Shame, Guilt and Empathy in Sex Offenders

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Overview

The literature concerning the self-conscious emotions is gravitating towards some interesting ideas about the dynamics of shame, guilt and empathy. This thesis concerns the development of thinking and empirical research in this area and addresses the potential position of the application of these hypotheses to sex offenders, and possible implications for their treatment.

Part 1 reviews the literature concerning shame, how it differs from guilt and other emotions, and relates specifically to empathy in the general population. The relevance of considering the self-conscious emotions in sex offenders, and the lack of empirical research into these emotions in this population is highlighted, as are problems in measurement.

Part 2 is the report of an empirical investigation into the prevalence of shame, guilt and empathy in sex offenders as compared to non-sex offenders, and the inter-relationships between these emotions amongst the sample as a whole. There was evidence for one prediction concerning the association of shame with self-oriented personal distress in the sample overall and also some unexpected findings, including a correlation between guilt and personal distress. This is an association that has been found in a previous study but has not been discussed in depth in the literature, and a hypothesis regarding this relationship is offered. Higher levels of other-oriented empathy were found for sex offenders, and the potential role of social desirability in this association is discussed. It was concluded that this study did not allow a fair assessment of the self-conscious emotions in sex offenders.

Part 3 reflects on the process of having carried out this research, and considers methodological issues such as self-report technique, the dynamics between the male offender participants and the female researcher, and problems with the population studied. Systemic issues are considered in the final section, where variations in approach between different forensic settings are explored, as are the impact of these on the research process.

Contents

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Part 1: Literature Review

Abstract

In this paper I will review literature concerning shame and distinguish it from other similar emotions such as embarrassment and guilt. Shame and guilt are emotional reactions that often occur in response to transgressions, and concern perceived evaluations by others and/or the self. It has been proposed that shame and guilt have very different effects, and that guilt acts as a mediator, whereas shame acts as a barrier to the experience of empathy. Shame and guilt and their relationship to empathy will be explored, and key studies demonstrating their inter-relationships will be critically evaluated.

The latter part of this review will focus on sex offenders, and will discuss the relevance of considering and incorporating an understanding of self-conscious emotions in the treatment of sex offenders. The emerging findings concerning shame, guilt and empathy will be explored in light of the fact that empathy training is a significant feature of most sex offender treatment programmes.

There is a dearth of research about shame in sex offenders, and its relationship to guilt and empathy in this population, although there is much speculation and some evidence that shame is prevalent within this population. If high levels of shame hinder the experience of empathy, then for those sex offenders who may be unable to, or have great difficulty experiencing empathy due to excessive shame, empathy training as part of their treatment might render them a greater risk. Such training might have the effect of teaching individuals who lack empathy to some degree skills

in acting empathically, but may not necessarily enhance the genuine experience of it. Thus, teaching empathy to some sex offenders may have the effect of improving their grooming skills as being able to feign empathy might be useful when it comes to securing victims.

Attribution theory is outlined and considered in terms of the treatment of sex offenders, and the view that guilt but not shame should be encouraged when working clinically with sex offenders will be explicated against the backdrop of what is currently known about shame and guilt, and their effects on empathy.

I) Shame

"How despicably have I acted!" she cried.-"I, who have prided myself on my discernment!-I, who have valued myself on my abilities! Who have often disdained the generous candour of my sister, and gratified my vanity, in useless or blameable distrust.-How humiliating is this discovery!-.... Till this moment, I never knew myself."

Jane Austen (1813)

Shame is an egocentric, self-involved, self-focused experience. The individual immersed in a moment of shame is far more concerned with the implications of their transgression for themselves, than for others (Tangney and Dearing, 2002).

Shame is generally viewed as an intense, rather debilitating, negative emotion involving feelings of inferiority, powerlessness and self-consciousness (Tangney, Miller, Flicker and Barlow, 1996). It is thought that shame concerns appraisals that the self is unable to generate a positive reflection in the eyes of others, and involves negative self-appraisals (e.g. Gilbert, 1998). Shame is considered fundamentally be a self-conscious emotion (Tangney and Fischer, 1995). The experience of shame is accompanied by a sense of exposure in front of a real or imagined audience and a feeling of being small (Covert, Tangney, Maddux and Heleno, 2003). Shame is also a threat emotion and motivates escape behaviour, concealment, (Tangney, 1995) and

submissive behaviour (Gilbert, Pehl and Allan, 1994). Often shame results in actual withdrawal from the problematic situation (Covert, *et al.* 2003).

A person experiencing a shame reaction may undergo a sudden affect-shift, such as a surge of anger or anxiety (Retzinger, 1991). They may be crippled by a blank mind, and lose confidence and the ability to think and act freely (Lewis, 1986). It is thought that shame has distinctive, submissive facial expressions, and may also engender a range of involuntary behaviours and experiences, including blushing, a hunched posture, avoidance of eye-contact and changes in speech (Keltner, 1995).

Because of its intense self-focus, shame impairs one's ability to generate effective solutions to interpersonal problems, and also diminishes confidence in one's ability to implement solutions (Self-efficacy) (Covert, *et al.*, 2003).

There has been an abundance of research into shame over the last fifteen years, and there is now a consensus that shame can be greatly pathogenic (Tangney and Fischer, 1995). Research suggests that shame is likely to be an important contributing factor to many common problems and psychopathologies, including family problems (Fossum & Mason, 1986), interpersonal relationships (Gilbert, Allan & Goss, 1996), social anxiety (Gilbert & Trower, 1990), eating disorders (Frank, 1991), depression (Andrews, 1995), alcoholism (Bradshaw, 1988), hostility (Retzinger, 1995), suicide (Mokros, 1995) and personality disorders (Linehan, 1993). Therapists may be able to enrich their effectiveness with their patients by developing a "third ear" for shame-related processes (Tangney and Dearing, 2002).

The term *external shame* (Gilbert, 1997) refers to how one perceives that others see one (Goss, Gilbert and Allan, 1994). The way in which external shame is experienced is dependent on how important others' views are to the self. Hence, the experience of external shame is affected by cognitions about the value of others' judgments. The term *internal shame* (Gilbert, 1997) concerns the idea of the self judging the self (Tarrier, Wells and Haddock, 1998), and pertains to a sense of failing to meet internalised standards.

Internal and external shame are not always correlated: For instance, one may feel no anxiety about one's flaws unless one expects that they will be revealed (Lewis, 1992). Sometimes an individual recognizes that other people consider their behaviour shameful, but the person themselves does not (Gilbert, 1998). For example a thief might understand that others disapprove of their behaviour, but have no internal shame for it themselves.

Proneness to Shame

Shame-proneness is the tendency to experience shame across a variety of situations (Covert *et al.*, 2003). It is thought that there are individual differences in proneness to shame, and in people's capacity to experience, and also manage and recover from shame episodes (Tangney and Dearing, 2002). Proneness to shame is positively related to many significant elements of poor interpersonal and psychological adjustment (Covert *et al.*, 2003).

Proneness to shame is likely to be influenced by factors such as early temperament, parental and socialization factors, and cultural environment (Tangney and Dearing,

2002). Research also indicates that shaming interactions between parents and their offspring are detrimental to neurological development, including specifically the orbital frontal cortex; An area associated with prosocial behaviours (Schore, 1994).

Evidence suggests that people who yield high scores on self-consciousness scales also tend to be shame-prone (Darvill, Johnson and Danko, 1992). When the self is the focus of one's attention, causes of events are likely to be attributed to the self (Duval and Wicklund, 1973). This was supported by studies involving looking at one's reflection in a mirror.

Distinctions Between Shame and Other Similar Emotions

Some of the literature reflects confusion between shame and other similar emotions (such as embarrassment and humiliation). This section will attempt to distinguish shame from such emotions.

Shame and Embarrassment

Embarrassment is also a self-conscious emotion, but it is considered milder, more specific and light-hearted. As illuminated by Miller and Tangney (1994), embarrassment occurs after relatively trivial accidents. Conversely shame is a more intense feeling following more serious transgressions, that results when one's deep-seated flaws are revealed to oneself and to others. This was supported by a study where participants described experiences of embarrassment and shame and rated them according to various dimensions. Clear differences in the structure and phenomenology of these two emotions were observed, that could not be explained simply by intensity of affect. Embarrassment is also distinguished from shame in

terms of its possible different developmental pathways (Lewis, 1995) and non-verbal presentations (Keltner, 1995).

Shame and Social Anxiety

Social anxiety concerns threatening evaluations by others (not the self) (Öhman, 1986). Socially anxious people are fearful of being shamed (Beck, Emery and Greenberg, 1985). Sympathetic arousal is associated with social anxiety (Miller, 1996), whereas parasympathetic arousal is associated with shame and embarrassment (Leary and Kowalski, 1995). Shame encompasses an established sense of inadequacy that continues to exist within the individual, in contrast social anxiety is centered around what one may become (Gilbert, 1998). Social anxiety tends to remit upon leaving the situation, unlike shame which is characterised by substantial rumination about one's inferiority and others' perceptions of it.

Shame and Humiliation

There has been little empirical research in the area of humiliation and its relationship to shame, but it has been considered in the context of Gilbert's (1989) evolutionary conceptualization, with humiliation being associated with "fight", and shame associated with "submit" responses (Morrison and Gilbert 2001; Gilbert, 1992). Humiliation shares many similarities with shame, such as sensitivity to social put down and rumination, but can be distinguished by its emphasis on harm done by others (Gilbert, 1998). It is the psychological scar of what was done to the self by another that is felt to be shameful, and the person who caused the harm is blamed and viewed as bad. An internal sense of inferiority is not necessary in humiliation, and this emotion is also accompanied by hatred and vengeful feelings.

Shame and Self-Esteem

Self-esteem has been defined as the extent to which an individual values, approves of and likes themselves (Blascovich & Tomaka, 1991). It is thought that there is a symbiotic relationship between shame and self-esteem, and both are affected by and also affect many other factors, such as scholastic success, quality of relationships, cognitive functioning, social skills, physical attractiveness, etc. (Tangney and Dearing, 2002). It has been found that internalized shame is correlated with self-esteem (Cook, 1991). Internalized shame has been defined as an "enduring, chronic shame that has become internalized as part of one's identity and which can be most succinctly characterized as a deep sense of inferiority, inadequacy or deficiency" (Cook, 1988).

It has been suggested that the extent to which shame proneness affects self-esteem depends on one's ability to recover from shame experiences (Tangney and Dearing, 2002). For example, a person may have high self-esteem yet still be shame-prone. A minor transgression may engender an acute sense of shame, rendering the person feeling worthless and defective momentarily. These experiences may even be regular but will not necessarily tarnish a person's self-view significantly, because they may be very good at recovering from shame experiences (Tangney and Dearing, 2002).

Tangney and Dearing (2002) hold that the difference between shame and self-esteem is that shame-proneness is the tendency to respond to triggering events with shame,

as opposed to self-esteem, which is a more consistent and stable self-evaluation, independent of triggers.

Clearly these two concepts overlap to some degree, and variations in definitions create some difficulties in discriminant validity when attempts to measure shame and self-esteem are made. For example, although the Internalized Shame Scale (Cook, 1988) separates self-esteem within a separate sub-scale, shame as measured by this scale (particularly early versions of it) has been found to be highly correlated with other measures of self-esteem (e.g. Coopersmith, 1967).

Shame and Narcissism

Narcissism as a disorder of personality is defined in DSM IV (American Psychiatric Association, 2000) as encompassing a grandiose sense of self-importance, a feeling of specialness, a need for admiration, a sense of entitlement, exploitative tendencies, arrogance and a lack of empathy, and is regarded as the hallmark of narcissistic disorders (Glasser, 1992).

Shame and narcissism share the common experience of the self as central. Whereas shame is a noxious experience of the self, a wave of self-disparagement, narcissism is a positive experience of the self, a state of self-love and adoration (Nathanson, 1987).

Another critical common feature of these two phenomena is the propensity to focus on the entire self. As outlined below in the section on Guilt, shame involves an intense and global self-focus. A similar process occurs in narcissism when

evaluating failure. Shame is a likely consequence of failure because of this focus on the whole self. Similarly, hubris is a likely outcome of success (Lewis, 1995). Narcissism is characterized by unrealistic evaluations of success. Such grandiose evaluation seeks to strengthen hubris and avoid shame, and is characteristic of the self-aggrandizing quality central to narcissistic behaviour (Lewis, 1995).

As discussed in the section on Shame and Empathy, shame-prone people tend to externalize blame (Tangney, 1991). This is also a consistent feature of narcissism, and stems from the need to defend against failure and hence, shame (Lewis, 1995).

Narcissism is widely recognized as a defence against the hatred of the self in shame (Nathanson, 1987). Some theorists (such as Lewis, 1992) assert that an inability to cope with feelings of shame underlies narcissism. Individuals with a narcissistic personality style are likely to be shame-prone and act to avoid experiencing shame. Given the drive to avoid shame and the reality that sometimes shame cannot be avoided, narcissists have extreme reactions to the shame experience. A narcissist who is shamed is likely to react with intense rage or depression (Lewis, 1992).

Montebarocci, Surcinelli, Baldaro, Trombini and Rossi (2004) highlighted the distinction between 'covert' narcissists; People who are inhibited and sensitive to humiliating experiences, and 'overt' narcissists; Exhibitionist, aggressive individuals who do not respect the needs of others. They correlated a measure of narcissism (the Narcissistic Personality Inventory; Raskin and Terry, 1988) with proneness to shame, as measured by the Shame-Guilt Proneness Scale (Battachi, Codispoti and Marano, 1994) amongst a sample of 165 students. They found overall that narcissism was

negatively correlated with both shame and guilt. Montebarocci *et. al.* (2004) pointed out that the measure of narcissism used in their study measured 'overt' narcissism. They explained their findings in terms of overt narcissists being immune to feelings of guilt due to personality structure, and negating feelings of shame as a defence against feelings of inferiority.

The study by Montebarocci *et. al.* (2004) represents a rare attempt to test empirically the assumed relationship between shame and narcissism. However, it suffers from the drawback that there is no concrete evidence that the low shame scores yielded by participants in this study were actually a defence against feelings of inferiority. Hence, although there is much speculation concerning shame as the hallmark of narcissism, particularly in the psychoanalytic literature (e.g. Glasser, 1992), there is little empirical evidence for this assertion.

II) The Difference Between Shame and Guilt

"A good conscience fears no witness, but a guilty conscience is solicitous even in solitude. If we do nothing but what is honest, let all the world know it. But if otherwise, what does it signify to have nobody else know it, so long as I know it myself? Miserable is he who slights that witness".

Lucius Annaeus Seneca, 5 BC - 65 AD.

Although the terms *shame* and *guilt* have often been used interchangeably (Tangney, 1991), much research indicates that these emotional experiences are distinct. As defined by Lewis (1971), in guilt, the self negatively evaluates particular behaviours,

and the focus is usually specific, often relating to behaviours that involve harm to another. Guilt is associated with empathy for the harmed other, and facilitates reparative action. It is uncomfortable but not debilitating. Conversely in shame, the self negatively evaluates the entire self. This painful, global affective state can motivate anger. Feelings of shame are overwhelming, and involve a pronounced self-focus. Shame takes the point of attention away from the distressed other, and draws it back to the self (Tangney, 1991). Further, evolutionary psychologists believe that shame evolved from submissive behaviour, and that guilt evolved from altruism (Gilbert, 1989).

Whereas the emphasis of shame is on a failing in the self ("look what *I've* done"), guilt is concerned with morally disappointing behaviour ("look what I've *done*") (Salovey, 2002 [cited in Tangney and Dearing, 2002]).

Distinctions between shame and guilt have been empirically tested. Tangney, Marschall, Rosenberg, Barlow, and Wagner (1994 [cited in Tangney and Dearing, 2002]) found upon asking adults and children about their experiences of shame and guilt, that the interpersonal focus varied between these two emotions. Shame experiences were characterized by other people's evaluations of the self, and guilt experiences emphasized one's effect on others. Tangney (1993) requested descriptions of personal experiences of both guilt and shame from a sample of 65 adults, and observed that shame experiences were harder to describe, more painful, and accompanied by a sense of both exposure and inferiority, in comparison to guilt experiences. Further evidence of the difference in interpersonal focus of these two emotions was obtained by Niedenthal, Tangney and Gavanski (1994) in a study

where participants were asked to imagine the unfolding of events under specific circumstances. It was found that participants were more likely to 'undo' aspects of the self in shame as compared to guilt experiences, and were more likely to 'undo' aspects of their behaviour in guilt than they did in shame experiences.

A person's knowledge of social norms, sensitivity to the dynamics of situations, and vigilance to social cues is known as self-monitoring (Snyder, 1974). A modest link between guilt-proneness and self-monitoring has been found (Tangney and Dearing, 2002), highlighting the relationship between the tendency to monitor one's behaviour and feelings of guilt. This association was not found for shame and self-monitoring. However, these findings are based on just one study, therefore the reliability for this idea is questionable.

Attribution Theory

Shame and guilt are inherently related to perceptions of ourselves, and levels of self-esteem. They can be discriminated according to Abramson, Seligman and Teasdale's (1978) dimensions of causal attributions (Tangney and Dearing 2002), which consider locus of control (internal versus external), globality (global versus specific) and stability (stable versus unstable).

In both shame and guilt, internal attributions are made. Whereas guilt is associated with specific and unstable attributions, shame involves global and stable attributions.

For example, a person who gets 'too' drunk at someone else's birthday celebration and behaves inappropriately to the point that it spoils the atmosphere, might feel

guilt. They may experience a sense of tension and remorse over what they have done, focusing on that specific indiscretion. They know that they are responsible for their behaviour (internal attribution), but acknowledge that the causes of this misdemeanor are rather specific; They know that they are not generally an irresponsible or rude person (specific attribution), and that the antecedents to their behaviour were unique to that particular event (unstable attribution).

Conversely, shame involves a focus on the entire self and is likely to be relatively persistent. Often internal, stable and global attributions are made when one experiences shame. Another person in similar circumstances may experience an acute sense of shame, feeling disgraced, small and wanting to hide. With a clear self-focus, they also know they are responsible (internal attribution), but may believe that the causes of this misdeed are a reflection of their personality – irritating, loud, aggressive (global attribution), and that this type of behaviour occurs within various settings (stable attribution).

III) Empathy

"The actor may feel the situation of the person in the part so keenly, and respond to it so actively, that he actually puts himself in the place of that person. From that point of view he then sees the occurrence through the eyes of the person who was slapped. He wants to act, to participate in the situation, to resent the insult, just as though it were a matter of personal honour with him."

Constantin Stanislavski, 1937

According to Feshbach (1975), empathy is the capacity to share another person's emotional world and requires the cognitive ability to take another person's perspective, to discriminate another person's specific emotional experience, and the affective capacity to engage freely in one's own range of emotion. Empathy is crucial to the development of trusting and rewarding experiences (Rogers, 1961), and is essential to higher social functioning (Rankin, Kramer and Miller, 2005). It promotes altruistic behaviour (Eisenberg, 2000) and suppresses aggression (Saarni, 1999).

Components of empathy begin to emerge by approximately age four, as noted by Eisenberg-berg and Neal (1979), who found that pre-schoolers attributed their prosocial behaviour to the needs of others. Empathy is an essential feature of a good therapeutic alliance (Rogers, 1975) and a healthy parent-child-relationship (Feschbach, 1987).

As noted by Tangney and Dearing (2002), empathy is a good moral experience, guiding people in morally good directions, and away from iniquity. Empathy helps us comprehend interpersonal situations, permitting sensitive responsivity to others. Of most importance however, is the fact that empathy allows us to discern when we have behaved towards others in a way that adversely affects them, and also fosters remedial action.

Research indicates that empathy is comprised of both cognitive and affective elements (Cliffordson, 2002; Davis, 1983; Eslinger, 1998; Grattan and Eslinger, 1989). Cognitive empathy involves perspective taking and reaching an intellectual

understanding of another's cognitive and affective state. Emotional empathy on the contrary, is a sudden powerful feeling of concern for another person in distress. For this type of empathy, the cognitive explanation for the other person's distress is not necessary (Rankin, Kramer and Miller, 2005). It would seem that the same is true the other way around; Psychopaths, for example, have been found to be deficient in processing affect such as fear and sadness (Blair, Jones, Clark and Smith, 1997), but do not display impairment in Theory of Mind tasks (Richell, Mitchell, Newman, Leonard, Baron-Cohen and Blair, 2003).

Empathy and Sympathy

There is a consensus that true empathy also consists of sympathy (Tangney and Dearing, 2002). Sympathy is an affective reaction of concern for another person in distress, rather than a vicarious experience of the same emotion, as in empathy (Decety and Chaminade, 2003, Eisenberg, 1986). Hence, sympathy can occur in the absence of empathy (Tangney and Dearing, 2002), and it would follow that empathy at a cognitive level can occur without sympathy, as in the cases of psychopaths, as outlined above.

Empathy, Personal Distress and Shame

When an individual experiences other-oriented empathy, they take the perspective of, and vicariously experience similar emotions to another person. They feel sympathy and concern for them, which often engenders extending help. In this scenario, the empathic person maintains a focus on the other person's needs and experiences (Tangney and Dearing, 2002).

