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The Relationships among Moral Judgement, Social Identification, and Stigmitization

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THE RELATIONSHIPS AMONG MORAL JUDGEMENT, SOCIAL

IDENTIFICATION, AND STIGMATIZATION

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By

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I would like to dedicate this thesis to my family, who endlessly support me in all of my endeavors. To my friends, Meg and Grace, who listened patiently to my excitement and frustration at every stage of this process. Finally, to my roommate Emily, who has worn a number of hats to help me in finishing this project.

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ABSTRACT

Stigma has had a perceived link with the concept of morality since the Grecian era (Goffman, 1963). The purpose of this study was to see if there was a correlation between moral judgement (using the Defining Issues Test 2; DIT2), social identification (using the Identification with all Humanity Scale; IWAHS) and stigma attributions toward those with mental illness. Specifically, whether those with a heightened sense of identification with all humanity and more developed moral judgement schemas are less likely to make negative stigma attributions toward persons with mental illness. The results this study supported correlations between those variables and the attribution variables of Pity, Segregation, Anger, Help, Avoidance, Fear, and Coercion. In regression analysis, the results supported that the IWAHS could predict coercion and segregation. There was also support in those regression analyses that certain demographic variables can act as a predictor of Pity, Help, and Avoidance attributions.

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The structure of society is built on the norms that the society has accepted. These norms can be fluid and may change as the society does; however, what does not change is that deviations from the accepted norms are stigmatized and punished. While the degree to which this occurs may vary depending on how grievous the perceived violation is, there are many cases where the offender has no control over whether they are in violation of the norms that society has created. Such offenses like missing a limb, having visible burns or scars, or being diagnosed with a mental illness are met with stigma for traits that they have little to no control over.

The mentally ill are as a population heavily stigmatized (Corrigan, Markowitz, Watson, Rowan & Kubiak, 2003), and stigmatization of the mentally ill is the focus of the current study. Stigma can take a number of appearances, and the consequences of being in possession of a stigmatizing attribute can differ. Much like the norms of society have changed, so have the ways we treat those who do not or cannot adhere to those norms (i.e., those who are stigmatized).

In the past, societal norms were more centered on the superstitious or the religious (Durand & Barlow, 2015; Goffman, 1963). The Greeks believed that stigma was a bodily sign that an individual had something bad or unusual about their moral status (Goffman, 1963). In the past, it was commonly believed that those with mental illness were possessed in some way. For this reason, the common treatment was to exorcise the entity possessing them, or failing that, to beat and confine the person until their body was no longer habitable (Durand & Barlow, 2015, p. 8). Physical abuse was seen as a proportionate response to those societally undesirable differences that those with mental illness held. As society changed and its knowledge of what causes mental illness changed

as well, treatment of those with mental illness changed minimally. However, stigma and understanding often go hand in hand, and treatment is one window through which understanding of mental illness can be viewed. Therefore, it is important to go back to the history of treatment of mental illness so that the stigmas that are still placed on those with mental illness today can be better understood.

A history of the treatment of mental illness

The 1300's saw the introduction of mental hospitals to where the mentally ill were sent away, this impulse toward segregation being a part of what has become known as the dangerousness attribution pathway (Corrigan et al., 2002). The most well-known of these hospitals was Saint Mary's of Bethlehem, an institution in which patients were so brutally mistreated that the name became synonymous with mayhem. The patients were chained to walls and were left in their rooms for days at a time. Tours were also lead through the building so that citizens could look at the mentally ill patients because such patients were viewed as subhuman like animals at a zoo.

When it came to light how these facilities were operating, many people began to champion reform. Reporters like Nellie Bly allowed themselves to be institutionalized and upon their release published exposes about the treatment that the patients were receiving. They made it clear that the treatment was too inhumane to stand. Many psychologists were at the forefront of this crusade for change. Individuals like Philippe Pinel made a number of suggestions throughout the late 19th century about what changes could be made to improve treatment of these persons with mental illness and aid in these persons' recovery. Such changes in treatment were revolutionary for the time and consisted primarily of encouraging a program of moral treatment that consisted mainly of

treating patients like patients rather than prisoners, improvements to nutrition, hygiene, and general living conditions (Goodwin, 2015). As treatment improved and populations increased, there was a rise in the number of people being housed in these facilities, and the progressive era saw a notable expansion of these institutions (Goodwin, 2015; Kim, 2016). The institutions were seen as a solution to social norms being broken. Now that the treatment being received inside them had improved, it was easier to justify using them as a tool for segregation (Kim, 2016).

The rise in institution populations meant that the quality of treatment once again receded. The facilities that were being used to house and treat persons with mental illness were not designed to hold large numbers, as more individualized treatment is what was helpful to patients. However, as the reform to these facilities had been so successful, and the treatment appeared to be as well, the population increased to a degree that the quality of treatment decreased dramatically (Durand & Barlow, 2015; Goodwin, 2015). Reform once again came to the forefront of many people's minds. There were a large number of voices calling for asylum downsizing. Need outweighed that reason, however, and the industry continued as before creating a massive downturn in quality of care as there was no mandate for it.

There is a link between the quality of the care given to those institutionalized and social care; it is why the mentally ill were and remain at risk of victimization. The way the system was, and to some extent remains, arranged put those with mental illness at a disadvantage. They could be committed involuntarily, and it was not until 1971 that quality of care was court mandated (French, 1987). Involuntary commitment serves as a way of segregation, as this is a fear attribution response. It follows that involuntary

commitment is preceded by a belief that the individual being committed is dangerous. This dangerousness requirement was adjusted in the O'Conner v. Donaldson decision so that the modern requirement is that the individual most pose a danger to themselves or others (Goldman, 2015; *O'Conner v. Donaldson*, 1975). This being the case, it is a question of whether some false attributions could lead to unnecessary commitment.

Future progress in treatment and the rise of successful use of medication as a manner of treatment created new traction for the reform movement. Improving treatment from what it had once been provided support to the idea that the conditions could be treated, which would mean that those who showed improvement from taking psychotropic drugs could be released having spent less time in the hospital than they would have otherwise (Madianos, 2010). What followed this realization was a series of changes that, while gradual, still took place more rapidly than other facilities could prepare for.

The process of deinstitutionalization in the United States began during the 1970's. President Carter alongside the National Institute of Mental Health passed legislation that began to close these mental hospitals but with the stipulation that community programs be put in place (Madianos, 2010). As a process, this could have some success. Community measures could have provided a dual effect of aiding the continued improvement of those who had been discharged from these institutions as well as using their reintroduction into the community to help reduce stigmatizing beliefs held about them. This could have been the case if these measures had actually been put into place effectively. As it was, the discharging of patients happened at a rate that the community was not equipped to handle. Hospital wards were closed, and discharged patients were

moved into facilities that did not have the room or means of care for them that they had previously had. If these patients did not have somewhere to go already arranged, then they were placed into assisted living or other such facilities that were oftentimes in rundown parts of town (Torrey, 2013).

Lack of preparation and capability meant that, in many cases, the discharged patients were not receiving the level of care that they still required. In a number of cases, this meant that the medications that they had been receiving, which had allowed their progress, were no longer available to them (Torrey, 2013). This in turn led to a rise in homelessness among these populations, another segment of the population that is often segregated and deals with a large degree of stigmatization.

These changes were seen in other contexts as well. With legislation in place that made involuntary commitment harder than it once was, along with the general public's desire to distance itself from those who deviate from social norms, a new manner of committing those who were see as not adhering to social norms occurred. In the years following deinstitutionalization, the number of patients in the hospitals went down but the prison population numbers went up (Kim, 2016). Thus, even though it was intended that changes in approaches to the treatment of mental illness would be of benefit, the plight of many with mental illness was not improved. Specifically, such changes still created a societal condition that increased the likelihood of stigmatization.

The stigmatization of those with mental illness

Among those with serious mental illness, defined as "a mental, behavioral, or emotional disorder that is diagnosable currently or within the past year of sufficient duration to meet the diagnostic criteria in the DSM which results in serious functional

impairment that interferes with or limits one or more major life activity" (National

Institute of Mental Health, 2016, para. 3), there is a greater risk of being a victim of

stigmatizing beliefs (Corrigan et al., 2002). The general public view persons with mental

illness through a lens of fear and loathing and have for decades thanks in part to the way

their illness have been historically treated along with legislative changes having to do

with their treatment (Link, Monahan, Stueve, & Cullen, 1999; Martin, Pescosolido, &

Tuch, 2000). Those with serious mental illness who have symptoms that may be

considered "threatening" are at a greater risk of being committed in some form (Levine,

1970). The more visible the symptoms an individual is displaying, the more threatening

they seem to a member of the general public because they are more easily able to see the

social norms that are being broken (Levine, 1970). Less visible mental illnesses do not

have the same stigma attached to them that more visible mental illnesses do. This is

problematic for a number of reasons but it fits with the general public's understanding of

what mental illness is. Those without experience with mental illness are not likely to

understand the complexity of it, which explains why they would be more likely to think

of schizophrenia than depression when they are thinking of mental illness (Martin,

Pescosolido, & Tuch, 2000; Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999).

When a person's mental illness is apparent to the public, they may be on the

receiving end of stigma. This stigma can take a number of appearances. As Corrigan et al.

