Measuring Victim Empathy among mentally disordered offenders: validating VERA-2

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Abstract

There are very few, if any, valid and victim-specific situation empathy measures available at present for use with mentally disordered offenders. The aim of this study was to validate a modified version (VERA-2) of the Victim Empathy Response Assessment (VERA) tool which was developed earlier (Young et al., 2008) to enable victim-specific situation empathy measurement in offenders. A total of 55 mentally disordered in-patients residing in a maximum security hospital were assessed on VERA-2 as well as on measures of antisocial personality traits, global affective empathy, violent cognitions, and reported remorse for the index offence. The VERA-2 cognitive and affective empathy scales were negatively correlated with antisocial personality traits and violent cognitions, and positively related to remorse for the index offence. Global affective empathy was positively related to VERA-2 affective empathy. Participants with a history of sexual offending had significantly higher cognitive empathy than other offenders. Acceptance of violence and remorse for the index offence were the best predictors of both cognitive and affective empathy. The findings suggest that the VERA-2 is a valid instrument for measuring victim empathy among mentally disordered offenders, and may prove useful in the context of future risk assessment and outcomes in this population.

Key words: offenders, empathy, affective, cognitive, violence, antisocial.
1.0. **Background**

In spite of the long-standing controversy about the concept and nature of empathy (Prestona & de Waal, 2002), there is an emerging consensus that empathy is a multi-dimensional concept (Davis, 1983; Baron-Cohen, 2011). Baron-Cohen (2011) emphasises two key components of empathy, namely cognitive and affective empathy, with the former (i.e., recognition of suffering and distress in another person) being a prerequisite for the latter (i.e., an emotional reaction). Affective empathy is considered largely genetically determined while cognitive empathy may be relatively more environmentally determined (Hughes et al., 2005). However, empirical research into empathy among animals and infants suggests that the recognition of distress in others is also instinctive and may be elicited without full conscious awareness (Prestona & de Waal, 2002).

Empathy primarily functions to help individuals to form and maintain social bonds and relationships throughout life (Anderson & Keltner, 2002). It motivates prosocial and moral functioning and the failure to empathize with others may result in social isolation and sanctions by the community (Ward & Durrant, 2013).

Violent offending has been associated with low empathy. A systematic review and meta-analysis of 35 studies employing a questionnaire method to investigate the relationship between empathy and offending found significant negative effect sizes for the relationship between empathy and offending, particularly for violent offending (Jolliffe & Farrington, 2004). The effect sizes were stronger for cognitive than affective empathy; however, both were substantially reduced after controlling for IQ and were eliminated altogether after controlling for socioeconomic status. A further study examining the association between self-reported offending among adolescents in a
classroom setting showed that low affective empathy, rather than cognitive empathy, was associated with self-reported offending (Jolliffe & Farrington, 2007). According to the authors of the community study, the most important finding was that offenders have deficits in affective rather than cognitive empathy and contradictory previous findings may be due to poor measures of affective empathy used in the studies reviewed in their systematic review.

There is evidence that empathy impairment is commonly found in people with schizophrenia and antisocial personality disorder (Morgan & Hodgins, 2004). All domains of empathy appear to be adversely affected in schizophrenia (Derntl et al., 2009). In a systematic review, Bragado-Jimenez and Taylor (2012) concluded that empathy impairment is associated with both schizophrenia and violence, but it remains unclear whether impaired empathy is a mediating factor in violence in people with schizophrenia and amenable to treatment. Nevertheless, empathy training features in many offender treatment programmes, including aspects such as role-reversal, reading victim impact statements or writing a letter of apology (Day et al., 2010).

Bragado-Jimenez and Taylor (2012) question whether some measures of empathy have sufficient reliability and validity for effective diagnostic use, but point to the advantages and frequent use of the Interpersonal Reactivity Index (IRI; Davis, 1983). However, Jolliffe and Farrington (2004) question the use of the IRI in offender populations and the measure has been shown to have poor reliability when used with prisoners (Ireland, 1999) and incarcerated violent offenders (Beven et al., 2004).