This is in contrast to a self-oriented personal distress response, a subset of empathy that, according to Davis (1983), is associated with fear, vulnerability and uncertainty, in which there is an emphasis on the emotions and requirements of the empathizer and their own empathic response. Davis (1983) described personal distress as "selfish" feelings of discomfort. It is thought that this response is due to "egoistic drift" (Hoffman, 1984). This is where a self-focused individual begins to feel empathy for another, but where the empathic affect diverts to one's own needs, hence, the other-oriented emphasis fades and the empathic response terminates (Tangney and Dearing, 2002). For example, a passer-by witnessing a road traffic accident may begin to empathise with the casualty, but soon become aware of and focus on his or her own response, which may in this instance include shock, sadness, disgust at the sight of gruesome injuries etc. Hence, attention to the needs of the casualty is superceded by the needs of the passer-by.

Davis (1983) hypothesized the existence of strong individual differences in empathy that exert a significant influence on emotional reactions. His Interpersonal Reactivity Index (IRI; Davis, 1980) is a comprehensive and multidimensional measure of empathy that clearly distinguishes personal distress as a discrete component of empathy.

The IRI has four subscales: Personal Distress; Perspective Taking; Empathic Concern; Fantasy. Personal Distress and Empathic Concern reflect the emotional dimension of empathy, and Fantasy and Perspective Taking assess the cognitive aspects of empathy. Davis (1983) suggested that empathic predispositions affect emotional reactions, and demonstrated evidence of the validity of the IRI in several

studies. A stable factor structure of the IRI over repeated administrations to different samples has been reported (Davis, 1980), as have satisfactory test-retest and internal reliabilities (Davis, 1983). Discriminant validity has been demonstrated in studies correlating the relevant subscales with measures of social competence, self-esteem, emotionality, sensitivity to others and emotional empathy (Davis, 1983).

Unlike self-oriented personal distress, other-oriented empathy is associated with altruistic behaviour (Batson, *et al.,* 1988). Personal distress has been found to be correlated with negative interpersonal behaviours amongst couples in relationships (Davis and Oathout, 1987), and also impedes prosocial behaviours (Estrada, 1995).

IV) Shame, Guilt and Empathy

Guilt and empathy are considered "moral" emotions, helping people to keep their behaviour in check. Empathy obstructs or prevents misdemeanours, and guilt fosters expiation and reparative action. It has been proposed that guilt and empathy work together to avoid and repair transgressions, and that shame impedes other-oriented empathic connection (Tangney and Dearing, 2002). The fixation with the self that occurs in shame is incongruous with the other-oriented nature of empathy.

There is evidence for a positive association between guilt and empathy, and a negative association between shame and empathy. For example, when children and adults described guilt episodes, they expressed more empathy for others compared to when they described shame episodes (Tangney, *et al.,*1994 [cited in Tangney and Dearing, 2002]). However, shame has been found to correlate with the 'selfish' aspect of empathy; Self-oriented personal distress. Tangney and Dearing (2002) assert that shame-prone people are more likely to experience an egoistic drift when

confronted with another individual's distress, in that they have a greater propensity to be distracted by their own emotional needs, rather than engaging with the other person's feelings.

Tangney (1991) investigated these relationships using self-report methods in four independent studies of American undergraduates, who received course credits for their participation.

In the first study, 101 participants completed the Self Conscious Affect and Attribution Inventory (SCAAI: Tangney, Burggraf, Hamme and Domigos, 1988 [cited in Tangney and Dearing, 2002]); a scenario-based scale that measures, amongst other variables, shame and guilt. Empathy was measured using Feshbach and Lipian's (1987) Empathy Scale for Adults (ESA; As cited in Tangney and Dearing, 2002). This measure yields four empathy subscales (General Empathy; Cognitive Empathy; Emotional Responsiveness; Affect Cue Discrimination) and a combined Total Empathy Index. It was found that shame was significantly negatively correlated with two Empathy subscales (Affective Cue Discrimination; Cognitive Empathy) and the Total Empathy Index. There was a negative correlation for shame and Emotional Responsiveness, but this was not significant. There was no correlation between shame and General Empathy. A positive correlation was found between guilt and the Total Empathy Index as well as General and Cognitive Empathy, but guilt was not significantly associated with Emotional Responsiveness or Affective Cue Discrimination. This study found a significant negative relationship between shame and some aspects of empathy, and a significant positive association between guilt and some aspects of empathy.

In Tangey's (1991) second study comprising 97 undergraduates, shame was found to be significantly negatively correlated with all aspects of empathy measured by the ESA, except for General Empathy, lending support to the hypothesis that shame and empathy have a negative relationship.

In the third study shame was found to be significantly positively correlated with general empathy. This appears to be counter evidence for the hypothesis under enquiry. However it was interpreted in terms of the General Empathy subscale of the ESA combining other-oriented empathy items with self-oriented personal distress items. This would fit with the hypothesis that shame and personal distress are positively associated. It is curious, however, that the effects of the self-oriented personal distress items within the General Empathy subscale did not exert such an influence in the other studies. Tangney (1991) offered the explanation that the personal distress items attenuated an otherwise inverse relationship between shame and other-oriented empathy in the studies that found this association, and superseded this relationship in the third study. This is an interesting speculation but not an empirical finding.

In the third study, there were no other significant correlations, and not all the correlations were negative. This study did not support the hypothesis that shame and empathy are inversely related. Guilt, however, was found to be significantly positively correlated with all aspects of empathy measured by the ESA, other than Affective Empathy, providing good evidence for the hypothesized relationship between guilt and empathy.

The fourth of Tangney's (1991) studies measured guilt and shame using the SCAAI, and measured empathy using Davis's (1983) Interpersonal Reactivity Index (IRI). There is no general measure of empathy within the IRI, and all personal distress items are confined to the Personal Distress subscale. Implementing this measure of empathy within Tangney's (1991) fourth study appears to have been a good potential practical solution to the problem of personal distress confounding the ESA.

In Tangney's fourth (1991) study all four scales of the IRI were significantly positively correlated with guilt as measured by the SCAAI. Whilst this finding lends strong support for the proposed relationship between empathy and guilt, the significant positive association between personal distress and guilt is inconsistent with the theory concerning shame, guilt and empathy. With guilt being associated with helping and altruism, it is perhaps unexpected that this self-oriented aspect of empathy would correlate with it. This apparently paradoxical finding is not specifically addressed in Tangney's (1991) paper. One possibility is that in response to another individual's distress, one may experience personal distress and then an egoistic drift as suggested by Tangney and Dearing (2002), but one's attention may drift back to the individual in distress. Hence, egoistic drift within personal distress might be a transient experience that can culminate in either shame or guilt.

The Personal Distress subscale of the IRI was significantly positively correlated with shame. This relationship is consistent with both the self-oriented nature of personal distress and also that of shame. Unexpectedly, there was a significant positive relationship between shame and Empathic Concern. This finding is incongruous

with the proposed negative relationship between shame and empathy, and is also not addressed in the original research. It is possible that this inconsistency was simply due to random error, or maybe that the hypothesis concerning the inverse relationship between shame and empathy is not a reliable association, and is dependent on the measures being used. Although there is reasonable evidence for the inverse relationship between shame and empathy when empathy is measured using the ESA, there is no evidence for this relationship when the IRI is used to measure empathy. No significant correlations were found between shame and Fantasy or shame and Perspective Taking. Overall, this study supported the hypothesis that both guilt and shame and also that shame and personal distress are positively correlated, but did not lend support to the suggested negative relationship between shame and empathy.

For all four studies, Tangney (1991) further refined the analyses and performed part correlations factoring out shame from guilt and guilt from shame. It was found that shame residuals were negatively correlated with all aspects of empathy as measured by the ESA, the only exception being General Empathy and Shame in study 2. There were no significant correlations between Shame and General Empathy overall, between Cognitive Empathy and Shame in Study 3, or between Emotional Responsiveness and Shame in Study 1. However, the remaining ten correlations between the various measures of shame and empathy as measured by the ESA across these four studies were significant, giving some support to the contention that shame and empathy are inversely related.

Partial correlational analyses of shame and guilt with Davis's (1983) empathy subscales revealed that Personal Distress was significantly positively associated with

shame residuals, and this was understood in terms of the self-oriented nature of both these variables. However, even with such statistical refinement, neither Fantasy nor Empathic Concern were found to be significantly negatively associated with shame. Perspective Taking was significantly negatively correlated with shame residuals, fitting with the suggested relationship between shame and empathy, and this was also significantly positively correlated with guilt. Tangney (1991) highlighted Davis's (1983) view that perspective taking is the quintessential aspect of mature adult empathy, strengthening the idea that guilt and empathy are related. Part correlations confirmed the significant positive relationship already observed between guilt and the expected IRI subscales, based on the original results.

Overall, Tangney's research provides some evidence for the proposed link between empathy and guilt, and the negative association between shame and empathy. It raises questions however, about whether the inverse association between shame and empathy is a function of the measure of empathy used. A difficulty with the first three studies is also that personal distress items within the general empathy measure may have clouded the picture somewhat.

With regards to the measure of shame and guilt used in Tangney's (1991) research, the SCAAI is a scenario-based measure. Tangney and Dearing (2002) cite as an advantage that such instruments inquire about specific reactions in particular contexts, allowing the measurement of the emotional reaction *per se*, as opposed to general feelings about the self. However, this also means that not all situations will be considered, resulting in an assessment of emotional reactions in particular contexts that may not reflect one's general tendency to respond. Further limitations,

as pointed out by Tangney and Dearing (2002), include that the SCAAI has weak internal consistency relative to other shame measures, and has been found to correlate with moral standards (Kugler and Jones, 1992), suggesting that it may be tapping values and standards, rather than the emotion guilt itself. On balance, Tangney and Dearing (2002) highlight that some degree of moral judgment is likely to be involved in the affective experience of guilt.

In Tangney's (1991) research discussed above, samples consisted of students. Her findings are therefore difficult to generalize to other populations as students might be considered a more intelligent than average sample. Importantly, they were psychology students earning course credits by participating in the research, perhaps suggesting that they were a relatively more self-aware group.

Other support for the hypothesis that shame inhibits empathy and that empathy is associated with guilt comes from a study where undergraduates described recent intense interpersonal conflict, from both their own, and their partner's perspectives (Leith and Baumeister, 1998). People whose descriptions were coloured by guilt were better able to shift perspectives than others. Findings for shame were less consistent, but when significant, shame experiences were associated with impaired perspective taking (Tangney and Dearing, 2002).

Tangney and Dearing (2002) assert that guilt catalyses other-oriented empathy. The person in the midst of a guilt reaction centers on the transgression. Focusing on the specific behaviour enables them to be free of the egocentricism that characterizes shame, and illuminates the repercussions of that behaviour for others (Tangney and

Dearing, 2002). There is a growing body of research amongst children, adolescents, undergraduates and adults supporting, to some degree, the suggestion that individual differences in proneness to shame are inversely related to a dispositional capacity for empathy, and that guilt-proneness is associated with empathy (Tangney and Dearing, 2002). However, findings are not especially consistent, particularly with regards to shame and empathy.

Theories Concerning Shame and Empathy

According to Roys (1997), shame hampers the possibility of empathic connection because shame impairs one's ability to experience a normal range of emotions. As has already been outlined, shame is a sense of not being acceptable. It is suggested by Roys (1997) that some people, depending on their experiences, can become stifled by shame. Such a focus on one's own sense of shame dampens the ability to experience one's other emotions, and therefore the capacity to share another's emotional experience. Further emotional exploration is halted following deployment (Moses-Hrushovski, 1994) of defence mechanisms, as triggered by the shame experience. In sum, shame may also inhibit empathy by way of restricting one's emotional repertoire.

The research by Tangney (1991) suggests that shame and guilt are distinct affective experiences. Her results supported the notion of a link between guilt and empathy, possibly due to empathic people being more likely to notice when they have caused another harm, and/or because the tendency to respond with guilt may facilitate an empathic connection with others. Additionally, it was postulated that both empathy and guilt stem from a more general level of psychological differentiation. Empathy

requires the capacity to differentiate between self and other, and guilt requires distinguishing between self and behaviour.

Tangney (1991) suggested that shame-proneness may be inversely related to empathic responsiveness because the shame-prone individual lacks the capacity for differentiation. In the experience of shame there is no clear distinction between self and behaviour. Specific behaviour may initially be negatively evaluated, but the adversity of the behaviour soon becomes generalized to the entire self. This global style may be mirrored in a blurring of the boundaries between self and behaviour, and also between self and others (Tangney, 1991). This may be more pronounced in moments of high affect, such as when confronted with a distressed other. Such situations may make it harder for the shame-prone individual to sustain a response involving other-oriented empathy, with a more self-oriented distress reaction being likely.

This seems highly pertinent to the area of sexual offending. Shame-prone sex offenders, confronted with their distressed victims, may, further to egoistic drift, experience personal distress, and bypass the opportunity of experiencing other-oriented empathy. It would appear that an important aspect of their treatment, therefore, might be to develop self-monitoring skills as a stepping stone to the development of empathy for others, which might show promise of alerting the perpetrator to the fact that they are attending mostly to their own negative experience, which could be used as a warning sign that they are not attending to someone else's. Awareness of the experience of others might only be possible further to acknowledgement of, rather than immersion in, one's own. It would

appear then, that screening for shame-proneness amongst sex-offenders might be beneficial and relevant in planning treatment for sex offenders.

Studies have shown that both adults and children who are shame-prone tend to externalise blame (Tangney, 1990; Burggraf, 1989 [cited in Tangney, 1991]). Such externalisation has been conceptualised as a defence against the painful experience of shame (Tangney, 1991). Whilst it is likely that this process provides short-term relief of shame, it is equally plausible that it impedes any possible empathic exchange (Tangney, 1991).

Marschall (1996 [cited in Tangney and Dearing, 2002]) induced feelings of shame in participants, and found that those who were not shame-prone were more likely to experience diminished empathy for a disabled person in a task subsequent to the shame induction. Hence, the shame-induction rendered low-shame-prone individuals relatively unempathic (Tangney and Dearing, 2002).

Thus, it seems that shame inhibits empathy for others by way of an excessive negative self-focus, by restricting the range of emotion experienced, and also by stimulating blaming of others and hostility towards the self and others (Proeve and Howells, 2002).

The Measurement of Shame, Guilt and Empathy

Shame, guilt and empathy have mostly been measured using self-report instruments, having the benefits of acquiring information directly from the respondent, but also the downfall of being susceptible to social desirability effects. Measures for these

emotions have taken the forms of straight questionnaires such as the IRI, or scenario-based tools, such as the SCAAI. These instruments are limited by the definitions of their authors. Definitions have changed over the years, and measurements have evolved to reflect these changing understandings. One difficulty in the research of shame and guilt is that these two emotions are often combined in measures. For example, one of the three subscales within the Revised Gudjonsson Blame Attribution Inventory (Gudjonsson and Singh, 1989) measures guilt, but includes items such as "I feel very ashamed of the crime I committed", which appears to relate to shame.

Many of the instruments fall within the categories of state or trait measures. State-based measures assess the respondent's current emotional state, and trait-based measures determine a person's more stable tendencies to respond in a particular manner. The research investigating the relationship between shame, guilt and empathy generally concerns proneness to experiencing these emotions.

V) Sex Offenders

In this section I will give examples of different types of sexual offending and discuss the prevalence of varying sexual offences so that the reader will be able to consider the data on self-conscious emotions and sex offenders in context. Sub-groups of offenders will be exemplified, emotions in sex offenders will be explored and treatment programmes will be discussed.

Sexual Offending

Sexual offending usually begins in adolescence (Butler and Seto, 2002), and is commonly considered sexual behaviour that victimises others as they do not, or are unable to, consent to the behaviour. These can include contact and non-contact offences (Towl and Crighton, 1996). Sex offenders can be defined legally by at least one of the following factors: Age difference between victim and offender; Use of force; Violation of kinship or close relationships (Towl and Crighton, 1996).

The most deviant sexual interests are more prevalent among sex offenders who have more than one victim, male victims, much younger or much older victims, and perpetrators who victimize strangers and use force (Barbaree and Marshall, 1989).

The Scale of the Problem

The Sexual Offences Act (2003) details numerous sexual acts including rape, assault and child sex offences as illegal. Sexual offences come under the category of violent crimes, and there has been a steady increase in rates of recorded sexual offences since 1983 (Towl and Crighton, 1996). In 2003-2004 there were 52,070 recorded sex offences: 26,709 were indecent assaults on a female; 1,942 were offences of gross indecency with a child. There were 13,247 rapes and 93% of victims were female. Recorded sexual offences increased by 7% in 2003-2004 (Dodd, Nicholas, Povey and Walker, 2004).

It is likely that reported figures for sexual offences are serious underestimates of actual levels of offending (Dodd *et al.*,2004) as indicated by the substantial number of rapes and indecent assaults that are not reported to the police (Clark, 1993 [as

cited in Clark and Stephenson,1993]) and the number of reports that do not result in convictions (Towl and Crighton, 1996).

Evidently, sexual offending is a very serious problem in society. Given the tendency for sex offenders to be repeat offenders, it is a matter of urgency that effective treatments are developed that bring an end to this destructive behaviour that creates such tragic consequences. It seems imperative that, rather than only provide sex offenders with tools for refraining from offending, treatment should transcend this relatively superficial level and address the deeper, inner negative emotions of sex offenders in addition, which might be significant factors in their offending.

Sex Offenders who Victimise Adults

The heterogeneity present in sexually assaultive behaviour has resulted in conceptual and nosological problems. Sexual aggression can range from minor instances of verbal communication and gestures to violent sexual attacks culminating in the death of the victim (Polascheck, Ward and Hudson, 1997). Some theorists (e.g. Polascheck, Ward and Hudson, 1997) include serious sexual assaults in their classifications of rape, for convenience.

There have been several typologies of rapists, including that of Groth (1979), who proposed a motivational typology, with some rapes being sadistic, others anger-motivated, and others motivated by power. There is some evidence that rapists differ from non-offending males in their lack of inhibition of arousal by portrayals of violent sexual behaviours (Abel, Becker, Blanchard and Flanagan, 1981), and other evidence that this difference is not clear cut (Darke, 1990).

Alternative taxonomies include The Massachusetts Treatment Centre Rapist Typology (Version 3, cited in Knight, Warren, Reboussin & Soley, 1998), an empirically-validated rapist classification system that is widely used (e.g. Brown and Forth, 1997). Types 1 and 2 are opportunistic, controlled by situational factors, such as potential victims being present during another antisocial act, e.g. burglary. These two types differ in terms of social competence, with Type 1 rapists being more skilled. Type 3 rapists are pervasively angry, and their anger is global, infiltrating all aspects of their lives. Types 4, 5, 6 and 7 are sexually motivated, distinguishable in terms of aggressiveness, fantasy, and power-reassurance, with the latter two further sub-divided according to social competence. The final motivation (types 8 and 9) is characterised by misogynistic anger, and is also distinguishable in terms of achieved social competence (Knight, Warren, Reboussin and Soley, 1998). An interesting area of research amongst rapists might be to explore whether and to what extent rapists within this classification system are shame-prone. One might speculate that the less socially competent, more angry, power-motivated sex-offenders within this typology might have higher levels of dispositional shame. Treatment for such individuals may need to focus on addressing their experiences of personal distress in response to others in distress, to begin the process of allowing their attention to shift from an egoistic self-focus to a consideration of others.

There is evidence contrary to the view that rape is a consequence of a lack of access to consenting partners (Groth and Burgess, 1977), and also to the view that it is due to distinguishing social skills deficits (Stermac and Quinsy, 1986). Whilst some research findings support the idea of characteristic attitudes ('rape myths', such as

'all women secretly want to be raped'), these beliefs are also found amongst men who have not been convicted of sexually aggressive offences (Koss, Leonard, Beezley and Oros, 1985).

Child Sex Offenders

Perpetrators of childhood sexual abuse are most commonly male adolescents or adults known to the child. Often they are members of the same household (Romans, Martin, Anderson, O'Shea and Mullen, 1996).

As noted by Hilton (1993), research suggests that previous childhood sexual abuse is more prevalent amongst male paedophiles (28%) than in the general population of males (Hanson and Slater, 1988) but no more common than in other psychiatric or forensic samples (Jacobson, 1989; Hanson and Slater, 1988). However, within the population of sex offenders generally, there is a higher prevalence of previous sexual abuse amongst child molesters (Freund and Kuban, 1993).

A repertory grid study carried out at Broadmoor Hospital found that child molesters and incest offenders viewed adult relationships in terms of dominance and submission, and also found adults overbearing (Howells, 1979). This adds to the evidence that child molesters do not feel sufficiently socially confident to establish adult relationships (Towl and Crighton, 1996), and also raises the possibility that these offenders might have high levels of shame, finding it easier to approach and interact with children, rather than adults. According to Freund, McKnight, Langevin and Cibiri (1972 [as cited in Cook and Wilson, 1979]), the child victim becomes a

surrogate for the adult female who is the preferred sexual partner, but who is inaccessible due to the social insecurities of the child molester.

Incest Offenders

Although the hypothesis that incest is transferred across generations has in the past been popular, it is not well-rooted in the evidence base (Towl and Crighton, 1996), with rates of victimisation of incest offenders being on average 20% (Baker, 1985 [as cited in Towl and Crighton, 1996]). This figure is not significantly higher than levels of previous victimisation reported in community studies (Williams and Finkelhor, 1990). Incest offenders have been found to be older and have poorer socio-educational status than offenders against non-relative minors (Curtin and Niveau, 1998). They have also been found to have less psychopathology than rapists (Firestone, Bradford, Greenberg and Serran, 2000).

