The impact of empathy training on offender treatment

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Amajor goal of treatment for violent and sexual offenders for sex is to increase the empathy felt by the offender for the disorders victims of their crimes. However, it is very difficult to Correctional measure changes in empathy brought about by treatment.[2] up This issue is complicated by the fact that there are offenders 1990 and deemed to be psychopaths, who characteristically lack had a empathy.[3] It is also unclear whether psychopaths are recidivism, treatable at all.[4] Sixty-eight sex and violent offenders showed who had gone through treatment at the Regional Empathy Health Centre in Abbotsford, British Columbia, treatment were examined. The post-treatment scores on the Interpersonal Reactivity Index[5] were compared with staff ratings of performance while in treatment, Psychopathy Checklist The emotional Revised[6] scores and recidivism data to see if a relationship existed.

Empathy and the successful the effects of treatment of psychopaths interpersonal

Researchers in the forensic field crimes on past have suggested that those who commit the most serious victims is seen interpersonal crimes do so partly as a deterrent to because of a profound lack of empathy.[7] Although this statement future offending probably does not apply to all and the creation convicted of assaultive crimes, is plausible for those who commit many such offences. Psychopaths, through such for example, have been shown be at high risk for violent reoffence and, by definition, are profoundly callous.[9]

Increasing empathy is often seen as a key to reducing the likelihood of offending against others.[10] Some form of empathy training is, therefore, a common treatment component for those convicted of crimes such as assault, robbery, murder and sexual assault.[11] The Regional Health Centre (RHC) in Abbotsford, British Columbia, offers intensive treatment for sex and violent offenders with personality (within the jurisdiction of the Service of Canada). Early follow-research on program participants between 1994 indicated that the sex offenders reduced incidence of overall and sexual [12] and that the violent offenders a decrease in violent offending.[13] training is an important aspect of the programs. Cognitive-behavioural therapy is part of the empathy training.[14] The emotional and cognitive awareness of the effects of interpersonal crimes on past victims is seen as a deterrent to future offending and the creation of new victims through such behaviour.

Given the clear theoretical relationship between increased empathic awareness and a reduction in reoffence, it is surprising that little research has been done on the effectiveness of empathy training.[15] One possible reason is that such training is commonly given within a larger multi-modal treatment

program.[16] It is difficult to assess the impact of one treatment component within such a program.

One way to assess the effects of empathy training is to examine the results of psychometric tests measuring the understanding of empathy concepts. Although there are some difficulties with this approach,[17] it is the best possible given the available data. One test commonly used is the Interpersonal Reactivity Index (IRI). The IRI does not directly measure empathy, but it is reasonable to assume an indirect connection between knowledge of empathy concepts and empathy itself. Post-treatment scores on the IRI were used to examine the impact of empathy training on participants. Because it is possible to know about empathy without being empathic, Psychopathy Checklist — Revised (PCL-R) scores were also examined; those with high scores on this scale are likely to be lacking in empathy. Staff ratings of offenders during treatment and the behaviour of offenders after treatment were also used to look at the effectiveness of empathy training, as was the impact of such training on the risk of post-treatment reoffence.

Profile of participants

The participants were 68 adult male inmates who participated in treatment at RHC in 1993 and 1994. Before and after completing treatment, program participants were required to complete a battery of psychometric tests, including the IRI. Thirty-one (46%) of the program participants in this sample were sex offenders. Thirty-seven (54%) were violent offenders.

The mean age of participants was 36 years. Most of the sample (75%) was Caucasian, with a significant minority (16%) of Aboriginal participants. The mean determinate sentence length for the group was 10.5 years: 38% were serving life sentences and 13% were designated as dangerous offenders. Of the 68 participants, 90% completed treatment. There were no major differences between the sex offenders and the violent offenders on any of these variables. The participants had been convicted of a median number of 11.5 crimes. Sex offenders had marginally fewer past convictions ($t = 1.93$, standard deviation 54.67; $p = .06$) than did violent offenders. None of the violent offenders had any sex crime convictions.

Procedure

Demographic and recidivism data were collected in early 1997 from National Parole Board files and the Offender Management System database. Psychometric test data were collected from RHC clinical files. The IRI is a 28-item scale with four subscales. These are:

- perspective taking, which measures the cognitive ability to appreciate others' point of view;
- empathic concern, which examines the affective ability to feel concern for others;
- fantasy, which assesses the ability to identify with fictitious characters; and
- personal distress, which assesses the extent to which the person shares the negative emotions of others.

