A. Name of Instrument: Interpersonal Reactivity Index (IRI)


C. Brief Description / Purpose: The IRI measures four different dimensions of dispositional empathy:

1) The Empathic Concern subscale assesses emotional empathy, or feelings of compassion for others in distress (e.g. “I often have tender, concerned feelings for people less fortunate than me.”)
2) The Perspective Taking subscale assesses cognitive empathy, or the tendency to see the world from others’ viewpoints (e.g. “I sometimes try to understand my friends better by imagining how things look from their perspective.”)
3) The Personal Distress subscale assesses self-focused responses to others’ suffering (e.g. “When I see someone who badly needs help in an emergency, I go to pieces.”)
4) The Fantasy subscale assesses empathy for fictional characters (e.g. “I really get involved with the feelings of the characters in a novel.”)

These subscales should be used separately since the instrument is not intended to measure overall empathy. In fact, if researchers are only interested in one particular subscale it would be appropriate for them to only use that one. The first three are most relevant to medical settings, with better interpersonal (e.g. prosocial behavior) and intrapersonal (e.g. mental well-being) implications associated with the other-oriented subscales (Empathic Concern and Perspective Taking) compared to the self-oriented one (Personal Distress).[1,2]

The IRI was originally validated in college student populations but has been widely used across many populations, including medical professionals. It is a 28-item self-report questionnaire that can be administered via paper-and-pencil or online surveys. Nine items are reverse-scored (see IRI instrument). It uses a 5-item Likert scale with two anchors (A=Does not describe me well; E=Describes me very well).

D. Development and Psychometrics: The IRI covers multiple dimensions of empathy, rather than assessing global empathy. Thus, each subscale should be examined separately in analyses. The instrument does not come with a set of norms nor does it have cut-off scores. It is intended to be used as a continuous measure of empathy-related dimensions in normal populations, rather than as a categorical measure (“high empathy” versus “low empathy”). Table 1 describes the original validation studies and Table 2 gives average scores of US general adult populations and college students.

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<th>Mean scores*</th>
<th>Psychometric concept tested</th>
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<td>Original scale development paper[^3]</td>
<td>Study 3: 28 item version of scale N=1161 college students; 50.1% female</td>
<td>EC: Males: 3.72 Females: 4.10 PT: Males: 3.40 Females: 3.57 FS: Males: 3.25 Females: 3.68 PD: Males: 2.35 Females: 2.75</td>
<td>Factor structure: Four factors confirmed</td>
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themselves subsequently report medical errors responsive to interventions medical students’ perspective declines during medical training is still being debated. finds that Scale of Physician Empathy physicians one additional factor, “involvement,” has been found besides the typical four16. The commonly used Jefferson Scale of Physician Empathy is correlated with the EC, PT, and FS subscales, but not PD.17 Moreover, some research finds that scores on the EC and PD subscales decline during medical training,18 although the issue of whether empathy declines during medical training is still being debated.19,20 One interesting study found that there was an increase in medical students’ perspective-taking scores after a medical humanities course, demonstrating that the PT subscale is responsive to interventions.21 Other studies find that medical residents who have lower PT and EC are more likely to subsequently report medical errors,22 and higher PT is also associated with increased well-being for the physicians themselves.23

Table 2. Mean scores for American college students and adults

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<th>Instrument details</th>
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<td>Empathic Concern (EC) and Perspective Taking (PT) subscales14</td>
<td>General Social Survey (GSS: 2002 and 2004 combined): Nationally representative US adult N=2,694; 52.9% Female -Mean age = 46.29 -80.3% White -13.1% African-American (AA) -6.6% Other Online: General US adult N=81,754; 42.6% Female -Mean age = 38.56 -86.1% White -2.2% AA -6.0% Asian -2.1% Hispanic -2.8% Other</td>
<td>GSS: EC overall: 3.99 (0.70) Males: 3.81 (0.68) Females: 4.15 (0.67) Online: EC overall: 3.77 (0.78) Males: 3.56 (0.80) Females: 4.06 (0.64) PT overall: 3.66 (0.75) Males: 3.58 (0.77) Females: 3.77 (0.69)</td>
<td>We examined age-related changes in empathy, finding a curvilinear relationship: middle-aged adult females have the highest EC and PT in US.</td>
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<td>All four subscales15</td>
<td>US college students N=13,737; 63.1% Female -Mean age = 20.3 -67.0% White</td>
<td>EC: 3.80 (0.65) PT: 3.46 (0.68) FS: 3.45 (0.80) PD: 2.66 (0.71)</td>
<td>We examined changes over time in empathy, finding that Empathic Concern and Perspective Taking scores declined from 1980 to 2009.</td>
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*Converted to 1-5 Likert scale from summed scores. No overall means were provided.