Risk Factors During Childhood

Males who were victims of childhood sexual abuse (Langstrom, Grann and Lindblad, 2000), and who experienced material neglect, lack of supervision, and abuse by a female (Salter *et al.,* 2003) have been found to be at increased risk of sexual offending. Men who were sexually abused as children are significantly more likely to become victimizers than women who were abused (e.g. Glasser *et al.* 2001). This has been explained in terms of male survivors directing their reactions externally, in contrast to female survivors who have tendencies to internalize their feelings and express them through self-destruction (Carmen, Rieker and Mills, 1984). In reflecting on this type of evidence, Gilbert's (1997) hypothesized distinction between internal and external shame may be helpful. An interesting study might be to explore

differences in shame levels between male and female survivors of childhood sexual abuse. It may be the case that men are more likely to experience external shame, and that for women, internal shame is more probable. Male sex offenders who were sexually abused as children might be abusing others because of their grave concern with the evaluation of others, and therefore project their anger at being evaluated via sexual aggression to those potentially evaluating others. This is consistent with ideas about male sexual offenders being insecure about their masculinity (see section on Shame, Guilt and Empathy in Sex Offenders). Perhaps females, with their tendencies to turn their anger inward, might react emotionally to their abuse with a stronger experience of internal shame. This idea could be tested by assessing and comparing men and women who were sexually victimized as children on measures of external and internal shame.

It is postulated that male survivors are left confused and anxious with regards to sexual identity, and make inappropriate attempts to assert their masculinity (Watkins and Bentovim, 1992; Glasser *et al.* 2001). Other risk factors include emotional rejection (Craissati, McClurg, Browne, 2002), and experiencing and witnessing intrafamilial violence (Salter *et. al*, 2003). Marshall and Barbaree (1990) highlight examples of poor socialization experiences such as violent parenting, as being the cause of powerful feelings of hostility and resentment, and significant precursors to sexual offending. Ward, Hudson, Marshall and Siegert (1995) put forward an attachment model of intimacy deficits, proposing that problematic parent-child relationships engender various insecure attachment styles amongst sex offenders. It would be beyond the scope of this review to explore the myriad of negative experiences that are thought to be precursors to shame. However it is likely that a

deep sense of shame would evolve in individuals subjected to such experiences as those described above.

Child Pornography and the Internet

Possession of and various forms of involvement with indecent photographs is an offence under the Protection of Children Act (1978). Due to the potent and generally collective societal condemnation of paedophiles, one might expect that external shame levels would be relatively high in this population. Obtaining child pornography was difficult in the past. The person would need to present themselves physically to a specialised sex shop, or provide personal details to a mail order organisation (Towl and Crighton, 1996). However, now the availability and quantity of child pornography is greater than it ever was before because of the internet; A medium that allows quick, nameless and faceless dissemination of child pornography around the world, and much of the internet-related child pornography is free (Taylor and Quayle, 2004).

Clearly technology development means that child pornography is not only readily available, but costs may be far less substantial, both financially and emotionally. A shame-prone person with a sexual interest in children and a high level of external shame might never have provided personal details or shown their face in a quest to acquire child pornography because of their avoidance of shame. However, a shame-prone person no longer needs to experience external shame to that degree when obtaining child pornography, as this is now a simple, quick, and most importantly, private experience. On balance, of course there is nothing good about child pornography being available on the internet, however, the ease and privacy with

which it can now be obtained might mean that less negative affect is experienced by potential perpetrators due to less external shame feelings when obtaining child pornography. Ultimately, this might mean less offending for that individual, but probably more offending from others, due to the need to create new material, and hence, new victims.

As noted by Towl and Crighton (1996), it is impossible to control the existence and volume of this type of pornography, and once a child's image enters and is distributed around the internet, its digital echo could be infinite. Unfortunately, this may also mean that some victims of child abuse, such as those who have been photographed or filmed, may consequently find it even harder to shed their shame, with the knowledge that images of them in positions that are likely to evoke a deep sense of shame might be circulated on the web and never destroyed, giving them an ever-present and infinite quality. Hence, we could be confronting a whole new dimension of indelible shame amongst victims of childhood sexual abuse, in this current age of technological growth. In view of the fact that a risk factor for becoming a perpetrator is having been a victim, the experience of shame, in response to an awareness of oneself in 'shameful' poses on the internet, might exacerbate the shame problem in those victims of childhood sexual abuse whose images were at one point circulated through the world wide web, and who then become perpetrators themselves.

VI) Shame in Sex Offenders

It has been proposed that levels of shame amongst sex offenders are high, due to the perceived disapproval of sexual offending amongst the general majority (Scheff and Retzinger, 1997). Scheff and Retzinger (1997) also postulate that sex offenders

harbour deep insecurities regarding their masculinity, and cite as evidence for this studies demonstrating either low or high self-esteem amongst rapists (Marshall and Marshall, 1981 [as cited in Scheff and Retzinger, 1997]; Marshall and Turner, 1985 [as cited in Scheff and Retzinger, 1997]; Lawson *et al.* 1979). In Lawson *et al's* (1979) study, corroboration of offenders' self-esteem levels was acquired by assessing prison staff's evaluations of those offenders, using the same scale. It was observed that those offenders who presented as being high on self-esteem were, according to the opinions of prison staff, in fact low on self-esteem. This research was understood in terms of a reaction formation, whereby sex offenders with very low self-esteem compensated for this with a false and increased bravado attitude that reflected hyperidentification with the traditional male role (Lawson *et al.* 1979). It is the opinion of Scheff and Retzinger (1997) that self-esteem is largely based on shame and pride, and that instruments that measure self-esteem do not discriminate between genuine pride and exaggerated, false self-confidence. Hence, they propose that unacknowledged shame drives the exaggerated masculinity and aggressiveness that characterizes some sex offenders.

Scheff and Retzinger (1997) present some interesting ideas, and it would appear logical that the incarcerated sex offending population might be replete with shame. Sex offenders are not only condemned by society as a whole, but also within the prison environment, as evident by the fact that many sex offenders in most prisons reside in a segregated unit, where they are protected from the hostility of non-sex offenders. However, there is little empirical evidence for this assertion that shame is prevalent amongst sex offenders, and the research of Lawson *et al.* (1979) suffers from significant limitations.

A difficulty with the research by Lawson *et al.* (1979) is that the opinions of prison staff would have been highly subjective and not necessarily a reflection of the offender's true character. Their opinions might have been coloured by the dynamics of the relationships between the staff member and inmate, and by the staff member's preconceptions and attitudes towards sex offenders. It is possible that offenders who yielded high scores on self-esteem really did have high self-esteem and low shame, and that the results were misinterpreted. Psychodynamic processes involving defence mechanisms such as reaction formation are almost impossible to test validly and reliably, as they exist within a relatively speculative context, creating great problems in measurement. Further, this research investigated only rapists, therefore cannot be generalized to the sex offending population at large.

Sigurdsson and Gudjonsson (1994) detected significantly higher shame amongst sex offenders in their study investigating the reasons why offenders confess to the police. This is a start to addressing the question of whether shame is especially prevalent in sex offenders, but there appear to be difficulties with validity of this research. The measure used in this study was the Confession Questionnaire (Gudjonsson and Petursson, 1991). This instrument does not assess shame, but Sigurdsson and Gudjonsson (1994) added in the question "Did you find it difficult to confess because you felt ashamed of your offence?" to the measure, especially for this study. Significantly greater endorsement of this item amongst sex offenders compared to other offenders was accepted as there being a relative abundance of shame amongst sex offenders (Gudjonsson, 2006). However, making this assumption on the basis of one question that directly asked the offender if they were ashamed about their

offence raises several issues. First of all, only one question was asked, and presumably, expressing shame within a single question is not likely to be a valid measurement of an emotion so multi-faceted and complex. Secondly, the question relates to specific behaviour rather than a global evaluation of the self, which, according to the literature reviewed, relates more to guilt than shame. Hence, this study suffers from the fairly common problem of confounding shame and guilt. Further, supplying the word "ashamed" with no explanation of the corresponding emotional experience is not likely to be a valid technique for assessing shame because of the subjectivity of individual definitions.

This was an interesting study with useful findings. It has been cited as evidence for raised levels of shame in sex offenders (e.g. Gudjonsson, 2006), but upon considering how shame was operationalised and measured in this study, and the subsequent weak validity, this finding cannot be taken as empirical evidence of the existence of relatively higher levels of shame amongst sex offenders. In addition, adding a question to a measure that was not present in the original instrument obviously means that it cannot be norm-referenced.

In a comprehensive study, Wright (2005) investigated, amongst other variables, the interrelationships between shame, guilt and empathy. She researched a sample of convicted offenders, but she did not separate sex offenders as a group (who only comprised 10% of the sample), therefore this study did not discriminate the dynamics of self-conscious emotions in sex offenders from those of non-sex offenders. Wright's (2005) findings included that shame and guilt were distinct emotions and

that shame was correlated with personal distress, but the positive association of guilt and empathy was not observed.

VII) Issues Pertaining to the Treatment of Sexual Offenders

Bumby, Marshall and Langton (1999) proposed a theoretical conceptualisation within which to consider the distinct negative affective experiences of shame and guilt in the context of sexually offending behaviour. Following a sexual offence, an attribution is made by the offender to explain their behaviour. When the offender makes an internal, global and stable attribution subsequent to having committed a sexual offence, the resulting affective experience is shame. This is likely to be associated with lower levels of self-efficacy, less adaptive coping, increased cognitive distortions, personal distress, externalisation of blame, and decreased victim-specific empathy. All of these effects make re-offending more likely.

Bumby, Levine and Cunningham (1996, as cited in Schwartz, 1999) found a significant positive association between shame-proneness, personal distress, self-consciousness and externalization, amongst a small sample of sexual offenders in outpatient treatment. They also found that those who were prone to guilt had higher levels of empathic concern and perspective taking ability. This is very much in line with the theory put forward by Tangney and Dearing (2002). At face value, this study appears to indicate that some of the observed inter-relationships between shame, guilt and empathy illuminated by Tangney and Dearing (1991) may also exist amongst sex offenders. However, the details of this study, such as the exact measures that were used, the methods employed and the sample tested, are unavailable as the paper was presented at a conference but was never published.

Much importance is placed on the idea of empathy as being deficient in sex offenders. Hence, many treatment programs comprise empathy training (Roys, 1997). However, Hilton (1993) challenged the practice of empathy training in child molesters, raising concern that such treatment programs may merely be teaching offenders to feign and speak the language of empathy, but not to have a genuine understanding of it. Roys (1997) warns that there is an insufficient appreciation of how empathy works and can be developed or repaired, and what offenders are being asked to do when they are told they must develop empathy is unclear.

Research on empathy in sex offenders presents a rather mixed picture, with some studies indicating lower levels of general empathy in sex offenders compared to non-sex offenders (e.g. Rice, Chaplain, Harris and Coutts, 1994), and other studies having found no differences (e.g. Langevin, Wright and Handy, 1988), and more recent studies broadly suggesting that sex offenders experience empathy in the same way that other people do in general, but that their empathy deficits are located specifically with regards to their own victims (e.g. Fernandez, Marshall, Lightbody and O'Sullivan, 1999; Fernandez and Marshall [as cited in Marshall, Hamilton and Fernandez, 2000]; Marshall, Champagne, Brown and Miller, 1997). As has been discussed above, there are some clear clinical implications regarding shame, guilt and empathy in sex offenders. Investigating self-conscious emotions, it appears, might be an illuminating area of research both at the level of scientific enquiry, and clinical formulation and treatment.

Much treatment for sex offenders is group-based. However, high levels of external shame may act as a deterrent to a sex offender genuinely engaging with such a social process, as this might mean being overwhelmed with the painful shame experience. On the contrary, as explained by Gilbert (1997), the amount of importance placed on the value of the opinions of others would affect the shame reaction, so it would be expected that sex offenders' beliefs about the value of judgments of other sex offenders (and staff) might be important to consider in group therapy. As found by Houston (1998), some offenders acknowledge the sexual nature of their behaviour, but their very tight construing of sexual offenders refers to rigid categories that they do not believe they fit into, such as 'strangers who abduct children' (Houston, 1998). Often, these conceptualizations do not reflect their own identity. This might mean that external shame is reduced in group therapy, as sex offenders in group therapy may not view themselves in as detrimental a fashion as they do other sex offenders. Further, the values of judgments of other sex offenders might seem irrelevant and unimportant to the individual sex offender.

It appears overall that issues of shame and guilt would be important to explore at the very start of therapy, or even earlier than that, such as at the point of arrest when confessions are sought (Gudjonsson, 2006).

Proeve and Howells (2002) note that the limited attention that has been given to shame in sex offenders has focused on the aspect of shame that concerns negative self-evaluation. They propose that there should be a greater emphasis on the facet of shame relating to scrutiny by others. Hence, an interesting area of research might be differences in external and internal shame within sex offender populations.

The predominant approach to the treatment of sex offenders in the UK is the risk-need model, which is primarily concerned with risk management and the protection of the community (Andrews and Bonta, 1998). An example of this would be the Sex Offender Treatment Programme (SOTP). Prisons in England and Wales have been conducting SOTP's since 1991. This is cognitive-behavioural group treatment that aims to change the way offenders think about their crimes and their victims (PDH, 2006).

Conversely the good-lives approach aims to enhance offenders' skills and self-esteem in order to improve their quality of life and hence lessen the chances of re-offending when released into the community (Marshall *et al.,* 2005). This is based on the premise that basic human needs motivate people to want certain outcomes such as relationships, food, autonomy (goods) etc. for optimal functioning. In the case of sexually abusive behaviour the problem is located in the means used to secure goods, e.g. seeking the primary human goods of intimacy and mastery in a sexual relationship with a child. It has been suggested by Marshall *et al.* (2005) that the focus on risk factors is a necessary but not sufficient treatment goal, and that the risk-need approach should be grounded in the good lives model, which is concerned with giving individuals the necessary conditions to lead better lives.

It is the view of the present author that Tangney and Dearing's (2002) outlook regarding self-conscious emotions would be highly relevant to both approaches of sex offender treatment. The risk-need model approach for sex offenders places an emphasis on empathy training. As previously stated, if shame inhibits empathy in

sex offenders by way of a global self-focus, it would seem important to intervene at a level that nurtures guilt and discourages shame, in order for a pathway to empathy to be created and barriers to it broken down. The good-lives approach stresses that reduction in recidivism should not be the sole aim of treatment, as this results in treatment programs that offenders may find hard to engage with as they may be considered rather irrelevant to them personally, and possibly also disempowering (Marshall *et al.,* 2005).

The good-lives approach considers the securing of goods, such as friendship, loving relationships and positive self-regard to be of paramount importance in the treatment of sex offenders. As has been demonstrated in this literature review, the tendency to experience shame as opposed to guilt has many disadvantages, and a significant feature of shame is the tendency to focus on the self. It would appear therefore, that shame is an obstacle to the development of healthy, empathic relationships, as well as positive self-regard, hence that this powerful emotion stymies the securing of goods. Reflecting on sex offender treatment highlights, even further, that addressing issues of shame in sexual offenders should be incorporated early in treatment.

Tangney and Dearing (2002) suggest that an exploration and appreciation of shame and guilt should be implemented as part of treatment programs for offenders in general, with the intention that a sense of guilt, rather than shame is encouraged, allowing offenders to accept responsibility for their crimes. They assert, in view of shame's association with maladaptive functioning, that shame-inducing sanctions should not be imposed.

This issue appears to be very relevant to the approach taken to sex offenders in particular. For example, in 2001, the News of the World newspaper developed a campaign for the naming and shaming of paedophiles (Do we need a 'Sarah's Law'? 2001). This campaign can be seen as a media provider's attempt to tune into society's emotional reaction to what is considered by the great majority as abhorrent behaviour, and provide a sense of control and containment through the proactive measure of naming sex offenders.

However, as explained by Bumby *et al.*, (1999), imposing a sense of shame on sex offenders engenders a negative appraisal of the self that discourages taking responsibility for behaviour. On the contrary, guilt reflects distress over engaging in particular behaviours and encourages taking responsibility and initiating change. This approach may result in offenders' consideration of the effects of their offences on victims, reparative action, higher levels of self-efficacy, more adaptive coping, and consequently decreased risk of re-offending (Bumby *et al.*, 1999). Hudson, Ward and Marshall (1992) put forward a similar conceptualization, highlighting that exploring this distinction should help offenders recognise that guilt, but not shame, is helpful.

VIII Conclusion

As has been reviewed in this paper, there is an emerging finding in various populations that high levels of shame are associated with low levels of empathy, and it has been postulated that shame acts as a barrier to the experience of empathy, whereas guilt acts as a catalyst to empathy. The underlying theoretical foundations are very interesting and evidence is developing in support of these ideas. However

findings have not been entirely consistent, and there is very little evidence of these relationships within the self-conscious emotions in sex offenders; A population that is considered by some to harbour extensive levels of shame. The data in support of the proposed inter-relationships between shame, guilt and empathy also appear to be wholly questionnaire-based, which gives rise to concerns regarding honesty in responding. This might be particularly relevant in forensic settings. No distinctions have yet been made between internal and external shame in sex offenders, and this population seems to be one where light shed on the workings of the self-conscious emotions would be particularly enlightening, especially given the emphasis of empathy training as treatment for sex offenders. Research into shame, and its relationship to guilt and empathy in sex offenders is much needed, and investigators might gain a clearer picture of these inter-relationships if the repertoire of measurement was extended beyond questionnaires only.

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Part 2: Empirical Paper

ABSTRACT

Objectives: To investigate the inter-relationships between shame, guilt and empathy in sexual offenders and prisoners without convictions of sexual offending, as well as group differences in these emotions.

Background: Previous research (Tangney, 1991) indicates a negative relationship between shame and empathy, and a positive relationship between guilt and empathy. These associations have not been investigated in depth amongst sex offenders.

Method and design: Sex offenders (28 males from one prison and two medium secure units) and non-sex offenders (28 males drawn from the general population of a prison who had never been convicted of sexual offences) participated in one-to-one interviews using published questionnaires and also a repertory grid (Kelly, 1955) measuring shame, guilt and empathy.

Results: Sex offenders had significantly higher Empathic Concern compared to non-sex offenders. Within the sample of offenders overall, Personal Distress was significantly correlated with both shame and guilt. The findings were interpreted in light of the available literature, however it was concluded that the diffuse effects of social desirability may have invalidated the results.

Conclusions: Overall, the proposed relationships between shame, guilt and empathy were not found, and the one that was (correlation between shame and personal distress) may have been an effect of social desirability. None of the expected differences between the two groups were found. It was concluded that the present study did not allow a fair assessment of these relationships.

INTRODUCTION

This paper reports on an investigation into the role of shame in sex offenders. In this introductory section shame is described and discussed in relation to other emotions. The impact of shame and guilt on empathy is considered both in the general population and more specifically in sex offenders. Personal construct theory provides a framework for investigating sex offenders and this approach is described.

Shame

Shame has been defined as the feeling experienced as a result of the unfavourable self-evaluation, or perceived evaluation from others, of one's feelings, behaviour and overall character. Shame is experienced in response to a perceived judgement of the whole self. Being a threat emotion, shame is characterised by a wish to hide, disappear or even die (Lewis, 1995). The shame experience encompasses a feeling of being small, and a sense of exposure in front of a real or imagined audience (Covert, Tangney, Maddux and Heleno, 2003).

Historically, shame has taken the form of the "hidden emotion" in psychopathology (Gilbert, 1988). Lewis (1987) spoke of unacknowledged shame, and its destructive consequences, having found that shame was ubiquitous but not discussed in psychotherapy sessions, and was instead ignored, disguised or denied (Scheff and Retzinger, 1997). She proposed that failing to confront shame in the therapeutic relationship was a frequent source of therapeutic impasse and symptom formation (Lewis, 1987).

According to Lewis (1987), there is a strong connection between shame and anger. Retzinger (1991) found that unacknowledged shame was a consistent precursor to anger, when analysing transcripts of quarrels between married couples. Based on this evidence, Scheff and Retzinger (1991) put forward a theory of shame/rage loops culminating in violence. They proposed that unacknowledged and un-discharged shame does not subside, but instead forms a shame-shame (resulting in withdrawal) or shame-rage (resulting in verbal or physical violence) loop.

Lewis (1971, 1976, and 1987) conceived a form of shame therapy where anger was acknowledged and traced back to shame. Analysis of therapy sessions indicated that feelings of shame were masked in verbal attack or withdrawal, indicating that feelings of shame and humiliation were too painful to be revealed, even to patients themselves. Instead of disclosing feelings of shame, patients sought to humiliate the therapist in return, resulting in a humiliation-counter-humiliation sequence (Scheff and Retzinger, 1997).

Lewis (1971) differentiated between overt and bypassed shame. Overt shame is characterised by emotional pain and unwanted physical symptoms such as sweating and blushing. This type of shame is visible to others and within the bearer's awareness. Conversely, bypassed shame is much less available to consciousness and is marked by repetitive, obsessive thoughts and slightly incongruous speech. It is also associated with shame-anger loops (Scheff and Retzinger, 1997). The research of Lewis (1971) indicated that men have proclivities towards bypassed shame (Lewis, 1987), in that they may bypass the painful experience of shame by becoming

angry. However, they are ashamed of their anger and angry that they are ashamed (Scheff and Retzinger, 1997).