To address the absence of valid and victim-specific situation empathy measures suitable for use in offenders, Young and colleagues (2008) developed the Victim Empathy Response Assessment
(VERA) tool. The VERA required participants to listen to staged radio-broadcasts between a male interviewer and a female victim involving five different trigger events (i.e., car accident, house fire, violent assault, child sexual abuse, and rape). Participants were then asked to rate how they felt whilst listening to the interview (reaction - affective empathy) and then how they thought the woman felt (recognition - cognitive empathy). The VERA has the advantage of measuring both ‘general empathy’, as measured by the mean response across vignettes, and victim-specific empathy relating to each of the five vignettes. The initial validation was carried out in a mentally disordered offender sample. Principal component analysis revealed two clear factors, which were labelled ‘distress’ and ‘excitement’.

The distress factor demonstrated good internal reliability across vignettes, whereas the excitement factor proved to have a weak factor structure and poor internal reliability. Therefore the excitement factor was disregarded and the items making up the distress factor were used to calculate scores for each vignette. Total cognitive and affective empathy scores were highly correlated for each vignette (r = .49-.76 and .61-.78 for affective and cognitive empathy, respectively). The VERA also indicated that different levels of empathy are elicited for different offence conditions, with the rape vignette eliciting the highest score and thus providing further evidence for situation specific as opposed to general levels of empathy. Further validation of the VERA was conducted in a community sample (Terry et al., 2009), which corroborated the findings in the previous study regarding the factor structure and good internal reliability across the vignettes.

When considering the further development and validation of VERA, Young et al. (2008) suggested that the realism of the vignettes could be enhanced by using videos rather than audio
recordings only, as then the full facial expressions, body language and demeanour of the actress could be observed. This led to the development of the VERA-2, which builds on the previous VERA protocol. It aims to assess both cognitive and affective victim-specific empathy using a video paradigm. Participants are required to watch videos of women, played by professional actresses, talking about incidents they have been involved in, of which four out of five are crime related vignettes.

2.0 Objectives

The current study aimed to validate the VERA-2 in mentally disordered offenders. Construct validity was tested by correlating the total cognitive and affective empathy scores across the five vignettes with relevant psychological measures. In view of the relationship between antisocial personality traits and general lack of empathy (Eysenck & Gudjonsson, 1989), the Eysenck Personality Questionnaire (EPQ-R) Psychoticism scale (Eysenck & Eysenck, 1991) was the key personality measure to validate the VERA-2 empathy scale. It is a measure of general antisocial traits rather than a direct measure of antisocial conduct (Eysenck & Gudjonsson, 1989). Neuroticism was also measured in view of its significant relationship with empathy (Eysenck & Eysenck, 1991; Gudjonsson et al. 2006).

Violent cognitions, which are highly predictive of both violent and non-violent offending (Gudjonsson et al., 2014; Unnever et al., 2006), are relevant to both cognitive and affective empathy (as Joliffe and Farrington (2004) had found an association between violent offending and poor empathic ability). These were measured by the Maudsley Violence Questionnaire (Walker, 2005). Global affective empathy, as measured by the Impulsivity, Venturesomeness, and Empathy (IVE) empathy scale (Eysenck & Eysenck, 1991) was used to validate the VERA-2
affective empathy scale. IVE-Empathy correlated significantly with affective but not with
cognitive empathy in a general population sample using the VERA-1 (Terry et al. 2009). The
application of the IVE-Empathy scale to forensic populations has been very limited. In an early
validation study, Eysenck and McGurk (1980) found that the IVE-Empathy scale discriminated
significantly between incarcerated offenders and normal controls and had similar reliability to
that found in normal controls.

