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1. Definition of Empathy

Empathy has been defined in two ways: (a) the cognitive awareness of another person’s internal states (thoughts, feelings, perceptions, intentions); (b) the vicarious affective response to another person. This chapter deals with affective empathy, because of its motive properties (see Ickes 1997 for cognitive empathy).

Affective empathy was initially defined as a match between the observer’s and the model’s feeling. It is now defined as it is here, more in terms of the processes that make an observer’s feelings congruent with the model’s situation not his own (Hoffman 1978, 2000). There may be a match, but not necessarily as when one feels empathic anger on seeing someone attacked even when the victim feels sad or disappointed rather than angry. Most of the research on affective empathy as a prosocial motive focuses on empathic distress because prosocial moral action usually involves helping someone in discomfort, pain, danger, poverty, and the like.

2. Modes of Empathic Arousal

Five empathy-arousal modes have been identified (Hoffman 1978). Three are primitive, automatic, and preverbal. (a) Mimicry, which has two steps: one spontaneously imitates another’s facial, vocal, or postural expressions of feeling, producing changes in one’s own facial or postural musculature; these changes trigger afferent feedback to the brain, which results in feelings that resemble the other’s feelings. (b) Classical conditioning, in which empathic distress becomes a conditioned response to distress in others through observing others in distress at the same time that one is in actual distress. (c) Direct association of cues from others or their situation with one’s own painful past experience. The empathy aroused by these three modes is passive, involuntary, based on the pull of surface cues, and requires little cognitive processing. Nevertheless, these modes are important because (a) they show that a person’s distress can indeed result from someone else’s painful experience; (b) they make empathy arousal possible in the early preverbal years of childhood; and (c) they give empathy an involuntary dimension throughout life.

Two empathy-arousing modes are higher order cognitive. (a) Verbally mediated association: language communicates the other’s distress and connects the other’s situation to one’s own painful past experience. (b) Perspective-taking: one feels something of the victim’s distress by imagining directly how the victim feels by using information one has about him or her. These higher order cognitive modes may be drawn out over time and subject to voluntary control, but they may also be triggered immediately on witnessing another’s distress. What they contribute to
empathy is scope; they also allow one to empathize with others who are not present.

Multiple modes are important because they enable observers to respond empathically to whatever distress cues are available (Hoffman 2000). Cues from the victim’s face, voice, or posture can be picked up through mimicry, situational cues, through conditioning or association. If a victim expresses distress verbally or in writing, or someone else describes the victim’s situation, one can empathize through verbally mediated association or perspective-taking. Empathic distress is thus a multidetermined hence reliable human response, which fits the argument that it survived natural selection and has a hereditary component (Hoffman 1981, Zahn-Waxler et al. 1992).

3. **Developmental Stages**

Mature empathy has a metacognitive dimension: one knows one’s feeling of distress results from another’s plight and how the other presumably feels. One thus has a sense of oneself and others as separate beings with independent inner states (that are only partly reflected in outward behavior), separate identities, and separate life conditions. Before 6 or 7 years children can empathize but without this metacognitive dimension. This suggests that empathic affect develops along with cognitive self/other development. Five stages of empathy development have been hypothesized (Hoffman 1978, 2000).

(a) **Global empathic distress**: newborns show a vigorous, agitated distress response to another infant’s cry. (b) **Egocentric empathic distress**: one responds to another’s distress as though oneself were in distress. This occurs when children can be empathically aroused by the three preverbal modes but still lack a clear self-/other distinction. (c) **Quasiegocentric empathic distress**: one knows the other is in actual distress but confuses the other’s inner states with one’s own and tries to help by doing for the other what would comfort oneself. (d) **Veridical empathic distress**: one’s feeling is closer to the other’s because one realizes the other has inner states independent of one’s own. (e) **Empathy for another’s experience beyond the immediate situation (e.g., chronic illness, economic hardship, deprivation)**: this high empathy level is possible when children realize that others have an identity and a generally sad or happy life condition; and empathy with an entire group (homeless; Oklahoma City bombing victims).

4. **Causal Attribution’s Shaping of Empathic Affect**

Humans spontaneously attribute causality to events (Weiner 1985) and they presumably do this when witnessing someone in distress. If they blame the victim, empathic distress is of course reduced. Otherwise, depending on the attribution, empathic affect may be shaped into four empathy-based moral affects (Hoffman 2000). (a) **Sympathetic distress**, when the cause is beyond the victim’s control (illness, accident, loss). (b) **Empathic anger**, when someone else is the cause. (c) **Empathic feeling of injustice**, when a discrepancy exists between the victim’s character and the victim’s fate (a good person fares badly). (d) Empathy-based guilt over inaction, when one does not help or one’s efforts to help fail and the victim’s distress continues; here one’s empathic distress combines with blaming oneself not for causing the victim’s distress but allowing it to continue.