Gilbert (1997) distinguishes internal from external shame, the former being a sense of failure at meeting ones own standards, and the latter a perception that others have judged them negatively. These two forms of shame are not necessarily correlated: for instance, as highlighted by Lewis (1992), if one has no expectation that their flaws would be revealed in front of others, they may not experience any shame about them. This may be the case, for example, in a situation where a politician is involved in a financial scandal that they claim to be regretful or apparently ignorant of once the scandal has been made public. Their external shame may be high, in stark contrast to their experiences of internal shame.

Shame and Guilt

Despite the tendency for the terms 'shame' and 'guilt' to be used interchangeably, research suggests that these two emotional states are discrete (Tangney, Marschall, Rosenberg, Barlow, and Wagner, 1994 [cited in Tangney and Dearing, 2002]). Whereas in shame the self negatively evaluates the entire self, motivates anger, and draws any attention away from the distressed other back to the self, guilt is a self-judgement of particular behaviours that has a specific focus, and is associated with empathy for the harmed other and reparative action (Lewis, 1971). Guilt is an unpleasant state, but much less painful than shame. In guilt, the focus is on the moral transgression, autonomic responses may be less pronounced, and one does not feel exposed (Lewis, 1987).

Shame, Guilt and Empathy

Tangney and Dearing (2002) propose a link between empathy and guilt, and an inverse relationship between empathy and shame. Feshbach (1975) described empathy as comprising cognitive elements (such as perspective-taking ability), affective cue discrimination (accurate perception of the affective states of others) and emotional responsiveness (the ability to experience a range of emotion). Davis (1983) draws a distinction between self-oriented distress and other-oriented empathy as emotional reactions to another's distress, in his Interpersonal Reactivity Index (IRI; 1983), that also measures perspective-taking; Both in real life and in the fictional realm. The Personal Distress Scale measures the extent to which individuals experience self-oriented fear or discomfort in response to the distress of another person, whereas the Empathic Concern Scale measures the degree to which other-oriented feelings of concern and compassion are experienced (Tangney and Dearing, 2002).

Based on their promising findings reflecting this relationship, Tangney and Dearing (2002) proposed a positive association between guilt and empathy. Guilt was found to be associated with both Davis's (1980) Perspective Taking and Empathic Concern scales of the IRI. In addition they found that proneness to shame was associated with high scores on Davis's (1983) Personal Distress scale, and inversely or negligibly related to other-oriented empathy, depending on the empathy measure used. These findings were evident to some extent across several independent studies using various populations (Tangney and Dearing, 1991, 2002).

The intense self-focus of shame appears to be antithetical to the other-oriented nature of true empathy. Tangney and Dearing (2002) assert that empathy and guilt operate in unison, with guilt being instrumental in preventing misdemeanours, and empathy being significant in their resolution. Conversely, shame appears to impede empathy. This may be due to egoistic drift (Hoffman, 1984), where one becomes distracted and preoccupied with their own emotional experience of personal distress when confronted with another individual in distress. Consequently, instead of maintaining an emphasis on the other person's experience and needs, the inward-focus of shame and its associated personal distress may impede a true empathic response (Tangney and Dearing, 2002).

Alternatively or in addition, an empathic response may be halted by the impact of shame, due to the reduced capacity of a shame-prone person to experience a normal range of emotions (Roys, 1997) further to the overpowering nature of shame. As a result, the capacity for appreciating the range of emotions of others is impaired (Roys, 1997).

Further support for Tangney and Dearing's (2002) theory comes from studies where undergraduates described recent experiences of interpersonal conflict, both from their own and their partners' perspectives (Leith and Baumeister, 1988). A clear finding was that those whose descriptions involved guilt had a greater propensity towards shifting perspectives, and less consistently, that descriptions that were coloured by shame were associated with impaired perspective-taking (Leith and Baumeister, 1988; Tangney and Dearing, 2002).

Further, research suggests that individuals who are prone to experiencing shame are also inclined to externalise blame (Tangney, 1990; Burggraf, 1989 [as cited in Tangney, 1991]), and this is also likely to hamper the experience of empathy (Tangney, 1991). Finally, induced shame in participants who were not shame-prone resulted in diminished empathy for a disabled individual (Marschall, 1996 [cited in Tangney and Dearing, 2002]).

In sum, shame inhibits other-oriented empathy, and this process is mediated by an excessive negative self-focus, a limited repertoire of affective experience, blaming of others, and hostility (Proeve and Howells, 2002).

Shame and Sex Offenders

Scheff and Retzinger (1997) assert that sex offenders feel ashamed because they have been publicly condemned for wrongdoing. They also hold, based on a series of investigations into rapists (Marshall and Marshall, 1981 [cited in Scheff and Retzinger, 1997]; Marshall and Turner, 1985 [cited in Scheff and Retzinger, 1997]; Lawson *et. al.* 1979), that sex offenders are insecure about their masculinity. It was found that levels of self-esteem (the degree to which one values oneself, Reber, 1985), were bi-modally distributed amongst this population, in that most of these men yielded either very low or very high scores. Although it may hold that pride is the foundation of high self-esteem and that persistent shame forms the basis of low self-esteem, the scales employed did not consider the participant's defence mechanisms, such as exaggerated confidence in self as a defence against shame (Scheff and Retzinger, 1997). Prison staff who knew the participants evaluated them using the same scale, and it was reported that those who yielded high scores in fact

had low levels of self-esteem according to staff, compensated for with a strong sense of bravado (Lawson *et. al.*, 1979; Scheff and Retzinger, 1997).

Scheff and Retzinger (1997) purport that self-esteem is based on shame and pride, and that measures of self-esteem used in the cited research confound genuine pride with exaggerated self-confidence. They assert that the exaggerated aggressiveness and machismo of sex offenders may be created by unacknowledged shame about sexuality.

According to Scheff and Retzinger (1997), successful understanding and treatment of sex offenders is impeded by their repressed and hidden shame, and offenders must reach the point of sharing and communicating their shame in order for treatment to be effective. It would follow from this perspective that shame is rife in this population of sexually-insecure men who have been publicly condemned for acts of abuse that are generally viewed by society as unacceptable. Many sex offenders are segregated in an independent unit within prisons, in order to protect them from the hostility and aggression expressed by other types of offenders towards sex offenders, for the perceived unacceptability of their behaviour. It would therefore be expected that levels of external shame would be higher amongst sex offenders compared to other types of offenders. There has been very little empirical research concerning shame in sex offenders, although Sigurdsson and Gudjonsson (1994) conducted a study and found some evidence of higher shame in sex offenders relative to other offenders.

A significant positive association between shame-proneness, personal distress, self-consciousness, and externalisation was found amongst a small sample of sexual offenders in outpatient treatment, in a study carried out by Bumby, Levine and Cunningham (1996, as cited in Schwartz, 1999). This study also found that offenders who were guilt-prone had higher empathy levels. Unfortunately this paper was presented at a conference and never published, and there is no detailed record of the methods employed or the measures used in this study. However, it is in line with the general findings concerning shame, guilt and empathy in the general population, and provides some evidence that the finding of significant positive associations between shame and personal distress, and guilt and empathy, may also apply to sex offenders. Given what is proposed about the effect of shame on empathy, and the likely prevalence of shame amongst sex offenders, it would follow that investigation of these self-conscious emotions within the sex offending population would be a worthy area of research.

Shame and Guilt in Sex Offenders and Personal Construct Theory

Personal Construct Theory (PCT) offers a way of understanding how offenders see the world, and provides techniques such as the repertory grid for understanding the structure and content of construing. PCT gives an insight into what is unique about that particular individual (Houston, 2003). McCoy (1977) describes shame in PCT terms as "awareness of dislodgement of the self from another's construing of your role". Guilt has been defined as "the awareness of dislodgement of the self from one's core role structure" (Kelly, 1955) and core role structure is generally explained in the PCT literature as the way in which one's self-identifying constructs are interrelated (Houston, 2003). The definition of internal shame (described above) is

consistent with the PCT definition of guilt, and definitions of external shame correspond to the PCT definition of shame.

For some offenders, being an abuser may be part of their core role. Any dislodgement from such a role might elicit negative affect, which may only be relieved by sexual experiences that affirm their original self-constructions. Kelly (1969a [cited in Horley, 2003]) refers to a concept called 'slot rattling' where the self is reconstrued at the opposite pole of a construct to which it had originally been assigned. In slot rattling a person internalises both poles of a construct, for example in an abusive relationship the abused would internalise both the role of the abuser and the abused. This is in line with Cordess and Cox (2004) who postulate that victims can become both victims and victimizers, as it is the relationship with the object, the self in relation to the other, that is internalized. It has been suggested that for some, acts of violence may be a manifestation of slot rattling, from a view of the self as weak to one characterised by power (Horley, 2003). Slot rattling may be observed in the victim of abuse who then abuses others (Adshead, 1994).

PCT would therefore hold that in sexual offenders for whom being an abuser is part of their core role, behaving in a way that is consistent with their self-view, i.e. committing sexual offences, should not lead to significant guilt. Conversely, for those individuals who do not see themselves as abusers, committing sexual offences should theoretically result in discomfort as a result of this inconsistency between self-view and actual behaviour. It would fit with this theory therefore, that sex offenders who have never themselves been sexually abused should have higher levels of guilt compared to sex offenders with a history of sexual abuse.

The PCT research into sex offenders emphasizes how such offenders construe their victims in order to avoid guilt, for instance, by construing their victims as consenting to the abuse, or having behaved provocatively, hence, not construing their own behaviour as harmful (Houston, 1998; Howells, 1979; Horley, 1988). Some offenders acknowledge the sexual nature of their behaviour, but their very tight construing of sexual offenders refers only to 'strangers who abduct children' or 'rapists with a knife' (Houston, 1998), and often does not reflect their own identity.

This drive to reduce guilt may also be apparent in the function of cognitive distortions, such as those outlined by Abel, *et. al.* (1989). As suggested by Marshall, Hamilton and Fernandez (2001), sexual offenders engage in distorted processes in order to protect themselves from their own and others' negative self-judgments. Evidence for this includes research carried out by Mihailides, Devilly and Ward (2004). Given the tendency for sex offenders to distance themselves from being a sex offender by, for instance, construing their behaviour as not harmful, or viewing their victims as consenting, it might be expected that sex offenders would have lower levels of internal shame compared to non-sex offenders.

Empathy in Sex Offenders

There is a consensus that lack of empathy is a significant factor in the perpetration of sexual offences (Marshall, Anderson and Fernandez, 1999). Whereas some studies indicate that this relates to empathy in general (such as that of Rice, Chaplain, Harris and Coutts, 1994), there is a trend towards the notion that sex offenders do not lack empathy *per se*, but that their empathy deficits are limited to their perceptions of

their victims. The differentiation between victim-specific empathy and general empathy is indicated by a growing body of evidence (Fernandez, Marschall, Lightbody and O'Sullivan, 1999; Fernandez and Marschall [as cited in Marshall, Hamilton and Fernandez, 2001]; Marshall, Champagne, Brown and Miller, 1997). Hence, it would follow that there should be no difference in empathy in general, between sex-offenders and non-sex offenders.

Shame, Guilt and Empathy in Sex Offenders

Extending the research of Tangney (1991; 1994; 1995a; 1995b; 1995c [as cited in Tangney and Dearing, 2002]); Tangney, Wagner, Burggraf, Gramzow and Fletcher (1991, cited in Tangney and Dearing, 2002), it would be expected that the inverse relationship evident between shame and empathy may also be apparent in the sex offender population. Bumby, Marshall and Langton (1999) hypothesized that internal, global and stable attributions made by sex offenders to explain their behaviour resulted in shame, making further offending more likely due to increased cognitive distortions, personal distress, externalization of blame, and decreased victim-specific empathy. Conversely, they postulated that if guilt was experienced, offenders might reflect on the effects of their behaviour on victims, potentially leading to reparative action. They, in line with Hudson, Ward and Marshall (1992), suggest that treatment should emphasize guilt rather than shame, as the former reflects distress at one's behaviour and fosters responsibility and change, in contrast to shame.

The Present Study

This study aims to measure levels of shame, guilt and empathy in sex offenders, and compare them with those of non-sex offenders. All questionnaires used will be trait-based, and have been selected because as a battery they generally measure internal shame, external shame and guilt as discreet entities (although see section on Measures for full details). The empathy measure has been selected because it has a separate scale for personal distress; An aspect of empathy that has been found to correlate with shame. It is also a comprehensive measure that encompasses both cognitive and affective aspects of empathy. Repertory grid technique elicits both direct and indirect measures and is therefore less susceptible to social desirability.

Given the emphasis of empathy training on psychological treatment for sex offenders, and also the emerging moderate, but mixed evidence that shame and empathy, (the latter being an emotion that is positively associated with guilt) are inversely related within some populations, the proposed relationships between shame, guilt and empathy were investigated in a sample of 28 sex offenders, and 28 non-sex offenders.

As previously detailed, in Tangney's (1991) studies two scales of empathy were used overall. Whereas the inverse relationship between shame and empathy was observed when the ESA (Feshbach and Lipian [1987], as cited in Tangney and Dearing [2002]) was employed as a measure of empathy, this relationship did not appear to exist when measuring empathy with the IRI. This raises questions regarding the validity of different scales measuring the same emotions. In this study, the IRI will

be used as a measure of empathy, as its relationship to shame is of interest and uncertain.

Due to the interest in separating out internal from external shame, separate measures will be employed for each of these types of shame. Finally, the guilt measure has been selected for its brevity. All measures used in this study are trait-based.

The present study fills some significant gaps in the literature, the most obvious being addressing the inter-relationships between self-conscious emotions amongst sex offenders. Findings concerning shame, guilt and empathy in sex offenders are based largely on one study with incomplete detail. It would appear though, that that these complex interactions might bear significance on the emotional reactions and further, the behaviour of sex offenders. Distinctions between external and internal shame have not been empirically investigated as yet, moving the research on shame and empathy in sex offenders a further step forward.

Based on the empirical findings and theoretical underpinnings discussed in this paper, it is specifically hypothesised that:

1. For sex offenders, shame and other-oriented empathy will be inversely related. This relationship will also be observed in the sample overall.
2. Amongst sex offenders, other-oriented empathy and guilt will be positively correlated. This will also be observed in the sample as a whole.

3. Shame and personal distress will be positively correlated amongst sex offenders. This relationship will also be observed when the whole sample is taken together.
4. Upon comparing sex offenders and non-sex offenders on measures of shame and empathy, there will be no difference in empathy but higher levels of external shame amongst sex-offenders as compared to non-sex offenders.
5. Sex offenders will have lower internal shame compared to non-sex offenders.
6. Sex offenders with no histories of sexual abuse will be more likely to experience guilt than those with previous histories of abuse.
7. Taking the sample as a whole, questionnaire measures of shame, guilt and empathy will be positively correlated with repertory grid measures of the same variables.

METHOD

Participants

All participants were English-speaking, incarcerated men, none of whom were diagnosed with a learning disability or neurological disorder. Sex offenders were recruited from an inner-city prison and two medium security hospitals. Non-sex offenders were recruited from prison only. Participants were classed as sex offenders if they had received a conviction for rape or indecent assault on an adult or child, for unlawful sexual intercourse with a child, or for the possession of indecent photographs. The comparison group of non-sex offenders consisted of men drawn from the general prison population whose offences ranged from burglary to attempted murder. These men had not necessarily been convicted for their crimes, and had never been convicted of a sexual offence on any previous occasion. Participants were invited to take part in a study about feelings in people who had committed offences. The study was granted ethical approval from various research ethics committees (see Appendices). Written informed consent was obtained from all participants (see Appendices).

Medium security hospitals

In the medium secure hospitals, Consultant Psychiatrists overseeing the care of sex offenders were written to and the inclusion criteria were explicated. Consultants responded with signed consent forms allowing the researcher to contact men whom they recommended as participants in the study, and also to have access to their notes.

The researcher, who gave a very brief description of the study, approached these men, and they were asked if they were interested in participating.

Prison

Prison officers, while taking into account the exclusion criteria, made recommendations of potential sex offender participants. This was also true for non-sex offenders, but for the men who were recommended from this population, the process was slightly different as it was necessary to ensure that they had no previous convictions for any sexual offences. Hence, prior to the researcher approaching them, their previous convictions were investigated for the presence of sexual offences by liaising with staff who were authorized to check these records. Once it was established that participants met the inclusion criteria, these men were also approached by the researcher, given a very brief description of the study, and asked if they were interested in participating.

Design

This study employed a mixed design, with some parts of the study being between subjects and other parts being within subjects. The independent variable was group status and the dependent variables were internal shame (as measured by the Internalised Shame Scale), external shame (as measured by the Other as Shamer Scale), guilt (as measured by the guilt sub-scale of the Hostility and Direction of Hostility Questionnaire), empathy (as measured by the four scales of the Interpersonal Reactivity Index), internal shame (as measured indirectly by the repertory grid), external shame (as measured both directly and indirectly by the

repertory grid), guilt (as measured both directly and indirectly by the repertory grid), and empathy (as measured directly by the repertory grid).

Measures

The Internalised Shame Scale (ISS; Cook, 1988) is a 30-item test that is composed of two scales, one measuring internalised shame (24 items) and the other measuring self-esteem. For this study only the shame scale was analysed due to the topic under investigation. This trait-based measure uses a five-point scale, with responses ranging from "never" to "almost always", and is a construct-valid and reliable instrument. Correlations with other affects that are theoretically linked with shame have been found to be significant, as measured by an affect checklist (Rybak and Brown, 1996). The scale has been found to be reliable, with Chronbach's alphas in the 0.90s (Turner and Lee, 1998), indicating good item homogeneity. Overall the ISS appears to be a measure of internal shame, although a small proportion of the items seem to relate to external shame.

The Other as Shamer Scale (Goss, Gilbert and Allan, 1994) was employed as a measure of external shame, and is an adaptation of the Internalised Shame Scale. It consists of 18 items, and uses a very similar 5-point scale. This trait-based measure has been shown to have good psychometric properties (Goss *et al.,* 1994). It correlates significantly with other measures of shame, such as the Internalised Shame Scale ($r = 0.81$, Goss *et. al.,* 1994).

The Interpersonal Reactivity Index (Davis, 1983) was used to measure empathy. There are four, seven-item sub-scales within this measure, each tapping a different

aspect of empathy: Fantasy (tendency to identify with fictitious characters); Perspective Taking (tendency to appreciate the views of others); Empathic Concern (tendency to experience feelings of warmth and compassion towards distressed others); Personal Distress (tendency to experience discomfort in response to the distress of others). The IRI is a trait-based instrument that uses a five-point scale, with responses ranging from 'nothing like me' to 'a lot like me'. Moderate associations have been found between the subscales of this Index and the Empathy Quotient (Lawrence, Shaw, Baker, Baron-Cohen and David, 2004), suggesting concurrent validity. The subscales have been found to have good construct validity, e.g. Davis (1983) found that the subscales correlated with various other measures of social functioning, such as sensitivity to others. Internal reliabilities have been found to be satisfactory (range = .71-.77), as have test-retest reliabilities (.60-.82) (Davis, 1980).

The guilt sub-scale of The Hostility and Direction of Hostility Questionnaire (Caine, Foulds and Hope, 1967), a trait-based measure, was used in this study to measure guilt. A modified version of the method of criterion groups was used in the validation of this measure. A consideration of the rank order of the various clinical groups on the subtests of the Hostility and Direction of Hostility Questionnaire suggests that each subtest is measuring that aspect of hostility (Caine *et. al.*, 1967). For the guilt subscale, highest means were yielded by melancholics and lowest means were obtained for normals, providing evidence of criterion validity. There is also evidence for the reliability of this measure, with the test re-test correlation being 0.75. The fact that it is an older questionnaire has strengths, as it is well-established and widely used, however this also means that a small proportion of the items appear

to include shame. An advantage is that this seven-item questionnaire is very quick to complete.

The Brief Symptom Inventory (Derogatis, 1993) assesses the severity of symptoms of psychological distress experienced over the past week, and is designed to reflect the psychological symptom patterns of psychiatric and medical patients as well as non-patients. Each of the inventory's 53 items is rated on a 5-point scale of distress, ranging from "not at all" (0) to "extremely" (4). It yields nine symptom dimensions and three global indices of distress, the latter of which will be reported in this study as they are considered more reliable than self-ratings of discrete symptoms (Derogatis, 1993). The three dimensions are the Global Severity Index (a measure of distress level), the Positive Symptom Total (an indication of the extent of the distress level) and the Positive Symptom Distress Index (a reflection of distress style). This scale has been found to be psychometrically robust. The internal consistency coefficients indicate that the items selected to represent each symptom construct are homogenous (Range = 0.71-0.85). The test re-test coefficients suggest that this scale provides consistent measurement across time (Range = 0.68-0.91; Derogatis, 1993).

Repertory grid technique (Kelly, 1955) is a widely used technique that allows the exploration of an individual's personal meanings. Administering the grid involved the elicitation from the individual of a sample of their constructs (adjectives) by asking them to compare and contrast a group of 'elements' (aspects of the self and significant others) (see list of elements in Appendices). Participants were also provided with three constructs: Shame, guilt and empathy, and definitions for these terms were given. They were then asked to rate each of the elements on a seven-

point scale on each of the constructs. The resultant repertory grid was analysed using the Gridcor (Version 4) computer package (Feixas and Cornejo, 2002), which allows the derivation of a range of both direct and indirect measures of self-conscious emotions.

