Theory Meets Practice: Empathy 2.0

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Over the past three decades, we have witnessed the rise, fall, and re-analysis of sexual offenders' victim empathy as a research and treatment target. In most forensic research, victim empathy (as defined and treated prior 2004) is uncorrelated with violent and sexual recidivism (see Hanson & Morton-Bourgon, 2004). And yet, a potential offender with intact empathy capacity should be moved to at least consider desisting in his offense process due to conflicting emotional states (i.e., sexual arousal and concern regarding victim's state). Some sexual offenders have problems experiencing general or victim empathy (Marshall, Hamilton, & Fernandez, 2001; Wood & Riggs, 2008). Before we eliminate general and victim empathy as stable and acute recidivism factors and intervention targets, we should identify the specific components of the process of empathy and how interruptions to these can affect empathic responses. As a partial resolution of conflicting research, this article offers suggestions on re-conceptualizing empathy and related constructs and how they might interrupt the offense process.

An Early Empathy Model Supported

According to social theory, the self is a duality: self-awareness, an internal focus on one’s thoughts and feelings, and an active self-in-the-world, or social object, that impacts others. The two aspects form an interactive whole required for empathy (Fenigstein, Scheier, & Buss, 1975). Following a review of the extant empathy literature, Marshall, Hudson, Jones, and Fernandez (1995) described empathy as a proposed multistage process involving both components of the self. The process was essentially a stage model:

- Recognition of the emotions of others
- Perspective-taking, or putting oneself in others’ place
- Emotional replication, or feeling the emotions that others feel in a given situation
- Response decision on possible action based on these emotions

The authors question the general assumption that empathy is a stable trait, suggesting that temporal factors affect the exercise and demonstration of empathy.

This groundbreaking work critically analyzed then-current sexual offender theory and treatment and noted a failure to address the nuances of the empathic response. Given the complexity of the model, inconsistent and inconclusive evidence of the capacity and tendency of offenders to experience and practice empathy would, and did, result. Problems in definition and measurement/assessment might be expected to play large roles in this.

The apparently discrepant research may be explained in part through individualized limitations or interference at specific points in the Marshall et al. model. Even before the activation of the model, the victim’s emotional reactions may be absent or ambiguous. He...
or she may not display negative emotion due to freezing, dissociation, enjoyment, or ignorance of being victimized. Table 1 illustrates ensuing hypothetical processes involved in each stage (assuming notable victim reaction to the abuse), and potential problems at each step.

### Table 1: The Empathic Response Process and its Potential Obstacles

<table>
<thead>
<tr>
<th>Step</th>
<th>Component Skill/Process</th>
<th>Potential Interference</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Sensory input</td>
<td>Fail to see/hear feel (organic dysfunction, weak stimuli)</td>
</tr>
<tr>
<td>2</td>
<td>Attention</td>
<td>Fail to notice or assign importance to (pre)cognitive sexual response, chemical interference, distracted by other cues; actively ignore</td>
</tr>
<tr>
<td>3</td>
<td>Organization/making</td>
<td>Combine data incorrectly, do not understand data</td>
</tr>
<tr>
<td>4</td>
<td>Memory retrieval</td>
<td>Absence of in-kind emotional experience; memory input, maintenance, or retrieval deficits; incorrect data retrieved, crimogenic beliefs recalled and activated</td>
</tr>
<tr>
<td>5</td>
<td>Comparison</td>
<td>Inaccurate comparison (apples and oranges); incorrect biased, or limited heuristic; compared with crimogenic beliefs</td>
</tr>
<tr>
<td>6</td>
<td>Labeling</td>
<td>Limited emotional vocabulary, incorrect emotional label, alexithymia</td>
</tr>
</tbody>
</table>

Recent research, including brain-imaging studies, into empathy in the general population lends credence to and expands the Marshall et al. (1995) model. It also illuminates potential areas of intervention. As a general rule, observation of the emotional state in another triggers brain regions associated with that emotion in the observer. For example, when one observes someone’s pain, the anterior insula and anterior cingulated cortex are activated, mirroring those regions in the one experiencing the pain (de Vignemont & Singer, 2006; Sommerville & Decety, 2006). Reflection on these responses builds a ‘theory of mind’ about others’ emotional states (see Carr, Iacoboni, Dubeau, Mazziotta, & Lenzi, 2003).