(2002) noted, these reactions are often multi-faceted and feed into one another. Those

with mental illness may be felt to be responsible for their illness and that perceived

controllability of their resulting behavior may result in different responses. Pity is a

possible reaction if it is believed that a person with mental illness is not responsible for

their mental illness; in other words, that person "can't help it" (Corrigan et al., 2003). Contrarily, if it is believed that a person is responsible for their mental illness they are more likely to experience anger because they "should have avoided the situation" (Corrigan et al., 2003, p. 165). In either case, the end of the personal responsibility pathway is help. Depending on the perception of responsibility and controllability, a person either will or will not be inclined to help a person with mental illness. There is then the dangerousness pathway. Stereotypes often color the way persons with mental illness are reacted to, a common stereotype being that they are violent and because of this dangerous (Corrigan, 2000). Dangerousness then leads to fear, as someone who is dangerous and violent is a person to be feared. Corrigan et al. (2002) then place avoidance, the impulse to avoid interaction with persons with mental illness, at the end of the dangerousness attribution pathway. Coercion and segregation stigma are most often seen when discussing how persons with mental illness should treat that illness. Coercion involves the forced treatment of a person with mental illness which can involve requiring them to enter hospitals, to take medication, and/or visit outpatient clinics (Corrigan et al., 2003). Segregation involves treating persons with mental illness away from the community, institutionalization being an example of this behavior.

As a group, society decides what attributes are considered normal. It is in the way that varying degrees of stigma can be applied to many who do not fit into that normative mold. As Goffman (1963) states, to truly fit every norm set by the American societal ingroup a person must be "a young, married, white, urban, northern, heterosexual, Protestant father of college education, fully employed, of good complexion, weight, and height, and a recent record in sports" (p.128). While these are the norms that have been

set, it is hard for anyone to meet the full list that Goffman proposed, and this list is far from fully inclusive. A more modern list states that the dominant cultural norm is "white, middle class, early middle-aged, heterosexual men" and everything that is encompassed by that identity (Kimmel, 2003, p. 85). For some this can have more detrimental effects than for others because once stigma becomes known, it can have effects like the ones above that those with mental illness have had to suffer.

Stigma comes from an individual being in possession of a trait that causes them to differ from the norms of a group and which makes them "discredited" (Goffman, 1963). What is stigmatizing in one environment may not be for another. The stigmatized may form their own ingroups where the trait that they possess that makes them discredited in a different group is part of the norm. When a stigmatized person does interact with a group that contains what Goffman calls "normal" they are then said to be in "mixed contact." In this instance, a discredited, stigmatized person cannot be certain of how an interaction with a normal will result until it has already begun. When individuals find themselves in mixed contact, it is possible that one or both parties may try to find a way out of the situation. A person who does not adhere to a certain social norm does not always have to live with stigma, as stigma comes from being discredited. There are those whose stigma is less apparent who exist in a state of being "discreditable" where they are "in possession of a trait that is discrediting when known" (Goffman, 1963, p. 42). The example that Goffman includes is one of an ex-mental patient who has not been outed to his employers and coworkers. In that situation the fear comes from not knowing if there will be acceptance from those who previously knew nothing about this discrediting trait. This frustration is meant to emphasize how the unnamed man, as with any who have a

discrediting attribute, is aware at all times that it is a possibility that when they are discredited that their prior behavior could be used to further any existing prejudices that a person may have.

How easily an individual becomes discreditable depends on how visible that attribute is. Not all discreditable attributes are as perceivable as others; mental illness is one of those traits. It has already been mentioned that there are those who do not believe that depression is a mental illness. In that way, it is not discreditable in the same way that schizophrenia or other severe mental illnesses are. This could be due to the visibility of these illnesses. Occasionally, visibility requires a degree of "know-about-ness" as Goffman (1963) calls it, where the more informed an individual is about a trait that could be stigmatized, the more apparent that trait is to them. Goffman includes a number of examples, but to draw attention to a point made previously, mental illness can be a condition where the more informed an individual is about them, the more apparent they become. While severe mental illnesses have more obvious signs and symptoms and are as such more visible to the uninformed, mental illness of any kind is more easily diagnosed by those who have a great deal of knowledge about them. From depression to schizophrenia, mental illness becomes more apparent the more informed a person is about what they are looking for (Martin, Pescosolido, & Tuch, 2000; Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999).

This knowledge does not have to come from learning and observation. In fact, when possible, many with stigmatizing traits do their best to pass. Passing is an attempt to disguise an individual's personal visibility. If a person is already known to possess a discrediting attribute, then they are found to have a great deal of personal visibility, at

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least to the person who is aware of them being in possession of this trait. Those who are capable of seeing through whatever methods an individual is using to pass may be able to do so for a number of reasons. The example Goffman (1963) gives of this of neighborhoods around mental hospitals. When the people in these hospitals are released, they may enter these neighborhoods for at least a brief period. As such, he states that these people have a higher tolerance for "psychotic behavior" (Goffman, 1963, p. 52). This is reminiscent of an idea that Corrigan proposed and supported in his research. One of the principal findings in Corrigan et al.'s (2014) study was that face to face interaction with an individual with a discrediting attribute such as mental illness increased the likelihood of the person interacting with them will hold fewer stigmatizing attributions toward the person with mental illness.

Attributions are made as a way of explaining the reason behind an action. They are made based on cause and controllability (Corrigan et al., 2003). These explanations may be made about one's own actions or as the actions of others and are a sort of schema for understanding and determining future behavior. When attributions are made about the actions and behaviors of the mentally ill, it can lead to differing responses on the behalf of those applying the attribution. Corrigan et al. (2003) found that if those surveyed felt that an individual was responsible for their mental illness (i.e., drug use), then the individual was more likely to feel anger toward this person. Anger and this responsibility attribution would mean an individual is less likely to provide help that a person with mental illness might need, regardless of perceived responsibility for the problem. These attributions that are being made affect the responses that the members of the public have toward those with mental illness. If the attributions happen to be negative, then

stigmatizing attitudes or beliefs may be a consequence. Researchers found that there were paths that initial attributions made (Corrigan, 2000; Corrigan et al., 2002; Corrigan et al., 2003). Responsibility attributions could lead to pity or anger, which in turn pertain to a helping response. Dangerousness attributions lead to fear which in turn leads to avoidance (Corrigan et al., 2002). These attribution paths will trigger certain schema responses. The helping schema could be triggered in one of two ways. If it is a product of pity, then the response is likely to be to provide help. If it is anger, then the opposite is true. The result of the dangerousness attribution was seen clearly throughout history, as those with mental illness were separated through the use of institutionalization. The need for avoidance is fulfilled through segregation of those who differ from the norm and trigger that dangerousness attribution.

The stigmas that can accompany these attributions can be harmful, as this illustrates. These desires to create social distance put those with mental illness at a disadvantage. In some cases, they do not receive the care they need, and in others they can result in harm coming to the individual. The assumption that these attributions can be changed and that the stigma they produce can be reduced has had some support (Corrigan, Gause, Michaels, Buchholz, & Larson, 2014). Through the use of the 27 question Attribution Questionnaire (AQ27), the same that this study will be utilizing, Corrigan was able to measure what attributions the sample was holding toward persons with mental illness. These original data were used as a baseline to measure what the most effective tool to change attributions was. The study found that the most successful tool was actual contact and teaching from a person with mental illness (Corrigan et al., 2014).

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This contact was shown more than any other to create lasting change by providing new information to add to the participant's person schemas about persons with mental illness.

Personal contact is why the schema is able to adjust for a long term period. It is more effective than a typical teaching tool as the individual is able to see them as a person rather than a vignette or lesson. By making that change to a person's schema, they are forced to also reexamine the way they identify with this person. As this schema for persons with mental illness changes, so must the way they view those persons as part of their ingroup.

Purpose of the Current Study

This sense of personal contact is what this study capitalizes on. Personal interaction with mental illness is, obviously, very dependent on experiences that society has provided and thus difficult to ensure that they happen at all. There is also no guarantee that should those interactions take place they will result in opportunities to reduce held stigmas. Therefore, it seems more practical to look at other factors that are involved in connection and the kind of contact that is facilitated between people. It is hypothesized here that one's identification with humanity and moral reasoning will relate to decreased stigmatization of those with mental illness. This is because identification with humanity and moral reasoning are both other oriented constructs that humanize and deemphasize differences as well as promote connection. Due to this, the belief is that these constructs could increase the likelihood of human connection in a similar manner to what Corrigan et al. (2014) observed with personal contact. If this occurs, it would offer further insight about the reasons for stigmatization of the mentally ill in the first place and help to answer who is most likely to place stigma.

The current study uses McFarland, Brown, and Webb's (2012) Identification with All Humanity scale as a means of measuring an individual's feelings of relationship with people. This scale measures their perceived relationship with their community, Americans (or the people of their country), and people all over the world. This scale was chosen as it was found to remain stable across time and to be free of the social desirability that often affects self-report data (McFarland et al., 2012). This measure was also found to predict a number of social concerns that could be related to those the present study was concerned with. McFarland et al. (2012) found that this measure to be positively correlated with moral identity, dispositional empathy, and principled moral reasoning.

The current study assumes that should an individual have a high level of personal identification with all of humanity that they will then be less likely to place negative stigma on those with mental illness. Identifying with all of humanity involves recognizing all of mankind as part of an individual's ingroup, this ingroup recognition thereby affecting how they react to people that they meet. When a person is faced with someone who is not part of their ingroup, they may react negatively. This is because a member of the outgroup does not adhere to the same norms as those in the ingroup, and the norms of a culture, society, or ingroup are entwined with their ideas of morality. These concepts would be a part of an individual's macromorality, the moral decisions that concern the broader structure of society and its rules (Rest et al., 1999). The way an individual does or does not adhere to that ingroup morality when faced with a situation is a micromoral interaction. Micromorality concerns the everyday decisions that a person faces throughout their life (Rest et al., 1999).

It is then the micromoral interactions that can determine how an individual treats a person who is not adhering to the formal structures of society. As has been demonstrated by the previous treatment of the mentally ill, those who do not adhere to the ingroup norms, and are therefore stigmatized, may also be dehumanized. This is why Corrigan et al. (2014) found that contact was so effective in changing the stigmatizing opinions of the participants; personal contact acts as an agent of humanization. This is another reason why the current study is utilizing Identification with All Humanity as a construct that could decrease the likelihood of stigmatization of the mentally ill. Those who identify strongly with all humanity experience a deep caring for all humans, regardless of how they may fit into their specific ingroup. It is therefore indicative of a drive for human connection. If a relationship occurs between this construct and stigmatization it could provide insight into why Corrigan et al. (2014) found personal contact so effective but also provide insight toward identifying those who are likely to place stigma and would benefit from this kind of intervention.