In view of the suggestion “that to be able to feel remorse, one must be capable of empathetic
identification” (Thomas, 1999, p. 131), the Gudjonsson Blame Attribution Inventory (GBAI;
Gudjonsson and Singh, 1989) was used to investigate the relationship between reported remorse
for the index offence and the VERA-2 empathy scores. Sex offenders have been shown to report
a higher level of remorse than other offenders (Gudjonsson and Bownes, 1991), and in their
meta-analysis Joliffe and Farrington (2004) found that low empathy was more strongly
associated with mixed offending than sex offending. Finally, in view of the possible relationship
between IQ and empathy (Joliffe & Farrington, 2004), IQ was measured should it need to be
controlled for in the analyses.

The following hypotheses were tested:

H1. Antisocial personality traits and violent cognitions will be negatively associated with both of
the cognitive and affective VERA-2 empathy scales, whereas remorse for the index offence will
be positively correlated with the empathy scores.
H2. The VERA-2 affective empathy scale will be positively associated with a general affective empathy questionnaire measure and neuroticism.

H3. Participants with a history of a sexual offence in their record will have higher VERA-2 empathy scores than those without such a record.

In order to test the discriminant validity of the VERA-2, three measures theoretically unrelated to empathy (EPQ-R extraversion, IVE-impulsivity, and IVE-venturesomness) were also examined in relation to cognitive and affective empathy, as well as the absence of a relationship between IVE-Empathy and cognitive empathy.

3.0. Materials and Method

3.1 Participants

The 55 male patients were recruited from Broadmoor Hospital, which provides security and treatment for high-risk mentally disordered offenders who are subject to compulsory detention because of their dangerous, violent or criminal propensities. Exclusion criteria were: intellectual disability, a history of serious head injury or neurological condition which affects mental functioning, acute psychosis, not English speaking and/or those who posed a risk of violence to the researchers. Four patients completed only one aspect of the research (either VERA-2 or psychometrics); one was transferred out of the hospital and three declined to participate further. Out of the 53 patients who completed the VERA-2, two declined to complete the rape vignette as they were apparently hypersensitive to the rape topic. A flowchart of recruitment is detailed in Figure 1.
The mean age of participants was 36.7 years (SD = 10.6). The majority of the sample (64%) were White British/European; 22 (40%) had a primary diagnosis of severe mental illness and 33 (60%) had a primary diagnosis of severe personality disorder, although the distinction between these groups is somewhat arbitrary due to the high level of comorbity in both groups. Most patients (n= 35, 64%), had committed a violent index offence; 14 (25%) sexual; two (4%) arson; two (4%) acquisitive and two (4%) were classified as ‘other’ (both threats to kill). Out of the 53 participants who completed the VERA-2, 21 (40%) had one or more sexual offence recorded against them, although in the majority of instances it was the index offence.

3.2. Measures

3.2.1 Victim Empathy Response Assessment-2 (VERA-2): VERA-2 is a software programme designed to measure the cognitive and affective components of victim empathy. It consists of five video clips, each of which is followed by two self-report, on-screen questionnaires. The five video vignettes feature women talking about incidents in which they have been involved; four describe being victims of crimes (arson, violent assault, child sexual abuse and rape), whilst one describes being the victim of a non-criminal act (car accident). This is in contrast to the original VERA which included two accident scenarios (car accident and house fire). In VERA-2 the house fire accident was revised to make it a criminal vignette regarding arson.

After watching each video, participants are asked to complete two on-screen questionnaires and rate (1) how they felt whilst watching the video (affective empathy) and (2) how they thought the woman felt (cognitive empathy) using eight negative emotions/feelings of distress (worried, sad,
upset inside, distressed, disturbed, angry, disgusted, frightened) which participants rated on a five-point Likert scale, ranging from 0, not at all, to 4, very much so. The programme prevents participants from moving onto the next video clip until both questionnaires have been fully completed, thus ensuring each participant has returned a full set of ratings. Total scores for each vignette and overall cognitive, affective and total empathy can then be derived from summing the responses, with higher scores being indicative of greater empathy.

