prompt given once: Prompt given twice:

13. If still no emotional content say 'what happened in the tape after s/he answered the phone/opened the letter?' and if still no then say 'how did the woman/man feel?':

No prompt needed: Prompt given once: Prompt given twice:

14. If still no emotional content show the tape again (last time):

Tape shown once: Tape showed twice:

15. Ask how they think the friend feels:

16. Ask what they think the friend will do next:

17. Show the 3 pictures and ask which one shows what comes next:

Correct: Incorrect: Time Taken: _____

18. Ask participant how they would feel if one of their friends received a letter/phone call like that:

Show 3 (Condition: _____)

19. Ask participant to tell you what they saw:

20. If no emotional content to answer say 'anything else?' or 'what else did you see?' (give this prompt twice):

No prompt needed: Prompt given once: Prompt given twice:

21. If still no emotional content say 'what happened in the tape after s/he answered the phone/opened the letter?' and if still no then say 'how did the woman/man feel?':

No prompt needed: Prompt given once: Prompt given twice:

22. If still no emotional content show the tape again (last time):

Tape shown once: Tape showed twice:

23. Ask how they think the friend feels:

24. Ask what they think the friend will do next:

25. Show the 3 pictures and ask which one shows what comes next:

Correct: Incorrect: Time Taken: _____

26. Ask participant how they would feel if one of their friends received a letter/phone call like that:

Show 4 (Condition: _____)

27. Ask participant to tell you what they saw:

28. If no emotional content to answer say 'anything else?' or 'what else did you see?' (give this prompt twice):

No prompt needed: Prompt given once: Prompt given twice:

29. If still no emotional content say 'what happened in the tape after s/he answered the phone/opened the letter?' and if still no then say 'how did the woman/man feel?':

No prompt needed: Prompt given once: Prompt given twice:

30. If still no emotional content show the tape again (last time):

Tape shown once: Tape showed twice:

31. Ask how they think the friend feels:

32. Ask what they think the friend will do next:

33. Show the 3 pictures and ask which one shows what comes next:

Correct: Incorrect: Time Taken: _____

34. Ask participant how they would feel if one of their friends received a letter/phone call like that:

Show 5 (Condition: _____)

35. Ask participant to tell you what they saw:

36. If no emotional content to answer say 'anything else?' or 'what else did you see?'(give this prompt twice):

No prompt needed: Prompt given once: Prompt given twice:

37. If still no emotional content say 'what happened in the tape after s/he answered the phone/opened the letter?' and if still no then say 'how did the woman/man feel?':

No prompt needed: Prompt given once: Prompt given twice:

38. If still no emotional content show the tape again (last time):

Tape shown once: Tape showed twice:

39. Ask how they think the friend feels:

40. Ask what they think the friend will do next:

41. Show the 3 pictures and ask which one shows what comes next:

Correct: Incorrect: Time Taken: _____

42. Ask participant how they would feel if one of their friends received a letter/phone call like that:

Show 6 (Condition: _____)

43. Ask participant to tell you what they saw:

44. If no emotional content to answer say 'anything else?' or 'what else did you see?' (give this prompt twice):

No prompt needed: Prompt given once: Prompt given twice:

45. If still no emotional content say 'what happened in the tape after s/he answered the phone/opened the letter?' and if still no then say 'how did the woman/man feel?':

No prompt needed: Prompt given once: Prompt given twice:

46. If still no emotional content show the tape again (last time):

Tape shown once: Tape showed twice:

47. Ask how they think the friend feels:

48. Ask what they think the friend will do next:

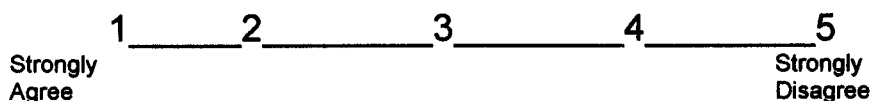
49. Show the 3 pictures and ask which one shows what comes next:

Correct: Incorrect: Time Taken: _____

50. Ask participant how they would feel if one of their friends received a letter/phone call like that:

Appendix 8

Empathy Scale (Em Pat Scale)



High score: Indicates a high level of empathy for others (i.e., an ability to understand another's emotions or feelings).

Low score: Indicates a low level of empathy for others.

Range: Empat-A (34-170); Empat-G (18-90); Total Empat (52-260)

Scoring: Score all items (except those which are reverse scored) according to the value indicated by the subject; e.g., if a number "5" is circled, score 5 points.