An individual's personal moral code may differ from others in their ingroup, as morality is a social concept and must be learned and developed. There is evidence that the development of moral reasoning occurs across three schema and that social and moral decision making becomes more complex as an individual passes through each schema (Rest, Narvaez, Bebeau, & Thoma, 1999). Rest, Narvaez, Bebeau, and Thoma (1999) referenced this when establishing the Defining Issues Test-2 (DIT2). The DIT2 measures the shifts between schemas which marks a change in maturity and thinking that an individual is displaying. It is most sensitive to the changes between the Maintaining Norms and Postconventional thinking schemas. The Maintaining Norms schema is where

an individual's moral reasoning begins to become more complex. In this schema the idea of law and order are closely connected; decisions based on the thinking of this schema involve, among other things, the knowledge that when laws are obeyed society benefits (Rest et al., 1999, p. 306). The Postconventional schema has a softer transition as it is believed that not everyone will fully reach this stage of moral thinking. This schema involves the understanding that rules are a tool for a moral purpose and should be critiqued and changed as society requires them to (Rest et al., 1999). Though it is most sensitive to the changes between those schemas the DIT2 also measures the Personal Interest schema. The Personal Interest schema involves making decisions because an individual has a personal investment in the consequences of the decision (Rest et al., 1999).

The sensitivity is important to the current study as it is looking to see if there is a relationship between moral reasoning and stigmatizing attributions. The assumption being that those who are utilizing more developed schemas when they are making decisions will then be less likely to endorse mental illness stigma. As those who are using those higher level schemas are making moral decisions that concern more people than themselves. Specifically, those individuals who primarily use the Postconventional schema are interested in norms that are not in the expense of others, meaning those who utilize this schema frequently would be less likely to endorse a norm that would result in harmful action toward those with mental illness. If a relationship is found between this construct and stigma, it could provide insight into who is most likely to place stigma on those with mental illness.

The DIT2 has been chosen for the task of measuring moral reasoning as opposed to any other measure due to its validity. As the population being studied consists of college aged students, the research suggests that the DIT2 reliably picks up on the variance that is attributed to education. The DIT2 has been used longitudinally to show that much of the change in moral development takes place in college (Rest et al., 1999). Though this study is not interested, specifically, in how moral reasoning changes over time, the variance that it is capable of measuring is of interest. This study is concerned with the factors that drive stigma and the variance that has been empirically linked with education by Rest et al. (1999) provides a variable for a possible correlation on what drives that stigma. The DIT2 has also been found to correlate with political attitudes. With the study's concern on mental illness this correlation makes this measure best for the task. This correlation could also provide support to any relationship of this nature found by the IWAHS.

Thus, the current study endeavors to see if identification with all humanity and moral reasoning relate to a decrease an individual's likelihood of endorsing mental illness stigma. Should these assertions be supported, this study would provide a clearer understanding of those factors that are related to mental illness stigmatization.

METHOD

Participants

Participants included 141 college students from Western Kentucky University. Of these participants, 19 had to be excluded due to not fully completing the provided surveys, leaving 122 participants whose data were examined. Among those surveyed 27 were male, 94 were female, and one participant who did not provide this information. Participants ranged in age from 18 to 28, with a mean of 19.06. Of these participants, 72 were Freshmen, 23 were Sophomores, 18 were Juniors, 9 were Seniors, and 1 was listed as Other. Among the participants who provided information about their ethnicity, 97 were White, 22 were African American, 1 was Asian American, 1 was Hispanic or Latino, and 1 indicated Other.

Materials

Demographics Questionnaire. The study utilized a demographics questionnaire which regarded the participant's background. The questions asked included age, gender, college classification, major, and ethnicity.

Moral Reasoning. In order to measure the development of moral reasoning, the Defining Issues Test-2 (DIT2; Rest et al., 1999) was used. The DIT2 consists of a series of five vignettes that participants are tasked with reading before they are asked to then make a decision on how they believe the main character of that vignette should act. For example after reading a vignette about stealing food in a famine participants then see "What should Mustaq Singh do? Do you favor the action of taking the food" (Rest et al., 1999). The questions are followed by the option to check that they should, can't decide, or should not; those three decision options are present with each vignette only differing in

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small details that make them specific to the particular vignette. After participants have made their decision, they are shown a series of twelve items or issues that they are asked to rate in importance in regards to making the decision that they did. These items are specific to the particular vignette but an example includes "Does the rich man have any legal right to store food when other people are starving" (Rest et al., 1999). After these questions have been rated, participants are tasked with ranking them from most important to fourth most important in making their decision.

There are three indices that are measured by this scale, Personal Interest (PI), Maintaining Norms (MN), and Postconventional (P). For each of these indices, the scores can range from 0 to 95 where the lower scores mean less frequent use of the schema the index represents and higher scores mean that schema is more frequently accessed. In their study, Rest et al. reported an alpha that was routinely found to be "in the upper .70s/low .80s." Cronbach's alpha coefficients found in this study were as follows: Personal Interest α = .632; Maintaining Norms α = .645; and Postconventional α = .705.

Identification with Humanity. In order to measure the degree to which a participant identified with others, the study utilized the Identification with All Humanity Scale (IWAHS; McFarland et al., 2012). The IWAHS consists of 9 questions measured at three different levels. Questions appear as so: How often do you use the word "we" to refer to the following groups of people? a. People in my community, b. Americans, c. People all over the world? Those are then rated using a five-point Likert scale ranging from 1 being "almost never" and 5 being "very often" (McFarland et al., 2012). This scale measures three different indices: My Community, Americans, and People all over the World. The scores for these indices range from 9 to 45, where the lower scores

indicate less connection with the group the index represents while a higher score indicates a stronger connection. In their study, McFarland et al. reported that the coefficient internal consistency of this scale across all levels when given to their student sample is as follows: "My Community" α = .89; "Americans" α = .83; "People all over the world" α = .81. Cronbach's alpha coefficients for internal consistency in this study was "My Community" α = .870; "Americans" α = .814, and "People all over the world" α = .799.

Stigma Attribution. In order to measure the manner and degree of stigma that an individual might have toward persons with mental illness, the study utilized the 27 question Attribution Questionnaire (AQ27; Corrigan et al., 2003). The AQ27 consists of a brief vignette followed by 27 questions designed to measure a number of stigmatizing reactions toward persons with mental illness including: anger, dangerousness, fear, avoidance, etc. These questions all relate to the vignette and include questions like the following: "How much do you agree that Harry should be forced into treatment with his doctor even if he does not want to?" These questions are all rated on a nine-point Likert scale which ranges from 1 being "not at all" to 9 being "very much" (Corrigan et al., 2002). This scale measures a number of indices including blame, anger, pity, help, dangerousness, fear, avoidance, segregation, and coercion. The scores for these indices range from 3 to 27, where the lower the score is the less the stigma that the index represents is attributed and the higher the score the more the stigma is attributed. According to Corrigan et al., the reliability of the scale for measuring these attributions is very high. The coefficients they reported measuring as follows: pity = .74, anger = .89, helping = .88, and coercion/segregation = .89 (Corrigan et al., 2003). Cronbach's alpha

coefficients for internal consistency regarding this study were pity = .698, anger = .832, fear = .934, helping = .867, coercion = .604, and segregation = .829.

Procedure

Participants were first asked to read and sign the informed consent document. After the document was read and signed, they were provided with a packet which consisted of the demographic questionnaire, DIT2, IWAHS, and AQ27. These packets all began with the demographics questionnaire but the other three surveys were counterbalanced. Data collection was conducted at the Research of Ethical Social Topics (REST) Lab and took no longer than 45-60 minutes to complete.

RESULTS

The descriptive statistics of all variables of interest can be found in Table 1. As Table 1 confirms, participants were low in terms of the development of moral reasoning overall as DIT2 scores illustrate that they were modal at the Personal Interests schema. The table also shows that participants' scores were a little higher than expected for a student population based on scores from previous research (McFarland et al., 2012). However, the pattern observed was typical. Table 1 confirms that participants' overall IWAHS scores were modal in the identification with community level, and the mean score of each level decreased as level of identification increased. Table 1 also shows that overall participants scored low in attribution of stigma, as AQ27 scores illustrate that the majority of scores were in the lower range of possibilities. The exceptions to this being Pity, Avoidance, and Coercion attributions, which are all in the upper range of scores, as Table 1 shows.

Table 1

Descriptive Statistics for conditions

	Total	
	M	*SD*
P	28.1977	14.4899
MN	30.4421	12.1108
PI	32.0206	10.9673
IWAHScomm	34.4344	6.5480
IWAHSamerica	31.6557	5.9582
IWAHSeverywhere	28.4262	6.1428

AQBlame	6.5820	3.44670
AQAnger	6.9508	3.8545
AQPity	20.3279	4.2377
AQHelp	7.6393	4.4296
AQDanger	10.8033	5.2769
AQFear	9.4016	5.5353
AQAvoid	13.4590	6.3326
AQSegregate	8.9016	4.7541
AQCoerce	16.4344	4.6068

Note: P = DIT2 Postconventional score, MN = DIT2 Maintaining Norms score, PI = DIT2 Personal Interest score, IWAHScomm = IWAHS identification with community score, IWAHSamerica = IWAHS identification with all Americans score, IWAHSeverywhere = IWAHS identification with all people everywhere score, AQBlame = AQ27 Blame attribution scores, AQAnger = AQ27 Anger attribution scores, AQPity = AQ27 Pity attribution scores, AQHelp = AQ27 Help attribution scores, AQDanger = AQ27 Danger attribution scores, AQFear = AQ27 Fear attribution scores, AQAvoid = AQ27 Avoidance attribution score, AQSegregate = AQ27 Segregation attribution scores, AQCoerce = AQ27 Coercion attribution scores

To address the current hypothesis (i.e, That identification with humanity and moral reasoning will relate to decreased stigmatization of those with mental illness.), bivariate correlations were first computed. These correlations were computed for each variable that was of concern to the present study: demographics indices, the three DIT2 indices, the three IWAHS indices, and each of the indices measured by the AQ27. These results are reported in full in Table 2.