In this study, external shame (labelled as 'shame' and defined as 'feeling that other people judge you negatively'), guilt (defined as 'judging your behaviour negatively') and empathy (defined as 'being able to really understand how someone else feels') were measured directly, based on ratings of the element 'myself now' on those constructs. Internal shame, external shame and guilt were also measured indirectly, by measuring the distances in perceptions of pairs of elements. In line with personal construct theory, internal shame was measured by calculating the distance between the elements 'myself now' and 'ideal self', external shame was measured by calculating the distance between 'myself now' and 'how others think I should be' and guilt was measured by calculating the distance between 'myself now' and 'myself before the offence'. There is considerable evidence for the validity and reliability of grid measures (Fransella, Bell and Bannister, 2004).

Additional information from the grid: Tightness of construing and dissociation

A useful way of describing a person's way of construing the world is in terms of the tightness of their construct system. If one's construing is very tight, their constructs are largely connected and lead to unvarying predictions. For example, a person who is 'clever' is also 'successful', implying a close association in the construer's view of the world between those two qualities. Their view of the world is likely to be rigid and inflexible. Conversely, in loose construing there is little connection between

individual constructs and how they are applied (Houston, 1998). Tightness of construing will be measured by considering the percentage of variation accounted for by the first component (the greater the percentage, the tighter the construct system).

Dissociation is a term used to describe the perceived distance between the self and others who engage in similar problematic behaviour. Dissociation can be understood as a mechanism to protect self-esteem by distancing oneself from negative stereotypes of other people with similar behaviour (Winter, 1992). A measure of dissociation will be obtained by calculating the distance between the elements 'myself now' and 'the sort of person who would commit a sexual offence / an offence like mine'.

Procedure

Once in a private interview room, the study was discussed in more detail, participants were given an Information Sheet (see Appendices), and consent was taken. Given the degree of literacy problems amongst the offending population all measures were presented orally (in the order listed above) and the process took the form of an interview, with responses being written down by the researcher. At the end of the interview participants were asked if they had ever experienced sexual abuse. They were also asked if they would like to be provided with [1]written feedback about the research when the study was over. Finally, demographic and background information was obtained from participants' notes.

[1] All participants who requested written feedback about the study were sent a debriefing letter (see Appendix) in the ensuing months.

RESULTS

Preliminary Analysis

All variables were examined for accuracy of data entry, missing values and appropriateness for parametric testing prior to statistical analysis, and outliers were removed. Some variables were slightly skewed, but normality for all variables was achieved by performing data transformations. No variables had significant kurtosis. Parametric statistics were used for continuous variables and non-parametric statistics were used for categorical variables.

Participants

Sex offenders

There were 28 participants in the sex offender group, and the mean age was 34 years old (range = 21 – 66 years). Nineteen sex offenders were white, eight were black and one was Asian. Sixteen had been given a psychiatric diagnosis (seven had been diagnosed with schizophrenia, five with a mood disorder, two with schizoaffective disorder, and two were psychopathic). Information regarding treatment for their sexual offending was only available for the eight sex offenders who were hospitalised: Two had received individual psychotherapy, one had participated in group psychotherapy, and five had never received treatment. Ten sex offenders were currently detained for sexual offences against children (four for indecent assault, three for rape, two for possession of indecent images of children and one for indecent exposure), 17 for sexual offences against people aged over 18 (11 for rape, four for indecent assault, one for attempted rape of an adult, one for attempted rape of an elderly person) and one was incarcerated for grievous bodily harm but had previous

convictions of sexual assault against children. Five sex offenders disclosed that they themselves had been victims of sexual abuse.

Non-sex offenders

There were 28 participants in the non-sexual offender comparison group, and the average age was 32 (range = 21 – 47 years). Fourteen non-sex offenders were black, 13 were white and one was Asian. Two comparison participants had psychiatric diagnoses (psychopathy and depression). Nine participants in this group were currently in prison for burglary, six for violence against the person, four for robbery, four for drug offences, two for kidnapping, and one each for breach of bail, criminal damage and fraud. Three non-sex offenders stated that they had experienced sexual abuse.

Questionnaire measures

Table 1 presents the means, standard deviations and minimum and maximum scores obtained on each of the measures used in this study, for each group.

Table 1: Descriptive statistics for questionnaire measures

Aspect being Measured/group	Measure	Mean	Standard Deviation	Mini-mum	Maxi-mum
	[2]BSI(GSI)	0.86	0.70	0.04	2.58
Symptoms sex offenders	[3]BSI (PST)	23.89	14.42	2	49
	[4]BSI (PSDI)	1.87	0.69	1	3.67
	BSI (GSI)	0.86	0.60	0.15	2.47
Symptoms non-sex offenders	BSI (PST)	24.50	12	3	48
	BSI (PSDI)	1.80	0.71	0.28	3.21
Internal shame sex offenders	[5]ISS (IS)	36.54	25.21	0.00	87
Internal shame non-sex offenders	ISS (IS)	32.61	17.70	8	77
External shame sex offenders	OAS	26.57	15.86	2	57
External shame non-sex offenders	[6]OAS	22.07	10.44	2	44
Guilt sex offenders	[7]HDHQ (Guilt)	3	2.16	0	7
Guilt non-sex offenders	HDHQ (Guilt)	2.75	1.82	0	6
	[8]IRI (PT)	16.07	4.88	7	24
Empathy sex	[9]IRI (F)	13.89	5.16	1	23
Offenders	[10]IRI (EC)	18.29	4.81	7	27
	[11]IRI (PD)	11.00	5.00	5	25
	IRI (PT)	15.57	4.58	5	24
Empathy non-	IRI (F)	13.26	4.51	4	24
sex offenders	IRI (EC)	14.93	3.07	9	20
	IRI (PD)	10.28	3.90	5	20

In this section, current means and standard deviations are placed in the context of previously published norms for each of the questionnaire measures.

[2] Brief Symptom Inventory (Global Severity Index)
[3] Brief Symptom Inventory (Positive Symptom Total)
[4] Brief Symptom Inventory (Positive Symptom Distress Index)
[5] Internalised Shame Scale (Internalised Shame)
[6] Other as Shamer Scale (External Shame)
[7] Hostility and Direction of Hostility Questionnaire (Guilt subscale)
[8] Interpersonal Reactivity Index (Perspective Taking)
[9] Interpersonal Reactivity Index (Fantasy)
[10] Interpersonal Reactivity Index (Empathic Concern)
[11] Interpersonal Reactivity Index (Personal Distress)

Symptoms

BSI (Derogatis, 1993)

The BSI manual (Derogatis, 1993) reports norms for an American adult psychiatric outpatient population (GSI: x = 1.32, sd = 0.72; PST: x = 30.80, sd = 11.63; PSDI: x = 2.14, sd = 0.61) and as illustrated in Table 1, the PST means for participants in the present study were lower, indicating that the extent of their distress was relatively less marked as reflected in fewer reported symptoms. However, scores for both groups on all symptom dimensions of the BSI were similar in this study.

Shame

Internalised Shame Scale (Cook, 1988); Other as Shamer Scale (Goss, Gilbert and Allan, 1994)

Goss, Gilbert and Allan (1994) used both the ISS (x = 32.1, sd = 16.2) and OAS (x = 20.0, sd = 10.1) on a population of British students. In the present study, the mean for internalized shame amongst non-sex offenders (32.61) was consistent with that obtained in Goss *et. al's* (1994) study, and internal shame amongst sex offenders (36.54) was higher. For external shame, sex offenders yielded higher scores (x = 26.57) on average than non-sex offenders (x = 22.07), who scored marginally higher than the undergraduates in Goss *et. al's* (1994) study.

Guilt

The Hostility and Direction of Hostility Questionnaire (Guilt sub-scale; Caine, Foulds and Hope, 1967)

Hatzitaskos, Soldatos, Sakkas and Stefanis (1997) used the Hostility and Direction of Hostility Questionnaire with a sample of men with antisocial personality disorder, serving in the Greek Air Force, currently hospitalized for poor psychological adjustment (x = 4.1, sd = 1.8). In the present study means for guilt were similar between groups (x = 3 for sex-offenders and 2.75 for non-sex offenders), and slightly lower than those reported by Hatzitaskos *et. al.* (1997).

Empathy

The Interpersonal Reactivity Index (Davis, 1983)

Moriarty, Stough, Tidmarsh, Eger and Dennison (2001) administered the IRI to a sample of male adolescent sex offenders (Fantasy: x = 12.80, sd = 4.51; Perspective Taking: x = 13.87, sd = 4.58; Empathic Concern: x = 13.27, sd = 4.11; Personal Distress: x = 12.73, sd = 4.11). In this study, Fantasy and Perspective Taking were relatively slightly higher (x = 13.89 and 16.07 respectively for sex offenders; x = 13.26 and 15.57, respectively, for non-sex offenders), Personal Distress was relatively slightly lower (x = 11 and 10.28 for sex offenders and non-sex offenders, respectively), and Empathic Concern was generally higher (x = 18.29 and 14.93 for sex offenders and non-sex offenders, respectively) than reported means from Moriarty *et. al's* (2001) study. A study investigating empathy among medical students found that mean scores on Fantasy, Perspective Taking and Empathic

Concern were 16.6 (sd = 6.0), 18.8 (sd = 4.5) and 20.3 (sd = 3.9) respectively, which are higher scores than in the current investigation and previously cited study. Personal Distress, conversely, was 8 (4.2) among medical students, lower than the other studies (Bellini and Shea, 2005). In the present study levels of Empathic Concern amongst non-sex offenders were fairly consistent with the adolescent sex offenders in Moriarty *et. al.'s* (2001) study, and levels of empathic concern amongst sex offenders were more consistent with levels of this aspect of empathy reported in medical students.

Statistical Analysis

Two-tailed tests were used as it was decided that none of the predictions were based on associations or differences that were well-enough established to warrant one-tailed tests.

Characteristics of sample

There were no significant differences between sex offenders and non-sex offenders in terms of age (t (46) = 0.96; $p = 0.34$), ethnicity ($x_2(1) = 2.63$; $p = 0.11$), current symptoms (BSI/GSI: t (52) = -.274, $p = 0.79$; BSI/PST: t (54) = -.171, $p = 0.87$; BSI/PSDI: t (54) = 0.40, $p = 0.69$) or previous experience of sexual abuse ($x_2(1) = 0.58$; $p = 0.71$). However, significantly more sex offenders had been given psychiatric diagnoses than non-sex offenders ($x_2(1) = 16.05$; $p = 0.001$).

Questionnaire data

Outliers and Transformations

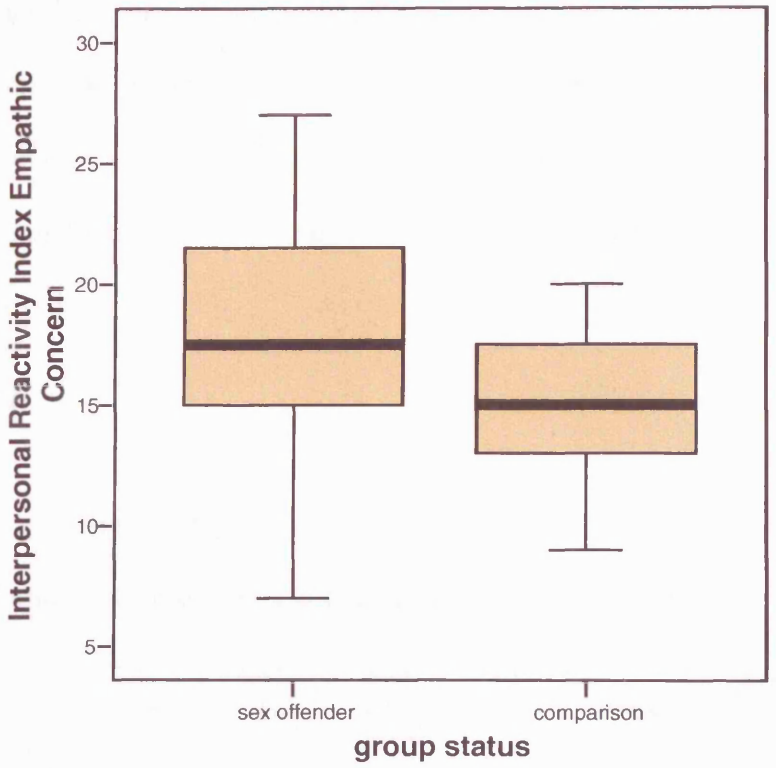
There were two outliers for the GSI subscale of the BSI (one in each group), and a further two outliers amongst non-sex offenders: One present in the OAS and the other in the Fantasy subscale of the IRI. All outliers were removed.

The GSI subscale of the BSI was slightly negatively skewed in the non-sex offender group (skewness = 1.104), however, normality was achieved further to a square root transformation being performed (skewness = 0.52).

Group differences between shame, guilt and empathy

To control for the effects of psychiatric illness, a one-factor 'group' (sex offenders Vs non-sex offenders) Multivariate Analysis of Variance (MANOVA) was carried out with psychiatric diagnosis as a covariate, and questionnaire measures of shame, guilt and empathy as dependent variables. The analysis revealed that there was no significant multivariate difference in shame, guilt and empathy between the two groups ($F(7, 45) = 1.3$, $P = 0.26$). However, univariate analysis revealed that sex offenders had significantly higher levels of empathic concern compared to non-sex offenders ($F(1,51) = 7.75$, $p = 0.01$). This finding was confirmed with an independent samples t-test ($t(45.8) = 3.11$; $p = 0.001$), and is graphically illustrated in Figure 1.

Figure 1 Empathic Concern amongst sex offenders and non-sex offenders



As not enough sex offenders (for the purposes of statistical analysis) admitted to having experienced sexual abuse, it was not possible to explore differences between sex offenders in levels of guilt depending on whether or not they themselves had been abused.

Correlations between variables

As it was predicted that the relationships between the self-conscious emotions would also exist for non-sex offenders, Pearson correlation coefficients were performed between the various measures of shame, guilt and empathy taking the entire sample as a whole.

An attempt was made to reduce the number of correlations performed by collapsing the three other-oriented empathy scales together to create the single variable 'other-oriented empathy' and by collapsing internal and external shame creating the variable 'shame'. However as demonstrated in Table 2, not all of the other-oriented empathy scales were highly correlated, therefore only the latter operation was possible.

Correlations between questionnaire measures

Table 2: Correlations between shame, guilt and empathy

	IRI (PT)	IRI (EC)	IRI (PD)	IRI (F)	ISS (ISS)	OAS	Shame	Guilt
IRI (PT)		0.29*	0.11	0.49**	0.07	-0.07	0.01	-0.05
IRI (EC)			0.01	0.24	0.14	0.16	0.14	0.10
IRI (PD)				0.28*	0.52**	0.49**	0.52**	0.43**
IRI (F)					0.31*	0.19	0.27*	0.26
ISS (IS)						0.85**	0.98**	0.72**
OAS							0.94**	0.65**
Shame								0.72**
Guilt								

* $P < 0.05$

** $P < 0.001$

As eight correlations were carried out between the various measures of shame, guilt and empathy, the family wise error rate was adjusted accordingly, and these tests had to show significance beyond the 0.006 level (0.05 /8 = 0.006).

As demonstrated in Table 2, it was found that Shame was correlated with the Personal Distress sub-scale of the IRI, and that this aspect of empathy was also correlated with guilt. These correlations are illustrated in Figures 2 and 3. There were no other significant correlations.

Figure 2 Correlation between Personal Distress and Collapsed Shame

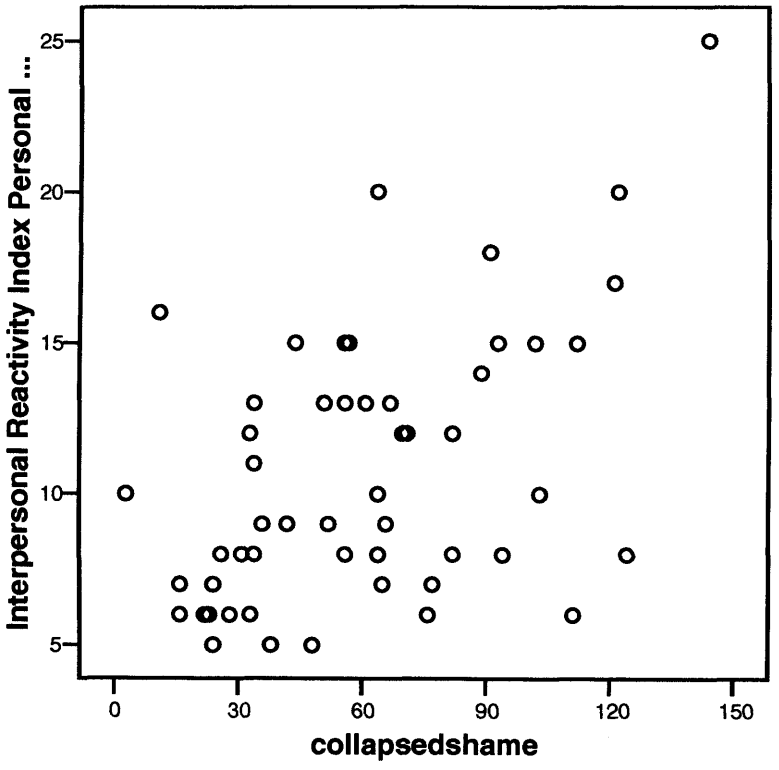
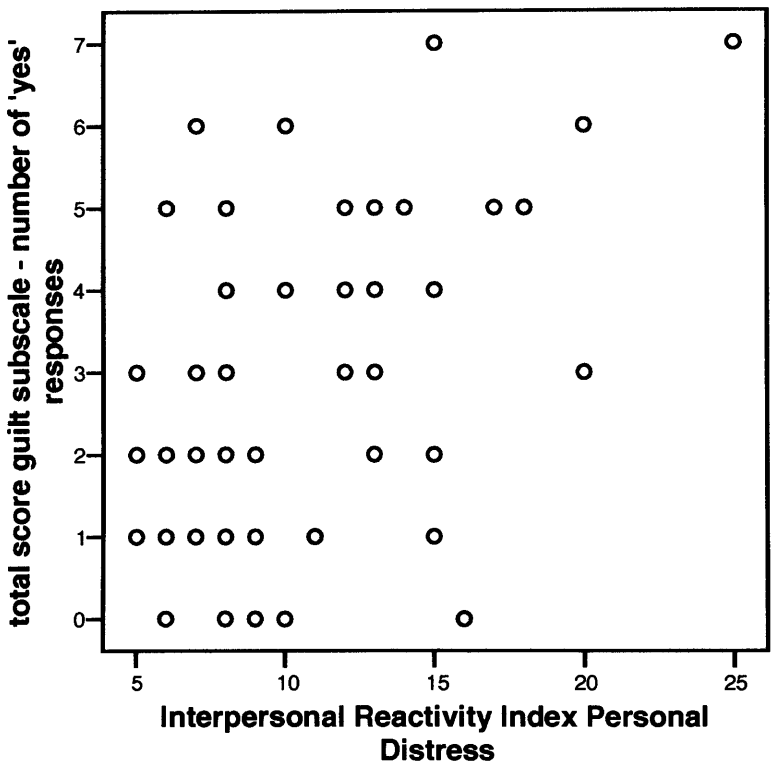


Figure 3 Correlation between Guilt and Personal Distress



Grid measures

As elucidated in the Method section, external shame, guilt and empathy were measured directly, based on ratings of the element 'myself now' on those constructs. Internal shame, external shame and guilt were also measured indirectly, by measuring the distances in perceptions of pairs of elements: Internal shame was measured by calculating the distance between the elements 'myself now' and 'ideal self'; External shame was measured by calculating the distance between 'myself now' and 'how others think I should be'; Guilt was measured by calculating the distance between 'myself now' and 'myself before the offence'.

Table 3 presents the descriptive statistics obtained for both the direct and indirect grid measures of shame, guilt and empathy, for each group.

Table 3: Descriptive statistics for grid measures

	Direct measure		
Aspect being measured/group	Median	Minimum	Maximum
External shame sex offenders	4	1	7
External shame non- sex offenders	3	1	7
Guilt sex offenders	3	1	7
Guilt non-sex offenders	2.5	1	7
Empathy sex offenders	5	1	7
Empathy non-sex offenders	5	1	7

	Indirect measure		
Aspect being Measured/group	Mean & standard deviation	Minimum	Maximum
External shame sex offenders	X = 0.32; sd = 0.23	0.00	0.89
External shame non- sex offenders	X = 0.29; sd = 0.21	0.01	0.87
Internal shame sex offenders	X = 0.31; sd = 0.24	0.00	0.87
Internal shame non- sex offenders	X = 0.27; sd = 0.25	0.01	0.77
Guilt sex offenders	X = 0.47; sd = 0.29	0.04	1.08
Guilt non-sex offenders	X = 0.45; sd = 0.34	0.00	1.11

As indicated in Table 3, medians for direct measures of shame and guilt were similar between the groups (but marginally higher for sex offenders), and both groups had identical medians for self-ratings of empathy. Means for all indirect measures were higher amongst sex offenders, and this difference was most pronounced for internal shame, followed by external shame and then guilt.