Reverse score the following items: 2,4(a), 4(b), 4(c), 4(d), 4(e), 5(a), 5(b), 5(c), 5(d), 6, 7, and 31. For example, if the number "2" is circled, score 4 points (see above Likert type scale).

Subscales:

General empathy (Emp-G)

The following items deal with general empathy; i.e., issues other than sexual abuse; e.g., minority groups, victims of non-sexual offenses, etc. Total the following items for subscale score:

1,3,6,8,9,12,15,20,23,25,29,30,32,34,37,43,44,45

Victim empathy (Emp-A)

The remaining 34 items deal with empathy for victims of sexual abuse: Total the following items for subscale score:

2, 4(a), 4(b), 4(c), 4(d), 4(e), 5(a), 5(b), 5(c), 5(d), 7, 10, 11, 13, 14, 16, 17, 18, 19, 21, 22, 24, 26, 27, 28, 31, 33, 35, 36, 38, 39, 40, 41, 42 Total these items for subscale score.

Subscales may be combined for a total score

1 _____ 2 _____ 3 _____ 4 _____ 5
 Strongly Agree Agree Neutral Disagree Strongly Disagree

- | | |
|--|-------------------|
| 8. People often get too caught up about security after a robbery: Putting bars on their windows, installing an alarm system, or buying a guard dog is overdoing it. | 1 2 3 4 5 |
| 9. People should pay their own way in life. We should have fewer social programs. | 1 2 3 4 5 |
| 10. It is unreasonable for the court to order a man to pay \$5,000 for emotional harm to someone he molested if the victim's therapy is paid for by someone else. | 1 2 3 4 5 |
| 11. It would be wrong for the court to order a man to pay \$5,000 to someone he molested, if the victim ended up using the money to buy a car, clothes, trips, etc. | 1 2 3 4 5 |
| 12. People take too much aspirin. If they wait, their headaches will just go away. | 1 2 3 4 5 |
| 13. Child molesters should not be given such long sentences, for example, 5 years: After all, it is not as if they killed anyone. | 1 2 3 4 5 |
| 14. If a man, who sexually assaulted his 18 year old daughter, has served his time and received treatment, he should be allowed to move back into the home if his wife wants him to. If his daughter doesn't want him to come back, she should move out. | 1 2 3 4 5 |
| 15. Just because a child is afraid of something doesn't mean that we should rush in and reassure them; that makes them soft. | 1 2 3 4 5 |
| 16. A man who molested a child 20 years ago should be given a lighter sentence than someone who did it last month. | 1 2 3 4 5 |
| 17. An adult who was sexually assaulted as a child 15 years ago should be able to forgive and forget the abuser by now, if the person who did it has led a good life and not assaulted anyone since. | 1 2 3 4 5 |
| 18. If someone was molested 18 years ago, they should be over it by now. | 1 2 3 4 5 |
| 19. If a 15 year old girl was sexually abused by her father 10 years ago, she's probably gotten over it. If she says that she has problems because of the abuse, she's probably saying it to be the center of attention. | 1 2 3 4 5 |
| 20. If I were honest about it, I would admit that I am tired of seeing all these ads on television which ask for money for starving children. | 1 2 3 4 5 |

1 _____ 2 _____ 3 _____ 4 _____ 5
 Strongly Agree Agree Neutral Disagree Strongly Disagree