Statistically significant correlations were observed between Community identification and Anger ($r = .207$, $p = .023$) and Fear attributions ($r = .202$, $p = .027$) A

statistically significant relationship was also observed between identification with Americans and Fear attribution ($r = .180$, $p = .049$) and Coercion ($r = .208$, $p = .022$). The observed results are in line with what was expected given prior research with this scale.

There were also statistically significant correlations observed between DIT2 scores and AQ27 score. There were statistically significant correlations observed between Postconventional schema and Pity attributions ($r = .188$, $p = .040$). There were also statistically significant correlations between the Maintaining Norms schema and Segregation attributions ($r = .202$, $p = .027$).

Correlations were also run on the demographic variables in order to account for their relationship with the dependent variables. Some statistically significant correlations were found. Gender shared a statistically significant relationship with Help ($r = -.210$, $p = .021$) and Avoidance attributions ($r = -.251$, $p = .006$). There was also a statistically significant correlation between Education and Coercion ($r = -.182$, $p = .047$).

Table 2

Correlation Matrix for Demographics, DIT2, IWAHS, and AQ27

	Age	Gender	ACT	GPA	Edu.	Majmin	P	MN	PI	Comm
Age	1.0									
Gender	-.117	1.0								
ACT	-.009	.053	1.0							
GPA	.299**	.055	.074	1.0						
Edu	.828**	-.028	-.069	.418**	1.0					
Majmin	-.083	-.068	-.062	-.077	-.023	1.0				
P	.020	.044	-.034	.163	.028	-.115	1.0			
MN	.068	-.148	.010	-.120	.024	-.109	-.539**	1.0		
PI	-.044	.020	-.094	-.020	-.006	.177	-.427**	-.416**	1.0	
Comm	-.182*	.152	-.021	.067	-.056	-.121	-.212*	.129	.091	1.0
America	.070	.118	-.061	-.007	.066	-.249**	-.215*	.197*	.031	.626**
Every	.096	.074	-.138	.055	.084	-.106	.049	-.021	-.012	.455**
Blame	.052	-.137	.030	.015	.103	.011	-.091	.050	-.013	.068
Anger	-.022	-.035	.119	.077	.071	-.087	-.037	.084	-.047	.207
Pity	-.072	.174	-.173	-.030	-.151	-.146	.188*	-.099	-.029	.053
Help	-.047	-.210*	.114	-.093	.019	-.042	-.113	.170	-.049	.038
Danger	-.017	-.121	-.051	-.010	.024	.036	-.057	.102	-.016	.091
Fear	.024	.002	-.057	-.022	.058	.019	-.029	.162	-.092	.202*
Avoid	-.088	-.251**	.026	-.048	-.026	.058	-.150	.173	.016	.035
Segregat	-.02	-.165	-.089	-.119	-.026	.112	-.112	.202*	-.071	-.022
Coerce	-.112	.064	.030	-.068	-.182*	.067	-.076	.170	-.100	.140

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	America	Every	Blame	Anger	Pity	Help	Danger	Fear	Avoid	Segregat	Coerce
Age											
Gender											
ACT											
GPA											
Edu											
Majmin											
P											
MN											
PI											
Comm											
America	1.0										
Every	.687**	1.0									
Blame	.016	-.043	1.0								
Anger	.156	.033	.296**	1.0							
Pity	.087	.114	-.227*	-.021	1.0						
Help	-.017	-.174	.235**	.366**	-.309**	1.0					
Danger	.169	.045	.160	.484**	.084	.383**	1.0				
Fear	.180*	.009	.098	.509**	.097	.392**	.869**	1.0			
Avoid	.068	-.070	.177	.279**	-.050	.539**	.441**	.348**	1.0		
Segregat	.152	.078	.147	.341**	.053	.342**	.691**	.611**	.626**	1.0	
Coerce	.208*	.094	.062	.270**	.134	.101	.366**	.334**	.233*	.447**	1.0

In further addressing the hypothesis, hierarchical linear regressions were conducted for the cases where statistically significant correlations were observed between the DIT2 or IWAHS scores and the AQ27 scores. These relationships (as listed above and seen in Table 2) were observed in the Pity, Segregation, Anger, Fear, and Coercion attributions. Significant correlations also existed between the Gender variable and a dependent variable which was not seen to have a significant relationship with those variables of the DIT2 and IWAHS, those being Help and Avoidance attributions. In total seven separate regression analyses were conducted for each of these dependent variables. Theses analyses each consisted of three blocks: the first block included demographic variables (i.e., age, gender, ACT, GPA, and ethnicity); the second block included DIT2 indices; and the third block included IWAHS indices. These analyses were conducted so that each independent variable's contribution to the variance could be observed.

For Pity scores (See Table 3), the demographic variables provided a significant contribution to variance overall in Block 1. Gender and Education appear to be most responsible for this contribution. Gender was a positive and significant predictor in block

one and remained so across all three blocks. Education was a negative and significant

predictor in block one and remained across all three.

Table 3

Summary of Linear Regression Analyses for Pity Attribution

		B	*SE B*	B	*T*	Sig.
Block 1	Age	.729	.491	.240	1.484	.141
(R^2 = .130,	Gender	1.938	.914	.190	2.121	.036
p = .014)	ACT	-.010	.004	-.220	-2.470	.015
	GPA	.122	.215	.056	.568	.571
	Education	-1.643	.719	-.386	-2.284	.024
	Majmin	-1.381	.933	-.132	-1.480	.142
Block 2	Age	.724	.488	.238	1.483	.141
(R^2 = .165,	Gender	2.065	.929	.203	2.221	.028
p = .206)	ACT	-.008	.004	-.185	-2.021	.046
	GPA	.049	.217	.022	.224	.823
	Education	-1.622	.715	-.381	-2.270	.025
	Majmin	-1.099	.957	-.105	-1.148	.253
	P	.109	.061	.374	1.783	.077
	MN	.075	.074	.212	1.015	.313
	PI	.089	.076	.224	1.170	.245
Block 3	Age	.754	.523	.248	1.442	.152
(R^2 = .171,	Gender	1.953	.949	.192	2.057	.042
p = .862)	ACT	-.008	.004	-.177	-1.895	.061

GPA	.040	.222	.018	.181	.857
Education	-1.660	.733	-.390	-2.265	.026
Majmin	-.910	1.010	-.087	-.900	.370
P	.114	.063	.388	1.816	.072
MN	.073	.075	.206	.971	.334
PI	.088	.077	.221	1.143	.256
IWAHScomm	.021	.081	.033	.263	.793
IWAHSamerica	.032	.110	.044	.288	.774
IWAHSeverywhere	.012	.090	.017	.133	.895

Note: Majmin = Ethnicity demographics P = DIT2 Postconventional score, MN = DIT2 Maintaining

Norms score, PI = DIT2 Personal Interest score, IWAHScomm = IWAHS identification with community

score, IWAHSamerica = IWAHS identification with all Americans score, IWAHSeverywhere = IWAHS

identification with all people everywhere score

For Segregation scores (See Table 4), none of the three blocks provided

significant contributions to variance. However, there was a single significant contribution

seen in the third block. Though there was no initial correlation noted between the

IWAHS measures, identification with Americans was shown to in block three. Though it

was not significant in block one when the measure was introduced, in block three a small

contribution was noticed (i.e., not significant when $p < .05$ but significant at $p < .10$) with

the Ethnicity measure when the contributions from the IWAHS were included.

Table 4

Summary of Linear Regression Analyses for Segregation Attribution

		B	SE B	B	T	Sig.
Block 1	Age	-.119	.574	-.035	-.208	.836
(R^2 = .053,	Gender	-1.743	1.067	-.153	-1.633	.105
p = .394)	ACT	-.003	.005	-.065	-.699	.486
	GPA	-.256	.251	-.105	-1.021	.309
	Education	.189	.840	.040	.224	.823
	Majmin	1.033	1.090	.088	.947	.345
Block 2	Age	-.160	.572	-.047	-.281	.779
(R^2 = .087,	Gender	-1.432	1.088	-.125	-1.315	.191
p = .255)	ACT	-.004	.005	-.070	-.728	.468
	GPA	-.190	.254	-.077	-.748	.456
	Education	.162	.837	.034	.194	.846
	Majmin	1.358	1.121	.116	1.211	.229
	P	.006	.072	.017	.077	.938
	MN	.077	.087	.194	.886	.378
	PI	-.005	.089	-.011	-.057	.955
Block 3	Age	-.494	.596	-.145	-.828	.410
(R^2 = .140,	Gender	-1.630	1.083	-.143	-1.505	.135
p = .094)	ACT	-.003	.005	-.051	-.530	.597
	GPA	-.120	.253	-.049	-.473	.637
	Education	.345	.836	.072	.413	.680

		B	SE B	B	T	Sig.
	Majmin	1.956	1.152	.167	1.698	.092
	P	.017	.071	.050	.231	.817
	MN	.075	.086	.190	.879	.381
	PI	-4.126E-5	.088	.000	.000	1.000
	IWAHScomm	-.155	.092	-.212	-1.682	.096
	IWAHSamerica	.269	.125	.332	2.145	.034
	IWAHSeverywhere	-.016	.102	-.020	-.153	.878

Note: Majmin = Ethnicity demographics P = DIT2 Postconventional score, MN = DIT2 Maintaining Norms score, PI = DIT2 Personal Interest score, IWAHScomm = IWAHS identification with community score, IWAHSamerica = IWAHS identification with all Americans score, IWAHSeverywhere = IWAHS identification with all people everywhere score

None of the three blocks provided significant contributions to variance for Anger (See Table 5). Though there was a correlation observed between the Identification with Community level of the IWAHS, this index did not offer much of a contribution when observed (i.e., not significant even at $p < .10$).

