

Empathy and Attitudes: Can Feeling for a Member of a Stigmatized Group Improve Feelings Toward the Group?

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Results of 3 experiments suggest that feeling empathy for a member of a stigmatized group can improve attitudes toward the group as a whole. In Experiments 1 and 2, inducing empathy for a young woman with AIDS (Experiment 1) or a homeless man (Experiment 2) led to more positive attitudes toward people with AIDS or toward the homeless, respectively. Experiment 3 tested possible limits of the empathy–attitude effect by inducing empathy toward a member of a highly stigmatized group, convicted murderers, and measuring attitudes toward this group immediately and then 1–2 weeks later. Results provided only weak evidence of improved attitudes toward murderers immediately but strong evidence of improved attitudes 1–2 weeks later.

What is the social significance of books such as *Manchild in the Promised Land* (Brown, 1965), *House Made of Dawn* (Momaday, 1968), *One Flew Over the Cuckoo's Nest* (Kesey, 1962), *The Color Purple* (Walker, 1982), and *Borrowed Time* (Monette, 1988), or of movies such as *A Raisin in the Sun* (Susskind, Rose, & Petrie, 1961), *The Elephant Man* (Cornfield & Lynch, 1980), *Rain Man* (Johnson & Levinson, 1988), and *Longtime Companion* (Wlodkowski & Rene, 1990)? We believe that each of these works, and many similar ones, seek to improve attitudes toward a stigmatized group—a racial or cultural minority, people with some social stigma, disability, or disease.

The strategy used is to induce the audience to feel empathy for one or a few members of the stigmatized group. By *empathy* we mean an other-oriented emotional response congruent with another's perceived welfare; if the other is oppressed or in need, empathic feelings include sympathy, compassion, tenderness, and the like (see Batson, 1991). Research indicates that empathic feelings often result when one takes the perspective of a person in need, imagining how that person is affected by his or her plight (see Coke, Batson, & McDavis, 1978; Stotland,

1969). Creators of works like those in the previous paragraph seem to believe that by inducing us to see the world from the perspective of a stigmatized group member we can be led to feel for this person and that these empathic feelings will generalize, making us feel more positively toward the group as a whole. But is it so?

Considering Empathy as a Source of Attitude Change in Light of Social–Psychological Theory and Research

When one addresses this question to social–psychological literature on inducing more positive attitudes toward stigmatized groups, one hears little in response. Clore and Jeffrey (1972) found that assuming the role of a disabled person by traveling about campus in a wheelchair for an hour, or watching someone else do this, significantly improved attitudes toward the disabled—not only on a measure immediately following the experience but also in response to a disguised attitude measure 4 months later. Although one might reasonably argue that the improved attitudes were due to cognitive consequences of the role-playing experience (e.g., increased information about and understanding of the problems facing the disabled), Clore and Jeffrey attributed their results to the emotional experience of empathy. In another context, effects of participation in the role-play simulations of discriminatory environments often used in educational settings, such as the “Blue Eyes–Brown Eyes” simulation developed by Elliott, have sometimes been interpreted in terms of empathy (e.g., Byrnes & Kiger, 1990). But, once again, results could be cognitively rather than emotionally mediated. In yet another context, Shelton and Rogers (1981) found that inducing empathy for whales led to more positive attitudes expressed in intention and action to help save whales (much as did the movie *Free Willie*, which prompted 40,000 telephone calls about joining a campaign to protect whales the first weekend it was shown; see Lemonick, August 2, 1993).

More typically, social psychologists seeking to improve attitudes toward a stigmatized group have focused on the pros and cons of providing positive, stereotype-inconsistent information

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It is with deep sadness that we report the death of Erin C. Mitchener shortly after completion of data collection for Experiment 1.

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about the group (e.g., Brewer, 1988; Rothbart & John, 1985; Weber & Crocker, 1983). Or they have focused on the pros and cons of personal contact with members of the group (Aronson, Blaney, Stephan, Sikes, & Snapp, 1978; Brewer & Miller, 1984; Cook, 1985; Wilder, 1978; Wilder & Shapiro, 1989). Stereotype-inconsistent information and intergroup contact are obviously important strategies for improving attitudes toward a stigmatized group; each is worthy of careful theoretical and empirical scrutiny.

At the same time, the possibility that empathy might be used to improve attitudes seems to deserve more attention than it has received to date. The most obvious and basic question, and the one we wish to address, is, Does it work? Does inducing empathy for a member of a stigmatized group lead to more positive feelings and concern for the group as a whole?

Difficulty of Improving Attitudes

Attitudes toward stigmatized groups are notoriously hard to change, for several reasons. First, *cognitive processes* can work against change. Recent cognitive analyses suggest that if we receive positive, stereotype-inconsistent information about a member of a stigmatized group, then rather than changing our view of the group as a whole, we may place this person in a subcategory or subgroup, treating him or her as an exception that does not change the rule (Brewer, 1988; Hamilton & Trolie, 1986; Rothbart & John, 1985). Only if the stereotype-inconsistent information is widely dispersed throughout the group, and we are made aware of this dispersion, is it likely to change our stereotype (Weber & Crocker, 1983). Second, there are also strong *motives* that can oppose change. A more positive attitude may carry implications for potentially costly prosocial action, may threaten one's own position of relative advantage (Levine & Campbell, 1972), or may threaten one's belief that the world is just (Lerner, 1980; Lerner & Miller, 1978).

Promise of Empathy as a Source of Attitude Change

Given these difficulties, one may doubt that simply inducing empathy for a member of a needy, stigmatized group can improve attitudes. Yet we can think of five reasons why it might. Three are primarily pragmatic; two are more theoretical. First, as novels, movies, and documentaries show, it is relatively easy to induce empathy for a member of a stigmatized group. Second, this empathy can be induced in low-cost, low-risk situations. Rather than the disruption of normal patterns of behavior required to create direct, equal-status, cooperative personal contact, we can be led to feel empathy for a stigmatized group member as we sit comfortably in our living room. Third, empathy-inducing experiences can be controlled to ensure that they are positive far more readily than can live, face-to-face, direct contact (see Gramza, Charnas, Konrad, & von Hippel, 1993).

Fourth, as an emotional response, empathy may directly address the central feeling and evaluation components of the attitude, rather than relying on inference from information. Empathy has been found to increase valuing the welfare of the person for whom empathy is felt and, moreover, this valuing has been found to endure even after the need and resultant empathic feelings are gone (Batson, Turk, Shaw, & Klein, 1995). To the

extent that this increased valuing generalizes to the group of which the person is a member, it may lead directly to more positive attitudes. Fifth and finally, if empathy evokes altruistic motivation (as much evidence now suggests; see Batson, 1991, and Batson & Oleson, 1991, for reviews), then it should produce a motivational counterbalance to the egoistic desires to (a) avoid personal costs and (b) maintain relative advantage. Increased valuing of the welfare of a stigmatized group should also make it more difficult to use derogation as a means of maintaining belief in a just world; it should encourage prosocial action to remove the injustice instead.

Collectively, these observations lead us to propose a three-step model of how empathic feelings might improve attitudes toward a stigmatized group: (a) Adopting the perspective of a needy individual who is a member of a stigmatized group (i.e., imagining how this individual is affected by his or her situation) leads to increased empathic feelings for this individual. (b) These empathic feelings lead to a perception of increased valuing of this individual's welfare. (c) Assuming that this individual's group membership is a salient component of his or her plight, the increased valuing should generalize to the group as a whole, increasing positive beliefs about, feelings toward, and concern for the group.

Problems With Empathy as a Source of Attitude Change

This three-step model notwithstanding, there are also several reasons to doubt the effectiveness of inducing empathy for a member of a stigmatized group as a means of improving attitudes toward the group. First and most obviously, empathy is typically felt for individuals as individuals, not for groups or abstract classes of people (Batson, 1991; Batson, Batson, et al., 1995). As Stalin put it, one death is a tragedy; a million is a statistic. Feeling empathy for an individual may increase concern for and valuing of that individual, but contrary to Step 3 of our model, the concern may not generalize. Much like person-specific cognitive information about one member of a stigmatized group, empathy may simply lead to personalization or subcategorization (Brewer, 1988; Rothbart & John, 1985; Weber & Crocker, 1983; Wilder, 1984). Although feelings toward the individual target of empathy may improve, this individual may be treated as an exception, leaving feelings about the group as a whole either unchanged or, by contrast, more negative.