3.2.2. Eysenck Personality Questionnaire – Revised; Short Scale (Eysenck & Eysenck, 1991): the EPQ-R Short Scale is a 48-item yes/no self-report questionnaire which measures Psychoticism (P), Extraversion (E), Neuroticism (N), and Lie (L). In this study the P scale was used to measure antisocial personality traits, because of its direct association with low empathy (Eysenck & Gudjonsson, 1989). The L Scale was used to measure the possible relationship between VERA-2 empathy and social desirability.

3.2.3 Impulsiveness, Venturesomeness and Empathy Questionnaire (IVE; Eysenck et al., 1985; Eysenck & Eysenck, 1991): the IVE is a 54 item yes/no self-report questionnaire which measures three personality traits; Impulsiveness (I), Venturesomeness (V) and Empathy (E). In this study the E subscale was used to measure general affective empathy. The EPQ-R P is negatively correlated with the IVE-E scale (Eysenck & Eysenck, 1991; Gudjonsson et al. 2006).

3.2.4 Maudsley Violence Questionnaire (MVQ; Walker, 2005): the MVQ is a 56 item true/false self-report questionnaire which measures violent cognitive styles. It measures two distinct factors: (i) Machismo (42 items) describes the belief that it is embarrassing to back down from violence, justifying violence in response to a perceived threat and viewing aggression as a strength, and (ii) Acceptance of Violence (14 items) describes a construct related to being generally accepting of violence such that it can be enjoyable in certain contexts. The MVQ was
initially validated using a ‘normal’ student adolescent population and the two constructs had adequate internal consistency (Machismo: $\alpha = 0.91$, Acceptance: $\alpha = 0.74$; Walker, 2005). It has been used successfully to predict the involvement in violent films and computer games among students (Sigurdsson et al., 2006), predict violence in a forensic in-patient population (Dutheil, 2010; Warnock-Parkes et al., 2008), is significantly correlated with conduct disorder and self-reported offending among young institutionalised offenders (Young et al., 2011), and has been used to determine treatment outcome in forensic inpatient populations (Cin-Ying Yip et al. 2013; Rees-Jones et al., 2012; Young et al., 2013). The three treatment outcome studies, all conducted among mentally disordered offenders in secure establishments, showed that violent attitudes were reduced following completion of cognitive skills programmes, which included empathy training.

3.2.5 Gudjonsson Blame Attribution Inventory-Revised (GBAI-R; Gudjonsson and Singh, 1989). This is a 42-item scale that measures how offenders attribute blame for their crime and how much remorse they report regarding their crime. The three scales are referred to as ‘external attribution’ (i.e. blaming the crime of the victims, society, or environmental factors), ‘mental element’ attribution’ (i.e. blaming the crime of mental difficulties), and ‘guilt feeling attribution’. Sex offenders have been shown to report higher level of remorse for their offence than other offenders (Gudjonsson and Bownes, 1991). In the current study the ‘guilt feeling attribution’ scale, referred to as GBAI-Remorse for the index offence, was used in view of the theoretical association between remorse and empathy (Thomas, 1999).
3.2.6 Wechsler Abbreviated Scale of Intelligence (WASI; Wechsler, 1999): full Scale intelligence was estimated using two subtests from the WASI (Vocabulary and Matrix Reasoning).

3.2.7 Demographic and Clinical Data: A review of patient files was conducted to record demographic data, index offence and primary diagnosis. Also recorded from the clinical record was whether or not there was a history of any type of sexual offence, either as the index offence or a separate offence.

3.3. Procedure

Participants who were deemed suitable for inclusion by their responsible clinician were approached by a researcher, with whom they discussed participation and were provided with an information sheet before their informed, written consent was gained. Testing was carried out in quiet, private rooms which were set up with a laptop. Two researchers were present during the procedure for safety reasons. Upon arrival participants were given an explanation of the procedure and had the chance to ask questions. In the large majority of cases, participants completed the VERA-2 procedure first, with the self-report questionnaires and the cognitive assessment being completed in a separate session. Restrictions on suitable room availability meant that some participants completed psychometrics and the cognitive assessment prior to the VERA-2 session.