Table 5

Summary of Linear Regression Analyses for Anger Attribution

		B	SE B	B	T	Sig.
Block 1	Age	-.881	.464	-.319	-1.899	.060
($R^2 = .060$,	Gender	-.722	.863	-.078	-.837	.404
$p = .314$)	ACT	.006	.004	.135	1.461	.147
	GPA	.040	.203	.020	.195	.846
	Education	1.282	.679	.332	1.888	.062

	Majmin	-.960	.881	-.101	-1.0899	.278
Block 2	Age	-.893	.469	-.323	-1.903	.060
$(R^2 = .066,$	Gender	-.619	.893	-.067	-.693	.490
$p = .868)$	ACT	.005	.004	.133	1.378	.171
	GPA	.066	.208	.033	.316	.753
	Education	1.270	.687	.328	1.849	.067
	Majmin	-.876	.920	-.092	-.952	.343
	P	-.002	.059	-.006	-.029	.977
	MN	.025	.071	.077	.349	.727
	PI	.000	.073	.001	.004	.997
Block 3	Age	-.689	.494	-.250	-1.396	.166
$(R^2 = .105,$	Gender	-.881	.896	-.095	-.983	.328
$p = .207)$	ACT	.005	.004	.132	1.360	.177
	GPA	.042	.209	.021	.199	.842
	Education	1.084	.692	.280	1.567	.120
	Majmin	-.376	.954	-.040	-.394	.694
	P	.014	.059	.051	.231	.818
	MN	.014	.071	.044	.200	.842
	PI	-.005	.072	-.015	-.075	.940
	IWAHScomm	.091	.076	.154	1.196	.234
	IWAHSamerica	.104	.104	.159	1.007	.316
	IWAHSeverywhere	-.081	.085	-.128	-.949	.345

Note: Majmin = Ethnicity demographics P = DIT2 Postconventional score, MN = DIT2 Maintaining Norms score, PI = DIT2 Personal Interest score, IWAHScomm = IWAHS identification with community

score, IWAHSamerica = IWAHS identification with all Americans score, IWAHSeverywhere = IWAHS identification with all people everywhere score

For Fear scores (See Table 6), a significant contribution to variance was seen in the third block from the IWAHS indices. Block three reveals that this contribution is primarily the result of the Identification with People Everywhere index of the IWAHS. There was a correlation observed in Table 2 between Fear and Identification with Americans, the contribution observed in the regression analysis was small (i.e., not significant when $p < .05$ but significant at $p < .10$).

Table 6

Summary of Linear Regression Analyses for Fear Attribution

		B	*SE B*	B	*T*	Sig.
Block 1	Age	-.295	.679	-.075	-.434	.665
($R^2 = .010$,	Gender	.042	1.264	.003	.033	.974
$p = .978$)	ACT	-.003	.006	-.044	-.459	.647
	GPA	-.154	.297	-.054	-.519	.604
	Education	.773	.995	.140	.778	.438
	Majmin	.125	1.291	.009	.097	.923
Block 2	Age	-.349	.676	-.089	-.516	.607
($R^2 = .047$,	Gender	.550	1.288	.042	.427	.670
$p = .242$)	ACT	-.002	.006	-.028	-.291	.772
	GPA	-.113	.300	-.040	-.376	.708
	Education	.745	.990	.135	.753	.453
	Majmin	.716	1.327	.053	.540	.590

	P	.083	.085	.219	.978	.330
	MN	.158	.103	.344	1.539	.127
	PI	.066	.105	.128	.627	.532
Block 3	Age	.066	.696	.017	.095	.924
(R^2 = .125,	Gender	.074	1.264	.006	.058	.954
p = .027)	ACT	-.002	.006	-.040	-.420	.675
	GPA	-.146	.295	-.051	-.495	.622
	Education	.369	.976	.067	.378	.706
	Majmin	1.717	1.346	.126	1.275	.205
	P	.116	.083	.306	1.394	.166
	MN	.135	.100	.293	1.345	.181
	PI	.054	.102	.105	.528	.598
	IWAHScomm	.168	.108	.198	1.558	.122
	IWAHSamerica	.251	.146	.268	1.718	.089
	IWAHSeverywhere	-.242	.120	-.270	-2.024	.046

Note: Majmin = Ethnicity demographics P = DIT2 Postconventional score, MN = DIT2 Maintaining Norms score, PI = DIT2 Personal Interest score, IWAHScomm = IWAHS identification with community score, IWAHSamerica = IWAHS identification with all Americans score, IWAHSeverywhere = IWAHS identification with all people everywhere score

No significant contributions to Coercion scores were observed across any of the three blocks (See Table 7). There was a correlation observed between this dependent variable and Identification with Americans (See Table 2), but when the regression was

run this variable was found to contribute only a small amount (i.e., not significant when p

$< .05$ but significant at $p < .10$).

Table 7

Summary of Linear Regression Analyses for Coercion Attribution

		B	*SE B*	B	*T*	Sig.
Block 1	Age	.538	.557	.163	.966	.336
($R^2 = .049$,	Gender	.861	1.036	.078	.831	.408
$p = .445$)	ACT	.000	.005	.008	.089	.929
	GPA	.043	.244	.018	.176	.861
	Education	-1.479	.816	-.320	-1.813	.073
	Majmin	.910	1.059	.080	.859	.392
Block 2	Age	.492	.553	.149	.890	.376
($R^2 = .089$,	Gender	1.223	1.053	.111	1.161	.248
$p = .191$)	ACT	.000	.005	.008	.089	.929
	GPA	.104	.246	.044	.421	.674
	Education	-1.504	.810	-.326	-1.856	.066
	Majmin	1.313	1.085	.116	1.210	.229
	P	.024	.070	.076	.347	.729
	MN	.096	.084	.251	1.148	.253
	PI	.009	.086	.020	.101	.920
Block 3	Age	.505	.577	.153	.875	.384
($R^2 = .141$,	Gender	.856	1.048	.077	.816	.416
$p = .098$)	ACT	.001	.005	.021	.221	.825

		B	SE B	B	T	Sig.
	GPA	.115	.245	.049	.470	.639
	Education	-1.580	.809	-.342	-1.952	.054
	Majmin	2.113	1.116	.186	1.894	.061
	P	.044	.069	.139	.639	.524
	MN	.086	.083	.223	1.035	.303
	PI	.006	.085	.014	.071	.943
	IWAHScomm	.007	.089	.009	.074	.941
	IWAHSamerica	.235	.121	.300	1.941	.055
	IWAHSeverywhere	-.068	.099	-.090	-.681	.498

Note: Majmin = Ethnicity demographics P = DIT2 Postconventional score, MN = DIT2 Maintaining Norms score, PI = DIT2 Personal Interest score, IWAHScomm = IWAHS identification with community score, IWAHSamerica = IWAHS identification with all Americans score, IWAHSeverywhere = IWAHS identification with all people everywhere score

For Help scores (See Table 8), demographic variables provided a significant to variance in the first block. Gender appears to be an important reason for this as it provided significant contributions across all three blocks. Age and Education also contributed as they provided significant contributions in the first two blocks, but not the third.

Table 8

Summary of Linear Regression Analyses for Help Attribution

		B	SE B	B	T	Sig.
Block 1	Age	-1.029	.503	-.335	-.2046	.043
($R^2 = .108$,	Gender	-2.516	.936	-.244	-2.689	.008

p = .040)	ACT	.007	.004	.155	1.713	.089
	GPA	-.327	.220	-.148	-1.486	.140
	Education	1.550	.736	.360	2.150	.037
	Majmin	-.840	.956	-.079	-.879	.381
Block 2	Age	-1.047	.506	-.341	-2.071	.041
(R^2 = .127,	Gender	-2.341	.963	-.227	-2.431	.017
p = .575)	ACT	.007	.004	.151	1.610	.110
	GPA	-.277	.225	-.125	-1.234	.220
	Education	1.524	.740	.354	2.059	.042
	Majmin	-.724	.992	-.068	-.730	.467
	P	-.007	.064	-.025	-.116	.908
	MN	.041	.077	.115	.539	.591
	PI	.002	.079	.004	.022	.982
Block 3	Age	-.862	.534	-.281	-1.615	.109
(R^2 = .154,	Gender	-2.372	.970	-.230	-2.445	.016
p = .289)	ACT	.006	.004	.125	1.319	.190
	GPA	-.279	.226	-.126	-1.231	.221
	Education	1.381	.749	.321	1.845	.068
	Majmin	-.561	1.032	-.053	-.544	.588
	P	.003	.064	.009	.043	.966
	MN	.033	.077	.091	.424	.672
	PI	-.003	.078	-.008	-.039	.969
	IWAHScomm	.054	.082	.083	.660	.511

		B	SE B	B	T	Sig.
	IWAHSamerica	.075	.112	.103	.671	.503
	IWAHSeverywhere	-.171	.092	-.245	-1.866	.065

Note: Majmin = Ethnicity demographics P = DIT2 Postconventional score, MN = DIT2 Maintaining Norms score, PI = DIT2 Personal Interest score, IWAHScomm = IWAHS identification with community score, IWAHSamerica = IWAHS identification with all Americans score, IWAHSeverywhere = IWAHS identification with all people everywhere score

For Avoidance scores (See Table 9), none of the three blocks provided significant contributions to variance overall. However, Gender was a negative and significant predictor across all three blocks.