E. Additional Studies Reporting Validity Evidence: The IRI has been widely used in a variety of populations and has been validated in several languages including Chinese,5 Dutch,6 French,7 German,8 Italian,9 Japanese,10 Korean,11 Spanish,12 and Swedish.13 The IRI was in the General Social Survey (GSS), a nationally representative sample of American adults, for two years. Average scores from the GSS, a large general adult online sample, and a sample of American college students are reported in Table 2. These can give readers an idea of typical score ranges.

F. Application to Health Sciences Education and / or Health Sciences Education Research: The IRI has been widely used within health and medical fields, on a variety of populations (e.g. medical students, residents, physicians, nurses, dentists), with a number of interesting findings that demonstrate its validity and utility within these settings. Within physicians one additional factor, “involvement,” has been found besides the typical four16.
There are a number of potential uses of the IRI within a medical school setting. For example, it could be used to screen prospective medical students, since normative data are available (Table 2). The IRI could also be used to better understand the pedagogical needs of medical students, since more empathic people are more responsive to emotionally evocative information and situations than less empathic people.\(^\text{24, 25}\) It could also be used to track medical students throughout medical school to examine changes within students across time, and perhaps make adjustments to curricula based on these results. Finally, the IRI could be administered to students before and after educational interventions to examine their efficacy.

G. Commentary: The IRI has good psychometric properties and is recommended for use in a variety of populations. There are some important points of consideration when using this scale.

1) The self-report nature of the scale makes it susceptible to social desirability and self-perception biases, especially for the EC and PT subscales.\(^\text{26}\) Yet there are correlations between IRI self-reports and observer ratings (e.g. sibling, friend) of empathy\(^\text{27}\). In addition, EC scores are correlated with prosocial behavioral outcomes, further validating the IRI, and especially the EC subscale \(^\text{28, 29}\).

2) Items in the EC subscale assess empathy for other’s suffering, rather than a more general process of feeling what others are feeling, which could allow for feelings of empathic joy and other positive emotions.

3) The IRI measures dispositional, or trait-based, empathy, which means that it assesses people’s chronic tendencies to empathize. Yet, the PT subscale is less heritable, and therefore, more changeable and responsive to interventions than the other subscales.\(^\text{30}\) This instrument would not be appropriate if researchers were interested in situational empathy, which involves immediate emotional responses to others’ situations (e.g. feelings of compassion, tenderness, and warmth).\(^\text{31}\)

4) The target of empathy is not consistent across the items. For example, in the EC subscale, the target of empathy is a general needy other, but in the PT subscale, the target varies from an abstract other to specific individuals (e.g. friends).

Yet despite these considerations, the IRI’s two main advantages are its excellent psychometric properties and its multidimensional approach. The multidimensional nature of the scale gives researchers and practitioners the flexibility to use the subscales that are most relevant to their project, since the different forms of empathy have different correlates and consequences.

H. Additional Citations:
3. Davis MH. A multidimensional approach to individual differences in empathy. JSAS Catalog of Selected Documents in Psychology1980;10(85).

I. Author’s Information:
Sara Konrath, PhD
Director, Interdisciplinary Program for Empathy and Altruism Research (iPEAR)
Assistant Professor, Institute for Social Research, University of Michigan
Adjunct Assistant Professor, Psychiatry Department, University of Rochester Medical Center
426 Thompson Street
Ann Arbor, MI 48104
Office phone: 734-763-1512
Email: skonrath@umich.edu