- | | |
|--|-------------------|
| 21. Police investigators and the courts have to be careful not to be fooled by victims of sexual assault, since they often exaggerate, describing the abuse as worse than it actually was. | 1 2 3 4 5 |
| 22. The public knows that people who are charged with sexual abuse sometimes lie. They forget that victims also lie to have things go their way too. | 1 2 3 4 5 |
| 23. All people on welfare should be made to work. | 1 2 3 4 5 |
| 24. Some adults press charges against someone who abused them when they were children, not because they have actually suffered any long term problems, but just because they want revenge against the adult. | 1 2 3 4 5 |
| 25. People who have AIDS weren't careful enough and that's why they got it. | 1 2 3 4 5 |
| 26. Most women who have been victims of childhood sexual abuse automatically blame their problems, even problems like promiscuity, on being victimized in childhood, rather than the choices which they have made in life. | 1 2 3 4 5 |
| 27. If an adult was molested as a child, it would be better for the adult not to keep on talking about it. If they keep it up, it does them more harm than good. | 1 2 3 4 5 |
| 28. There is too much talk about sexual abuse on TV and in school; it is putting ideas into children's minds that they would not have thought about by themselves. | 1 2 3 4 5 |
| 29. A lot of war veterans exaggerate their problems to get money from the government. | 1 2 3 4 5 |
| 30. It's best to ignore a young child's crying in the night. Otherwise the child gets spoiled. | 1 2 3 4 5 |
| 31. It would be fair if the courts ordered every man who is convicted of sexually playing with a young child to pay for that child's therapy, no matter what the therapy would cost. | 1 2 3 4 5 |
| 32. Individuals who have moved to Canada from other countries are being given jobs that rightfully belong to Canadians. | 1 2 3 4 5 |
| 33. It would be unfair if the courts ordered every man who is convicted of having intercourse with a girl who is 13, 14, or 15 to pay for the girl's therapy, no matter what the therapy would cost; some girls who are that age know what they are doing. | 1 2 3 4 5 |
| 34. There is no good reason for so many beggars on the streets: They could find a job, like washing dishes in a restaurant, if they really wanted to. | 1 2 3 4 5 |

1 _____ 2 _____ 3 _____ 4 _____ 5
 Strongly Agree Agree Neutral Disagree Strongly Disagree

- | | |
|---|-------------------|
| 35. A man does not have to be as concerned about the effect of his sexual activity with his 14 year old daughter if she is already sexually active. | 1 2 3 4 5 |
| 37. It's wrong for companies to be forced to hire a certain number of minority group members. | 1 2 3 4 5 |
| 38. In the long run, a man who goes to prison for 2 years for sexually abusing a child suffers just as much or more than the victim. | 1 2 3 4 5 |
| 39. The hurt most children suffer when they are just fondled by an adult is like having a sprained wrist: It feels bad for a while but it will soon heal without any after effects. | 1 2 3 4 5 |
| 40. Putting a man's name in the paper for fondling a child can be as harmful to him as the fondling was to the child. | 1 2 3 4 5 |
| 41. If a man loses a job he has had for 20 years or more and also loses his pension because he touched a child sexually a few times, it harms the man more than the sexual touching harmed the child. | 1 2 3 4 5 |
| 42. Sending a man to prison for a sexual assault he committed 15 years ago can't help the victim now. It's wrong to punish the man just for the sake of punishment. | 1 2 3 4 5 |
| 43. Some minority groups are not as well educated as the general population. Just because they have less education doesn't mean that we should lower job requirements for them. | 1 2 3 4 5 |
| 44. If a woman isn't physically harmed from having her purse snatched, she isn't going to suffer any emotional problems. | 1 2 3 4 5 |
| 45. People who fought in the war usually exaggerate the injuries they got. | 1 2 3 4 5 |

Appendix 9

A-Empat

Read each statement and put a circle around the answer which best describes your view.

1. There is no reason for so many overweight people. They should stop eating too much.



Strongly Agree



Agree



Neutral



Disagree



Strongly disagree

2. A sex-offender should be made to pay for their victim's therapy.



Strongly Agree



Agree



Neutral



Disagree



Strongly disagree

3. Women should get paid the same as men for doing the same job.



Strongly Agree



Agree



Neutral



Disagree



Strongly disagree

4. All people on benefits should be made to work.



Strongly Agree



Agree



Neutral



Disagree



Strongly disagree

5. Sex-offenders should not be given long sentences; it's not as if they killed anyone.



Strongly Agree



Agree



Neutral



Disagree



Strongly disagree

6. People should wait for headaches to go away, they take too many pills.

| | | | | |
|----------------|-------|---------|----------|-------------------|
| ✓ | ✓ | ✓/x | x | x |
| Strongly Agree | Agree | Neutral | Disagree | Strongly disagree |

7. Parents shouldn't always comfort their child when they get scared. This will make them soft.

| | | | | |
|----------------|-------|---------|----------|-------------------|
| ✓ | ✓ | ✓/x | x | x |
| Strongly Agree | Agree | Neutral | Disagree | Strongly disagree |

8. Someone who was raped 20 years ago should be over it by now.

| | | | | |
|----------------|-------|---------|----------|-------------------|
| ✓ | ✓ | ✓/x | x | x |
| Strongly Agree | Agree | Neutral | Disagree | Strongly disagree |

9. I get sick of seeing ads on TV which ask for money for poor people.

| | | | | |
|----------------|-------|---------|----------|-------------------|
| ✓ | ✓ | ✓/x | x | x |
| Strongly Agree | Agree | Neutral | Disagree | Strongly disagree |