Table 9

Summary of Linear Regression Analyses for Avoidance Attribution

		B	SE B	B	T	Sig.
Block 1	Age	-1.382	.738	-.309	-1.873	.064
(R^2 = .096,	Gender	-4.200	1.372	-.280	-3.060	.003
p = .071)	ACT	.004	.006	.060	.660	.511
	GPA	-.148	.323	-.046	-.458	.648
	Education	1.541	1.080	.246	1.426	.157
	Majmin	.302	1.402	.020	.215	.830
Block 2	Age	-1.45	.737	-.314	-1.908	.059
(R^2 = .124,	Gender	-3.792	1.403	-.252	-2.703	.008
p = .323)	ACT	.004	.006	.067	.719	.474
	GPA	-.058	.327	-.018	-.178	.859
	Education	1.467	1.079	.234	1.360	.177

	Majmin	.486	1.446	.031	.336	.738
	P	.019	.093	.044	.207	.836
	MN	.118	.112	.227	1.059	.292
	PI	.072	.115	.123	.628	.532
Block 3	Age	-1.484	.781	-.331	-1.900	.060
(R^2 = .148,	Gender	-3.979	1.419	-.265	-2.805	.006
p = .405)	ACT	.004	.006	.062	.654	.515
	GPA	-.007	.331	-.002	-.022	.983
	Education	1.470	1.095	.234	1.342	.182
	Majmin	1.105	1.510	.072	.732	.466
	P	.037	.093	.086	.398	.691
	MN	.109	.112	.209	.970	.334
	PI	.071	.115	.122	.620	.537
	IWAHScomm	-.065	.121	-.068	-.540	.590
	IWAHSamerica	.276	.164	.259	1.681	.096
	IWAHSeverywhere	-.170	.134	-.167	-1.266	.208

Note: Majmin = Ethnicity demographics P = DIT2 Postconventional score, MN = DIT2 Maintaining Norms score, PI = DIT2 Personal Interest score, IWAHScomm = IWAHS identification with community score, IWAHSamerica = IWAHS identification with all Americans score, IWAHSeverywhere = IWAHS identification with all people everywhere score

DISCUSSION

The purpose of this research study was to examine whether tools could be found to predict the likelihood of endorsing stigma against those with mental illness. The current study acted with consideration to the previous research conducted by Corrigan et al. (2014), which showed that personal contact was the construct which had the most success in reducing stigma toward persons with mental illness. The present study utilized the Defining Issues Test 2 (DIT2) and Identification with all Humanity (IWHAS) scales which measure constructs that are other oriented and promote connection similar to that of personal connection. It is for that reason that the present study hypothesized that higher connection with all humanity and more developed moral reasoning would relate to decreased negative stigma attribution.

The hypothesis was partially supported. A number of correlations were observed which supported the theorized relationship. These correlations were observed in both the IWAHS and the DIT2. However, when linear regression was run only some of the relationships observed between the IWAHS indices were noted to be significant predictors. There were some small contributions observed in linear regression by those indices of the DIT2, but as mentioned in the results, these contributions were not statistically significant.

The study illustrates that some stigma attributions can be predicted by the measures utilized here. The results showed that, though there was no initial correlation between Segregation and the IWAHS indices, close identification with Americans was a significant positive indicator of endorsing that Segregation attribution. As Corrigan et al.'s (2002) research showed, segregation is a distancing impulse. It involves treating

persons with mental illness somewhere else, institutionalization may be a result of this impulse. Thus, it makes sense both in the context of this and previous research that closer identification with Americans would show an increased likelihood of this sort of stigma. Those who identify closely with Americans, or their countrymen, have a strong connection with their ingroup. As has been stated, those with mental illness often do not or are incapable of fitting the expected societal norms or the norms of the ingroup, which makes them part of the outgroup. Often those who are members of the outgroup are treated negatively by those who are part of the ingroup. It then makes sense that close identification with Americans, or close identification with the ingroup, would predict segregation attribution as segregation is a tool that has been frequently used to act as a distance themselves from the outgroup.

The results then go on to support that Fear attributions can, to a degree, be predicted by the IWAHS indices. The results found that close identification with everyone, or close identification with humanity, showed a negative relationship with fear attribution. Close identification with humanity has previously been linked to dispositional empathy and a lack of ethnocentrism (McFarland et al., 2012). It is a construct that humanizes. This is why the measure was initially chosen for the study. The results then support these assumptions. Fear attribution is a part of the dangerousness pathway. Those who identify strongly with humanity have greater empathy for those with mental illness and, as such, are not as likely to fear those with mental illness. Having just previously noted that there is a relationship between segregation and identification with Americans, it is worth noting that segregation is also linked with the dangerousness attribution pathway. That aforementioned relationship, makes the small contribution that

identification with Americans makes to the Fear attribution (i.e., not statistically significant at the level that this study was concerned with; see Table 6) more relevant. Identification with Americans had a positive relationship with fear attribution. Much like higher identification with Americans could predict a stronger likelihood of endorsing Segregation attribution, this same identification predicts a stronger likelihood of endorsing Fear attribution.

Although the primary concern of this research was to find if the measures of concern had a relationship with negative stigma attribution, a number of significant relationships were discovered that concerned the demographics variables that were included in Block 1 in the linear regression analyses. Having just mentioned how the identification with Americans variable is related to Fear and Segregation attributions, it is perhaps worth noting that the Ethnicity variable showed a small (i.e. not statistically significant; see Table 4) contribution in Block 3 when the IWAHS variables were introduced into the regression. The Ethnicity variable showed a positive relationship with Segregation attribution. Based on the way this nominal variable was entered, this means that those who identified themselves as a minority group (i.e. African American, Asian American, Hispanic or Latino, or Other) are more likely to endorse Segregation attribution. This could be for a number of reasons, possibly for much the same that those with high identification with Americans are likely to. When considering (American) societal norms, it is considered normative to be white and this is noted by both Goffman (1963) and Kimmel (2003). It has also been stated in Goffman's (1963) research that those who are a member of the outgroup may form their own ingroup, and thus have their own ingroup norms. Therefore, much like those who have a high identification with

Americans, it is possible that a lack of adherence to ingroup norms leads to a desire for distance or segregation from those who are not adhering.

A negative relationship was observed between Education and Pity attribution that remained strong across all three blocks. From this relationship it can be said that the more education an individual has had, the less likely they were to endorse the Pity attribution. This is surprising, as it would be expected that the more educated a person is the more likely they would be to endorse the pity attribution. It is therefore possible that a number of factors could be influencing this relationship. It could be, given the average age of participants skewed young (mean of 19.06), that this result is a byproduct of the large population of young participants in the sample. However, it is also possible that, for this sample, the results are as they appear. There was not a strong relationship with Anger attribution, an attribution parallel from pity in this attribution pathway, so it is possible that the observed Pity relationship exists without contributing to an increase in the more negative Anger relationship. Meaning that these results could merely be suggesting that as an individual becomes more educated rather than an increase in the opinion that a person with mental illness cannot help their actions because of their illness their education contributes knowledge that there are mechanisms at that person's disposal which they can use to help themselves.

Perhaps the most interesting relationships observed, however, were those that occurred with gender. From the linear regression analyses it was determined that gender shared a significant relationship with Pity, Help, and Avoidance stigma attributions. These relationships showed that gender was a significant, positive predictor of Pity and Help attributions and a significant negative predictor of Avoidance attribution. In other

words, the results showed that women are more likely to promote pity and helping attributions while being less likely to promote avoidance stigma.

With the Pity attribution being described by Corrigan et al. (2002) as the result of an individual attributing no blame for a harmful event, its relationship with gender makes sense. When societal conditioning and norms are considered, as they should be given the subject of the current study, it can be said that women are normatively conditioned from an early age to be empathetic and understanding. Assuming this is the case, it would then rationally follow that, much like those who strongly identify with all humanity who show strong dispositional empathy, that women would be more empathetic and show more pity for those with mental illness as the results show is the case. Indeed, this has been illustrated in noteworthy research which illustrates that women possess heightened empathy (Gilligan, 1980).

A similar explanation can then be made for why women are more likely to endorse helping attribution. The Help attribution follows pity in the personal responsibility attribution pathway, the theory being that Pity attribution will lead into actual helping behavior while on the opposite end of that pathway Anger attribution is less likely to lead into actual helping behavior. The results seem to support the theory in this particular case, as the data indicate that women are the ones more likely to endorse the two attributions, which is also supportive of previous research on gender differences (Gilligan, 1980).

The results regarding Avoidance attribution are perhaps the most surprising when considered in isolation. Avoidance attribution is linked to Fear and Segregation attributions, in the sense that avoidance is often a response to fear and then the surest way

to avoid is to segregate from the community. The assumption is then that women should be the ones to endorse this avoidance stigma, perhaps due to a number of underlying pressures and norms that we have accepted as normative to society. There is a prevailing societal pressure on women that they are responsible for their own safety (Stanko, 1995). When this idea is coupled with the knowledge that there is a societal assumption that persons with mental illness can pose a higher threat of danger or violence, it can make the results seen in Table 9 seem surprising. However, when these results are instead considered alongside those other relationships surrounding gender, a clearer picture is displayed. As mentioned, the results have supported that women are more likely to support Pity and Help attributions. It would then make sense that women would be less likely to promote Avoidance attribution as it is hard to provide beneficial help to an individual when avoiding them.

Future directions

In further research, greater insight could be provided, perhaps, if the age of the sample pool was extended. By expanding the population from which the sample was taken to include both younger and older demographics it is possible that a different relationship might be seen regarding the moral reasoning variables and attribution. Considering a great deal of moral development occurs in the years an individual spends in college, younger participants could provide insight to the potential influence of the PI scores and older participants could provide further insight into the influence of P scores as further moral development takes place in those years after college. Given the results surrounding gender, future research may also be able to gain further insight in its effects on stigma attribution. A focus on gender could illuminate if there is a relationship

between gendered social norms and interaction with persons with mental illness. With the results that the present study has found, along with the evidence found in previous research, further attention may also want to be paid to the IWAHS. Specifically, given the current political climate, the identification with Americans variable may provide different or more pronounced results to a number of the variables it was connected to in the current research. At the time of writing this study, the gun control debate spent a great degree of time in the attention of the media and that conversation often draws in the subject of mental illness and the potential dangerousness of persons with mental illness.

