

This is the pre-peer reviewed version of the following article: Hockley, O. & Langdon, P.E. (2015). Men with intellectual disabilities with a history of sexual offending: empathy for victims of sexual and non-sexual crimes *Journal of Intellectual Disability Research*, 59, 332-341, which has been published in final form at [10.1111/jir.12137](https://doi.org/10.1111/jir.12137). This article may be used for non-commercial purposes in accordance with Wiley Terms and Conditions for Self-Archiving.

Men with intellectual disabilities with a history of sexual offending: empathy
for victims of sexual and non-sexual crimes

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Peter E Langdon is funded by a National Institute for Health Research
Postdoctoral Fellowship

This article presents independent research funded by the National Institute for Health Research (NIHR). The views expressed are those of the author(s) and not necessarily those of the National Health Service, the National Institute for Health Research or the Department of Health.

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Abstract

Background: The objectives were (a) to compare the general empathy abilities of men with intellectual disabilities (IDs) who had a history of sexual offending to men with IDs who had no known history of illegal behaviour, and (b) to determine whether men with IDs who had a history of sexual offending had different levels of specific victim empathy towards their own victim, in comparison to an unknown victim of sexual crime, and a victim of non-sexual crime, and make comparison to non-offenders. **Methods:** Men with mild IDs ($N = 35$) were asked to complete a measure of general empathy and a measure of specific victim empathy. All participants completed the victim empathy measure in relation to a hypothetical victim of a sexual offence, and a non-sexual crime, while men with a history of sexual offending were additionally asked to complete this measure in relation to their own most recent victim. **Results:** Men with a history of sexual offending had significantly lower general empathy, and specific victim empathy towards an unknown sexual offence victim, than men with no known history of illegal behaviour. Men with a history of sexual offending had significantly lower victim empathy for their own victim than for an unknown sexual offence victim. Victim empathy towards an unknown victim of a non-sexual crime did not differ significantly between the two groups. **Conclusions:** The findings suggest that it is important include interventions within treatment programmes that attempt to improve empathy and perspective-taking.

KEYWORDS: LEARNING DISABILITIES, SEXUAL OFFENDING, EMPATHY, OFFENCE PROCESS, SEX OFFENDERS, NEURODEVELOPMENTAL DISORDER; FORENSIC MENTAL HEALTH

Men with intellectual disabilities with a history of sexual offending: empathy for victims of sexual and non-sexual crimes

Many theories have been developed in an attempt to try to understand empathy and the complex process of empathising. For example, Davis (1983, 1980) theorised that empathy is a multidimensional construct incorporating both emotional and cognitive elements, while some earlier theorists endorsed either a cognitive/perspective-taking, (Selman 1976, Selman 1980, Kerr and Spieroff 1952), or an emotional (Stotland *et al.* 1978, Mehrabian and Epstein 1972) based approach to our understanding of empathy.

More recent theories of empathy recognise that the process clearly involves both affective and cognitive components, although some tend to focus more on either the affective or the cognitive. Hoffman (2000) placed greater emphasis on emotion, but recognised that cognition is important. He argued that “the cognitive dimension...helps give structure and stability to empathic affects, which should make empathic affects less vulnerable to bias (p. 216).” He further argued that empathy becomes “bonded” with cognition giving cognition the ability to motivate behaviour. Hoffman’s (2000) work goes one step further, providing not only a developmental model of empathy, but a theoretical model that links empathy to other emotional states such as sympathy, guilt, and anger, as well as other important constructs such as responsibility, and behaviour, including pro-social behaviour. Central to his theory is an attempt to understand moral development and behaviour more effectively, which has also been tackled by other theorists from complementary perspectives (Gibbs 2003, Gibbs 2010).

Other related theories have attempted to understand empathy or aspects of development that relate to empathy. These include “theory of mind” (Premack and Woodruff 1978), mentalisation (Fonagy *et al.* 2002), various developmental models

of perspective taking (Selman 1976, Selman 1980, Flavell *et al.* 1990, Feffer and Gourevitch 1960, Newman 1986), and more recently, social mindfulness (Van Doesum *et al.* 2013). All of these theories together attempt to provide a theoretical understanding of how the mental states of others are represented, internalised, develop, and in turn, determine behaviour.