5. **Empathy as a Prosocial Motive**

Empathy correlates positively with helping. There is also experimental evidence that arousal of empathic distress leads to helping; and that observers help more quickly the greater the victims’ pain and the higher the observers’ empathic distress. Furthermore, observers’ empathic distress becomes less intense and they feel better if they help, but not if they don’t help or if despite their best efforts and through no fault of their own, the victim’s distress is not alleviated, which implies that the main objective of empathy-based helping is to alleviate the victim’s distress. There is also evidence that empathy reduces both aggressive and manipulative (Machiavellian) behavior. It thus seems clear that empathic distress is a prosocial motive. See reviews by Hoffman (1978, 2000) and Eisenberg and Miller (1987).

Empathy has limitations, however (Hoffman 1984, 2000). (a) Egoistic motives may intervene and one may not help, even at the price of feeling guilty afterwards. (b) **Empathic distress increases with the level of victims’ distress**, but empathic distress can become aversive enough to shift one’s attention from the victim’s to one’s own personal distress (empathic overarousal). (c) **People empathize with almost anyone in distress** (the victims in research are usually strangers), but they empathize more with kin, in-group members, friends, and people who share their personal concerns (familiarity bias)—which may not be a problem except when intergroup rivalry contributes to intense empathic anger (hatred, ethnic cleansing) toward outgroup members. (d) **People empathize more with victims who are physically present (here-and-now bias), probably because most empathy-arousing processes require immediate situational and personal cues.**

6. **Socialization by Parents and Peers**

The role of parent as socializer has three facets: model, disciplinarian, nurturer. Each contributes to children’s empathy and prosocial behavior, although discipline has been the most studied (Hoffman 2000). The
discipline method most likely to contribute to empathy, helping, and guilt over harming others is a type of reasoning called induction, often used by educated middle-class American parents when children harm or are about to harm someone. Inductions direct the child’s attention to the victim’s distress and may thus engage the empathy-arousing modes noted above. They also highlight the child’s role in causing the victim’s distress, which may lead to empathy-based transgression guilt. Power-assertive disciplines (physical force, threats, commands) are associated with low empathy, low helping, and low guilt, although some power assertion may be needed at times to get children to attend and process an induction’s message.

Parents’ behavior outside discipline encounters may provide prosocial models that reinforce children’s empathic proclivity and legitimize helping (Eisenberg and Fabes 1998, Hoffman 2000). Examples are expressing compassion toward people in difficult straights such as the homeless; linking a television protagonist’s feelings or situations with the child’s own experience; pointing out similarities among all humans such as sadness due to separation and loss. Parent models may thus reinforce children’s empathic dispositions especially when they are bystanders and someone needs help. Parent models may also make children more receptive to inductions, and, along with inductions, make children more receptive to claims of their peers (Hoffman 2000).

Piaget suggested in the 1930s that interaction with peers (not parents, who are too powerful) fosters prosocial moral development in children (Piaget 1932). Cognitive-developmental psychologists have recently elaborated this view (Turiel 1998), briefly as follows: children ‘co-construct’ and discover moral norms in the give-and-take of peer interaction (disputes, arguments, negotiations). These peer conflicts put pressure on children to take different points of view and to consider and coordinate the needs and rights of self and others (for example, regarding claims to ownership and possession of objects). This is a compelling hypothesis that merits research. Hoffman (2000) suggests that the peer interaction processes involved can serve to add the finishing touches to the prosocial outcomes of having inductive, nurturant, prosocial models as parents.

7. The Role of Cognition

Though we deal with empathic affect, cognition’s importance is evident in two empathy arousal processes (verbally mediated association and perspective-taking), in the key role of self/other differentiation in empathy development; in the production of empathic anger and empathy-based guilt through causal attribution; and in children processing the information in inductions. Beyond that, cognitive development enables humans to form images, represent people and events, and imagine themselves in another’s place; and because represented people and events can evoke affect, victims need not be present for empathy to be aroused in observers. Empathy can be aroused when observers imagine or read about victims, discuss or argue about economic or political issues that involve victims, or make moral judgments about hypothetical moral dilemmas (see Moral Reasoning in Psychology) in which there are victims. See Hoffman (1987, 2000) for discussion of the importance of cognition, including the cognitive dimension of moral principles, in empathy’s development and prosocial functioning.