Ratings of inmate performance while participating in treatment were also used to assess achievement

during therapy. Each offender's performance was rated by an experienced coder using the qualitative final performance review by treatment staff. Three-point Likert scales were used, where 1 equals poor, 2 equals fair, and 3 equals good. Performance in each treatment module was rated using these scales, as was the staff assessment of overall performance in the treatment program and reduction in the risk of reoffence.

Two trained, independent raters scored the PCL-R by reviewing Correctional Service of Canada files, a procedure that has been shown to be reasonably valid.[18] The inter-rater reliability was excellent.[19] Forty-nine of the total sample of 68 (72%) were classified as non-psychopaths (PCL-R scores of less than 30). Nineteen (28%) of the treatment participants were classified as psychopaths (PCL-R scores of 30 or more). There were no significant differences between the sex offenders and the violent offenders in terms of PCL-R ratings.

Results

PCL-R scores

There was only one marginally significant difference between psychopaths and non-psychopaths on the IRI. This was on the empathic concern subscale: psychopaths scored marginally worse than non-psychopaths post-treatment ($t = 1.78$, standard deviation: 51; $p < .10$). There were no significant correlations between the IRI subscales and participants' total PCL-R scores.

Treatment Performance

Previous research on this sample[20] found that higher PCL-R scores were associated with poorer performance while in treatment, particularly in the empathy module.Performance in the empathy module (participation and understanding of concepts) was not significantly associated with any of the post-treatment scores on the IRI.

Recidivism

The analysis did not include those who had received no form of release nor new charges. Any recidivism (suspension or revocation of release, or new charges) was coded as 1. Those who had been released and had not had any of the above problems were coded as 0, or no recidivism. PCL-R scores and staff ratings of performance while in treatment were not significantly associated with recidivism in this sample. There were several significant differences on the IRI between those who recidivated and those who did not. However, the pattern of findings was not consistent. Those who did not recidivate scored significantly better on the performance subscale of the IRI than those who recidivated. However, on the personal distress subscale, those who recidivated scored significantly better than those who did not.

Table 1

Differences Between those who Recidivated and those who did not on the Interpersonal Reactivity Index			
Index subscales	**Did not recidivate**	**Recidivated**	**values (df)**
(post-treatment scores(SD))+			
Perspective taking	20.53 (3.50)	17.89 (4.56)	2.12 (44)**
Empathic concern	21.42 (3.95)	20.33 (3.90)	0.93 (44)
Fantasy	12.63 (4.13)	14.11 (4.88)	1.08 (44)
Personal distress	7.42 (4.67)	11.00 (5.46)	2.32 (44)**

* = p < .10; ** = p < .05; ***= p < .01; **** = p < .001.
+ = Higher scores are “better” on this scale.
= n ranges from 19 to 22.
‡ = n ranges from 27 to 32.

Discussion

This study found no real connections between treatment and reoffending and the IRI, a scale aiming to measure empathic awareness.

There are several possible reasons for the lack of findings. The simplest is that the IRI does not measure empathic awareness. The lack of association between PCL-R scores and the IRI tends to support this hypothesis. However, this lack of association could result from the multifaceted nature of the PCL-R and few of the items may be directly connected to empathy.

There is also a lack of association between performance in the empathy module and the IRI, which also seems to support the hypothesis that the IRI does not measure empathy. But even if this scale does measure empathic awareness, such awareness does not necessarily mean that a person will actually be empathic. For a connection to be found between these scale scores and recidivism, empathic behaviors would have to be connected to empathic awareness and practised within the specific context of an opportunity to reoffend.

This series of connections suggests that it would only have been surprising if there had been significant associations between the IRI and recidivism data.

The limitations in the study’s design and the relatively small sample may also have contributed to the general lack of findings. The results of this study indicate that scores on the IRI should not be used to make predictions about recidivism. The use of psycho-metric test data to measure a behaviour as specific as recidivism is generally inadvisable unless the scale has been specifically designed for the purposes of risk assessment.[21]

These findings do not discredit the connection between empathy and recidivism. Further work is clearly needed to test this hypothesis and to support or refute the use of empathy training within offender treatment programs.

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