The VERA-2 procedure consisted of verbal instructions explaining the procedure together with accompanying text played through the laptop, supplemented by clarification from the researcher if required. The first VERA-2 video was then played and the participant completed two on-
screen self-report questionnaires relating to (1) affective empathy and (2) cognitive empathy. This procedure was repeated until all the video vignettes had been shown. Vignettes were presented in a pre-determined order: arson, car accident, violent assault, child sexual abuse and rape.

Demographic and clinical data were obtained from a review of patient files. Participants completing the research received £10 in thanks for their time.

3.4 Ethical Considerations

The project was reviewed and approved by the North London Research Ethics Committee (REC Ref: 11/LO/0314). No individual without the capacity to give full, informed consent was invited to take part in the study. Participants were informed of the nature of the videos prior to taking part and were free to stop their participation at any point without giving a reason. A full debrief was provided by the researcher at the end of the session, including informing the participant that the women were actresses.

3.5 Statistical Analysis

To assess the internal consistency of the cognitive and affective scales Cronbach’s α was calculated. Pearson’s correlations were conducted to examine the relationship between the VERA-2 scale scores the psychometric measures and the participant’s age. Independent t-tests were performed to assess differences between VERA-2 cognitive and affective scores within the whole sample, and between diagnostic subgroups.
In order to investigate the individual and total contribution of the predictor variables in explaining cognitive and affective empathy, a multiple regression using a forced entry method was conducted on the data (Tables 3 and 4). With regard to affective empathy EPQ-R-Psychoticism, IVE-Empathy, MVQ-Machismo, MVQ-Acceptance, and GBAI-Remorse were entered in the regression. For cognitive empathy the same measures were entered, apart from IVE-Empathy because this was not hypothesised to have a relationship with cognitive empathy. Data properties were examined, including multicollinearity, and found to be suitable prior to running these analyses (Field, 2009).

4.0 Results

4.1. VERA-2

Cronbach’s \( \alpha \) ranged between .78-.91 for the cognitive empathy scales and .91-.94 for the affective empathy scales indicating overall good internal reliability for both the cognitive and affective empathy scales in each vignette. Cronbach’s \( \alpha \) for total cognitive and affective empathy were .94 and .98, respectively. The total cognitive and affective scores were significantly correlated (\( r=.57, p<.001 \)). The mean cognitive empathy scores were all significantly higher than the affective empathy scores (see Table 1).

---------Table 1---------

4.2. Psychometric measures

Table 2 shows the correlations between the VERA-2 cognitive and affective empathy scores and the psychometric measures. As predicted, affective empathy was negatively correlated with the EPQ-R–P and MVQ scales, and positively with IVE–Empathy and GBAI-Remorse. The correlations were of medium to large effect size. Cognitive empathy correlated negatively with EPQ-R–P and the MVQ scales and positively with GBAI-Remorse; the strongest correlations
(medium effect size) were acceptance of violence and remorse regarding the index offence.

EPQ-R-N was not significantly correlated with either cognitive or affective empathy. Cognitive and affective empathy were not correlated with IQ, or social desirability (EPQ-R-L). For this reason, IQ and social desirability were not controlled for in the correlations reported.

As expected, EPQ-R-E and IVE-Impulsiveness did not correlate significantly with cognitive and affective empathy. However, IVE-Venturesomeness correlated significantly with cognitive empathy (p< .05, two-tailed test) with a medium effect size.