A key determinant of generalization of the valuing and concern evoked by empathy may be the extent to which group membership is a salient aspect of the need situation toward which empathy is evoked. Only if one empathizes in response to a need related to group membership would we expect the empathy to improve attitudes toward the group as a whole. Accordingly, we shall limit our consideration to needs of this kind.

Second and related is the issue of scope of the group to which we wish attitudes to change. There are often a number of overlapping subgroups within a broad stigmatized group. For example, within the broad group of people with AIDS, there are homosexual men with AIDS, drug users with AIDS, young women with AIDS, children with AIDS, and so on. Inducing empathy for a young woman with AIDS might improve attitudes toward that relatively narrow, atypical subgroup but leave atti-

tudes toward the broader group, people with AIDS, quite unchanged. A localized effect like this would be expected if subcategorization occurred and if the effects of emotional empathy parallel the effects of cognitive stereotype-inconsistent information. It would also be expected if the person feeling empathy were using an averaging model to form attitudes. Feeling positively toward one individual might have a noticeable effect on feelings toward that individual's narrow subgroup but not the broader group, just as a sugar cube might have a noticeable effect on taste when added to a glass of water but not to a 10-liter tank.

Third, there is the issue of victim responsibility. As emphasized by Ryan (1971) and others, an important component of the stereotype of most stigmatized groups is the perception of victim responsibility. Whether one thinks of the homeless, the poor, minorities, people with disabilities, or people with AIDS, part of the stereotype is that these individuals are in some way responsible for their situation, that they brought it on themselves. Weiner's (1980) research on attribution and empathy suggests that it is easier to feel empathy for someone who is not responsible for his or her need, someone who is an entirely innocent victim. But it may also be easier to see such a group member as atypical, resulting in subcategorization and little or no change in attitude toward the group as a whole. These observations suggest a trade-off: It may be harder to feel empathy for a stigmatized group member who is perceived to be responsible for his or her plight (Weiner, Perry, & Magnusson, 1988), but perhaps only this empathy leads to more positive attitude change toward the group as a whole.

Fourth, empathizing with a member of a stigmatized group may be personally threatening. To the extent that perspective taking makes salient one's own vulnerability to a similar plight, it may lead to a defensive response in which one tries to distance oneself psychologically from the individual and the stigmatized group. Distancing may result in reduced empathic feelings and perhaps even derogation of or blaming the victim (Lerner, 1980; Lerner & Miller, 1978; Ryan, 1971; Walster, 1966). A defensive response may be especially likely when the potential empathizer perceives that his or her own situation is similar to the victim's (Burger, 1981; Shaver, 1970; Thornton, Hogate, Moirs, Pinette, & Presby, 1986). If a defensive response occurs, then an attempt to induce empathy may not only fail to improve attitudes, it may make them worse.

Experiment 1: Attitudes Toward People With AIDS

This conceptual analysis led us to conduct three experiments to test the hypothesis that inducing empathy for a member of a stigmatized group can improve attitudes toward the group as a whole. In Experiment 1, we manipulated three independent variables in a $2 \times 2 \times 2$ factorial design: (a) empathy for a member of a stigmatized group (low vs. high); (b) degree to which this person was responsible for being a member of the group (not responsible vs. responsible); and (c) scope of the group toward which attitudes were assessed (broad vs. narrow). Drawing on an example used previously, the broad stigmatized group was people with AIDS; the narrow subgroup was young women with AIDS. Participants for Experiment 1 were young women in an introductory psychology course.

We chose this stigmatized group and participant population for our first experiment for several reasons. First, young women with AIDS are a distinct and atypical subgroup within the larger group of people with AIDS. By inducing empathy for a young woman with AIDS and then assessing attitudes toward either people with AIDS (broad group) or young women with AIDS (narrow group), we could test the generality of the effect of empathy on attitudes. Second, using people with AIDS as the stigmatized group, it was easy to provide information concerning victim responsibility; following Weiner et al. (1988), participants could learn either that the young woman got AIDS in a hospital (victim not responsible) or by engaging in unprotected sex (victim responsible). To avoid having the information about how she got AIDS prevent the induction of empathy (Betancourt, 1990; Weiner, 1980; Weiner et al., 1988), we took care to present this information after participants had listened to the young woman talk about the effects on her life of having AIDS.

Fourth, using a young woman with AIDS as the target of empathy and young women as participants, we could assess the possibility that experiencing empathy might be personally threatening. Assuming that statistics on the relatively high percentage of women university students who engage in unprotected sex applied to the women in our sample, we believed that taking the perspective of a young woman who got AIDS through unprotected sex would be personally threatening to at least some of our participants, especially if they were then asked to express attitudes toward the narrow subgroup of young women with AIDS (Burger, 1981; Shaver, 1970).

Predictions

The basic prediction for Experiment 1 was that subsequent attitudes toward people with AIDS will be more positive in the high-empathy condition than in the low-empathy condition. If, however, victim responsibility undercuts empathy, then this effect should be limited to participants in the victim-not-responsible condition. Alternatively, if participants in the victim-not-responsible condition subcategorize the target, then empathy should improve attitudes only in the victim-responsible condition. (If both processes occur, empathy should produce no effect.) If the attitude effects of empathy are relatively narrow, then empathy should improve attitudes toward young women with AIDS but not toward people with AIDS in general. Alternatively, if taking the perspective of a young woman who got AIDS through unprotected sex is personally threatening, then attempting to induce empathy in this condition should not improve attitudes toward the personally relevant subgroup, young women with AIDS. (Once again, if both processes occur, empathy should produce little effect on attitudes.)

Method

Participants

Participants for Experiment 1 were 96 female students in introductory psychology at the University of Kansas receiving credit toward a course requirement. Using a randomized-block procedure, we assigned 12 participants to each cell of our 2 (empathy) \times 2 (victim responsibility) \times 2 (scope of stigmatized group) design. On the basis of both indirect and direct probes during debriefing, we excluded data from 9 additional

students because they doubted the veracity of the audiotaped interview that presented the young woman with AIDS. No more than 2 students were excluded from any one cell, and the pattern of suspicion across cells was well within the limits of chance, $\chi^2(7, N = 105) = 4.04, p > .50$, so suspicion did not seem to be a problem for interpreting results.

Procedure

Participants were conducted through the procedure individually. On arrival, they were escorted into a research cubicle and given a written introduction that presented the study as a pilot test of a new programming idea for the local university radio station. The new program, "News from the Personal Side," sought to go "beyond the facts of local events to report how these events affect the lives of the individuals involved." Participants in the study would listen to a brief pilot broadcast and then complete several questionnaires designed to assess their emotional and evaluative responses. The introduction gave the following explanation: "The broadcast tape you will hear is real; it involves an interview with a young woman from the Kansas City area who is experiencing the personal tragedy of AIDS." In actuality, the interview was fictitious, scripted in such a way that we could introduce victim-responsibility information at the very end. Finally, participants read that one factor the professor conducting the research had found to be "especially important in determining reactions to broadcast material is listening perspective. Therefore, you will be asked to take a particular listening perspective toward the broadcast."

After participants had finished reading the introduction and signed a consent statement, the experimenter checked to be sure they were comfortable listening to an interview concerning AIDS. All participants said that they were. The experimenter then readied a tape player, placed three reaction questionnaires face down on the desk to be completed after listening to the tape, and gave participants a sheet with listening-perspective instructions. The experimenter left participants alone to read the instructions, listen to the tape, and complete the questionnaires.