Statistical Analysis

Monotonous constructs, outliers and transformations

For one sex offender, ratings for the direct measure of guilt were monotonous (each element was given the same rating of 1 on this construct, therefore the whole construct was removed). For indirect measures, there were two outliers for external shame (both from the group of non-sex offenders), and three for internal shame (two from the sex-offender, and one from the non-sex offender group). All outliers were removed from the data set. External shame was slightly positively skewed for non-sex offenders (skewness = 1.13) but this was corrected with a square root transformation (skewness = 0.19).

Group differences between direct grid measures of shame, guilt and empathy

In order to investigate differences between the groups in levels of external shame, guilt and empathy measured directly, Mann-Whitney U tests were carried out as the data were ordinal. In total three such comparisons were executed. The family wise error rate was modified accordingly to 0.016 for these comparisons (0.05 /3). No significant differences were found between the groups on any of these variables (shame: z = .551, $P = 0.582$; guilt: z = .293, $P = 0.77$; empathy: z = .66, $P = 0.51$).

Group differences between indirect grid measures of shame and guilt

Another one-factor 'group' (sex offenders Vs non-sex offenders) MANOVA was carried out with psychiatric diagnosis as a covariate, and indirect measures of internal shame, external shame and guilt as dependent variables. The analysis revealed that there was neither a significant multivariate difference in internal shame, external shame and guilt between the two groups ($F(3, 47) = 0.96$, $P = 0.42$), nor any univariate differences between the groups on these variables.

Correlations between variables

Again, as it was predicted that the relationships between the self-conscious emotions would also exist for non-sex offenders, correlations were performed between the various measures of shame, guilt and empathy taking the entire sample as a whole.

An attempt was made to reduce the number of comparisons by collapsing the indirect measures of internal and external shame as these variables were highly correlated ($r = 0.67$, $n = 52$, $p = 0.001$), resulting in the variable 'indirect shame'.

Table 4 presents correlations between shame, guilt and empathy as measured by the grid and questionnaires.

Table 4: Correlations between grid and questionnaire measures of shame, guilt and empathy

	[12]Ind shame	Direct [13]ext shame	Direct guilt	Ind guilt	Empathy	Shame	OAS	HDHQ	IRI (PT)	IRI (EC)	IRI (PD)	IRI (F)
Ind shame		0.4**	0.32*	0.16	-0.16	0.18	0.11	0.82	-0.19	0.001	0.03	0.01
Direct ext shame			0.46**	0.23	-0.05	0.28*	0.26	0.21	-0.31*	0.06	0.19	-0.06
Direct guilt				0.36**	-0.02	0.29*	0.31*	0.35**	-0.22	-0.05	-0.24	-0.03
Ind guilt					0.08	0.18	0.14	0.21	0.01	0.25	0.22	0.02
Empathy						0.09	0.06	0.09	0.08	0.06	-0.28*	0.05
Shame							0.94**	0.70**	0.01	0.14	0.52**	0.27*
OAS								0.64**	0.07	0.16	0.49**	0.19
HDHQ									-0.06	0.09	0.34*	0.24
IRI (PT)										0.29*	0.11	0.49**
IRI (EC)											0.13	0.24
IRI (PD)												0.28*
IRI (F)												

* $P < 0.05$

** $P < 0.001$

As illustrated in Table 4, no significant correlations were found between indirect shame and personal distress, as measured by a Pearson correlation. For correlations between direct shame and empathy, empathy and guilt, and direct shame and personal distress, Spearman's rho correlations were performed, and the family-wise error rate was adjusted to 0.01 (0.05 /5). As can be seen in Table 4, no significant correlations were found between any grid measures of shame and empathy.

[12] Ind = Indirect
[13] Ext = External

Correlations between questionnaire and grid measures of shame, guilt and empathy

One Pearson and seven Spearman correlations were carried out to correlate the questionnaire measures of shame, guilt and empathy with grid measures of these same concepts, and the family-wise error rate was appropriately adjusted to 0.007 for the non-parametric correlations (0.05/7). To reduce the number of correlations, the collapsed variables 'direct shame' and 'indirect shame' were used, rather than analyzing internal and external shame separately as measured by questionnaires, and indirectly from the grid. Correlations between the various questionnaire and grid measures can also be seen in Table 4.

As illustrated in Table 4, no significant correlations were found between the various shame measures (Indirect shame and collapsed shame; OAS and direct external shame). Neither were there any significant correlations between the guilt subscale of the HDHQ and the indirect measure of guilt from the grid, although for direct guilt and the guilt subscale of the HDHQ, significance was almost achieved ($p = 0.008$). There were no significant correlations between empathy as measured by the grid and IRI (PD), or between empathy measured by the grid and any questionnaire measures of empathy.

Additional information obtained from grid

Two additional measures were taken from the repertory grid: Tightness of construing and distance of the self from an offender considered likely to commit a similar crime ('dissociation'). These data are presented in Table 5.

Table 5: Descriptive statistics for tightness of construing and dissociation

Aspect being Measured/group	Mean	Standard Deviation	Minimum	Maximum
Tightness sex offenders	73.08	9.11	51.61	89.84
Tightness non-sex offenders	69.46	11.36	43.68	88.81
Dissociation sex offenders	0.96	0.47	0.09	1.75
Dissociation non-sex offenders	0.80	0.62	0.08	2.61

As illustrated in Table 5, means for both tightness and dissociation were slightly higher for sex-offenders. Two independent samples t-tests were carried out to look at group differences on these variables. The family-wise error rate was modified accordingly (0.05/2 = 0.025), but no significant differences were found between the groups for either variable ($t(53) = 1.30$, $p = 0.20$ for tightness; $t(54) = 1.06$, $p = 0.29$ for dissociation).

Case example

In order to illustrate the value of repertory grids as a tool that can be used in the assessment of sex offenders, this section will discuss a case example.

Participant number 11 was a 24-year old white man, with a history of sexual abuse, currently serving a prison sentence for the rape of an adult female. There were themes of negative emotion and aggression apparent in his elicited constructs (e.g. Feel bad; Angry; Hated; Evil; Dangerous). This participant's ratings were often polarized, indicating that he has a unidimensional view of the world and thinks in dichotomous terms (e.g. Loyal-disloyal; Protective-unprotective), with little flexibility. A large proportion of the variance (67.83%) was accounted for by the first component, further indicating tightness of construing as features of this individual's construct system. The correlation between shame and empathy was negative (-0.61). That these two concepts are seen as dissimilar is confirmed by the substantial distance of 1.90 between empathy and shame, and is graphically illustrated in Figure 4.

Figure 4: Plot for Participant no. 11

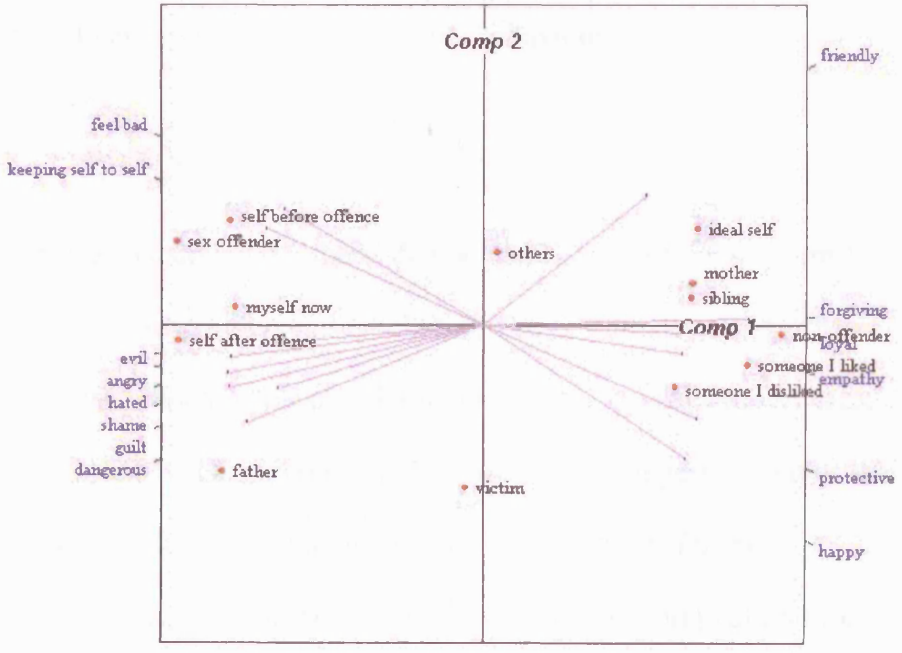


Figure 4 plots loadings of elements and constructs on the first principal component, represented by the horizontal axis, against those on the second, represented by the vertical axis.

The plot reveals an interesting picture. The element 'others' (how other people think I should be) is viewed as closer to 'ideal self' than 'myself now', indicating that this man's ideal self and his perception of what others expect of him, are more similar (measured as 0.59) to each other than is his present view of himself to his ideal self. The large distance (1.62), as indicated above, between 'ideal self' and 'myself now' (representing internal shame) in Figure 4 depicts this distance graphically. The small distance (0.32) between 'myself now' and 'sex offender' indicates that he continues to see himself as a sex offender, which would be crucial information in the formulation of this man's difficulties and problem behaviour, having important implications for treatment and predicting his future behaviour.

The plot illustrates that 'victim' and 'others' do not load heavily on Component 1, whereas most of the remaining elements (excluding 'father') are described in some way by this component. Based on the plot, Participant no. 11 does not have a clear view of his victim, or of how other people think he should be, suggesting that neither of these two elements are very salient to him. Additional evidence for this hypothesis could be the frequent mid-point ratings evident on his original grid for constructs relating to these elements. 'Victim' is the only element strongly associated with Component 2 rather than Component 1, implying that she is viewed

by this sex offender as different to most of the other elements in this man's construct system. Only 7.97% of the variance is accounted for by Component 2.

Consistency between grid measures and questionnaire measures is reflected in a high level of internal shame (1.62) as measured indirectly by the grid, as well as a high score on the questionnaire measure of internal shame (87), measured by the ISS.

DISCUSSION

This study set out to investigate the role of shame in sex offenders. It was hypothesized that shame would be negatively correlated with empathy, and that guilt would be positively correlated with empathy. It was also expected that shame and personal distress would be positively correlated. Differences were not predicted between sex offenders and non-sex offenders in levels of other-oriented empathy, but higher external shame and lower internal shame were anticipated amongst sex offenders. Finally, it was expected that sex offenders with no histories of sexual abuse would be more likely to experience guilt than those with previous histories of abuse.

This study found that sex offenders had significantly higher levels of empathic concern compared to non-sex offenders, and that personal distress was significantly correlated with both guilt and shame amongst the entire sample of offenders, using questionnaire measures. There were no other significant findings.

As previously discussed, the Empathic Concern scale of the IRI assesses the extent to which respondents experience other-oriented feelings of compassion and concern (Davis, 1980; Tangney and Dearing, 2002). A higher level of empathic concern among sex offenders as compared to non-sex offenders is a curious finding. One might speculate that an individual who behaves in a sexually intrusive and domineering manner towards another human being would be no more aware of, considerate or concerned for the well-being of other people than a person who engages in acquisitive or drug-related crime (which in this study amounted to approximately half of the non-sex offender sample). The literature in the area of empathy and sex offending broadly indicates that sex offenders do not differ significantly from non-sex offenders in empathy levels generally, but that victim-specific empathy may be impaired, particularly amongst child sex offenders (e.g. Finklehor, 1986; Marshall, Hudson, Jones and Fernandez, 1995) and hence this finding is inconsistent with the literature overall.

It is possible that this emotional aspect of empathy really was higher amongst sex offenders in this study, and that a greater sensitivity and attunement to the emotional world of another person exists for sex offenders in relation to non-sex offenders. Higher empathy may be a helpful quality in the securing of victims through the grooming process, and may genuinely be raised in some sex offenders, particularly child sex offenders. Indeed, Tierney and McCabe (2001) found, in their evaluation of measures used for sex offenders, that child sex offenders yielded significantly higher scores on a measure of general empathy (the Mehrabian and Epstein Empathy Scale) compared to adult sex offenders (but not compared to non-sex offenders). Conversely, and in line with much of the literature concerning empathy in this

population, child sex offenders demonstrated deficiencies in empathy for victims of child sexual abuse. Tierney and McCabe (2001) consequently questioned the value of addressing general empathy amongst child sex offenders, and suggested that general empathy and issue-specific empathy may be different constructs. However, as the hypothesis regarding the inverse relationship between shame and empathy concerns dispositional responding, in the present study it appeared logical to measure general empathy, rather than the sort that is victim or issue-specific. However, the possibility remains that, with more than a third of the sex offending sample in the present study being classified as child sex offenders, these participants yielded relatively higher scores compared to adult offenders (as a minority of studies have previously found) and increased the average score of sex offenders overall, creating a statistically significant difference. Future studies may benefit from not mixing adult and child sex offenders together as a group, as evidence suggests that child sex offenders may be a more distinct subgroup who share many similarities with, but who may also have some important differences in comparison to adult sex offenders (e.g. Romans, Martin, Anderson, O'Shea and Mullen, 1996; Hilton, 1993; Freund and Kuban, 1993; Howells, 1979).

It might be the case that some sex offenders have higher empathy, and that their superior empathic concern is misguided and misused, as has been suggested regarding Adolf Hitler and his capacity to empathise with others (Gordo, 2006). However, significantly higher empathy amongst sex offenders is a rare finding in the literature, and difficult to explain.

A possibility is that sex offenders demonstrated a significantly higher display of empathic concern but this was in fact specious. Perhaps sex offenders felt more of a need to demonstrate greater empathy to the female researcher due to a multitude of factors, including social desirability, and habitual behaviour towards young women. Moriarty *et. al's* (2001) research suggests that adolescent sex offenders had lower empathic concern as measured by the IRI than the adult sex offenders in the present study, and the non-sex offenders in the present study had similar levels of empathic concern to the adolescent sex offenders. The sex offenders' levels of empathic concern in the present study were actually more consistent with empathic concern levels of medical students as reported by Bellini and Shea (2005) who used the IRI to measure empathy. A possible explanation for this is that there is no difference in empathy levels, generally, between sex offenders and non-sex offenders, in line with recent thinking (Fernandez, Marshall, Lightbody and O'Sullivan, 1999; Fernandez and Marshall [as cited in Marshall, Hamilton and Fernandez, 2000]; Marshall, Champagne, Brown and Miller, 1997), and that these levels are low in relation to medical students (a population that might be considered especially empathic) but that as sex offenders grow in age and develop in experience, they learn to feign empathy. In so doing, they may project an image of a highly empathic individual, similar to the type of impression that may be exuded by the kind of person who dedicates their life to the concern and well-being of others. This would be consistent with the position taken by Hilton (1993), who challenged the practice of empathy training in sex offenders, raising concern that such treatment programs may merely be teaching sex offenders to fake and speak the language of empathy, but not to have a genuine understanding of it.

Interestingly, both groups in the present study scored the same, overall, on empathy measured directly by the grid. This inconsistency amongst different measures of the same phenomenon is likely to be due to the different ways of defining empathy. The grid measure of empathy was based on only one question, and related more to the cognitive rather than emotional aspects of empathy. The more cognitive components of empathy measured by the questionnaire were in fact similar between groups.

As predicted, it was found that Personal Distress was significantly positively correlated with shame amongst the sample as a whole. This finding can be interpreted in terms of Tangey and Dearing's (2002) suggestion that shame-prone individuals are more vulnerable to "egoistic drift", in that they become distracted by their own emotional response when faced with a distressed other, rather than maintaining a focus on the other's needs. Tangney and Dearing (2002) report that this pattern has been found amongst individuals from many walks of life (e.g. Tangney, 1991), and the present study may widen the population that this association might be appropriately applied to.

This study also found a significant positive association between Personal Distress and Guilt. This relationship is difficult to justify theoretically as it would not be expected that Personal Distress, a self-oriented experience, would be associated particularly with the other-oriented nature of guilt (Tangey and Dearing, 2002). However, some research has demonstrated a positive correlation between guilt and personal distress (e.g. Tangney, 1991), even though these inconsistencies have not been well addressed. A potential explanation for this positive relationship is that personal distress does not necessarily follow a straight trajectory towards shame, but

might act as a kind of relay station, where either guilt or shame could be the resultant emotional experience, depending on various factors. Tangney and Dearing's (2002) conceptualization of shame-fused guilt might be linked to the relationship between personal distress and guilt. This is where guilt becomes maladaptive further to becoming fused with shame, with the shame element of this potent emotional concoction causing difficulty for the person. Possibly, one of the deciding factors in whether shame or guilt occurs in an individual following a transgression is that individual's response to personal distress. It is conceivable that the personal distress response creates a pathway to shame through its self-oriented focus which may cultivate global cognitions about the self and develop into shame-fused guilt or pure shame. Building on Tangney and Dearing's idea of shame-fused guilt, it may be that personal distress creates a bridge to shame or shame-fused guilt by setting off global attributions about the self. Alternatively, an individual experiencing personal distress and egoistic drift might drift their attention back from the self to the distressed other, allowing guilt and consequently empathy to spawn. This hypothesis is diagrammatically illustrated in Figure 5 (see Appendices). These ideas are simply speculative, but could become an area worthy of further empirical investigation.

One possibility is that both these significant associations are spurious findings, and a mere result of the various demand characteristics and social desirability effects that might have occurred in the dynamic between the male offenders and female researcher.

It was predicted, in line with an emerging finding amongst various populations (Tangney, 1991, 1994, 1995a, 1995b, 1995c [as cited in Tangney and Dearing,

2002]; Tangney, Wagner, Burggraf, Gramzow and Fletcher [1991, as cited in Tangney and Dearing, 2002]), that shame and empathy would be inversely related, and that empathy and guilt would be positively correlated. No such relationships were found in this study. One possibility for this is that these inter-relationships do not exist for sex offenders. The pattern of results in previous studies is promising, especially with regards to guilt and empathy, but the link between shame, guilt and empathy is not an extremely consistent observation (e.g. Tangney, 1991). Perhaps in some populations the proposed relationship between the self-conscious emotions does not exist, or operates quite differently. Much of the research in this area has involved American students, and other populations that might be rather different to offending populations. One could speculate that the emerging finding regarding shame, guilt and empathy is less likely to be generalizable to populations of offenders, whose emotions may interact in ways that are extraordinary in comparison to non-offending populations. Wright (2005) investigated self-conscious emotions within a sample of British convicted offenders, and her findings did not support the existence of these emotional inter-relationships.

Alternatively, the inverse relationship between shame and empathy may only be detected if some but not other measures of these emotions are used. Support for this idea comes from Tangney's (1991) studies, where the inverse relationship between shame and empathy was not evident when the IRI was used, but was clearly present when an alternative measure of empathy was utilised. This illuminates the need for greater consistency between measures of the same phenomena, and may be a factor in this relationship not being found in the present study.

It could be argued that the participants in this study were not responding honestly, particularly about the emotional aspect of empathy, and were selecting answers that would appear socially desirable; Hence a true test of these hypotheses may not have been possible in this study. A future, similar study might be improved by including a measure of social desirability (as discussed below).

It was predicted that there would be significantly higher external and lower internal shame among sex offenders as compared to non-sex offenders. There were no significant results for these variables, and both types of offender demonstrated proclivities towards higher internal shame. This may be a further indication that participants in this study were responding according to a socially desirable response set. Responses indicating high internal shame may have been considered by offenders to be more socially desirable in the eyes of the researcher.

This study did not find that shame was a significant feature of sex offenders compared to other types of offender. There may have been a myriad of reasons for this as is being addressed in this paper, nevertheless, it is interesting to reflect on the possible clinical implications had shame been found to be important for these men. It would seem that de-constructing this powerful and painful emotion might be a helpful step in their rehabilitation. As discussed, shame encompasses an intense self-focus, and may inhibit a person's capacity to take the position of and vicariously experience the emotions of another. Consequently, the welfare of others is difficult for shame-prone individuals to appreciate. As recommended by Bumby *et. al.* (1999), the treatment of sex offenders may be more successful if shame is de-emphasised and guilt is encouraged. This would allow the self-focus of shame to be

diluted, responsibility for one's behaviour and its effects on others to be considered, and possibly the enhancement of empathy.

It was not possible to assess the impact of previous sexual abuse amongst sex offenders on guilt, as not enough participants admitted to having ever experienced sexual abuse to allow statistical analysis. Previous research has indicated the prevalence of childhood sexual victimization to be at least twice the rate that was found in this study (Hanson and Slater, 1988; Jacobson, 1989). It is possible that this may also have been due to the impression that the men in this study were trying to create for the researcher. It is generally agreed that a risk factor for becoming a perpetrator is a history of previous victimisation (Glasser and Kolvin, 2001), particularly amongst paedophiles, and the relatively small number of sex offenders, and also non-sex offenders, who admitted to having been sexually abused in this study suggests that the given responses to the question of whether or not they had been abused were not a true reflection of the actual incidence of childhood sexual abuse. Some studies raise concerns that social desirability, with regards to admission of previous sexual victimization, is manifested in sex offenders over-reporting their histories of adverse childhood experiences such as sexual abuse (e.g. Hindman, 1988), in order that perpetrators can explain their abusive behaviours and elicit sympathy from the researcher. Other studies did not find support for this (e.g. Lee, Jackson, Pattison and Ward, 2002). However, as outlined below, in this study there appeared to be under-reporting of previous sexual victimization amongst both sex offenders and non-sex offenders. It is possible that a number of sex offenders may not have wanted the researcher to think that that they were in fact perpetrators. Therefore it may follow that under-reporting of childhood victimization might occur

for sex offenders. For non-sex offenders, it is possible that previous victimization was not often admitted due to the concern of appearing vulnerable and un-manly in the eyes of the researcher.