Limitations

As with any research, the present study is not without limitations. A primary limitation is that the sample consists primarily of young, college students. The majority of the sample consists of students aged between 18 and 19, with few aged over 20 years old. It is also a source of some concern that so much of the sample population is female, which could affect the strength of some relationships seen. Generalizability of the results is also a concern. All of the participants are students at Western Kentucky University, and there is a degree of homogeneity to the sample pool (i.e. that participants are predominantly young, white, and female). When partnered with the assumption that most of the participants are from the same state or if not that then more broadly from the South, this could have an effect on their responses to the surveys provided. Table 10 shows a comparison of the sample population to the larger populations of the Western Kentucky University campus and the United States.

Table 10

Comparison of Sample Demographic Statistics to WKU and US Populations

	Total				
	Sample		WKU*		U.S.**
	Frequency	%	Frequency	%	%
Men	27	22.1%	8,329	41.1%	49.2%
Women	94	77.0%	11,948	58.9%	50.8%
Not Listed	1	.8%	0	0%	0%
African American	22	18.0%	1,767	8.7%	13.3%
American Indian or Alaska Native	0	0%	38	.2%	1.3%
Asian	1	.8%	295	1.5%	5.7%
Hispanic/Latino	1	.8%	588	2.9%	17.8%
Native Hawaiian or Pacific Islander	0	0%	21	.1%	.2%
White	97	79.5%	15,604	77%	76.9%
Other	1	.8%	1,964	9.7%	2.6%

*Note: * (Western Kentucky University, 2017) ** (U.S. Census Bureau, 2017)*

Conclusion

The goal of the study was to find support to the hypothesis that moral development and identification with all humanity have a relationship with the degree of mental illness stigmatization. A hypothesis which was partially supported and the results which were observed provided some insight about that stigma attribution. Though moral reasoning did not have any significance as a predictor, the influence of identification with all humanity was seen in the results. Where this relationship between the IWAHS indices

and attribution is concerned, the most insight is provided about Fear and Segregation attribution, two attributions who are linked by Corrigan et al. (2002) by a single attribution pathway. Additionally, the study found a number of relationships between gender and attribution which suggest an avenue for future research where those variables and the potential cause for their relationship are concerned. The conclusion is then that there is some predictability to the kind of stigma likely to be attributed based on factors like degree of identification. As this research was influenced by the results found by Corrigan et al. (2014), the results support the idea of personal connection and group identification as being a source of stigma reduction. However, it is important to note that future research with a broader sample pool would be required to support the generalizability of this data to the greater population. Bearing this in mind, the current study does provide foundational support for a relationship between the levels of identification that the IWAHS measures and the kind of stigma attributions that are being made.

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APPENDIX A: DEMOGRAPHICS

1. Age: _____ years.

2. Gender (circle one):   Male   Female

3. Please indicate the following:
    a. ACT score: _____   or SAT Score: _____

    b. Cumulative College GPA: _____ 3.6 - 4.0
                                _____ 3.1 - 3.5
                                _____ 2.6 - 3.0
                                _____ 2.1 - 2.5
                                _____ below 2.1
                                _____ N/A (i.e., entering or 1st semester freshman)

    c. Education level: _____ Freshman
                           _____ Sophomore
                           _____ Junior
                           _____ Senior
                           _____ Other: _____

    d. Major (if you uncertain, please state "undeclared"): _____

6. Ethnicity (*optional*):   _____ African American/Black
                                     _____ American Indian or Alaska Native
                                     _____ Asian
                                     _____ Hispanic/Latino
                                     _____ Native Hawaiian or Pacific Islander
                                     _____ White
                                     _____ Other: _____

PLEASE READ THE FOLLOWING STATEMENT ABOUT HARRY:

Harry is a 30 year-old single man with schizophrenia. Sometimes he hears voices and becomes upset. He lives alone in an apartment and works as a clerk at a large law firm. He has been hospitalized six times because of his illness.

NOW ANSWER EACH OF THE FOLLOWING QUESTIONS ABOUT HARRY. CIRCLE THE NUMBER OF THE BEST ANSWER TO EACH QUESTION.

1. I would feel aggravated by Harry.

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
not at all								very much

2. I would feel unsafe around Harry.

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
no, not at all								yes, very much

3. Harry would terrify me.

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
not at all								very much

4. How angry would you feel at Harry?

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
not at all								very much

5. If I were in charge of Harry's treatment, I would require him to take his medication.

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
not at all								very much

6. I think Harry poses a risk to his neighbors unless he is hospitalized.

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
none at all								very much

7. If I were an employer, I would interview Harry for a job.

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
not likely								very likely

8. I would be willing to talk to Harry about his problems.

   1   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**
not at all   very much

9. I would feel pity for Harry.

   1   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**
none at all   very much

10. I would think that it was Harry's own fault that he is in the present condition.

   1   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**
no, not at all   yes, absolutely so

11. How controllable, do you think, is the cause of Harry's present condition?

   1   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**
not at all under   completely under
personal control   personal control

12. How irritated would you feel by Harry?

   1   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**
not at all   very much

13. How dangerous would you feel Harry is?

   1   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**
not at all   very much

14. How much do you agree that Harry should be forced into treatment with his doctor even if he does not want to?

   1   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**
not at all   very much

15. I think it would be best for Harry's community if he were put away in a psychiatric hospital.

   1   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**
not at all   very much

16. I would share a car pool with Harry every day.

   1   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**
not likely   very likely

17. How much do you think an asylum, where Harry can be kept away from his neighbors, is the best place for him?

   1   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**
not at all   very much

18. I would feel threatened by Harry.

   1   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**
no, not at all   yes, very much

19. How scared of Harry would you feel?

   1   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**
not at all   very much

20. How likely is it that you would help Harry?
   1   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**
definitely   definitely
would not help   would help

21. How certain would you feel that you would help Harry?

   1   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**
not at all certain   absolutely certain

22. How much sympathy would you feel for Harry?

   1   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**
none at all   very much

23. How responsible, do you think, is Harry for his present condition?

   1   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**
not at all   very much
responsible   responsible

24. How frightened of Harry would you feel?

    1   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**
not at all   very much

25. If I were in charge of Harry's treatment, I would force him to live in a group home.

    1   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**
not at all   very much

26. If I were a landlord, I probably would rent an apartment to Harry.

    1   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**
not likely   very likely

27. How much concern would you feel for Harry?

    1   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**
none at all   very much

This questionnaire is concerned with how you define the issues in a social problem. Several stories about social problems will be described. After each story, there will be a list of questions. The questions that follow each story represent different issues that might be raised by the problem. In other words, the questions/issues raise different ways of judging what is important in making a decision about the social problem. You will be asked to rate and rank the questions in terms of how important each one seems to you. Please turn the page to begin.

FAMINE

The small village in northern India has experienced shortages of food before, but this year's famine is worse than ever. Some families are even trying to sustain themselves by making soup from tree bark. Mustaq Singh's family is near starvation. He had heard that a rich man in his village has supplies of food stored away and is hoarding food while its price goes higher so that he can sell the food later at a huge profit. Mustaq was desperate and thinks about stealing some food from the rich man's warehouse. The small amount of food that he needs for his family probably wouldn't be missed.

What should Mustaq Singh do? Do you favor the action of taking the food? *(Mark one)*

___ Should take the food _____ Can't Decide _____ Should not take the food

Please rate in the space beside each statement how important each particular
   item/question is in making a decision about what you should do one way or another.

1=Great 2=Much 3=Some 4=Little 5=No

1. Is Mustaq Singh courageous enough to risk getting caught stealing? ___
2. Isn't it only natural for a loving father to care so much for his family that he would steal? ___
3. Shouldn't the community's laws be upheld? ___
4. Does Mustaq Singh know a good recipe for preparing soup from tree bark? ___
5. Does the rich man have any legal right to store food when other people are starving? ___
6. Is the motive of Mustaq Singh to steal for himself or to steal for his family? ___
7. What values are going to be the basis for social cooperation? ___
8. Is the epitome of eating reconcilable with the culpability of stealing?___
9. Does the rich man deserve to be robbed for being so greedy? ___
10. Isn't private property an institution to enable the rich to exploit the poor? ___
11. Would stealing bring about more total good for everybody concerned or not? ___
12. Are laws getting in the way of the most basic claim of any member of society? ___

Now that you have rated these items, please rank them below from most important to
   fourth most important in making a decision about what Mustaq Singh should do.

_____ # of Most important item _____ # of Third most important item
_____ # of Second most important _____ # of Fourth most important item

REPORTER

Molly Dayton has been a news reporter for the *Gazette* newspaper for over a decade. Almost by accident, she learned that one of the candidates for Lieutenant Governor for her state, Grover Thompson, had been arrested for shop-lifting, 20 years earlier. Reporter Dayton found out that early in his life, Candidate Thompson had undergone a confused period and done things he later regretted which were very out-of59 character now. His shop-lifting had been a minor offense and charges had been dropped by the department store. Thompson has not only straightened himself out since then, but in addition built a distinguished record in helping many people and in leading community projects. Now, Reporter Dayton regards Thompson as the best candidate in the field and likely to go on to important leadership positions in the state. Reporter Dayton wonders whether or not she should write the story about Thompson's earlier troubles because in the upcoming close and heated election, she fears that such a news story would wreck Thompson's chance to win.

Do you favor the action of reporting the story? *(Mark one)*

___ Should report the story ____ Can't Decide ____ Should not report the story

Please rate in the space beside each statement how important each particular item/question is in making a decision about what you should do one way or another.