Manipulation of empathy. Empathy was manipulated by the listening-perspective instructions. Instructions in the *low-empathy condition* asked participants to "take an objective perspective toward what is described. Try not to get caught up in how the woman who is interviewed feels; just remain objective and detached." Instructions in the *high-empathy condition* asked participants to "imagine how the woman who is interviewed feels about what has happened and how it has affected her life. Try to feel the full impact of what this woman has been through and how she feels as a result." Participants were asked to be sure they had these instructions clearly in mind before listening to the interview tape. Each participant's listening-perspective instructions had been placed in a folder in advance, allowing the experimenter to remain unaware of her empathy condition.¹

Julie, a young woman with AIDS. All participants heard exactly the same interview up to the last segment. In the interview, a young woman named Julie talked about her life since unexpectedly learning 3 months ago that she was HIV positive:

Well, as you can imagine, it's pretty terrifying. I mean, every time I cough or feel a bit run down, I wonder, is this it? Is this the beginning—you know—of the slide? Sometimes I feel pretty good, but in the back of my mind it's always there. Any day I could take a turn for the worse. (pause) And I know that—at least right now—there's no escape. I know they're trying to find a cure—and I know that we all die. But it all seems so unfair. So horrible. Like a nightmare. (pause) I mean, I feel like I was just starting to live, and now, instead, I'm dying. (pause) It can really get you down.

The interview continued with Julie describing precautions she was taking to avoid infection, how as an only-child she regretted that her parents would never have grandchildren, her concerns about what might happen

if her friends at work or her boss found out that she had AIDS, and her worries about upcoming medical bills because the small company where she worked did not provide health insurance.

Manipulation of victim responsibility. The interview ended with the interviewer asking Julie how she got AIDS. In the *victim-not-responsible condition*, Julie explained,

Well, the summer after my senior year in high school, I was out with some friends. We were on our way to a movie when our car was hit by a drunk driver. It was a really bad accident. I lost a lot of blood, and when I got to the hospital they gave me several pints. I'm still not quite sure how—neither are the doctors—but they say that at some point during that night, I must have come into contact with the AIDS virus. It may have been the blood. They had two other cases in that same hospital right around that time.

In the *victim-responsible condition*, Julie said instead,

Well, the summer after my senior year in high school, I kind of went crazy. The whole summer was one big party because it was the last time my friends and I would be together. We spent 3 weeks at the beach. We weren't doing anybody harm; just having fun. But, well, I kind of slept around quite a bit and didn't really protect myself. I just didn't think about the dangers. I guess I thought I was safe, and the guys we were hanging out with seemed really nice. They were a little wild and crazy, but not really bad. Obviously, I made a big mistake.

In each responsibility condition the interview ended with the interviewer thanking Julie for talking about her experience and providing some insight into what it was like to live with AIDS.

Measuring empathic feelings for Julie. After listening to the interview, participants completed three questionnaires. The first listed 24 adjectives describing different emotional states and was used to assess empathic response to Julie's plight. For each adjective, participants were asked to report how much (1 = *not at all*, 7 = *extremely*) they had experienced that emotion while listening to the broadcast. The list included six adjectives used in much previous research to assess empathy, *sympathetic, compassionate, soft-hearted, warm, tender, and moved* (see Batson, 1991, for a review), providing a check on the effectiveness of the empathy manipulation.

Measuring attitudes toward people with AIDS. The second questionnaire assessed participants' attitudes toward people with AIDS. This was the major dependent measure. For participants in the *broad-group condition*, the questionnaire was entitled, "Attitude Questionnaire: AIDS Victims."² Modeled on McConahay's (1986) Modern Racism Scale, it contained the following seven items designed to assess beliefs about, concern for, and feelings toward people with AIDS:

1. For most people with AIDS, it is their own fault that they have AIDS. (1 = *strongly disagree*, 9 = *strongly agree*)

¹ Stotland's (1969) classic research on empathy using physiological measures had suggested that perspective instructions like these manipulate empathic emotional arousal. Coke et al. (1978), using a misattribution of arousal technique, had demonstrated that the prosocial consequences of perspective instructions like these are a result of their effect on physiological arousal, not of experimental demand or cognitive effects.

² Even though some people consider the term *AIDS victims* pejorative, we used it because our interest was in stereotypic, prejudicial beliefs and attitudes toward a stigmatized group, and this term, common in the media, seemed most clearly associated with these beliefs and attitudes.

2. Most people with AIDS could have avoided contracting the disease. (1 = *strongly disagree*, 9 = *strongly agree*)
3. How much do you personally care about the plight of people with AIDS? (1 = *not at all*, 9 = *very much*)
4. Our society does not do enough to help people with AIDS. (1 = *strongly disagree*, 9 = *strongly agree*)
5. Compared with other social problems we face today (e.g., crime, education, drugs, homelessness, environmental protection, energy conservation), how would you rate the importance of helping people with AIDS? (1 = *not at all important*, 9 = *extremely important*)
6. Our society should do more to protect the welfare of people with AIDS. (1 = *strongly disagree*, 9 = *strongly agree*)
7. In general, what are your feelings toward people with AIDS? (1 = *extremely negative*, 9 = *extremely positive*)

Items 1 and 2 were reversed in scoring, so that for each item larger numbers indicated a more positive attitude. For participants in the *narrow-group condition*, the questionnaire was entitled, "Attitude Questionnaire: Young Women with AIDS." It contained the same seven items, but for each item the phrase "people with AIDS" was replaced by "young women with AIDS." The experimenter remained unaware of which version of the attitude questionnaire each participant received.

Broadcast evaluation. Consistent with the cover story, the third questionnaire concerned evaluation of the pilot broadcast. It asked participants how interesting and worthwhile they thought the broadcast was and how likely they would be to listen to such a program.

Debriefing. After participants completed these three questionnaires, the experimenter returned and initiated an interview about reactions to the broadcast. This interview led to a careful probing for suspicion and then a full debriefing. In the course of the debriefing, participants in the victim-not-responsible condition were assured that current screening practices had virtually eliminated the possibility of contracting AIDS in the hospital from a transfusion of infected blood. Once participants were debriefed, they were thanked for their assistance and excused.

Results and Discussion

Effectiveness of the Empathy Manipulation

Even though they had heard exactly the same interview tapes, we assumed that participants in the high-empathy condition, who were asked to imagine Julie's feelings while listening, would experience more empathy for her than would participants in the low-empathy condition, who were asked to remain objective. We were also aware that among those induced to feel empathy, learning that Julie was to some degree responsible for her plight might lessen empathy.

We checked the effectiveness of the empathy manipulation by using participants' self-reports of emotional response after hearing the broadcast. As in previous research, responses to the six empathy adjectives were averaged to form an index of self-reported empathy (Cronbach's $\alpha = .92$). Mean score on the empathy index for participants in each cell of the 2 (empathy) \times 2 (victim responsibility) design are reported in Table 1.³

Consistent with expectations, scores on the empathy index were significantly higher in the high-empathy condition than in the low ($M_s = 5.30$ and 4.01 , respectively, on the 1–7 scale), $F(1, 92) = 26.39, p < .0005$. There was also a significant Empathy \times Responsibility interaction, $F(1, 92) = 5.00, p < .03$. Tests for simple main effects revealed that the effect of the

Table 1
Self-Reported Empathy: Experiment 1

Empathy condition	Responsibility condition	
	Victim not responsible	Victim responsible
Low	3.70	4.32
High	5.56	5.05

Note. $N = 24$ per cell. Response scale from 1 (*not at all empathic*) to 7 (*extremely empathic*). In the victim-not-responsible condition, participants learned that Julie had contracted AIDS in the hospital; in the victim-responsible condition, participants learned that she had contracted it through unprotected sex.

empathy manipulation in the victim-not-responsible condition was highly reliable, $t(92) = 5.21, p < .0001$; the effect in the victim-responsible condition was weaker but still reliable, $t(92) = 2.05, p < .05$.

This pattern of results suggested that the empathy manipulation was effective in inducing empathy in both the victim-not-responsible and the victim-responsible conditions, but its effect was stronger in the victim-not-responsible condition. As we had anticipated it might, learning that Julie had contracted AIDS through unsafe sex weakened the empathy induction. It seemed important to keep this qualifier in mind when interpreting attitude effects.