Some have explicitly used these theories to further our understanding of criminal behaviour. For example, Blair (2006) argued that difficulties with “theory of mind” may not lead to reduced empathy and delayed moral development and therefore antisocial behaviour, considering that some types of offenders make use of “theory of mind” skills when committing offences (e.g. conning others). Instead, he argued that “theory of mind” may relate to antisocial behaviour through problems with social perspective taking, or social information processing, drawing on the work of Dodge (Crick and Dodge 1994, Crick and Dodge 1996, Dodge 1980) who demonstrated that aggressive boys maintain a hostile attributional bias. However, Blair (2006) did point out that although people with psychopathy do not have problems with “theory of mind”, they do have difficulties with responding to others emotional states, and therefore problems with empathy. Others have recognised the relationship between moral development and social information processing and their relationship to criminal offending (Palmer 2003b, Palmer 2003a).

Moral development theory, as mentioned by Blair (2006), rests on theories of perspective taking, along with cognitive development and social role taking opportunities (Gibbs 2003, Gibbs 2010, Gibbs 1979, Kohlberg 1969, Kohlberg 1976, Kohlberg 1958, Piaget 1932, Hoffman 2000) which lead to decentration and development, and therefore changes to the structure of moral schema. Hoffman (2000) considered perspective taking to be a method by which empathy is “activated”

and he argued that empathy is the primary motivator of moral behaviour, while Gibbs (2010), on the other hand, argued that both empathy *and* moral principles motivate moral behaviour.

Regardless of the theoretical perspective, empathy and related theories have implications for our understanding of the aetiology of criminal behaviour, especially considering the relationship between moral reasoning and empathy, and their relationship to criminal offending (Stams *et al.* 2006, Jolliffe and Farrington 2007, Jolliffe and Farrington 2004). There is evidence to suggest that moral reasoning may relate to criminal offending amongst men with IDs (Langdon *et al.* 2010a, Langdon *et al.* 2011a, Langdon *et al.* 2010b, Langdon *et al.* 2013, Langdon *et al.* 2011b), and evidence that the relationship between empathy and offence supportive beliefs is mediated by moral reasoning (Langdon *et al.* 2011b). van Vugt *et al.* (2011) also reported that adolescents with a history of sexual offending and borderline IDs have a “moral developmental delay” similar to that found amongst young offenders.

There is also evidence to suggest a relationship between offending and empathy. Jolliffe and Farrington (2004), within their meta-analysis, reported that there was a relationship between empathy and offending, but this tended to disappear when intelligence and socioeconomic status were controlled. They also reported that the relationship between empathy and offending was strongest for violent offenders, and younger offenders, and weakest for sexual offenders. They went on to demonstrate a relationship between empathy and self-reported offending amongst adolescents, although there were some differences according to type of offence, and adolescent girls and boys (Jolliffe and Farrington 2007).

The relationship between empathy and criminal offending amongst people with IDs is relatively less clear. Proctor and Beail (2004, 2007) reported that

offenders with IDs were actually better at emotional recognition, while offenders and non-offenders with IDs did not score differently on a measure of general empathy. Langdon *et al.* (2011b) also reported no difference between offenders and non-offenders with IDs on a measure of emotional empathy. Ralfs and Beail (2012) went on to demonstrate that there were no differences between sex offenders and non-offenders with IDs on measures intended to assess components of empathy, including emotional recognition, perspective taking, emotional replication, and response decision, drawing on the model developed by Marshall *et al.* (1995). In fact, the literature examining the empathy skills of sexual offenders without IDs is inconsistent, and the review by Jolliffe and Farrington (2004) indicated that the relationship between offending and empathy was lowest for sexual offenders. However, some studies have reported that sexual offenders tend to score lower on measures of empathy (Marshall *et al.* 1993, Marshall and Maric 1996), and Marshall *et al.* (1995) argued that it may be the case that sexual offenders may only lack empathy for their own victims, rather than possess a general empathy deficit.