1=Great 2=Much 3=Some 4=Little 5=No

1. Doesn't the public have a right to know all the facts about all the candidates for office? ___
2. Would publishing the story help Reporter Dayton's reputation for investigative reporting? ___
3. If Dayton doesn't publish the story wouldn't another reporter get the story anyway and get the credit for investigative reporting? ___
4. Since voting is such a joke anyway, does it make any difference what reporter Dayton does? ___
5. Hasn't Thompson shown in the past 20 years that he is a better person than his earlier days as a shop-lifter? ___
6. What would best serve society? ___
7. If the story is true, how can it be wrong to report it? ___
8. How could reporter Dayton be so cruel and heartless as to report the damaging story about candidate Thompson? ___
9. Does the right of 'habeas corpus' apply in this case? ___
10. Would the election process be more fair with or without reporting the story? ___
11. Should reporter Dayton treat all candidates for office in the same way by reporting everything she learns about them, good and bad? ___
12. Isn't it a reporter's duty to report all the news regardless of the circumstances? ___

Now that you have rated these items, please rank them below from most important to

fourth most important in making a decision about what Reporter Dayton should do.
_____ # of Most important item _____ # of Third most important item
_____ # of Second most important _____ # of Fourth most important item

SCHOOL BOARD
Mr. Grant was elected to the School Board District 190 and was chosen to be Chairman. The district was bitterly divided over the closing of one of the high schools. One of the high schools had to be closed for financial reasons, but there was no agreement over which school to close. During his election to the School Board, Mr. Grant had proposed a series of "Open Meetings" in which members of the community could voice their opinions. He hoped that dialogue would make the community realize the necessity of closing one high school. Also he hoped that through open discussion, the difficulty of the decision would be appreciated, and the community would ultimately support the school board decision. The first Open Meeting was a disaster. Passionate speeches dominated the microphones and threatened violence. The meeting barely closed without fist-fights. Later in the week, school board members received threatening phone calls. Mr. Grant wonders if he ought to call off the next Open Meeting.

Do you favor calling off the next Open Meeting? *(Mark one)*
___ Should call off the next open meeting ____ Can't Decide ____ Should have the next open meeting

Please rate in the space beside each statement how important each particular item/question is in making a decision about what you should do one way or another.

1=Great 2=Much 3=Some 4=Little 5=No
1. Is Mr. Grant required by law to have Open Meetings on major school board decisions? ___
2. Would Mr. Grant be breaking his election campaign promises to the community by discontinuing the Open Meetings? ___
3. Would the community be even angrier with Mr. Grant if he stopped the Open Meetings? ___
4. Would the change in plans prevent scientific assessment? ___
5. If the school board is threatened, does the chairman have the legal authority to protect the Board by making decisions in closed meetings? ___
6. Would the community regard Mr. Grant as a coward if he stopped the Open Meetings? ___
7. Does Mr. Grant have another procedure in mind for ensuring that divergent views are heard? ___
8. Does Mr. Grant have the authority to expel troublemakers from the meetings or prevent them from making long speeches? ___

9. Are some people deliberately undermining the school board process by playing some sort of power game? ___
10. What effect would stopping the discussion have on the community's ability to handle controversial issues in the future? ___
11. Is the trouble coming from only a few hotheads, and is the community in general really fair-minded and democratic? ___
12. What is the likelihood that a good decision could be made without open discussion from the community? ___

Now that you have rated these items, please rank them below from most important to fourth most important in making a decision about what Mr. Grant should do.
_____ # of Most important item _____ # of Third most important item
_____ # of Second most important _____ # of Fourth most important item

CANCER

Mrs. Bennett is 62 years old, and in the last phases of colon cancer. She is in terrible pain and asks the doctor to give her more pain-killer medicine. The doctor has given her the maximum safe dose already and is reluctant to increase the dosage because it would probably hasten her death. In a clear and rational mental state, Mrs. Bennett says that she realizes this; but she wants to end her suffering even if it means ending her life.

Should the doctor giver her an increased dosage?

Do you favor the action of giving more medicine? *(Mark one)*
____ Should give Mrs. Bennett an increased dosage to make her die
____ Can't Decide
____ Should not give her an increased dosage

Please rate in the space beside each statement how important each particular item/question is in making a decision about what you should do one way or another.

1=Great 2=Much 3=Some 4=Little 5=No

1. Isn't the doctor obligated by the same laws as everybody else if giving an overdose would be the same as killing her? ___
2. Wouldn't society be better off without so many laws about what doctors can and cannot do? ___
3. If Mrs. Bennett dies, would the doctor be legally responsible for malpractice? ___
4. Does the family of Mrs. Bennett agree that she should get more painkiller medicine? ___
5. Is the painkiller medicine an active heliotropic drug? ___

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6. Does the state have the right to force continued existence on those who don't want to live? ___
7. Is helping to end another's life ever a responsible act of cooperation? ___
8. Would the doctor show more sympathy for Mrs. Bennett by giving the medicine or not? ___
9. Wouldn't the doctor feel guilty from giving Mrs. Bennett so much drug that she died? ___
10. Should only God decide when a person's life should end? ___
11. Shouldn't society protect everyone against being killed? ___
12. Where should society draw the line between protecting life and allowing someone to die if the person wants to? ___

Now that you have rated these items, please rank them below from most important to fourth most important in making a decision about what the doctor should do.

_____ # of Most important item _____ # of Third most important item
_____ # of Second most important _____ # of Fourth most important item

DEMONSTRATION

Political and economic instability in a South American country prompted the President of the United States to send troops to "police" the area. Students at many campuses in the U.S.A. have protested that the United States was using its military might for economic advantage. There is widespread suspicion that big oil multinational companies were pressuring the President to safeguard a cheap oil supply even if it means loss of life. Students at one campus took to the streets in demonstration, tying up traffic and stopping regular business in town. The president of the university demanded that the students stop their illegal demonstrations. Students then took over the college's administration building, completely paralyzing the college. Are the students right to demonstrate in these ways?

Do you favor the action of demonstrating in these ways?

____ Should continue demonstrating in these ways
____ Can't Decide
____ Should not continue demonstrating in these ways

Please rate in the space beside each statement how important each particular item/question is in making a decision about what you should do one way or another.

1=Great 2=Much 3=Some 4=Little 5=No

1. Do the students have any right to take over property that doesn't belong to them? ___

2. Do the students realize that they might be arrested and fined, and even expelled from school? ___
3. Are the students serious about their cause or are they doing it just for fun? ___
4. If the university president is soft on students this time, will it lead to more disorder? ___
5. Will the public blame all students for the actions of a few demonstrators? ___
6. Are the authorities to blame by giving in to the greed of the multinational oil companies? ___
7. Why should a few people like the Presidents and business leaders have more power than ordinary people? ___
8. Does this student demonstration bring about more or less good in the long run to all people? ___
9. Can the students justify their civil disobedience? ___
10. Shouldn't the authorities be respected by students? ___
11. Is taking over a building consistent with principles of justice? ___
12. Isn't it everyone's duty to obey the law, whether one likes it or not? ___

Now that you have rated these items, please rank them below from most important to fourth most important in making a decision about what the students should do.

_____ # of Most important item _____ # of Third most important item
_____ # of Second most important _____ # of Fourth most important item

APPENDIX D: IDENTIFICATION WITH ALL HUMANITY SCALE (IWAHS)

1. How close do you feel to each of the following groups?

    1 = not at all close

    2= not very close

    3 = just a little or somewhat close

    4 = pretty close

    5 = very close

  a. People in my community

  b. Americans

  c. People all over the world

2. How often do you use the word "we" to refer to the following groups of people?

    1 = almost never

    2 = rarely

    3 = occasionally

    4 = often

    5 = very often

  a. People in my community

  b. Americans

  c. People all over the world

3. How much would you say you have in common with the following groups?

    1 = almost nothing in common

    2 = little in common

    3 = some in common

4 = quite a bit in common

5 = very much in common

    a. People in my community

    b. Americans

    c. People all over the world

Please answer all remaining questions using the following choices:

1 = not at all

2 = just a little

3 = somewhat

4 = quite a bit

5 = very much

4. Sometimes people think of those who are not a part of their immediate family as "family." To what degree do you think of the following groups of people as "family?"

a. People in my community

b. Americans

c. All humans everywhere

5. How much do you identify with (that is, feel a part of, feel love toward, have concern for) each of the following?

a. People in my community

b. Americans

c. All humans everywhere

6. How much would you say you care (feel upset, want to help) when bad things

happens to

a. People in my community.

b. Americans.

c. People anywhere in the world.

7. How much do you want to be:

a. a responsible citizen of your community.

b. a responsible American citizen.

c. a responsible citizen of the world.

8. How much do you believe in:

a. being loyal to my community.

b. being loyal to America.

c. being loyal to all mankind.

9. When they are in need, how much do you want to help:

a. people in my community.

b. Americans.

c. people all over the world.

APPENDIX E: HUMAN SUBJECTS REVIEW BOARD APPROVALL

WKU INSTITUTIONAL REVIEW BOARD
OFFICE OF RESEARCH INTEGRITY

DATE: September 21, 2017

TO: Rebecca Isaacs
FROM: Western Kentucky University (WKU) IRB

PROJECT TITLE: [1129481-1] The Relationships among Social Judgments, Identification, and Stigmatization
REFERENCE #: IRB 18-072
SUBMISSION TYPE: New Project

ACTION: APPROVED
APPROVAL DATE: September 21, 2017
EXPIRATION DATE: May 11, 2018
REVIEW TYPE: Expedited Review

Thank you for your submission of New Project materials for this project. The Western Kentucky University (WKU) IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on the applicable federal regulation.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by a *signed* consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require each participant receive a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this office prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please use the appropriate reporting forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

This project has been determined to be a Minimal Risk project. Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of May 11, 2018.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Paul Mooney at (270) 745-2129 or irb@wku.edu. Please include your project title and reference number in all correspondence with this committee.

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This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Western Kentucky University (WKU) IRB's records.