Effect of Experimental Manipulations on Attitudes Toward People With AIDS

To assess attitudes, we first created an index by averaging responses to the seven attitude items, with scores on the negatively worded items reversed (Cronbach's $\alpha = .78$ overall; .79 and .76 for participants expressing attitudes toward "people with AIDS" and "young women with AIDS," respectively). Mean response on this attitude index for participants in each cell of the 2 (empathy) \times 2 (victim responsibility) \times 2 (scope of group) design are reported in Table 2. Across the entire design, participants in the high-empathy condition reported more positive attitudes toward people with AIDS ($M = 6.93$ on the 1–9 scale) than did participants in the low-empathy condition ($M = 6.41$), $F(1, 88) = 5.10, p < .03$. This was the only significant main effect or interaction. As predicted, inducing

³ Scope of group was not included as a factor in Table 1 because this manipulation was not introduced until after empathy had been measured. It was not surprising that an analysis including scope of group as a factor revealed that it had no significant effect—main effect or interaction—on empathy; all $F_s < 2.30, p_s > .10$. We did not attempt to create indexes of vicarious personal distress or sadness in these experiments because previous research had indicated that, when learning via audiotape of a chronic need not involving physical suffering, participants often report being distressed and saddened for the target—an empathic response—rather than being directly distressed or saddened by the target's suffering (see Batson et al., 1988, 1991).

Table 2
Attitude Toward People With AIDS: Experiment 1

Empathy condition	Responsibility condition			
	Victim not responsible		Victim responsible	
	Broad group	Narrow group	Broad group	Narrow group
Low	6.38	6.33	6.62	6.30
High	7.10	7.11	7.43	6.08

Note. $N = 12$ per cell. Response scale from 1 (*extremely negative attitude*) to 9 (*extremely positive attitude*). In the victim-not-responsible condition participants learned that Julie had contracted AIDS in the hospital; in the victim-responsible condition, participants learned that she had contracted it through unprotected sex. The broad group was people with AIDS; the narrow group was young women with AIDS.

empathy for Julie produced more positive attitudes toward the stigmatized group of which she was a member.⁴

Even though no interactions were statistically reliable, a look at the cell means in Table 2 indicates that the empathy effect occurred in only three of the four Victim Responsibility \times Scope of Group conditions. The empathy effect disappeared when participants who learned that Julie had contracted AIDS through unprotected sex were asked to express their attitudes toward "young women with AIDS." In this condition, instructing participants to imagine how Julie felt about her plight produced a nonsignificant trend toward expression of less positive attitudes.

As previously suggested, some of our female participants may have found it threatening to think about young women with AIDS just after imagining the feelings of a young woman who had contracted AIDS through unprotected sex. If they too had engaged in unprotected sex, then their own potential to get the disease may have been made salient, increasing the personal threat and producing defensive distancing and derogation (Lerner, 1980; Novak & Lerner, 1968; Ryan, 1971; Walster, 1966), thereby reducing empathy. Recall that scores on the empathy index were somewhat lower in the high-empathy/victim-responsible condition, which might explain the less positive attitudes. Consistent with these suggestions, an internal analysis in which a median split on the empathy index was substituted for the empathy manipulation produced a consistent empathy main effect in all four Victim-Responsibility \times Scope-of-Group conditions, including the victim-responsible/narrow-group condition, $F(1, 88) = 5.37, p < .025$.

Empathic Feelings as Mediator of the Effect of the Empathy Manipulation on Attitudes

Having found that (a) our perspective-taking manipulation of empathy increased self-reported empathic feelings, (b) our empathy manipulation improved attitudes toward people with AIDS, and (c) self-reported empathic feelings were associated with improved attitudes, it was still important to test explicitly the predicted mediation. The empathy manipulation should affect attitudes through its effect on empathic feelings. Consistent with this prediction, a simple path analysis based on multiple

regression revealed that over 70% of the effect of the empathy manipulation on scores on the attitude index could be attributed to mediation by self-reported empathy. The direct effect of the empathy manipulation on attitudes (independent of its effect on self-reported empathy) did not approach statistical significance, $F(1, 87) = 1.53, p > .20$. These results indicated that the empathy effects of perspective taking improved attitudes, not direct cognitive effects or experimental demand (Orne, 1962).

Implications of Experiment 1

Overall, results of Experiment 1 were supportive of the hypothesis that inducing empathy for a member of a stigmatized group can improve attitudes toward the group as a whole. Experiment 1 was designed not only to test this hypothesis but also to explore several possible limits. Across the different experimental conditions included to test factors we thought might undermine it, the empathy-attitude effect seemed remarkably robust. Of the possible limiting conditions we considered, the only one for which we obtained any evidence was defensive derogation.

As an initial test of the effect of empathy on attitudes toward a stigmatized group, Experiment 1 was certainly encouraging. But several questions could be raised concerning the stigmatized group we studied—people with AIDS and, specifically, young women with AIDS. First, it is worth noting that our participants expressed relatively positive attitudes toward this group even in the low-empathy condition ($M = 6.41$ on a 1–9 scale). Whether this positivity is valid or is inflated by concerns for self-presentation and political correctness, we cannot be sure. Other researchers have reported that people with AIDS are stigmatized (e.g., Herek, 1990), leading us to suspect inflated positivity (as is common in ratings of many stigmatized groups, including racial and ethnic minorities).

Second, a young woman is not the stereotypic AIDS victim, regardless how she got the disease. Perhaps empathizing with such a victim changed participants' perceptions of people with AIDS by causing participants, when determining their attitudes, to weight more heavily their feelings about young women with AIDS, a subgroup for which they may have more positive attitudes than for the more typical men with AIDS. This possibility seemed relatively unlikely, given that participants' expressed

⁴ We assumed that the attitudes of participants in the high-empathy condition became more positive rather than that attitudes of participants in the low-empathy condition became more negative. To check this assumption, we collected data from 22 additional women from the same participant population, who had not listened to the interview with Julie. These women came to the laboratory to participate in a totally different experiment. Before beginning that experiment, they were asked "to complete a brief attitude questionnaire for a research project being done by a friend." All who were asked agreed. For 11 of the 22, the questionnaire they completed was the broad-group ("people with AIDS") version of the AIDS questionnaire; for the other 11, it was the narrow-group ("young women with AIDS") version. Mean response of these participants on the broad-group version was 6.36; mean response on the narrow-group version was 6.30. Supporting our assumption, these means closely matched the means for participants in the low-empathy condition of Experiment 1, which were 6.50 (broad group) and 6.32 (narrow group).

attitudes were as positive toward people with AIDS as toward young women with AIDS, but it could not be entirely ruled out.

To address these and similar concerns about the specific stigmatized group studied, we conducted a second experiment in which empathy was induced for a more typical member of a stigmatized group, a homeless man. We again manipulated victim responsibility but, given the typicality of a homeless man, assessing attitudes toward homeless men as well as the homeless in general seemed neither necessary nor appropriate. All participants were asked to express attitudes toward "the homeless." Both men and women undergraduates participated in Experiment 2.

Experiment 2: Attitudes Toward the Homeless

Paralleling Experiment 1, the basic prediction for Experiment 2 was that subsequent attitudes toward the homeless will be more positive in the high- than in the low-empathy condition. If, however, victim responsibility undercuts empathy, then this effect should be limited to participants in the victim-not-responsible condition. Alternatively, if participants in the victim-not-responsible condition subcategorize the target, then empathy should affect attitudes only in the victim-responsible condition. (If both processes occur, empathy should produce no effect.) We did not expect any defensive derogation in Experiment 2 because it seemed unlikely that undergraduates would feel personally vulnerable to homelessness.

Method

Participants

Participants were 46 introductory psychology students at the University of Kansas (18 men, 28 women) receiving credit toward a course requirement. Using a randomized-block procedure, we assigned 12 participants to three of the four cells of our 2 (empathy) \times 2 (victim responsibility) design and 10 to the fourth cell (low-empathy/victim-responsible). (The imbalance was due to experimenter error.) Insofar as possible, the proportion of men in each cell was kept constant, ranging from .33 (4 of 12) to .42 (5 of 12). On the basis of both indirect and direct probes during debriefing, we excluded data from 4 additional students (1 man in the high-empathy/victim-not-responsible condition, 1 woman in the low-empathy/victim-responsible condition, and 2 women in the high-empathy/victim-responsible condition) because they doubted the veracity of the audiotape that presented the homeless man.

Procedure

Participants were conducted through the procedure individually by a same-sex experimenter. On arrival, they were escorted into a research cubicle and given a written introduction that described a broadcast pilot-testing project similar to that in Experiment 1. This time, however, participants were to listen to a local homeless man describe his situation and need.