Indeed, Marshall *et al.* (2001) demonstrated that child sexual offenders, other offenders and non-offenders did not differ in levels of cognitive empathy towards a child injured in a car crash. However, sexual offenders had significantly less cognitive empathy towards a hypothetical child abuse victim, and their own victim, but the degree of deficit was greatest towards their own victim. Marshall and Mouldon (2001) reported similar findings for rapists when responding to their own victim and an unknown victim of rape. Findings similar to Marshall *et al.* (2001) and Marshall and Moulden (2001) have also been reported by others (Fernandez and Marshall 2003, Marshall *et al.* 1997, Whittaker *et al.* 2006).

Treatment programmes for sexual offenders with IDs incorporate interventions that aim to improve victim empathy (SOTSEC-ID 2010, Murphy *et al.* 2007, Rose *et al.* 2002, Lindsay *et al.* 1998b, Lindsay *et al.* 1998c, Lindsay *et al.* 1998a, Michie and Lindsay 2012). Ralfs and Beail (2012) reported that sexual offenders with IDs and non-offenders do not have differing levels of empathy, while the literature pertaining to sexual offenders without IDs suggests that a specific deficit may actually exist regarding specific victim empathy, rather than a general empathy deficit (Marshall *et al.* 2009). However, it may be the case that sex offenders with higher levels of “deviance”, and histories of other offending behaviour (Smallbone *et al.* 2003), or associated problems with psychopathy and histories of childhood abuse (Graham *et al.* 2012) indeed have a general empathy deficit.

Considering the literature pointing to a relatively robust lack of specific victim empathy amongst sexual offenders without IDs, and the suggestion that sexual offenders with higher levels of risk are more likely to have general empathy deficits, we undertook the current study by recruiting men with IDs who had a history of sexual offending and men with IDs who had no known history of engaging in illegal behaviour. Using a similar method to Marshall *et al.* (2001) both groups were asked to complete a measure of general empathy, and then a measure of specific victim empathy in reaction to an unknown victim of a non-sexual and a sexual crime. Sexual offenders were also asked to complete this measure again in relation to their most recent real victim. It was specifically hypothesised that (a) sexual offenders and non-offenders would not differ significantly on the measure of general empathy, and the measure of specific victim empathy in relation to the victim of a non-sexual crime, (b) sexual offenders would have significantly lower levels of victim empathy than non-offenders towards the unknown victim of a sexual offence, (c) there would be no

significant difference between sexual offenders and non-offenders with regards to victim empathy towards an unknown victim of a non-sexual crime, and (d) sexual offenders will have significantly lower victim empathy towards their own victim in comparison to an unknown victim of a sexual offence, and an unknown victim of a non-sexual crime.

Method

Participants

Nineteen men ($M_{age} = 39.89$, $SD = 14.86$, $M_{FIQ} = 63.16$, $SD = 2.67$) with a history of sexual offending, and 16 men ($M_{age} = 38.69$, $SD = 12.97$, $M_{FIQ} = 63.00$, $SD = 4.26$) with no known history of illegal behaviour were recruited from the east of England. The Full Scale IQ, $z = -.08$, $p = .94$, 99.9% CI [.93, .95], nor age, $z = -.23$, $p = .83$, 99.9% CI [.83, .82], differed significantly between the two groups.

Men with no history of illegal behaviour were recruited through community services for people with IDs. Sexual offenders were recruited from inpatient forensic mental health services and were detained using sections of the Mental Health Act, 1983 (as amended, 2007). The frequency of known sexual offending within the sexual offender group ranged from one to 18 offences ($M = 3.11$, $SD = 3.98$). Forty-eight percent of these offences involved children, while the remainder involved adults, including some offences involving vulnerable adults, and convictions for exposure. Potential participants with a diagnosis of an autistic spectrum disorder were excluded.