**Empathy, Interrupted**

Cognitive appraisal and attention modulate this process (Lamm, Nusbaum, Meltzoff, & Decety, 2007). Meaning making, (e.g., “she really means ‘yes’”, “he’s not enjoying this”, “she deserves this”, “he’s feeling pain”) inhibits or excites emotional identification with the individual. Thus, ‘implicit theories’ (Ward, 2000) and emotional processing style, essentially ‘trait’ aspects of the individual, affect state reactions in vivo. Such mental status attributions involve a distinct pattern of neural responses involving temporal and parietal regions (attention) and medial prefrontal regions (inferential construction based on observation—see Zaki, Weber, Bolger, & Oschner, 2009). Accuracy of these attributions is dependent on sustained attention to relevant cues (for example, voice tone, facial expression, and behavior) and on one’s ability to assemble this data to mirror actual affective states of the observed (Zaki et al., 2009). With the addition of the ‘in-kind’
emotional response (limbic and premotor regions), empathy occurs. Zaki et al. suggest accuracy also is context-dependent, multimodal, and dynamic.

In our work, we can infer that empathic ability, even when intact, may be present to varying degrees in an individual across time, setting, and competing goals and emotional states. Therefore, the offender might correctly identify suffering in a victim in a video, but fail to do so when aroused in a sexually charged setting. The experience of conflicting emotional states if he notices victim distress, could be resolved by reinterpreting or ignoring the distress (Janssen, Vorst, Finn, & Bancroft, 2002).

SOs may suppress empathic response (in-kind emotional reaction to the emotions of others) due to avoidance of the negative self-appraisal that would result (Marshall et al., 2001). Alternately, or concurrently, they may be prone to ‘hijacking’ of slower, deliberative cognitive processing of such information due to exaggerated emotion-desire-based response (Toates, 2009; Janssen, Everaerd, Spiering, & Janssen, 2000). Persons whose emotional responses are hypersensitive or dysregulated (as in PTSD or traumatic brain-injured individuals), and those with limited ‘mental work space’ (due, for example, to dulling effects of alcohol and other drugs, cognitive impairments, etc.) would also hypothetically tend to fail to notice the responses of others or to include this information in their decision-making. Indeed, animal studies reveal inhibitory effects on neuron size and connectivity of chronic stress-induced corticosteroids in the hippocampus and prefrontal cortex, key brain regions for consolidating emotional and long- and short-term memory data and meaning/decision making (see Davidson & McEwen, 2012 for a review). At the same time, the amygdala, the primary brain region responsible for the experience of emotions, is stimulated toward excessive neuronal growth (Davidson & McEwen, 2012).

Alexithymic individuals are ‘emotionally blind’ toward their own internal states (Feldman Hall, Dalgleish, & Mobbs, 2012). Further, because they lack this important comparative database, they cannot interpret the emotional states of others, and cannot feel empathy. They demonstrate reduced neural activation within the anterior insula and temporoparietal junction, key regions in the experience of distress and perspective-taking (Feldman Hall et al., 2012). Males are almost twice as prone to alexithymia as females, and experience a greater number of obstacles to emotional recognition (Salminen, AffiliationsResearch and Development Centre of the Social Insurance Institution, Turku, Finland.

New Research and Interventions

The empathic response thus described is dependent on emotional and behavioral reactions in the one being observed. In offending, this can only occur during or after the initiation of an offense. A much more preferable empathic response anticipates a victim’s reaction prior to the offense, resulting in termination of the offense process. To experience an empathic reaction prior to committing the offense, a potential offender must accurately
anticipate a victim's response. This would necessitate higher cognitive abilities such as sequencing, hypothesizing, imagining, and accurate anticipation of another's likely response. These must be done with sufficient clarity, detail, and intensity to evoke the in-kind emotional reaction in the offender.

Some researchers are attempting novel methods to enhance individual's abilities to empathize. Compassion meditation training (e.g., Lutz, Greischar, Perlman, & Davidson, 2009) improves brain (insula and anterior cingulate cortex) response to others, building mental expertise to cultivate the desires for others' happiness and to alleviate their suffering (Lutz et al., 2009). These desires constitute the operational definitions of loving kindness and compassion. They are key factors involved in training US veterans with post-traumatic stress disorder to reconnect with their loved ones and community (Lutz et al., 2009). For sexual offenders, loving kindness and compassion could comprise the difference between an offender failing to activate an empathic response (or ignoring it), and one who uses empathy to prevent or desist from an offense. Future research in application of compassion meditation training could assess the extent to which offenders trained in cultivating compassion can be oriented to avoid initiation of offense-related behaviors due to their desires for others' wellbeing.