After participants read the introduction and signed a consent statement, the experimenter readied a tape player, noted that the homeless man they would hear was "Harold Mitchell" (actually fictitious), and placed a large envelope bearing Harold's name next to the tape player. The experimenter explained that the envelope contained three questionnaires that were to be completed once the tape ended. The experimenter also informed participants that if any background information was available on this particular homeless man, the envelope would contain a brief

background-information form. Participants were asked to read this form after listening to the tape but before completing the questionnaires. The experimenter then gave participants a sheet with listening-perspective instructions and left them alone to read these instructions, listen to the tape, read the background information, and complete the questionnaires.

Manipulation of empathy. Listening-perspective instructions to be objective or to imagine, like those used to create low-empathy and high-empathy conditions in Experiment 1, were used in Experiment 2. As before, the experimenter remained unaware of each participant's empathy condition.

Harold Mitchell, a homeless man. All participants heard exactly the same tape of "Harold" describing his life on the streets and in the shelter, his poverty and loneliness, his needs for clothing, food, a place to wash, friendship, and help in dealing with the agencies.

Manipulation of responsibility. When participants finished listening to the tape and opened the envelope, they found a background-information form. For those in the *victim-not-responsible condition*, the form read,

Harold Mitchell is 56 years old and has been in Lawrence for 4 months. He became homeless 3 years ago after losing his job because of an illness. His age and health problems have kept him from securing employment since then. He has no immediate family to assist him.

For those in the *victim-responsible condition*, the form instead read,

... He became homeless 3 years ago after he decided he was tired of working and quit his job. He has not tried to secure employment since then. He has no immediate family to assist him.

The form each participant received had been placed in the envelope in advance, allowing the experimenter to remain unaware of the victim-responsibility manipulation.

Measuring empathic feelings for Harold. After reading this form, participants completed three questionnaires. The first was exactly the same emotional response questionnaire used to assess empathy in Experiment 1.

Measuring attitudes toward the homeless. The second questionnaire assessed participants' attitudes toward the homeless. This was the dependent measure. It contained 9 items, 6 of which closely paralleled Items 1, 3, 4, 5, 6, and 7 used in Experiment 1, simply substituting "homeless people" or "the homeless" for "people with AIDS." The three new items were, (a) "Most homeless people just don't want to work." (b) "Most homeless people could get a job and get off the streets if they wanted to." (c) "Most homeless people choose to live that way." Anchors for all 3 items were 1 = *strongly disagree* to 9 = *strongly agree*. As for Experiment 1, negatively worded items were reversed in scoring, so that larger numbers always indicated more positive attitudes.

Broadcast evaluation and victim-responsibility manipulation check. Consistent with the cover story, the third questionnaire concerned evaluation of the broadcast. In Experiment 2 we added an item to this questionnaire to check the effectiveness of the victim-responsibility manipulation: "To what extent is this person responsible for his being homeless?" (1 = *not at all*, 9 = *very much*).

Debriefing. Once participants completed these questionnaires, they were probed for suspicion, fully and carefully debriefed, thanked for their assistance, and excused.

Results and Discussion

Effectiveness of the Empathy Manipulation

Even though all participants had heard exactly the same broadcast tape, we assumed that participants in the high-empa-

thy condition, who were asked to imagine Harold's feelings while listening, would experience more empathy for him than participants in the low-empathy condition, who were asked to remain objective. We were also aware that among those induced to feel empathy, learning that Harold was responsible for his plight might lessen empathy.

As in Experiment 1, we checked the effectiveness of the empathy manipulation using participants' self-reports of emotional response after hearing the broadcast. Once again, responses to the six empathy adjectives (*sympathetic, compassionate, soft-hearted, warm, tender, and moved*) were averaged to form an index of self-reported empathy (Cronbach's $\alpha = .93$). Mean score on this empathy index for participants in each cell of the 2 (empathy) \times 2 (victim responsibility) design are reported in Table 3.

Consistent with expectations, scores on the empathy index were significantly higher in the high-empathy condition than in the low ($M_s = 4.99$ and 3.40 , respectively, on the 1–7 scale), $F(1, 42) = 18.11, p < .0005$. The responsibility main effect and the Empathy \times Responsibility interaction were not significant. There were highly significant differences between low- and high-empathy conditions in both the victim-not-responsible and victim-responsible conditions (both $t_s > 3.00, p_s < .005$). We concluded that the empathy manipulation in Experiment 2 was effective and not qualified by victim responsibility. The cleaner empathy manipulation in Experiment 2 was likely due to clearer separation of the empathy-inducing tape and the victim-responsibility information.⁵

Effectiveness of the Victim-Responsibility Manipulation

We expected that participants who learned Harold was homeless because he got tired of working, quit, and had not looked for another job would consider him more responsible for being homeless than would participants who learned that he was homeless because of his advanced age and poor health. To check the effectiveness of this manipulation, participants were asked on the final evaluation questionnaire the extent to which they thought Harold was responsible for being homeless. As expected, participants in the victim-responsible condition rated

Table 3
Self-Reported Empathy: Experiment 2

Empathy condition	Responsibility condition			
	Victim not responsible		Victim responsible	
	Mean score	<i>n</i>	Mean score	<i>n</i>
Low	3.61	12	3.15	10
High	5.18	12	4.79	12

Note. The response scale anchors were from 1 (*not at all empathic*) to 7 (*extremely empathic*). In the victim-not-responsible condition, participants learned that Harold was homeless because he had lost his job because of illness; in the victim-responsible condition, participants learned that he was homeless because he had quit his job and had not sought another.

Table 4
Attitude Toward the Homeless: Experiment 2

Empathy condition	Responsibility condition			
	Victim not responsible		Victim responsible	
	Mean score	<i>n</i>	Mean score	<i>n</i>
Low	5.95	12	5.93	10
High	7.09	12	6.41	12

Note. The response scale anchors were from 1 (*extremely negative attitude*) to 9 (*extremely positive attitude*). In the victim-not-responsible condition, participants learned that Harold was homeless because he had lost his job because of illness; in the victim-responsible condition, participants learned that he was homeless because he had quit his job and had not sought another.

him as much more responsible than did participants in the victim-not-responsible condition ($M_s = 7.23$ and 3.17 , respectively, on the 1–9 scale), $F(1, 42) = 69.04, p < .0001$. Perceived responsibility was not affected by the empathy manipulation or the interaction (both $F_s < 1.0$). We concluded that the victim-responsibility manipulation was successful.

Effect of Experimental Manipulations on Attitudes Toward the Homeless

We created an index of attitudes toward the homeless by averaging responses to the nine attitude items, with scores on the negatively worded items reversed (Cronbach's $\alpha = .87$). Mean response on this attitude index for participants in each cell of the 2 (empathy) \times 2 (victim responsibility) design are reported in Table 4.

Participants who were led to empathize with homeless Harold reported more positive attitudes toward homeless people in general ($M = 6.75$ on the 1–9 scale) than did participants who were asked to remain objective ($M = 5.94$), $F(1, 42) = 5.03, p < .03$. Neither the responsibility main effect nor the interaction approached significance (both $F_s < 1.0$). As in Experiment 1, we also performed an internal analysis based on a median split on self-reported empathy. This analysis produced only one reliable effect, a main effect for empathy, $F(1, 42) = 18.01, p < .0005$ (other $F_s < 1.0$). Participants reporting relatively high empathy for Harold expressed more positive attitudes toward the homeless ($M = 7.00$) than did participants reporting low empathy for Harold ($M = 5.61$).

Empathic Feelings as Mediator of the Effect of the Empathy Manipulation on Attitudes

Once again, it was important to test explicitly the predicted mediation. As had been true for Experiment 1, a simple path

⁵ Preliminary analyses including sex of participant as a factor revealed no reliable sex effects, either main effects or interactions, on this or any other reported measures for either Experiment 2 or Experiment 3. Therefore, sex is not included as a factor in the reported analyses.

analysis based on multiple regression revealed that over 95% of the effect of the empathy manipulation on scores on the attitude index could be attributed to mediation by self-reported empathy. The direct effect of the empathy manipulation on attitudes (independent of its effect on self-reported empathy) did not approach significance, $F(1, 41) = 0.01, p > .50$.