Design

A simple between groups and within groups design was used. Sexual offenders and non-offenders were asked to complete a battery of assessment questionnaires, and comparisons were made between the two groups, while both groups completed one

measure multiple times having had a vignette read to them, or in response to their own victim.

Measures. General Intellectual Functioning. The Wechsler Abbreviated Scale of Intelligence (WASI, Wechsler 1999) was used to estimate the general intellectual functioning of participants. The WASI is a shortened version of the Wechsler Adult Intelligence Scale – III (WAIS-III, Wechsler 1998), and contains four subtests which assess verbal and non-verbal reasoning.

General Empathy. The Empathy Quotient (EQ; Baron-Cohen and Wheelright 2004) was used to assess general empathy. The questionnaire presents 60 general statements of which 40 are scored, while the remaining 20 are filler statements. The measure aims to measure both cognitive and emotional empathy, but the wording of the EQ is complex, and therefore the items were read to participants, and the understanding of each question was checked as necessary. The EQ has robust properties (Baron-Cohen and Wheelright 2004).

Victim Empathy. The Victim Empathy Scale – Adapted (VESA; Beckett and Fisher 1994, Langdon *et al.* 2007, Keeling *et al.* 2007) was used to measure specific victim empathy. This 30-item measure is completed in response to questions which incorporate a specific victim's name. It has been shown to have excellent internal consistency (Langdon *et al.* 2007), and *higher* scores indicate *lower* victim empathy.

For the present study, sexual offenders and non offenders completed the VESA on two occasions following having had one of two vignettes read to them. The two vignettes depicted different types of victims (a) a sexual offence victim: “A 20 year-old man named Sam was asked to babysit his neighbour's 9 year-old daughter named Tracey. He was alone in the house with her while her parents had gone out for the night. While he was with her, he showed her his penis. He then undressed her and

tried to have sex with her, and (b) a non-sexual offence victim: “A 20 year old man called James was driving too fast along the road. He had been drinking in the pub. He drove up onto the pavement and hit a girl named Jane with his car.” The vignettes were designed to clearly describe an offence and were kept as simple as possible, while attempting to ensure that there was little ambiguity that the perpetrator was culpable. Sex offenders were asked to complete the VESA a third time in reference to their most recent real victim.

As a consequence of using vignettes, the VESA had to be adapted further because some of the questions were directly about sexual offending, which was inappropriate for use with the victim of the non-sexual offence. For example the question “Do you think that (victim name) thought you were sexy?” was adjusted to be “Do you think that (victim name) thought you were nice?” In total, seven items had to be adjusted in this manner.

Risk. The Static-99R (Harris *et al.* 2003) was used to measure actuarial risk amongst sexual offenders. This is a ten item assessment considers static risk factors and has been shown to predict recidivism with sexual offenders who have IDs (Lindsay *et al.* 2008). The Static-99R contains items about intra- or extra-familial offending, number of victims, number of sentencing dates and whether or not the offender had male victims. Risk levels are based on the outcome score for the ten factors. Scoring results in one of four categories of risk (a) low risk, (b) moderate-low risk, (c) moderate-high risk, or (d) high risk.

Procedure

A favourable ethical opinion for this study was given by the Cambridge 4 National Health Service (NHS) Research Ethics Committee. Staff and carers were asked to share information with men who were likely to have capacity to give or withhold

consent to participate in the study. Men who expressed an interest in finding out more about the study were provided with a study information sheet, which was read to them. All potential participants were afforded ample opportunity to ask questions, and offered time to make a decision as to whether they wished to take part. All participants were informed that a decision to take part or not take part would not affect the care they received within the NHS or from another care provider. All participants were also informed that they could withdraw at anytime without giving a reason.

All participants were asked to provide signed consent to participate in the study. A mutually convenient time was then arranged to meet with each participant and ask them to complete the measures. The order in which the measures were completed was randomised.