8. Gender Differences

Girls are socialized more than boys to be kind and feel responsible for others’ well-being. Girls are thus expected, increasingly with age, to be more empathic and prosocial and less likely to harm others. The research supports these expectations but in varying degrees (Eisenberg and Fabes 1998). Girls show more kindness and consideration for others and, to a lesser extent, are more likely to help and share. They are less likely to harm others and more apt to feel guilty when they do. They are also more empathic than boys, but this is clear only with self-report, especially questionnaire measures, in which it is obvious what is being assessed and responses are under the subject’s control. It is not clear with unobtrusive naturalistic observations or physiological indices of empathy. The empathy findings may thus reflect subjects’ conceptions of what boys and girls are supposed to be like. Whether they reflect gender differences in actual behavior is a matter for future research to decide.

See also: Adulthood: Prosocial Behavior and Empathy; Altruism and Prosocial Behavior; Sociology of; Antisocial Behavior in Childhood and Adolescence; Moral Reasoning in Psychology; Social Cognition and Affect, Psychology of; Social Support, Psychology of

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Prosopagnosia

Prosopagnosia is a neuropsychological condition involving loss of ability to recognize familiar faces. Prosopagnosic patients instead rely on voice, context, name, or sometimes clothing or gait to achieve recognition of people they know. The problem in face recognition is not due to blindness (the person with prosopagnosia can still see) or general intellectual impairment (people are still recognized from nonfacial cues). Yet even the most familiar faces may go unrecognized: famous people, friends, family, and the person’s own face when seen in a mirror.

Face recognition impairments are socially disabling, and most patients develop strategies for tackling the problem. They may note carefully what clothes someone is wearing, ask relatives always to wear a particular distinctive item, or become adept at initiating or maintaining a conversation whilst they work out who they are talking to. These strategies are not completely effective. One prosopagnosic patient lost a legal action when he discussed his case with his opponent’s lawyer—he thought it was his own advocate because he was wearing similar court clothes.

Prosopagnosia should not be confused with other types of impairment that can compromise face recognition (Young 1992). In prosopagnosia, recognition from other cues than the face is usually possible. In contrast, cases of inability to recognize people from face, voice, and name have been described—these seem to reflect loss of semantic information about the identities of individuals. There are also reports of problems of name retrieval (anomia), in which familiar people are successfully recognized and appropriate semantic information is accessed, but their names cannot be recalled. Face recognition impairments therefore reflect damage to an underlying system which can break down in different ways.

Although reports of problems affecting face recognition after brain injury can be traced back to the nineteenth century, prosopagnosia was identified as a distinct neuropsychological problem by Bodamer in 1947 (Ellis and Florence 1990). Whilst it is generally considered a rare deficit, there are now several hundred case descriptions in the literature. These include cases where brain injury early or late in life has led to inability to recognize previously familiar faces, and developmental cases where the disorder is present from birth. People with prosopagnosia know when they are looking at a face, and can describe its features, but the loss of any sense of overt recognition is often complete, with no feeling of familiarity. In contrast, other aspects of face processing, such as the ability to interpret facial expressions, or to match views of unfamiliar faces, can remain remarkably intact in some (though not all) cases. The ability to recognize everyday objects other than faces may also remain good, and many prosopagnosic patients are able to read without difficulty. In one of the cases of early acquired deficit, a child who had remained unable to recognize any faces since suffering meningitis and subsequent complications in infancy was nonetheless able to learn to read (Young and Ellis 1989); this underlines the implication that reading and face recognition depend on different types of visual analysis.

Deficits commonly associated with prosopagnosia include a visual field defect in the left upper quadrant, achromatopsia (loss of color vision), and topographical disorders (inability to find one’s way about). These are useful clinical pointers, but they are thought to be due to anatomical proximity of otherwise unrelated processes rather than having any direct functional significance; cases of prosopagnosia without each of these associated deficits have been described, and they have also each been reported in the absence of prosopagnosia.

Studies of prosopagnosia initially concentrated on the location of the lesions responsible, and to what extent the problem is specific to face recognition. More recent work has asked whether there exist different underlying forms of deficit, and has explored the implications of findings of covert recognition.

1. Lesions Causing Prosopagnosia

The underlying pathology involves lesions affecting ventromedial regions of occipitotemporal cortex; these include the lingual, fusiform, and parahippocampal