It was also anticipated that questionnaire measures of shame, guilt and empathy would be significantly correlated with repertory grid measures of the same variables. This was not found in the present study, and may have been due to variations in definitions of variables between the types of measures. For example, guilt in PCT terms was measured indirectly by the grid through calculating the distance between 'myself now' and 'myself before the offence', whereas the guilt sub-scale of the HDHQ focuses on self-judgement of previous bad behaviour, as opposed to dislodgement from one's core role.

Previous research amongst the general population indicates a relationship between the variables measured in this study, although generally these relationships were not found in the present study. It is proposed that this was not necessarily due to these relationships not existing amongst these variables within the present population, but to the effects of a socially desirable response set and the rather complicated dynamics created between the male offenders and female researcher.

The tendency to present oneself positively in the completion of self-report measures has been termed socially desirable responding (Paulhaus, 1998). Much research indicates that offenders in general tend to respond to self-report measures dishonestly (e.g. Holden, Kroner, Fekken and Popham, 1992). Tierney and McCabe (2001) found that violent offenders who yielded high scores on a measure of impression

management emitted significantly lower antisocial attitudes. They stressed that the transparency of questionnaire items and the impact of social desirability on responding are generally considered serious problems when assessing sex offenders. Abel, Becker, Blanchard and Mavissakalian (1975) found in their investigations of sex offenders that a number of participants faked good responses. Hence, whether the responses of sex offenders reflect their genuine feelings, or are expressions of how they wish to be perceived, is questionable.

If socially desirable responding was the main factor behind many of the findings in this study, then researchers and clinicians must question the value of using self-report measures with forensic populations. Anecdotal evidence lends support to the possibility that there may really have been high levels of external shame amongst this sample of sex offenders. Several men who had committed sexual offences against children independently asked the researcher to enter their cell to see pictures that they had drawn (such as, of Jesus Christ). It was difficult not to be struck by the prominent posters of female adult pornography on these sex offenders' walls, and it is plausible that the invitations to view artistic creations were pretexts upon which to draw the researcher in to their cells, where what may be considered ordinary and relatively acceptable sexual preferences could be explicitly demonstrated, possibly in the hope that the researcher may consider the offender to now have (or to have always had) acceptable sexual tendencies. Further anecdotal evidence for the presence of high external shame amongst sex offenders comes from the observation that many convicted sex offenders explicitly denied their offences (as has been found to be a position commonly taken amongst sex offenders, e.g. Birgisson, 1996), and

one sex offender approached the researcher at a later point and asked her if she judged him in a negative way.

Future studies should consider employing a social desirability scale or a lie scale, such as the Marlowe-Crowne Social Desirability Scale (Crowne and Marlowe, 1960), or the Paulhus Deception Scale (Paulhaus, 1998) to allow the assessment of social desirability, honesty of responses and to control for untrue responses. An interesting comparison might be responses to measures of shame, guilt and empathy between two groups of sex offenders; those subjected to a lie detection examination (i.e. polygraph), and those who are not. The belief that dishonest responses could be detected may discourage untrue responses and therefore provide a more accurate snapshot of the interactions between self-conscious emotions among sex offenders.

It may also be more appropriate that in future studies of this sort the interviews are conducted by male researchers, to potentially lessen the effects of social desirability, and that target questions are merged within more neutral questions, to make what is being investigated less obvious. The indirect grid measures appear to have lower face validity than the questionnaire measures, and perhaps building on this technique by adding an indirect measure of empathy to the grid (e.g. as has been employed by Widom, 1976, by defining empathy as accurate construing of another person's constructions), and combining this technique with more subtle assessments would be a more valid way of measuring shame, guilt and empathy amongst offenders.

Clinicians and researchers working with offenders may need to concentrate on expanding their repertoire of approaches to measurement, and develop less

transparent assessment tools that are not so vulnerable to impression management, and that can detect emotions without asking about them directly. These could take the form of performance-based measures, which might be less vulnerable to social desirability than self-report measures. Serin and Mailloux (2003) describe the use of a performance-based measure of empathy, incorporating the work of Hanson and Scott (1995). Such tests may be less vulnerable to faking than self-report measures, and might provide more valid assessments of the phenomena under investigation.

There is evidence for the validity and reliability of all of the measures used in the present study, as outlined in the Method section. However, as with most measures of emotional and psychological constructs, improvement would be possible and desirable.

The Internalised Shame Scale (ISS), which was used in this study to measure internal shame, has been found to correlate positively with measures of self esteem (Cook, 1991). This has the obvious problem of questionable validity, and raises the possibility that what was in fact being measured in this study was self esteem and not internal shame, or perhaps a combination of several self-conscious emotions. On balance, perhaps it is difficult to separate shame and self-esteem because they have a complex relationship, and may operate in unison. The blurring of definitions of self-esteem and internal shame is also reflected in the Personal Construct Psychology literature, where the distance between the self and the ideal self (which, in the present study was used as a measure of internal shame), is sometimes understood as a measure of self-esteem (e.g. Winter, 1992).

A further problem with the use of the ISS in this study as a measure of internal shame is that some of the items in the ISS appear to relate to external shame. Hence, if shame was being measured by this scale in the present study, it may not have been purely internal. However, one of the aims of this research was to distinguish internal from external shame, and there is little choice of instruments for assessing external shame. Perhaps a future study of this sort could involve constructing and utilizing new questionnaire measures of internal and external shame. It may be the case, with the relatively recent advent of the distinction between external and internal shame, that measures of these dimensions of shame might initially suffer from similar confusion apparent in early measures of guilt and shame.

The guilt subscale of the Hostility and Direction of Hostility questionnaire (HDHQ; Caine, Foulds and Hope, 1967) includes a small number of items that appear to relate to shame. As mentioned, this blurring of definitions of shame and guilt is characteristic of older measures, which reflects the changing definitions of such emotions over time. The validity of this measure may be further questionable when considering the method used in the validation of this instrument (criterion groups; See Method section), which involved ordering various clinical subgroups on the subtests. Melancholics yielded the highest scores for the guilt subscale, and mentally healthy individuals attained the lowest scores, with various other classifications in between. Evidence of this quality appears presumptuous, as, for instance, 'normal' or as yet undiagnosed individuals may experience and respond to transgressions with extreme guilt. Perhaps future similar studies should investigate more recent instruments that measure guilt, such as the Guilt Inventory (Kugler and Jones, 1992), as potentially more valid measures of guilt.

Finally, there are many advantages to the Interpersonal Reactivity Index (IRI, Davis 1980; used in this study to measure empathy) such as the fact that it contains a separate scale for personal distress. However, it has been argued by some investigators (e.g. Lawrence, Shaw, Baker, Baron-Cohen and David, 2004) that personal distress is not pure empathy. So, whilst it is an extremely important concept to isolate, one view is that it is perhaps misplaced in an instrument that claims to measure empathy. The IRI has also been found to correlate significantly with measures of impression management, and to have no relationship to performance-based empathy measures (Serrin and Mailloux, 2003). This supports the suggestion that in the present study, the assessment of empathic concern may have in fact become an assessment of social desirability. Future studies might consider the use of alternative empathy measures, such as the Empathy Quotient (Baron-Cohen and Wheelwright, 2003), and combining them with performance-based measures.

A limitation of this study was also that there was substantial heterogeneity within the sample. A particular problem was that significantly more sex offenders had psychiatric diagnoses compared to non-sex offenders. This could have implications for the real root of any between-group differences if found in future studies; As such differences could be due to the sequela of schizophrenia and other forms of mental illness prevalent amongst some sex offenders. One possibility might be that shame is the seed of psychopathology. Its association with mental illness appears to be broad in scope (e.g. Linehan, 1993; Frank, 1991; Andrews, 1995) and it might be feasible that shame proneness is in fact a precursor to or a risk factor for poor mental health. Due to the potential interaction between shame and mental illness, future studies

might be improved if sex offenders from special hospital, who are likely to be diagnosed with a serious mental illness, are excluded from participation.

Finally, given the prevalence of undiagnosed psychopathy in forensic populations (e.g. Bland, Newman, Dyck and Orn, 1990), and the association of psychopathy with empathy deficits (Anckarsater, 2005), if this study were to be repeated in some form it may be wise to screen for psychopathy, perhaps by using the Hare psychopathy checklist-revised (Hare, 1991) and exclude psychopaths from participating. Self-conscious emotions may operate rather differently in this population and confound the variables under investigation. It might be advisable to split the research interview into two sessions if this measure was included, as the original test battery took a rather long time to complete.

Overall, the main hypotheses of this study were not supported, and the one that was (correlation between personal distress and shame) may have been a consequence of socially desirable responding. This makes it difficult to draw any firm conclusions directly from the research with regards to the hypotheses under investigation, or possible clinical implications. However it seems highly important that self conscious emotions in sex offenders are better understood and that more research is generated within this area. Clarification of the role of shame and its relationship to other emotions, such as personal distress is very much needed, and further research might also shed light on the maintenance of discrete sexual attacks. As suggested by Tangney (1991), shame-prone individuals may experience greater difficulty if they feel responsible for the other person's distress. This could indicate a vicious circle for sex offenders, where negative affect such as shame, is an antecedent to sexual

offending, and where the knowledge that one is responsible for their victim's distress exacerbates feelings of personal distress and shame. Negative affect can foster anger and hostility (Berkowitz, 1989); Emotions that have been found to play a significant role in sexual aggression (McKibben, Proulx, and Lusignan, 1994). The specific offending situation might be fertile ground for the complex interactions of self-conscious emotions, primary emotions and cognitive appraisals in sex offenders.

Although the grid measures did not reveal group differences, consideration of an individual grid revealed interesting themes within that participant's construct system, and was informative as to his style and flexibility of construing, suggesting (consistent with previous literature, e.g. Houston, 1998; Howells, 1979) the possible utility of the grid as an idiographic measure with this population.

CONCLUSION

The present study found significantly higher levels of empathic concern among sex offenders than non-sex offenders, and also significant positive correlations between personal distress and shame, as well as personal distress and guilt, within this sample overall. These findings have been interpreted in the context of the available literature, and findings in the present research that have not been addressed in the literature have been reflected on. However, a possible explanation for the findings overall, supported by anecdotal evidence, is that the offenders in this study were trying to present themselves positively in the eyes of the researcher, and ironically, this may be a finding in itself, indicating the possible prevalence of external shame, particularly amongst sex offenders in this study. Recommendations for future

studies have been made, and suggestions include employing more subtle methods for assessing emotions in this population, a lie scale for detecting dishonesty in responses, and also a male researcher to lessen the effects of social desirability.

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PART 3: CRITICAL APPRAISAL

ABSTRACT

This paper will reflect on the process of having carried out a study investigating emotions in sex offenders, and will critique the study. The first part will deal with methodological aspects of the research process including self-report, social desirability, the scientific method, the dynamic between the female researcher and male participants, sampling issues and use of data. The latter part of this critical appraisal will consider the attitude of staff to sex offenders in hospital as compared to those in prison.

Methodology

Self-report is the most common method used in clinical psychology, and there are many advantages to using self-report questionnaires and conducting interviews, such as increasing the chances that all the questions will be understood and answered, and rather obviously, acquiring personal information directly from the respondent. However, there are numerous associated problems of validity (Barker, Pistrang and Elliot, 2002) with the self-report method.

Honesty in responding is not guaranteed, and, as may have been evident in the present research, may not be very likely in some situations. People may be disguising the truth for various reasons, including to deceive either themselves and/or the experimenter, thus, perhaps with the conscious or unconscious attempt to avoid feelings of internal or external shame. This tendency to respond untruthfully to questions that threaten an individual's self-presentation is a diffuse and prevalent

problem in psychology and other fields (Schaeffer, 2000), and particularly in forensic settings (Holden, Kroner, Fekken and Popham, 1992).

In this research in particular, the issue of social desirability appeared to be prominent, although it should be noted that concern over the impression one is creating for others is ubiquitous (see Leahy, 1996). There was a strong sense that sex offenders were eager to impress the researcher. Some individuals went to great lengths to manage and present themselves in ways that were, possibly from their perspectives, acceptable or attractive. This was an issue both in hospital and prison.

For example in hospital, one sex offender attended the interview in a full dress suit, including a dress shirt, bow tie, top hat and tails. This was a patient who the researcher had seen on the ward on occasion (but who had not been aware of her), prior to the research interview. During the interview the researcher noted that the patient's accent had changed somewhat to a rather 'posh' one. Being a little struck by this man's appearance, the researcher asked him if he was going somewhere that day, and he explained that he had dressed in this manner for the research interview. It was assumed that the change in accent was also for this purpose (but for obvious reasons this was not questioned).

In prison, several men who had committed sexual offences against children made attempts to draw the relatively young, female researcher into their cells to show her some kind of product of their imaginations, such as pictures they had drawn or material they had written. These men also had rather explicit female adult pornography on their walls. To the researcher at the time this felt as though what

was being communicated was the message that they were no longer, or never had been, paedophiles or child molesters, as evidenced by their 'normal' and/or 'healthy' sexual interests in female adults. This may have been an indication of the potentially high levels of external shame present within this population.

Another possibility is that in fact what they wanted was to see the researcher's reaction to such graphic and potentially offensive material, or that drawing a young woman into their cells was part of a fantasy that did not materialise. Similarly, such behaviour may have been an attempt at redressing the power balance that may have been perceived, such as that created by the researcher having been dressed smartly, holding a brief case, with keys attached to her belt. This may have been exacerbated by the way that the researcher was treated by Prison Officers; With deference and as though she was in a high status position in a setting that was almost military and that operated within a strong hierarchical structure. Possibly, leading the researcher into their cells, decorated with images of women in what could be described as abject and demeaning positions, somehow returned a degree of power back to these sex offenders, who may have felt rather powerless under the aforementioned circumstances.

These reflections highlight that the ways in which sex offenders, both in hospital and prison, responded in this research, would have been influenced by their perceptions of the researcher's view of them, and their feelings towards the researcher, as well as or as opposed to the way things really were. This dynamic has implications for, not only the present research in particular, but also research using self-report methods in general, and in addition female staff working with male sex offenders.

With regards to the present research, there are reasons to believe that responses were dishonest, and that the results demonstrating significantly higher empathy amongst sex offenders should not necessarily be taken at face value, as these men might have been responding according to a socially desirable response set. Although having a female researcher had some definite advantages in working with this sample such as ease of recruiting, the disadvantages included dishonesty of responding, resulting in a data set that most probably was not in fact a true reflection of what was being measured. Future studies using male sex offenders might yield more valid data if the researcher was male (and for many male sex offenders potentially less intimidating) and if the measures used were more subtle. These could take the form of further measures from the grid, and also performance-based measures (e.g. Serin and Mailloux, 2003; Hanson and Scott, 1995). It is difficult to anticipate what appropriate performance-based measures of self-conscious emotions might entail, and it would be expected that there might be great difficulties with the validity and reliability of such measures, but perhaps it is helpful to identify this as an area in much need of further investigation.

In terms of self-report methods in general, it is important to consider that this is an extremely common and popular method of gathering data across social sciences (Barker, Pistrang and Elliot, 2002). Therefore, numerous research findings discussed in the literature are based on data gathered in this way. As outlined by Barker, Pistrang and Elliot (2002), both psychoanalysts and social psychologists express doubts about self-report methods. Psychoanalysts have little regard for such methods, as conscious self-knowledge is considered limited, with important feelings

existing unconsciously and being guarded by defence mechanisms such as denial or repression. Social psychologists consider that biases exist that cloud peoples' judgement, such as self-serving biases: The tendency to take credit for success and deny responsibility for failure (Fiske and Taylor, 1991; Barker, Pistrang and Elliot, 2002). It is plausible that both defences and biases come into play in the collection of data via self-report methods.

A major advantage to gaining self-report data via standardised questionnaires is that the questions are standardised. Fitting with the scientific method, this should allow studies to be replicated (Popper, 1959) because the measures used are the same. Rigorous methods are employed when scientific research is conducted with the intention that bias and errors are minimised, allowing clear conclusions to be drawn (Barker, Pistrang and Elliot, 2002).

This study is a good example of how the scientific method can be threatened and jeopardised depending on factors such as the gender of the researcher. It is plausible that quite different results might have been obtained if the researcher conducting the interviews in this study was male. Replication is a prerequisite to valid and reliable scientific research, but as this study has exemplified, other factors may affect the replicability of findings even if standardised measures are used.

Clearly, there are some significant disadvantages to gathering self-report data. However, this does not debunk the self-report method overall, but highlights that self-report data would be more or less appropriate in certain settings. On reflection, gathering information via self-report may not have been the best-suited method to

have applied in the present study, and perhaps more consideration should have been given to this issue at the planning and designing stage of this research.

The behaviour of both groups of men was rather notable. As mentioned, sex offenders appeared enthusiastic to impress the researcher. Most non-sex offenders behaved in ways that indicated that they were attracted to the researcher. They went to great lengths to make themselves available to participate, missed activities such as exercise, ate meals incredibly quickly so that the researcher wouldn't be waiting around and potentially interview somebody else, formed a queuing system amongst themselves, provided the researcher with scraps of paper detailing their identification and location whilst passing her on the wing so that she might locate them and interview them, and often approached her in a flirtatious manner. By the time data collection was complete, the researcher was left with a list of men who requested with enthusiasm to participate in the study.

Male prisons are predominantly male environments, with a relatively small proportion of female staff who have direct contact with inmates. The non-sex offenders appeared to be highly motivated to participate in the study and one reason for this could have been that being in a room alone with a young woman was something to be fought for as they had been deprived of such contact for a length of time. It was of interest that this display of flirtatious behaviour subsided once the interview began, which suggests that it may have been due to the machismo present on the prison wings. Once the private research interview had commenced and there was no audience of fellow inmates to impress, behaviour was more neutral. Boyd and Grant (2005) found that the only difference in male inmates' perceptions of male

and female Prison Officers was that female staff were viewed as more professional. In the present study, the behaviour of inmates generally appeared much more boundaried and professional during the private research interview, in contrast to situations where other prisoners were present.

Again, although enthusiasm to participate might be an expected outcome amongst inmates suffering from boredom, perhaps the extent of keenness and the style in which this was expressed would have been rather different if the researcher was male.

This has implications for clinical work between male inmates and female staff, such as Psychologists. Clearly there may be a number of process issues involving gender, attraction and bravado present in such relationships, and these may act as barriers to clinical work and might need to be attended to and overcome before any useful clinical work can be completed. On the contrary, it could be argued that such behaviour might be worked with and reflected back to the inmate and used as an opportunity to consider behaviour towards women if this was an issue for them. Either way, the impact of relatively young female staff working in a men's prison should be carefully considered. Perhaps more sessions would be required so as to allow time for the novelty of having one-to-one contact with a female to wear off, and real clinical work to begin. It may also be beneficial if sessions took place away from the inmate's location, to bypass the effects of trying to impress fellow inmates with 'success' with the female staff member.

With regards to the sample used, although this study included a population of offenders who had never been convicted of sexual offences in order to isolate being a sex offender as the independent variable, there was no true control group as all participants in the study were incarcerated. There may be significant effects on self-conscious emotions of being cut off from society at large and placed in an institution further to behaviour deemed unacceptable. For example, being incarcerated may engender a deep sense of shame, and this may vary depending on amount of time already served. Time did not allow the inclusion of more participants, but the study would have been better designed if it included a control group of sex offenders who were living in the community. This would have allowed the exploration of self-conscious emotions in sex offenders without the confound of detention. A further problem with the comparison group used in this study was that many of these participants were remand as opposed to sentenced prisoners. Therefore a number of these men may have later been judged to have been innocent and released from prison. Remand prisoners may have had rather different experiences of self-conscious emotions (for example, possibly lower levels of shame and guilt) compared to sentenced prisoners or those participants subjected to a hospital order. The study as it was would have been improved if all comparison participants were sentenced rather than remand prisoners.

This section closes with comments regarding optimal use of data. An attempt was made to consider the scores yielded on the BSI by participants in this study in relation to another population, referenced in the BSI Manual (Derogatis, 1993). However, norms were obtained from a sample of American Adult Psychiatric

outpatients. This was not an appropriate sample with which to consider scores obtained by participants in the present study, considering the likely differences between samples. A better sense of how symptomatic participants in the present study were would have been obtained if they were compared to a sample of inpatients, and a more accurate comparison could have been made if a statistical procedure, such as an independent samples t-test, would have been performed using data from a published study.

Further, offending histories were not recorded in detail. However it would have been interesting to have reviewed this data, in particular to have gained a clearer impression of the sex offending sample. For example, The Massachusetts Treatment Centre Rapist Typology (Version 3, cited in Knight, Warren, Reboussin & Soley, [1998]) is a commonly used taxonomy for sexual crimes and includes categories for opportunistic rapists controlled by situational factors, such as potential victims being present during another antisocial act, e.g. burglary. Such offenders' levels of shame and other emotions might be quite different to those of sex offenders who originally set out to commit a sexual crime. Additionally, the number of sexual offences ever committed might have affected shame levels, with a greater number of previous convictions resulting in higher or possibly even lower shame (the latter effect being a possible consequence of practice at justifying such behaviour). It would have been interesting to consider offending history in more detail.