Data Analysis

All data were entered and analysed using IBM SPSS Statistics Version 20.0.0. Descriptive data were generated and inspected for departures from normality. Some of the data was skewed and as a consequence, non-parametric statistics were calculated and Monte Carlo simulations drawing 10000 samples were used in order to calculate the 99.9% confidence interval for the p value. The Mann Whitney U test was used to make between group comparisons, while the Friedman and the Wilcoxon tests for post-hoc testing, using Sidak's adjustment ($p = 0.018$), were used to make within group comparisons on the VESA.

Results

Using the STATIC-99 to estimate risk revealed that 47.4 % ($n = 9$) of the sex offender group were rated as "high" risk, and 42.1% ($n = 8$) were rated as "moderate

to high” risk. Only two participants, or 10.5%, were rated as “low to moderate” risk, while no participants were rated as “low” risk.

Turning to empathy, sex offenders scored significantly lower on the measure of general empathy than non-offenders, $z = -2.80$, $p = .005$, 99.9% CI [.003, .008] (two tailed). Examining specific victim empathy amongst the sexual offenders across the two vignettes and their own victim revealed a significant difference, $\chi^2(2) = 20.19$, $p < .000$, 99.9% CI [$<.0001$, .0007]. Post-hoc testing revealed that sexual offenders had significantly less victim empathy for their own victim, in comparison to an unknown victim of a sexual crime, $z = -2.90$, $p = .002$, 99.9% CI [.0002, .003], or an unknown victim of a non-sexual crime, $z = -3.58$, $p < .001$, 99.9% CI [$<.0001$, .001]. Sexual offenders also had significantly less victim empathy for the unknown victim of a sexual crime than the unknown victim of a non-sexual crime, $z = -3.33$, $p < .001$, 99.9% CI [$<.0001$, .0004], Table 1.

Insert Table 1 About Here

Non-offenders had significantly greater empathy for the unknown victim of a sexual offence than for the unknown victim of a non-sexual crime, $z = -1.76$, $p = .04$, 99.9% CI [.035, .048]. Comparing the sexual offenders and the non-offenders revealed that the sexual offenders had significantly less victim empathy toward the unknown victim of a sexual offence than did non offenders, $z = -3.68$, $p < .001$, 99.9% CI [$<.0001$, .001], while victim empathy toward the unknown victim of a non-sexual crime did not differ significantly between the two groups, $z = -2.80$, $p = .41$, 99.9% CI [.39, .42], Table 1.

Discussion

Considering our hypotheses, first, non-offenders had greater general empathy than sexual offenders, and as a consequence our hypothesis that there would be no difference was rejected. Second, sexual offenders did have lower victim empathy than non-offenders toward an unknown victim of a sexual offence, and therefore, this hypothesis was accepted. Third, there was no difference between sex offenders and non-offenders in terms of their victim empathy towards an unknown victim of a non-sexual crime, and this hypothesis was accepted. Finally, sexual offenders did have lower levels of victim empathy towards their own victim in comparison to an unknown victim of a sexual offence, or an unknown victim of a non-sexual crime, and again, this hypothesis was accepted.

While there is robust evidence that men with IDs who have committed offences differ on several psychological constructs in comparison to non-offenders (Langdon and Murphy 2010, Lindsay 2002, Lindsay *et al.* 2013, Lindsay *et al.* 2004a, Lindsay *et al.* 2010, Lindsay *et al.* 2001, Lindsay *et al.* 2006a, Lindsay *et al.* 2004b, Lindsay *et al.* 2006b, Lindsay *et al.* 2007a, Lindsay *et al.* 2007b, Michie *et al.* 2006, Parry and Lindsay 2003, Steptoe *et al.* 2006, Langdon *et al.* 2007, Langdon *et al.* 2013, Langdon *et al.* 2011b, Langdon and Talbot 2006, Talbot and Langdon 2006), the evidence to date suggests that men with IDs who have a history of offending, including sexual offending, do not have difficulties with empathy and associated constructs (Ralfs and Beail 2012, Proctor and Beail 2007). This finding is broadly consistent with the finding that sexual offenders without IDs tend not to have general empathy deficits (Jolliffe and Farrington 2004, Marshall *et al.* 1995).