---------Table 2---------

Further analysis (two-tailed tests), not reported in Table 2, revealed that the cognitive (r = .25) and affective (r = .16) scales were not significantly related to the age of participants at the time of the assessment. An independent t-test revealed no significant difference in cognitive (t = -.13, df = 51) and affective (t = -.33, df = 51) empathy between the two diagnostic groups (i.e., primary diagnosis of severe mental illness or personality disorder). Since impaired empathy is both a feature of severe mental illness (schizophrenia) and personality disorder, and both commonly involve comorbid psychiatric problems, there was no expectation of differences between these groups and the analysis was purely exploratory.

4.3. Multiple regression

The results of the two multiple regressions revealed that the predictors accounted for 24.0% and 33.4% of the variance in cognitive and affective empathy, respectively (see Tables 3 and 4). Acceptance of violence and remorse were the most powerful predictors for both cognitive (β -.32 and .26) and affective (β -.25 and .38) empathy.

--------Tables 3 and 4--------
4.4. **Sex offenders versus other offenders**

Tables 5 and 6 show the differences in the VERA-2 cognitive and affective empathy vignette scores between those with a history of sexual offences (n = 21) and other offenders (n = 32). The differences were most marked in relation to cognitive empathy, where significant differences emerged on four of the vignettes with large effect sizes being found in relation to the child sexual abuse (1.01), rape (.83), car accident (.81), and total cognitive empathy (.82) scales. For affective empathy, a significant difference between the two groups was only found on the violent assault vignette (effect size = .58.)

Tables 5 and 6 about here

5.0 **Discussion**

H1, H2 and H3 were all supported, apart from the non-significant relationship of empathy with EPQ-R-N, demonstrating robust construct validity of VERA-2. As predicted, antisocial personality traits, violent cognitions and remorse for the index offence were correlated with both cognitive and affective empathy. The correlations were consistently higher for affective than cognitive empathy. The exception was the relationship with acceptance of violence, which was identical for cognitive and affective empathy (i.e., r -.43). The correlations with machismo were more modest, but still significant. Acceptance of violence and remorse regarding the index offence were the best predictors of both cognitive and affective empathy. However, their relative contribution to the variance in empathy was different for cognitive than affective empathy. The hierarchical regressions showed that acceptance of violence was a relatively more powerful predictor than remorse for cognitive empathy (β -.32 and .26), whereas the reverse was true for affective empathy (β -.25 and .38) empathy. This supports the construct validation of the
VERA-2 relating to H1. H3 predicted, offenders with a history of sexual offending obtained significantly higher scores on cognitive empathy across the vignettes than the other offenders.

The present finding regarding violent cognitions is consistent with the literature that acceptance of violence is a better predictor of involvement in violent films and computer games than machismo (Sigurdsson et al., 2006). The implication is that there is a salient relationship between the belief that violence is acceptable and justified, and low cognitive and affective empathy. This finding suggests that either the VERA-2 is a more direct measure of violent cognition than empathy, or that violent cognitions form an integral part of empathy. The latter proposition is certainly possible and merits further research.

The finding that reported remorse for the index offence was significantly correlated with both VERA-2 cognitive and affective empathy, whose content had nothing to do with their crime, has both theoretical and clinical relevance. The finding supports Thomas’ (1999) suggestion that the capacity for empathy is a prerequisite to feelings of remorse which infers that improving capacity for empathy may increase feelings of remorse. This has implications for empathy training (Ward & Durrant, 2013) and the current Government focus on ‘restorative justice’, which is reported to have reduced reoffending (Ministry of Justice, 2012).

Empathy training has largely focused on the treatment of sex offenders (Ward & Durrant, 2013). The finding that sex offenders had significantly higher cognitive empathy than non-sex offenders in the current study is robust. Nevertheless whilst the greatest differences between the two offender groups related to the sexual vignettes, the scores on the other vignettes (apart from violent assault) were also highly elevated. It may be that being apprehended for a sexual offence
increases the general capacity to recognise suffering in others (cognitive empathy), whilst having relatively less impact on affective empathy. The finding for the violent assault vignette may be spurious; this vignette did not discriminate between the offender groups with regard to cognitive empathy, but it did for affective empathy (medium effect size). Future research should investigate possible differences in empathy between VERA-2 vignettes and their relationship with type and extent of offending history. It is also possible that the order in which the vignettes are presented affects the scores on the individual vignettes. A randomised presentation of the vignettes was not possible in the present study due to the modest sample size, but would be desirable in a larger study.