To promote loving kindness and compassion in individuals, some researchers are exploring moral elevation, defined as an emotional, behavioral, and even transformational response to witnessing acts of uncommon moral goodness (Aquino, McFerran, & Laven, 2011). The physical/emotional sensations associated with moral elevation may be the result of a release of oxytocin in response to perceived signals of trust or trustworthiness, such as when witnessing acts of moral goodness (Aquino et al., 2011; Zak, Kurzban, & Matzner, 2005). The positive experience of moral elevation associated with viewing or performing acts of uncommon goodness increases the likelihood of the individual performing such acts in the future (Aquino et al., 2011). Conceptually, this is accomplished by increasing the priority of acting morally (perhaps perceived as alleviating or preventing others' suffering) relative to competing motivations (for power, pleasure, etc.). Further, it increases the saliency of cues (visual, auditory, etc.) and risks of suffering in the individual's attention, or priming the empathy pump, as it were.

Moral elevation in conjunction with compassion and loving kindness could provide offenders with not only motivation to choose nonoffending in the moment, but also a desire to prevent future offending. The latter would occur in part because these three skills/states would undermine implicit theories motivating the offending in the first place (e.g. viewing the world as hostile or women as dangerous, entitlement; Ward, 2000; Polaschek & Gannon, 2004). Indeed, even socially dominant individuals perform good deeds towards 'outgroups' after witnessing acts of uncommon moral goodness (Freeman, Aquino, & McFerran, 2009). The sense of moral identity obviously must be based in accurate assessment of one's potential to act immorally, or a grandiose sense of moral perfection could ensue, justifying any action by the individual.

With proper modeling of moral behavior enhancing the individual's desire to behave in kind, self-as-moral becomes a more central component of the individual's self-definition, and is more likely to be activated in vivo (see Aquino, Freeman, Reed, Lim, & Felps, 2009; Aquino & Reed, 2002). The social cognitive model of moral identity (Aquino et al., 2009) argues that it is the experience of being moral as central to one's identity that defines it. Implicit theories and cognitive distortions would allow offenders to maintain self-consistency of their identity as they redefine selfishness, harm, and abuse as morally neutral or positive. However, positive modeling of others' moral actions, along with other interventions impacting distortions and criminogenic implicit theories, would have the opposite effect. For example, an offender in a Circles of Support and Accountability program, through contact with community circle members, experience the pleasurable effects of witnessing members' acts of moral goodness, along with their direct encouragement to view himself as moral and behave morally. This would increase the saliency of environmental and intra-personal cues providing him an opportunity to demonstrate his own moral behavior, reinforcing his identity as moral, and providing pleasurable hormonal effects in his brain.

At the behavioral level, moral identity must be accessed prior to and/or during an offense
if it is to affect the outcome. Disinhibition through drugs, sexual, anxious, or aggressive arousal, etc. conceivably diminish the accessibility of one's moral identity in given situations by dampening frontal lobe activity. Further, self-as-moral can be viewed as competing for ‘air time’ with other identities: ‘monster’ or ‘pervert’, ‘great lover’, ‘inadequate’, ‘worthless’, etc. As with the reading and processing of emotional cues, this moral reasoning would be prone to numerous potential obstacles to observation, recall, reasoning, etc. Therefore, one set of interventions could assess and improve deficits in generating hypothetical situations based on the individual’s environment, and potential actions and their likely consequences. These skills combine all those involved in empathy, compassion/loving kindness, and moral activation/identity. Individuals with irremediable deficits in any of these areas can be taught to employ external controls and environmental structure to reduce exposure to activating stimuli.

Conclusions

Because empathy is a multistage process coordinating numerous individual skills, it will be difficult to measure and teach. Past efforts expected an offender to generate an empathic response simply by being exposed to a video of or letter from a distressed victim (Marshall et al., 1995). These efforts further expected this experience to generate identical reactions in the offender’s life. If we can assess at which points an offender lacks ability, skill, or obstacles, we can more effectively target interventions to the individual. For empathy to affect behavior, loving kindness, compassion, and moral identity must be sufficiently intact and available to the individual in the moment. Again, we can assess clients’ capacities and skill levels for each of these and tailor our interventions to the individuals’ needs. Future research should more carefully explore the empathy process and component skills, loving kindness, compassion, and moral elevation and identity in sexual offender populations. Research can also seek to verify the efficacy with offenders of existing interventions for training these skills.

References