Feelings Toward Harold

In addition to empathy for Harold inducing more positive attitudes toward the homeless in general, we were interested in explicitly testing the prediction from our three-step empathy-attitude model that the empathy manipulation would cause participants to feel more positively toward Harold, the specific homeless person whose appeal they heard (Step 2), which would in turn mediate the effect of empathy on attitudes toward the homeless in general (Step 3). To assess this prediction, in Experiment 2 we added an item to the evaluation questionnaire: "How positively do you feel toward this person?" (1 = *not at all*, 9 = *very*).

An analysis of variance (ANOVA) on responses to this item revealed two reliable main effects: one for empathy, $F(1, 42) = 8.51, p < .01$, and one for victim-responsibility, $F(1, 42) = 8.51, p < .01$ (identical means in the low-empathy/victim-not-responsible and high-empathy/victim-responsible cells accounted for the identical F values). The Empathy \times Responsibility interaction was not reliable, $F < 1.0$. Participants in the high-empathy condition felt more positively toward Harold ($M = 6.38$) than did participants in the low-empathy condition ($M = 5.27$); participants in the victim-not-responsible condition felt more positively toward him ($M = 6.38$) than did participants in the victim-responsible condition ($M = 5.27$).

The main effect for victim-responsibility indicated that, even though this manipulation had no reliable effect on participants' feelings toward the homeless in general, it did affect how they felt about the specific individual who was or was not responsible. The main effect for empathy indicated that inducing empathy led to more positive feelings toward the specific homeless individual, as it did toward the homeless in general. A simple path analysis based on multiple regression indicated that over 94% of the effect of the empathy manipulation on feelings toward Harold could be attributed to self-reported empathy; the direct effect of the empathy manipulation did not approach significance ($F < 1.0$). In contrast, less than 40% of the effect of the responsibility manipulation could be attributed to self-reported empathy; the direct effect of responsibility remained highly significant, $F(1, 41) = 7.08, p < .015$. A final path analysis indicated that over 91% of the effect of the empathy manipulation on attitudes could be attributed to mediation through feelings toward Harold; the direct effect of the empathy manipulation on attitudes did not approach significance ($F < 1.0$).

So, as predicted by our three-step model, inducing empathy for a homeless man (Step 1) led to more positive feelings toward that individual (Step 2), and these more positive feelings led to more positive attitudes toward the homeless as a group (Step 3). Victim responsibility affected feelings toward the individual but not toward the homeless as a group.

Implications of Experiments 1 and 2

Taken together, results of Experiments 1 and 2 provided encouraging initial support for the idea that inducing empathy for a member of a stigmatized group could improve attitudes toward the group as a whole. Still, questions remained.

First, as were the attitudes toward people with AIDS in Experiment 1, attitudes toward the homeless in Experiment 2 were somewhat positive even in the low-empathy condition ($M = 5.94$ on a 1–9 scale). Given the considerable evidence for negative attitudes in the society toward each of these groups, we suspect reports were inflated by concerns for positive self-presentation and political correctness. If, however, the reports were not inflated, and attitudes toward each of these groups are somewhat positive in the absence of empathy, then a question remains about the effect of empathy on attitudes toward a more clearly stigmatized group.

Second, a question also remains about the temporal durability of empathy-induced attitude change. In Experiments 1 and 2, we assessed attitudes within a few minutes of inducing empathy. Being emotions, empathic feelings are likely to be relatively short lived. Are the attitudinal effects equally short lived? If the effects are a function of an excitation transfer (Zillmann, 1978) or misattribution process (Schachter & Singer, 1962), then they likely are quite time bound.

Yet there is some evidence that the effects of empathy may be more enduring. Experiencing empathy has been found to lead to a change in valuing of the welfare of the person for whom empathy is felt, a change that endures even after the empathy is gone (Batson, Turk et al., 1995). In line with this evidence, we found in Experiment 2 that inducing empathy led to more positive feelings toward Harold and that those feelings mediated the effect of empathy on attitudes toward the homeless. Also, the finding by Clore and Jeffrey (1972) that an empathy-inducing role-playing experience had a significant effect on an indirect attitude measure taken 4 months later certainly suggests longevity. Still, it seemed important to test more directly the durability of empathy-induced attitude effects.

Experiment 3: Caring for Killers

In Experiment 3, we addressed these two concerns. First, we examined the effect of empathy on attitudes toward a highly stigmatized group, convicted murderers. Second, in addition to our usual procedure of assessing attitudes in the laboratory immediately after inducing empathy for a member of the group, we assessed attitudes 1 to 2 weeks later in a totally different context. This was done by having a young woman unassociated with the laboratory session conduct a telephone survey on students' attitudes toward prison reform, ostensibly as part of a class project. The only experimental manipulation in Experiment 3 was a perspective-taking manipulation of empathy because, by definition, murder involves premeditation and so responsibility for the crime. Paralleling predictions for Experiments 1 and 2, we predicted more positive attitudes toward convicted murderers in the high-empathy condition than in the low.

Method

Participants

Participants were 60 students (30 men, 30 women) in an introductory psychology course at the University of Kansas receiving credit toward a course requirement. Using a randomized-block procedure, 15 men and 15 women were assigned to each experimental condition (low empathy, high empathy). On the basis of both direct and indirect probes during debriefing, we excluded data from 2 additional students (both were women in the high-empathy condition) because they doubted the veracity of the audiotaped interview that presented the convicted murderer.

Procedure

Laboratory session. Participants were conducted through the laboratory session individually. On arrival, they were escorted into a research cubicle and given a written introduction that described a broadcast pilot-testing project similar to those in Experiments 1 and 2. This time, however, the pilots were for a new series, "Behind Bars," and participants were to listen to an interview with an individual from one of three quite different incarcerated groups: convicted murders serving life without parole, white-collar criminals serving up to 5-year sentences, and teenagers temporarily detained for minor offenses. Through a rigged drawing, all participants were assigned to hear an interview with a convicted murderer. The experimenter then readied a tape player, placed three reaction questionnaires face down on the desk to be completed after listening to the tape, and gave participants a sheet with listening-perspective instructions. The experimenter left participants alone to read these instructions, listen to the tape, and complete the reaction questionnaires.

Manipulation of empathy. Listening-perspective instructions to be objective or to imagine, like those used to create the low- and high-empathy conditions in Experiments 1 and 2, were used in Experiment 3. As before, the experimenter remained unaware of each participant's empathy condition.

James Stevens, a murderer serving life without parole. All participants heard exactly the same interview, ostensibly with a convicted murderer, James Stevens (actually fictitious). In the interview, James described a longstanding feud with his next-door neighbor, Paul Mitchell, how he shot and killed Paul, his arrest, his life in prison, and his feelings about it all:

James: . . . Pretty soon, things went from bad to worse. He'd dump garbage over the fence into my back yard. I sprayed red paint all over the side of his house. Then he set fire to my garage with my car in it. He knew that car was my pride and joy. I really loved it and kept it in great shape. By the time I woke up and they got the fire out, the car was ruined—totaled! And he just laughed! I went crazy—not yelling; I didn't say anything, but I was shaking so hard I could hardly stand up. I decided right then that he had to die. That night when he came home, I was waiting on his front porch with my hunting rifle. He laughed at me again and said I was chicken, that I didn't have the guts to do it. But I did. I shot him four times; he died right there on the porch. I was still standing there holding the rifle when the cops came.

Interviewer: Do you regret doing it?

James: Now? Sure. I know that murder is wrong and that nobody deserves to die like that, not even him. But at the time all I wanted was to make him pay—big—and to get him out of my life. (Pause) When I shot him, I felt this big sense of relief and release. I felt free. No anger; no fear; no hate. But that feeling lasted

only a minute or two. He was the one that was free; I was going to be in prison for the rest of my life. (Pause) And here I am. . . .

Measuring empathic feelings for James. After the interview, participants completed three questionnaires. The first was exactly the same emotional response questionnaire used to assess empathy in Experiments 1 and 2.