However, within the current study, sexual offenders with IDs did have lower general empathy, as measured by the EQ, than non-offenders, and this finding is inconsistent with the findings from other studies, (Proctor and Beail 2007, Ralfs and

Beail 2012, Langdon et al. 2011b). The most likely reason for the finding that sexual offenders with IDs did have difficulties with general empathy within the current study is because 89.5% of the sample were rated as “moderate to high” or “high” risk using the STATIC-99. As a consequence, this sample would be likely to have high levels of “deviancy”; it has been suggested that offenders with higher deviance may have difficulties with general empathy (Smallbone et al. 2003). Neither Proctor and Beail (2007), Ralfs and Beail (2012) or Langdon *et al.* (2011b) measured risk or “deviance” within their studies, and as a consequence, it may have been the case that the samples of offenders within these three studies were relatively lower risk offenders.

Considering victim empathy, the finding that sexual offenders with IDs had the greatest difficulty empathising with their own victim, in comparison to an unknown victim of a sexual offence and a non-sexual offence, and that their ability to empathise was less than non-offenders, is consistent with the findings reported in the literature pertaining to sexual offenders without IDs (Marshall and Moulden 2001, Marshall et al. 2001, Fernandez and Marshall 2003, Marshall et al. 1997, Whittaker et al. 2006).

Most treatment programmes for sexual offenders with IDs aim to improve victim empathy (SOTSEC-ID 2010, Murphy et al. 2007, Rose et al. 2002, Lindsay et al. 1998b, Lindsay et al. 1998c, Lindsay et al. 1998a, Michie and Lindsay 2012), and some of these programmes have evidenced that specific victim empathy increases following treatment (SOTSEC-ID 2010). Empathy can be considered from either a cognitive, affective, or combined viewpoint, but developmental shifts in empathy are thought to be brought about by decentration which occurs as a consequence of cognitive maturation, as well as social role taking opportunities (Hoffman 2000). Sexual offenders with IDs appear to have a moral developmental “delay” (van Vugt et al. 2011), and considering the relationship between empathy, moral development and

criminal offending (Gibbs 2003, Gibbs 2010, Hoffman 2000, Stams et al. 2006, Langdon et al. 2011a, Langdon et al. 2011b, Jolliffe and Farrington 2007, Jolliffe and Farrington 2004), coupled with the findings of the current study, it may be sensible for treatment programmes for men with IDs who have a history of sexual offending to focus much more strongly on improving empathy and perspective taking, in an attempt to bring about developmental shifts in moral schema (Langdon et al. 2013).

However, further research is required before this recommendation is strongly endorsed, as there are some problems with the current study that need highlighting. Although the EQ is meant to measure both the affective and cognitive components of empathy, it is not clear whether the VESA is a measure of affective, or cognitive empathy, or both. As a consequence, it may be the case that the differences within the current study reflect difficulties with perspective taking and cognitive empathy, which theoretically would be associated cognitive distortions that are used to neutralise negative affect, or emotional empathy, as a consequence of cognitive dissonance (Festinger 1962). The measurement issues need to be examined, as questionnaire-based assessment tools may not be the most effective assessment method of affect. Additionally, the sample size used within the current study is small. This is problematic, although the differences within and between the groups are robust.

In conclusion, the findings that sexual offenders with IDs have difficulties with general and victim empathy is relevant for our understanding of sexual offending behaviour and warrants the inclusion of interventions within treatment programmes that attempt to improve empathy and perspective-taking.

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Table 1.

Mean and standard deviation across Groups for the Empathy Quotient and the Victim Empathy Scale by Vignette or Own Victim

	Group	
	Sexual Offenders	Non-offenders
Empathy Quotient	34.53 (7.79)	43.47** (10.45)
Victim Empathy Scale		
Non-Sexual Offence	11.16 (10.68)	8.25 (5.20)
Sexual Offence	25.11 (16.26)	7.06*** (5.09)
Own Victim	44.74 (22.65)	-

Note: Lower scores on the Victim Empathy Scale indicate greater empathy;

** $p < 0.01$; *** $p < 0.001$