Finally, repertory grids were used in this study as it was thought that more subtlety was needed than the rather obvious self-report measures. Indirect as well as direct measures were taken from the grid and this allowed variables such as internal shame

to be measured without making this obvious to participants. Thus, another dimension of some of the variables was able to be considered through the use of repertory grids in this study. Only certain information was required from the repertory grids, however, given the magnitude of the data available from the grids, it seems to some degree wasteful that more data was not analysed from them. For example, a measure of ambivalence could have been obtained further to examination of the nature of the constructs elicited, and content analysis (Landfield, 1971 [cited in Winter, 1992]) of elicited constructs could also have been carried out, allowing classification of constructs (Winter, 1992). It would have been interesting to have explored whether sex offenders and non-sex offenders differed in levels of ambivalence, or to have performed a content analysis and have assessed whether certain categories (such as egoism) were associated with shame (as might be predicted given the intense self-focus of shame). Overall, there could have been better use of the data in this study.

Systemic issues

The contrast of conducting research in two very different types of settings, with offenders who had committed crimes that fell under the same category, was extensive and fascinating. In the two hospitals that ended up being used in this research, and also in other hospitals where ethical approval had been granted, and the administration eventually completed (but too late for these settings to be included in the study), a much more rigorous process had to be followed. The researcher had to write to and/or meet Consultant Psychiatrists to discuss the research process and measures in some detail, and patients were very carefully hand-picked as being appropriate potential participants. The researcher needed to obtain written and

signed consent from Psychiatrists for each individual being recommended to participate. When the researcher entered the wards and asked to meet patients, her identity was questioned and checked, and nursing staff inspected documents giving permission to ask the patient to participate. It was also noted that nurses, in general, explained to patients that their participation was entirely voluntary, and would not affect their treatment on the ward. Overall, it seemed that patients were protected by staff, and were treated with care and respect.

Conversely, sex offenders and other offenders in prison were treated quite differently to this. When Prison Officers escorted inmates to the interview room, inmates may have at times been made to feel as though they had to participate, and that if they did not, this would be frowned upon, perhaps for not treating the researcher with the respect that was evident in the approach that a number of Prison Officers took with her. Once the investigator and inmate were alone, a description of the study was given and information about participation being entirely voluntary and unrelated to their treatment on the wing was made explicit. At this point, a number of sex offenders in prison made an informed choice to not participate in the study.

This is a slightly worrying prospect, raising issues about how research is conducted in prisons, and to what extent inmates perceive and are given the message that they have rights to refuse participation, and will not resultantly suffer negative consequences.

It was also far less complicated to be given permission to interview inmates, and actually make a prompt start to data collection. There was no Research &

Development board for the prison, and ethical approval was obtained in the form of a casual email.

These circumstances were antithetical to the rigour and close attention to detail that was endemic in the process of researching hospital patients, at the level of both individual treatment of offenders, and administration. Some aspects of this may be considered positive, such as permitting the efficient and time-economical collection of data, but in other important ways, such as how inmates may have been made to feel about participating, this might have been less desirable and/or ethically sound.

The researcher acted very responsibly under these circumstances and did not use this situation to her advantage in terms of recruitment of participants; However, it is disconcerting to think that provisions were not made at times, to protect inmates' rights and freedom of choice, by prison staff. Another, possibly less experienced or ethically minded researcher, may have responded differently.

In conclusion, this paper has outlined the process of conducting research with sex and non-sex offenders in hospital and prison, and has critically reflected on some aspects of the methodology employed in this study. Contrasts of attitudes towards offenders in different settings have also been considered. Overall, the process was fascinating and highlighted various complicated and sensitive matters that can arise during the process of conducting such research.

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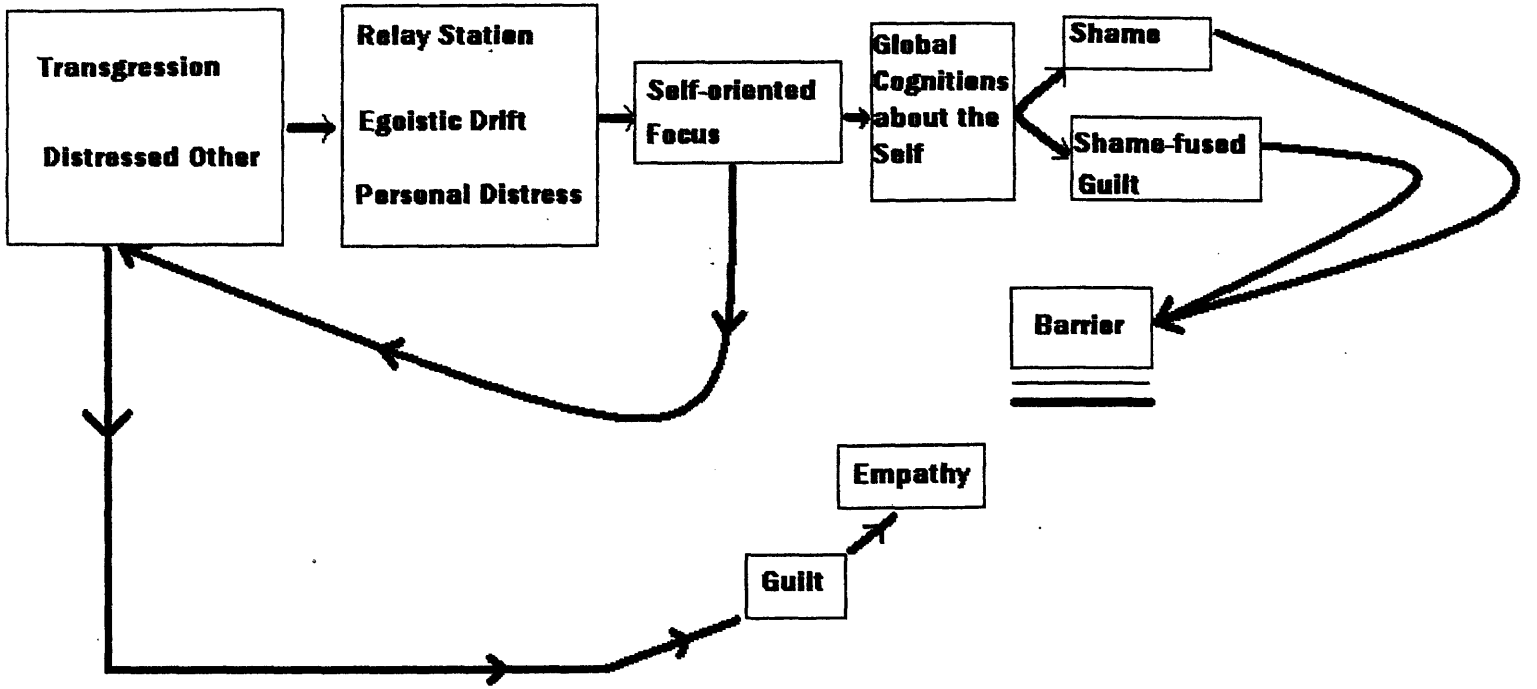
APPENDIX

Appendix

Figure 5: The Role of Personal Distress in Shame, Guilt and Empathy

Figure 5: The Role of Personal Distress in Shame, Guilt and Empathy



Appendix

Approval / Ethical Approval for the Research to Begin

NHS

Northern and Yorkshire Multi-Centre Research Ethics Committee

26 October 2004

Mrs. Abigail San
UCLTrainee Clinical Psychologist
UCL
Sub-Department of Clinical Health Psychology

Dear Mrs. San,

Full title of study: Shame and guilt: a pathway to empathy in sex offenders?
REC reference number: 04/MRE03/28
Protocol number: 2

Thank you for your letter of 11 October 2004, responding to the Committee's request for further information on the above research.

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

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.

The favourable opinion applies to the research sites listed on the attached sheet.

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 Type: Application
Version: 2
Dated: 11/10/2004
Date Received: 13/10/2004

Document Type: Investigator CV
Version: N/A Professor David Anthony Winter
Dated: 17/05/2004
Date Received: 17/05/2004

Document Type: Investigator CV
Version: N/A Abigail San
Dated: 17/05/2004
Date Received: 17/05/2004

Document Type: Protocol
Version: 2
Dated: 11/10/2004
Date Received: 13/10/2004

Document Type: Covering Letter
Version: N/A
Dated: 12/05/2004
Date Received: 17/05/2004

Document Type: Summary/Synopsis
Version: 1
Dated: 05/05/2004
Date Received: 17/05/2004

Document Type: Peer Review
Version: N/A memo from Nancy Pistrang
Dated: 04/12/2003
Date Received: 17/05/2004

Document Type: Copy of Questionnaire
Version: N/A Personality Questionnaire (HDHQ)
Dated: 17/05/2004
Date Received: 17/05/2004

Document Type: Copy of Questionnaire
Version: N/A IRI Questionnaire
Dated: 17/05/2004
Date Received: 17/05/2004

Document Type: Copy of Questionnaire
Version: N/A ISS Questionnaire
Dated: 17/05/2004
Date Received: 17/05/2004

Document Type: Participant Information Sheet
Version: 3
Dated: 20/10/2004
Date Received: 20/10/2004

Document Type: Participant Consent Form
Version: 1
Dated: 05/05/2004
Date Received: 17/05/2004

Document Type: Response to Request for Further Information
Version: N/A

Dated: 11/10/2004
Date Received: 13/10/2004

Document Type: Other
Version: N/A Repertory Grid
Dated: 17/05/2004
Date Received: 17/05/2004

Document Type: Other
Version: N/A Brief Sympton Inventory
Dated: 17/05/2004
Date Received: 17/05/2004

Management approval

If you are the Principal Investigator for the lead site: You should obtain final management approval from your host organisation before commencing this research.

The study should not commence at any other site until the local Principal Investigator has obtained final management approval from the relevant host organisation.

All researchers and research collaborators who will be participating in the research must obtain management approval from the relevant host organisation before commencing any research procedures. Where a substantive contract is not held with the host organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Statement of compliance *(from 1 May 2004)*

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.

REC reference number: 04/MRE03/28	**Please quote this number on all correspondence**

Yours sincerely,

Chairman, Northern & Yorkshire MREC

Enclosures *List of names and professions of members who were present at the meeting and those who submitted written comments*

Standard approval conditions

List of approved sites

Barnet, Enfield and Haringey NHS

Mental Health NHS Trust

18 October 2005

Mrs Abigail San

Dear Mrs San,

Title: **The relationship between shame, guilt and empathy in sex offenders**
REC reference number: **04/MRE03/28**

I am pleased to note that you have received the favourable opinion of the Research Ethics Committee for your study.

All projects must be registered with the Research Department if they use patients, staff, records, facilities or other resources of the Barnet, Enfield and Haringey NHS Mental Health Trust.

The R&D Department on behalf of Barnet, Enfield and Haringey NHS Mental Health Trust is therefore able to grant approval for your research to begin, based on your research application and proposal reviewed by the ethics committee. Please note this is subject to any conditions set out in their letter dated 26 October 2004 & 28 June 2005. Should you fail to adhere to these conditions or deviate from the protocol reviewed by the ethics committee, then this approval would become void. The approval is also subject to your consent for information to be extracted from your project registration form for inclusion in NHS project registration/management databases and, where appropriate, the National Research Register.

You are obliged to adhere to the research governance framework as set out by the Department of Health Research Governance Framework for Health and Social Care*.

It is required that all researchers submit a copy of their report on completion and details on the progress of the study will be required periodically for longer projects. Copies of all publications emanating from the study should also be submitted to the R&D Department.

Furthermore, all publications must contain the following acknowledgement.

"This work was undertaken with the support of Barnet, Enfield and Haringey NHS Mental Health Trust, who received "funding" from the NHS Executive; the views expressed in this publication are those of the authors and not necessarily those of the NHS Executive".

"a proportion of funding" where the research is also supported by an external funding body; "funding" where no external funding has been obtained.

Best wishes and every success with the study.

Yours sincerely,

Assistant Director R & D

*Further information on research governance can be obtained on the DH web pages at http://www.doh.gov.uk/research/

KNEESWORTH HOUSE
PSYCHIATRIC HOSPITAL

Ms Abigail San

26 April 2005

Dear Abigail,

Re: The relationship between shame, guilt and empathy in sex offenders

Many thanks for the amended information sheet for participants which I have just received.

The Research Committee at Kneesworth House Hospital are happy for you to recruit participants from those members of our patient population who have a previous conviction for a sex offence.

, our programme co-ordinator for inappropriate sexual behaviours can supply you with an up-to-date list of patients convicted of a sexual offence. She will also be pleased to speak with you and facilitate your access to the Hospital.

As a condition of access, the Hospital asks that you keep us up-to-date on progress every six months. We would also ask that you supply the Hospital Library with a copy of your thesis and copies of any journal articles of book chapters arising from the research.

If you have any questions or concerns, please do not hesitate to contact me.

Yours sincerely,

Chair of Research Committee
Kneesworth House Hospital

Abigael San

Appendix

Letter to Consultant Psychiatrists Requesting Recommendations of their Patients as Potential Participants in this study and Debrief Letter to Participants

Sub-Department of Clinical Health Psychology
UNIVERSITY COLLEGE LONDON
GOWER STREET LONDON WC1E 6BT

www.ucl.ac.uk/clinical-health-psychology/

Name of Consultant
North London Forensic Service
Camlet Lodge Regional Secure Unit

12th July 2005

Dear Dr. _____,

Re: Shame, guilt and empathy in sex offenders

I am writing to request your help in identifying patients to participate in the above named doctoral thesis research. I have received approval from Barnet, Enfield and Haringey LREC to undertake part of this research at Camlet Lodge.

The research is an investigation into shame, guilt and empathy in sex offenders. It is predicted that high levels of shame will be associated with low levels of empathy, that empathy and guilt will be correlated, and that offenders who have not been sexually abused themselves will be characterised by greater levels of shame and guilt than those with a history of abuse. Shame will be measured using the Internalised Shame Scale (Cook, 1994) and the Other as Shamer Scale (Goss, Gilbert and Allan, 1994). Guilt we be measured using the guilt sub-scale of the Hostility and Direction of Hostility Questionnaire (Caine, Foulds and Hope, 1967), and empathy will be measured using the Interpersonal Reactivity Index (Davis, 1980). A measure of shame, guilt and empathy will also be obtained using repertory grids.

Inclusion / exclusion criteria:
English-speaking men who have committed at least one sexual offence against an adult or child (not necessarily index offence). Offences can cover the spectrum of sexual offences, ranging from indecent exposure to sexual homicide. The study will not include men diagnosed with a learning disability or neurological disorder.

I am based at North London Forensic Service where my supervisor is Sara Henley. Should you recommend any of your patients for participation, I would be grateful if you could return the enclosed consent form(s) to me, and discuss it with them at your next meeting. The research is being presented to patients as an investigation into feelings in people who have committed offences.

I will then arrange to visit them to administer the questionnaires and interview, which will take 1-2 hours to complete. This can be done over two sessions if preferred. I will explain the full consent procedures, and obtain a signed consent form from them. I will also require access to their notes in order to obtain background information. I assure you that the confidentiality of your patients will remain intact at all times.

If you have any patients that you think would be suitable, please could you return the enclosed form(s) to me as soon as possible. If you know of any other suitable patients on another consultant's caseload, I would also be grateful for this information so that I can contact them.

Should you have any questions, please do not hesitate to contact me
( ).

Thank you for your time.

Yours sincerely,

Abigail San
Trainee Clinical
Psychologist (UCL)

Sue Carvalho
Head of North London
Forensic Service Psychology
Department

Sara Henley
Consultant Clinical and
Forensic Psychologist
Clinical Manager of
Specialist Services

Sub-Department of Clinical Health Psychology
UNIVERSITY COLLEGE LONDON
GOWER STREET LONDON WC1E 6BT

www.ucl.ac.uk/clinical-health-psychology/

28th July 2006

Dear

Many thanks for your participation last year in my research, which was about some of the emotions that different types of offenders experience. This involved me reading out some statements about how you might be feeling, and your reactions to other people. I also asked you to what extent you agreed with those statements. In addition, you were asked to describe yourself and some people that you knew.

I found that there were differences in concern about other peoples' distress depending on what type of offence respondents had committed. This could mean various different things, including that some offenders are more able to tune in to the feelings of others compared to other types of offenders.

Looking at all offenders together, I found that those people who experienced a lot of negative emotions (for example feeling unimportant compared to others) were also more likely to feel distressed when faced with another person who was in some kind of difficulty. This might have been because such people can get a bit distracted by their own feelings when they become aware of someone else's distress. Similar findings have also been reported in different populations, such as students.

Some of the findings in this study were expected, and some were not. The best thing to do would be to repeat the study in a slightly different way and see if the same results emerge. Until then, it would be quite difficult to draw any firm conclusions, especially as this was quite a new area of research, and one of the things researchers have to do is repeat their studies several times to make sure that their results were not found by chance.

Thank you so much for participating and helping to further our understanding of emotions in offenders.

Yours sincerely,

Abigail San
Trainee Clinical Psychologist

Appendix

Participant Information Sheet

Sub-Department of Clinical Health Psychology

UNIVERSITY COLLEGE LONDON

GOWER STREET LONDON WC1E 6BT

Ref: 04/MRE/03/28

INFORMATION SHEET

Feelings in people who have committed offences

www.ucl.ac.uk/clinical-health-psychology/

Would you like to take part in a research study? Before you decide, please think about what it will involve. Please read this carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like to know more. Take time to decide whether or not you wish to take part.

We are interested in feelings. What people think about their offences can make them feel lots of different things. We can make treatment better if we know a bit more about how people who have offended think and feel. We are asking for about two hours of your time, where a researcher will ask you questions about your thoughts and feelings. We want to understand how you see things. We have picked you for the study because we're interviewing other people who have offended in similar ways. We are hoping to talk to about 56 people altogether.

It is up to you to decide whether or not to take part. If you decide to, you will be given this Information Sheet to keep. You will also be asked to sign a form that says you agree to be part of the study. We may wish to look at your medical records to find out a bit more. If you say you'll take part, you will also be allowing us to read your medical notes, which will be kept strictly confidential. You can stop the interview at any time without saying why. This won't affect your treatment. If you do or don't participate, you will still get the same treatment.

There will be either one or two interviews- it's up to you if you want to do it all in one day, or on two different days. After this, you won't be asked to do anything else. If you need to travel to a clinic especially for the research, we will pay back your travel expenses.

We really don't think you will be harmed at all by taking part in this project, and there are no special compensation arrangements. If you want to complain, or if you're not happy about how you've been treated whilst being part of this study, the normal National Health Service complaints procedures will be available.

All information known about you will be kept strictly confidential, but if anything you say suggests that someone might be in danger, a senior member of staff will be told straight away. Your name and address won't be written on anything outside the hospital/surgery.

The results of the study will be published in a journal, and a copy of the report will also be given to staff in this unit. Anybody who takes part will be sent something in the post explaining what we found. No names will be used in any report.

The research is being organised and paid for by University College London. The Central Office for Research Ethics Committee are happy for the research to be done.

If you want to know anything else, please contact Abigail San, Trainee Clinical Psychologist at the Sub-Department of Clinical Health Psychology, University College London,

Please keep this Information sheet. Thank you for reading this, and for taking part in the study (if you decide to).

Appendix

Participant Consent Form

Sub-Department of Clinical Health Psychology
UNIVERSITY COLLEGE LONDON
GOWER STREET LONDON WC1E 6BT

Centre Number: :
Study Number:
Patient Identification Number for this trial:

CONSENT FORM

Title of Project: *Emotions in people who have committed offences*

Name of Researcher: Abigail San

Please initial box

1. I confirm that I have read and understand the information sheet dated ..... (version .....) for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that sections of any of my medical notes may be looked at by a responsible individual from UCL. I give permission for this individual to have access to my records. ☐

4. I agree to take part in the above study. ☐

Name of Patient	Date	Signature
Name of Person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

1 for patient; 1 for researcher; 1 to be kept with hospital notes

Appendix

Grid Measures

Repertory Grid

A. Myself before ever having committed a sexual offence
B. Myself just after having committed any sexual offences
C. How I would like to be
D. Myself now
E. How others think I should be
F. _____Someone I sexually offended against
G. _____ A person I liked
H. _____A person I disliked
I. My mother (or mother figure)
J. My father (or father figure)
K. _____Brother or sister nearest my age (or person most like a sibling)
L. The sort of person who would commit a sexual offence
M. The sort of person who would not commit a sexual offence

- Add shame, guilt, empathy

SHAME – feeling that other people judge you negatively
GUILT – judging your own behaviour negatively
EMPATHY – being able to really understand how someone else feels

Repertory Grid C

A. Myself before ever having committed my last offence
B. Myself just after having committed my last offence
C. How I would like to be
D. Myself now
E. How others think I should be
F. _____Someone I offended against
G. _____ A person I liked
H. _____A person I disliked
I. My mother (or mother figure)
J. My father (or father figure)
K. _____Brother or sister nearest my age (or person most like a sibling)
L. The sort of person who would commit an offence like mine
M. The sort of person who would not commit an offence like mine

- Add shame, guilt, empathy

SHAME – feeling that other people judge you negatively
GUILT – judging your own behaviour negatively
EMPATHY – being able to really understand how someone else feels

Name: Code: Date: *SBW/101295©*

Role Title List																		Construct (1)	Contrast (2)
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Sort	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O			* *	
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