The absence of a relationship between EPQ-R-N and VERA-2 empathy was unexpected. N is a dimension of personality that reflects proneness to feelings of anxiety, tension, guilt, and depression (Eysenck & Gudjonsson, 1989), which would be expected to be associated with reported distress when witnessing people suffering. There may have been problems with the use of the N measure in the current study. Eysenck and Eysenck (1991) found a large effect size ($r = .52$, $p<.001$) between EPQ-R-N and IVE-E on a normative sample of persons in the general population, whereas in the present study no significant relationship was found between the two measures ($r = .12$). This may have been due to the short version of the EPQ-R being used in the current study, or the nature of the population.

Discriminant validity of the VERA-2 empathy scales was supported by the non-significant relationship between the empathy scales and extraversion and impulsivity, and the finding that IVE-Empathy was not significantly correlated with cognitive, which is consistent with the findings of Terry et al. (2009) using the VERA-1. However, venturesomness, which is also
known as sensation seeking, showed a significant relationship with cognitive empathy. One possible explanation is that the participants who scored more highly on venturesomness had greater exposure to violent video games or violent encounters and this had reduced their capacity for empathy while watching the vignettes in the current study. Future research needs to measure previous exposure to violence, including video games, because it may reduce people’s capacity for empathy through a desensitisation process (Anderson et al., 2010).

In their systematic review and meta-analysis, Jolliffe and Farrington (2004) suggest that prior to empathy training being provided, scales must be developed that can accurately assess empathy and evaluate outcome in the offender population. Effective treatments also need to be developed and the present findings suggest one should focus on modifying violent cognitions using cognitive behavioural therapy programmes such as R&R2 (Rees-Jones et al., 2012; Cin-Ying Yip, et al. 2013; Young et al., 2013).

The current study has a number of limitations including not fully investigating differences between vignettes. With a larger sample, inter-vignette analysis may help to investigate the relationship between sexual and non-sexual violent offending and victim-specific empathy. All the actresses who role-played the victims were female and, due to repeated exposure of this type of media, participants may not have found the videos particularly distressing. Further, the fixed order of the vignettes (progressing from lesser to greater severity; i.e. from arson and car accident to child abuse and rape) is a limitation in this study. It may be that there was some ‘emotional residue’ left over as the vignettes progress, which may have affected participants ability to effectively rate their own, and the victim’s emotions. Future research with this tool could counter this by presenting the vignettes in a randomised order.
A further limitation warrants discussion, relating to the measures used to test the concurrent validity of the VERA-2 empathy scales, particularly cognitive empathy. The questionnaires used in the study were selected for their relative brevity in order to reduce the administration time of the battery. However we suggest that future research include the Hogan Empathy Scale (Hogan, 1969) which is a measure of cognitive empathy validated among offenders, and the Antisocial Personality Questionnaire (Blackburn, 1999) which is a more specific measure of antisocial traits than the EPQ-R-P scale. This would assist in strengthening and further clarifying the current finding of an association between antisocial personality traits and low empathy (both cognitive and affective). Future research could also expand upon the positive finding that VERA-2 scores were not associated with socially desirable responding (non-significant correlation with the EPQ-R-Lie scale), by conducting simulation studies in which participants were instructed to respond normally or to “fake good”.

6.0 Conclusions

This study demonstrates that VERA-2 is a valid instrument for measuring affective and cognitive empathy among mentally disordered offenders. Future studies should investigate the role of victim-specific empathy and violent cognitions, particularly in relation to the index offence, and incorporate this knowledge into the treatment of offenders and risk management.
References


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