10. Victims of sexual abuse often describe the abuse as worse than it was.

| | | | | |
|----------------|-------|---------|----------|-------------------|
| ✓ | ✓ | ✓/x | x | x |
| Strongly Agree | Agree | Neutral | Disagree | Strongly disagree |

11. People often worry too much after a break-in, fitting an alarm is over the top.

| | | | | |
|----------------|-------|---------|----------|-------------------|
| ✓ | ✓ | ✓/x | x | x |
| Strongly Agree | Agree | Neutral | Disagree | Strongly disagree |

12. Most women who have been sexually abused blame all their problems on the abuse.

| | | | | |
|-----------------------|--------------|----------------|-----------------|--------------------------|
| ✓ | ✓ | ✓/x | x | x |
| Strongly Agree | Agree | Neutral | Disagree | Strongly disagree |

13. Talking about being abused does more harm than good.

| | | | | |
|-----------------------|--------------|----------------|-----------------|--------------------------|
| ✓ | ✓ | ✓/x | x | x |
| Strongly Agree | Agree | Neutral | Disagree | Strongly disagree |

14. Parents should ignore their child if they cry at night. Or else they get spoiled.

| | | | | |
|-----------------------|--------------|----------------|-----------------|--------------------------|
| ✓ | ✓ | ✓/x | x | x |
| Strongly Agree | Agree | Neutral | Disagree | Strongly disagree |

15. It's wrong to fine a man for having sex with a 13 year old girl. Some 13 year old girls know what they are doing.

| | | | | |
|-----------------------|--------------|----------------|-----------------|--------------------------|
| ✓ | ✓ | ✓/x | x | x |
| Strongly Agree | Agree | Neutral | Disagree | Strongly disagree |

16. Homeless people don't try hard enough to get jobs.

| | | | | |
|-----------------------|--------------|----------------|-----------------|--------------------------|
| ✓ | ✓ | ✓/x | x | x |
| Strongly Agree | Agree | Neutral | Disagree | Strongly disagree |

17. A man who goes to prison for a sexual offence suffers as much as the victim

| | | | | |
|-----------------------|--------------|----------------|-----------------|--------------------------|
| ✓ | ✓ | ✓/x | x | x |
| Strongly Agree | Agree | Neutral | Disagree | Strongly disagree |

18. The hurt people feel when they have been abused soon goes away.

| | | | | |
|---------------------------|--------------|----------------|-----------------|------------------------------|
| ✓ | ✓ | ✓/x | x | x |
| Strongly Agree | Agree | Neutral | Disagree | Strongly disagree |

19. If a woman isn't injured from having her bag stolen, she'll be okay.

| | | | | |
|---------------------------|--------------|----------------|-----------------|------------------------------|
| ✓ | ✓ | ✓/x | x | x |
| Strongly Agree | Agree | Neutral | Disagree | Strongly disagree |

20. A man shouldn't be punished for a sexual assault he did 15 years ago.

| | | | | |
|---------------------------|--------------|----------------|-----------------|------------------------------|
| ✓ | ✓ | ✓/x | x | x |
| Strongly Agree | Agree | Neutral | Disagree | Strongly disagree |

Appendix 10

| | | |
|------------|--|--|
| A-Q.V.E.S. | | |
|------------|--|--|

NAME: _____ MIN: _____ DATE: _____

Please circle who was your last victim:
 Adult (16 years and more): Male / Female
 Child (15 years or less): Male / Female

Think about your last victim; then read each statement and answer in this questionnaire. For each statement, put a circle around the answer which best describes your view.

Thinking about your victim, would you think he/she:

1. Enjoyed what happened?



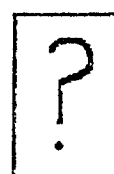
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

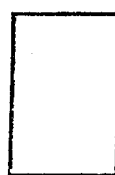
2. Thought you were sexy?