Measuring attitudes toward convicted murderers. The second questionnaire assessed participants' attitudes toward "people behind bars." To fit the cover story there were three parts to this questionnaire, one for each of the groups from which interviews were ostensibly being drawn: Part 1 assessed attitudes toward convicted murderers serving life without parole; Part 2, attitudes toward white-collar criminals serving up to 5 years; and Part 3, attitudes toward teenagers temporarily detained for minor offenses. Part 1 was the major dependent measure. Paralleling the attitude items in Experiments 1 and 2, it contained eight items designed to assess beliefs about, concern for, and feelings toward convicted murderers:

1. Convicted murderers have no one to blame but themselves for their troubles. (1 = *strongly disagree*, 9 = *strongly agree*)
2. Anyone who commits murder must be inhuman. (1 = *strongly disagree*, 9 = *strongly agree*)
3. Anyone who commits murder should be punished to the full limit the law allows for their crime. (1 = *strongly disagree*, 9 = *strongly agree*)
4. No one would commit murder unless he or she had a moral or mental deficiency. (1 = *strongly disagree*, 9 = *strongly agree*)
5. How much do you personally care about the plight of convicted murderers serving life without parole? (1 = *not at all*, 9 = *very much*)
6. Compared with other social problems we face today (e.g., homelessness, education, drugs, AIDS, environmental protection, energy conservation), how would you rate the importance of improving conditions for convicted murderers? (1 = *not at all important*, 9 = *extremely important*)
7. Our society should do more to rehabilitate and educate convicted murderers. (1 = *strongly disagree*, 9 = *strongly agree*)
8. In general, what are your feelings toward convicted murderers? (1 = *extremely negative*, 9 = *extremely positive*)

Items 1–4 were reversed in scoring, so that for each item larger numbers indicated a more positive attitude.

Broadcast evaluation. Consistent with the cover story, the third questionnaire concerned evaluation of the pilot broadcast. It asked participants how interesting and worthwhile they thought the broadcast was and how likely they would be to listen to such a program.

Debriefing. After participants completed these three questionnaires, they were probed for suspicion, informed that the interview they heard was fictitious, and told we were studying emotional and evaluative reactions to interviews with individual criminals (but not the specific hypothesis we were testing). Following debriefing, participants were thanked and excused.

Telephone interview. All participants were contacted by telephone 1 to 2 weeks after they had taken part in the laboratory session. The contact was made by an undergraduate woman who had prior experience in telemarketing but no knowledge of the hypothesis of the experiment or of the experimental conditions. On reaching a participant, she introduced herself and explained that she was "conducting a small survey for a class in current political issues," saying "I was wondering if I could ask you a few quick questions. . . ." If participants said they were

busy, she explained that it was important that they participate because they were part of a stratified sample carefully selected to represent the student population, and she asked if she could call back. All agreed to being contacted again and were, producing 100% participation in the telephone interviews. When participants agreed to be interviewed, the caller explained,

It is for a team project on prison reform, and my task is to do a small survey to find out what KU students think about this issue There is a proposal for allowing more freedom inside prisons, and increasing education and rehabilitation efforts to give prisoners an opportunity to make a useful contribution to society. So I would like to read you a few statements about this. Then you can give me your opinion about each using a 1–5 scale.

She then read the following five statements and recorded the participant's response to each.

1. Prisoners are already allowed too much freedom (visitation, time spent outside cell, TV, etc.). (1 = *strongly disagree*, 5 = *strongly agree*)
2. It is inhumane to make prisoners spend extended periods of time in a small room like a prison cell. (1 = *strongly disagree*, 5 = *strongly agree*)
3. Murderers should have the same rights and privileges as other criminals in the prison. (1 = *strongly disagree*, 5 = *strongly agree*)
4. Convicted murderers should not have any education and rehabilitation opportunities. (1 = *strongly disagree*, 5 = *strongly agree*)
5. In general, what are your feelings toward convicted murderers? (1 = *extremely negative*, 5 = *extremely positive*)

Once participants had answered the questions, they were thanked for their time, and the call was terminated. None of the participants indicated any awareness of the connection between the call and their prior laboratory experience, nor were they made aware of it.

Results and Discussion

Effectiveness of the Empathy Manipulation

Even though all participants had heard exactly the same interview, we assumed that those in the high-empathy condition, who were asked to imagine James's feelings while listening, would experience more empathy for him than would those in the low-empathy condition, who were asked to remain objective. As before, we checked the effectiveness of the empathy manipulation using participants' self-reports of emotional response after hearing the interview. Once again, responses to the six empathy adjectives (*sympathetic*, *compassionate*, *soft-hearted*, *warm*, *tender*, and *moved*) were averaged to form an index of self-reported empathy (Cronbach's $\alpha = .91$). Indicating the effectiveness of the manipulation, self-reported empathy was higher in the high-empathy condition ($M = 3.18$) than in the low-empathy condition ($M = 2.01$), $F(1, 58) = 14.75$, $p < .0005$. Note that these means are considerably lower than the means on the empathy index in Experiments 1 and 2 (see Tables 1 and 3). Predictably, participants were less likely to report empathy for a convicted murderer than for a young man with AIDS or a homeless man.

Effect of Empathy for James on Attitudes Toward Convicted Murderers: Laboratory Session

To assess attitudes toward convicted murderers in the laboratory session, we created an index by averaging responses to the eight attitude items, with scores on the negatively worded items reversed (Cronbach's $\alpha = .70$). Responses on this attitude index were lower in the low-empathy condition ($M = 4.20$ on the 1–9 scale) than the attitude responses had been in the low-empathy conditions of Experiments 1 and 2, suggesting that convicted murderers were indeed a negatively valued group.

Turning to our hypothesis, there was only limited support for an empathy–attitude effect in the laboratory session. Responses on the eight-item attitude index in the high-empathy condition ($M = 4.48$) were somewhat but not reliably higher than responses in the low-empathy condition, $F < 1.0$. Only on the last, general item, “In general, what are your feelings toward convicted murderers?” (1 = *extremely negative*, 9 = *extremely positive*), was there a significant difference between empathy conditions; participants in the high-empathy condition reported more positive feelings ($M = 3.33$) than did participants in the low-empathy condition ($M = 2.50$), $F(1, 58) = 4.93$, $p < .04$. Internal analyses provided more consistent support for an empathy–attitude relationship. Self-reported empathy for James as measured by the empathy index was positively correlated with scores on both the eight-item attitude index, $r(58) = .55$, $p < .0005$, and the last, general item, $r(58) = .46$, $p < .0005$. Using regression to test mediation, more than 90% of the effect of the empathy manipulation on the last, general item could be attributed to mediation through self-reported empathy; the direct effect did not approach significance, $F(1, 57) = 0.49$, $p > .50$.

Feelings Toward James

To assess feelings toward the specific convicted murderer participants heard, we asked on the evaluation questionnaire: “How positively do you feel toward the person who was interviewed?” (1 = *not at all*, 9 = *very*). Participants in neither condition felt especially positively toward James, but those in the high-empathy condition reported more positive feelings toward him ($M = 4.07$) than did those in the low-empathy condition ($M = 3.03$), $F(1, 58) = 6.71$, $p < .02$. Once again, using regression to test mediation, over 99% of the effect of the empathy manipulation on feelings for James could be attributed to mediation through self-reported empathy; the direct effect did not approach significance, $F(1, 57) = 0.06$, $p > .50$. This pattern was consistent with Step 2 of our three-step model. Over 88% of the effect of the empathy manipulation on the last, general attitude item (reported earlier) could be attributed to mediation through feelings for James; the direct effect did not approach significance, $F(1, 57) = 0.81$, $p > .35$. This pattern was consistent with Step 3 of our three-step model.

In sum, in the laboratory session the limited attitude effects of the empathy manipulation that we found were mediated by self-reported empathy and feelings for James, as predicted by our three-step empathy–attitude model. At the same time, the failure to find a reliable effect of the empathy manipulation on responses to the eight-item attitude index cast some doubt on the ability of perspective-taking induced empathy to improve

attitudes toward a highly stigmatized group such as convicted murderers.

Effect of Empathy for James on Attitudes Toward Convicted Murderers: 1–2 Weeks Later

To assess attitudes toward convicted murderers 1 to 2 weeks later, we created an index by averaging responses to the five attitude items from the telephone interview, with scores on the negatively worded items reversed (Cronbach's $\alpha = .78$). To facilitate comparison of responses on this index, which used a 1–5 response scale, with responses to our other attitude measures, which used 1–9 response scales, we multiplied scores on this index by 9/5. Consistent with predictions of our empathy–attitude model, responses on this delayed attitude measure were significantly more positive in the high-empathy condition ($M = 5.42$) than in the low-empathy condition ($M = 4.68$), $F(1, 58) = 5.11, p < .03$. There was also a significant difference between empathy conditions on the last, general item: “In general, what are your feelings toward convicted murderers?” Participants in the high-empathy condition reported more positive feelings ($M = 4.32$) than did participants in the low-empathy condition ($M = 3.24$), $F(1, 58) = 6.81, p < .02$. Means for each empathy condition on the eight-item attitude index used in the laboratory session and on the five-item attitude index used in the telephone interview (adjusted to a 1–9 scale) are presented in Table 5.

Self-reported empathy and feelings toward James, each measured in the laboratory session, were both significantly positively correlated with scores on the five-item attitude index, both $rs(58) = .36, p < .01$. (Predictably, the correlations after the 1–2 week delay were not as strong as correlations with the 8-item attitude index used in the laboratory session.) Regression analyses testing mediation replicated the findings of Experiment 2. Over 75% of the effect of the empathy manipulation on attitudes 1 to 2 weeks later could be attributed to mediation through self-reported empathy; the direct effect did not approach significance, $F(1, 57) = 1.28, p > .25$. Over 60% of the same effect could be attributed to mediation through feelings for James; once again, the direct effect did not approach significance, $F(1, 57) = 2.12, p > .15$.

Table 5
Attitude Toward Murderers in Experiment 3: At Laboratory Session and in Telephone Interview 1–2 Weeks Later

Empathy condition	Time of measurement of attitudes	
	Laboratory session	Telephone interview
Low	4.20	4.68
High	4.48	5.42

Note. $N = 30$ (15 men, 15 women) in each empathy condition. Laboratory session response scale anchors were from 1 (*extremely negative attitude*) to 9 (*extremely positive attitude*). To permit easy comparison, telephone interview responses were transformed from a 1 (*negative attitude*) to 5 (*positive attitude*) scale to a 1–9 scale by multiplying scores by 9/5.

Implications of Experiment 3

Certainly the most striking result of Experiment 3 is that, although there was only limited evidence of an effect of inducing empathy for a convicted murderer on attitudes toward murderers measured immediately, there was clear evidence of an effect 1 to 2 weeks later. Although one might argue that this result was due to differences between the two attitude measures, that seems unlikely. The telephone interview measure had fewer items and a more restricted response scale, and its items seemed no more relevant. Rather, analogous to the sleeper effect sometimes found in persuasion research (Hovland & Weiss, 1951; Pratkanis, Greenwald, Leippe, & Baumgardner, 1988), participants in Experiment 3 seemed to resist letting their empathy-induced feelings for James influence their attitudes toward convicted murderers measured immediately, when they were aware of the influence. Later, with their guard down, the effect on their attitudes showed through. In the laboratory, they took the first two steps in our three-step model but balked at the third; 1 to 2 weeks later, they had taken the third.

Like the results reported by Clore and Jeffrey (1972), our finding that an empathy-inducing listening perspective improved attitudes toward convicted murderers 1 to 2 weeks later suggests that the empathy–attitude effect is not as short-lived as we had feared. Apparently, it can outlive the empathic emotion itself.

Results of Experiment 3 also seemed effectively to lay to rest any lingering concerns about the attitude effects of empathy being a result of experimental demand (Orne, 1962). A demand explanation would predict positive attitude change in the laboratory session and no effect in the unrelated telephone interview 1–2 weeks later; we found just the opposite.

The other major implication of Experiment 3 is that the empathy–attitude effect does not seem to be limited to improving attitudes toward groups that are already somewhat positively valued. We attempted to change attitudes toward convicted murderers not because this is a group toward which many people feel attitudes should be improved but precisely because it is not such a group. As expected, attitudes in the low-empathy condition were on the negative end of the scale (although, once again, we suspect there may have been some inflation). Initially, there was only limited evidence that inducing empathy improved attitudes; over time, however, there was a clear effect. So it does seem possible to use empathy to improve attitudes toward a highly stigmatized group.

This is not to say that there are no limits on the groups toward which attitudes can be changed. We doubt that attempts to induce empathy toward unrepentant child or animal abusers or toward rapists would meet with much success; indeed, we hope they would not. To the extent that this failure is due to the inability to induce empathy for these individuals, such a limit would still be entirely consistent with the claim that empathy can improve attitudes. The limit would be on the conditions under which it is possible to induce empathy, not on the attitude effects once empathy is induced.

General Discussion

Across three experiments, empathy led to more positive attitudes toward a stigmatized group: people with AIDS (Experi-

ment 1), the homeless (Experiment 2), and convicted murderers (Experiment 3). Moreover, it did so (a) for men as well as women (Experiments 2 and 3) and (b) regardless of whether the person for whom empathy was induced was or was not responsible for his or her plight (Experiments 1 and 2).

Of the possible limiting conditions considered, the only one for which we found any evidence was defensive derogation. Those young women in Experiment 1 who (a) were induced to imagine the feelings of a young woman with AIDS and (b) subsequently learned that she had contracted AIDS through unprotected sex, expressed somewhat more negative attitudes toward young women with AIDS than did similar participants not induced to imagine the young woman's feelings. A possible source of this difference seemed to be the inhibition of induced empathy in this condition. Because our primary concern in the present research was to test the effectiveness of empathy in inducing positive attitude change toward stigmatized groups broadly conceived, we did not follow up on the possibility of defensive derogation. It does, however, seem worth further research.

Two conceptual implications of the present evidence for an empathy-attitude relationship deserve specific comment. First, we found that it was possible to evoke empathy for a victim who was responsible for his or her own plight if the empathy induction occurred before participants learned about victim responsibility. Weiner and his colleagues (Betancourt, 1990; Weiner, 1980; Weiner et al., 1988) have found that learning about victim responsibility before an empathy induction strongly inhibits empathic emotions. Our results suggest that once empathic emotions are aroused, they are less vulnerable to information about victim responsibility. Once aroused, empathic feelings appear to have some inertia.

Second, our emotion-based approach to attitude change did not seem vulnerable to the subcategorization effects that often plague cognitive approaches, such as learning stereotype-inconsistent information about an individual group member (Brewer, 1988). In each of our experiments, low-empathy and high-empathy participants received exactly the same information about the stigmatized group member, so stimulus properties could not account for observed attitude differences. Following Brewer's (1988) dual-process cognitive model, one might assume that our high-empathy listening perspective led participants to shift from category-based, top-down processing to personalized, bottom-up processing. But in Brewer's model, the personalized impression formed by imagining an individual group member's feelings should be dissociated from and have no effect on impressions of the group as a whole: "Personalization involves, in effect, a 'decategorization' of the target individual and reduces the probability that experience with that individual will be generalized in any form to more inclusive social categories" (Brewer, 1988, p. 27).

In contrast, our results indicate that positive empathic feelings induced for an individual stigmatized group member generalize to the group as a whole. Whether this occurs because the target of empathy is salient and becomes a prototype for the group as a whole or because there is less person-category discrimination in the affective domain than in the cognitive domain, we cannot say. But we found no evidence that personalization eliminated generalization of empathically induced positive feelings to the

group as a whole. This could be an important advantage of an empathy-based emotional approach over an information-based cognitive approach to improving attitudes toward stigmatized groups.

As noted at the outset, attitudes toward stigmatized groups are notoriously hard to change. Cognitive strategies based on providing positive information about the group show only limited effects (Rothbart & John, 1985; Weber & Crocker, 1983); behavioral strategies based on cooperative, equal-status, personal contact show positive effects under certain conditions, but such contact is often difficult to initiate and orchestrate (Aronson et al., 1978; Brewer & Miller, 1984; Cook, 1985; Wilder & Shapiro, 1989). Perhaps an emotional strategy based on empathy can add a new arrow to our quiver. This arrow, used either alone or in concert with cognitive and behavioral strategies, may enable us better to hit the elusive target of improving attitudes toward the stigmatized.

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