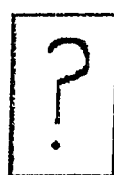
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

Thinking about your victim, would you think he/she:

3. Took it all as a game?



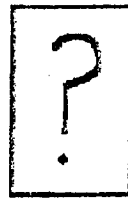
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

4. Had shown you they didn't mind?



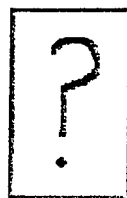
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

5. Could have stopped this happening if they wanted to?



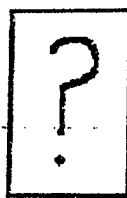
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

Thinking about your victim, would you think he/she:

5. Was turned on by you?



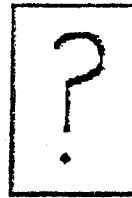
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

7. Wanted things to go further?



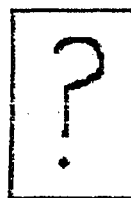
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

8. Was in charge of what happened?



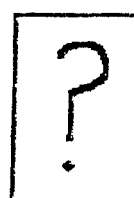
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

Thinking about your victim, would you think he/she:

9. Felt good about what happened?



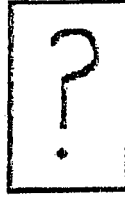
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

10. Felt okay in the situation?



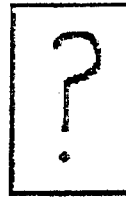
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

11. Was secretly excited?



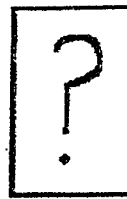
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

Thinking about your victim, would you think he/she:

12. Had nice sexy thoughts afterwards?



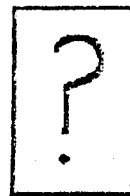
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

13. Felt guilty about how they had behaved?



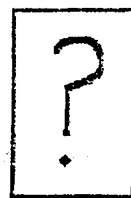
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

14. Was afraid?



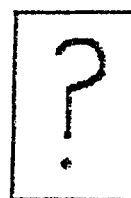
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

Thinking about your victim, would you think he/she:

15. Thought about what happened afterwards?



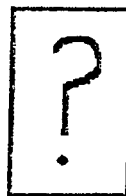
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

16. Hoped that it might happen again?



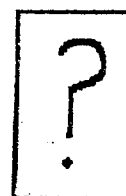
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

17. Felt sorry for themselves afterwards?



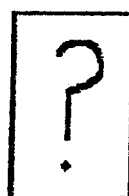
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

Thinking about your victim, would you think he/she:

18. Felt sorry for you over what happened?



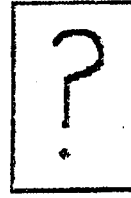
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

19. Had led you on?



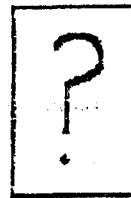
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

20. Felt angry about what had happened?



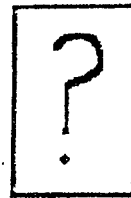
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

Thinking about your victim, would you think he/she:

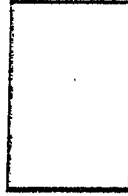
21. Had experienced something like it in the past?



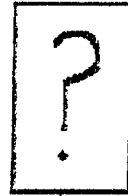
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

22. Felt picked-on by what had happened?



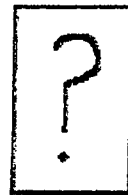
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

23. Worried that someone might find out what happened?



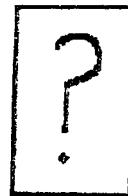
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

Thinking about your victim, would you think he/she:

24. Would like to do it again if they had the chance?



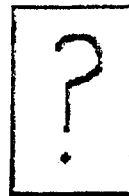
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

25. Had done more sexual things than others their own age?



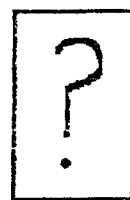
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

26. Had been led on by you?



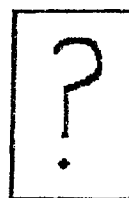
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

Thinking about your victim, would you think he/she

27. Wasn't sure what their feelings were?



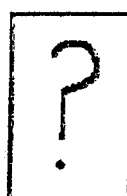
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

28. Felt dirty inside of themselves?



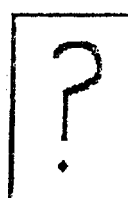
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

29. Was able to forget about it?



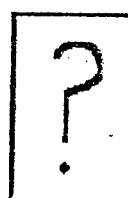
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW

Thinking about your victim, would you think he/she:

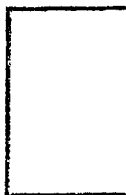
30. Was harmed by what happened?



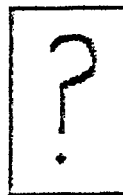
2
YES
VERY MUCH



1
A LITTLE



0
NO
NOT AT ALL



DON'T
KNOW