

How can Respectfulness in Medical Professionals be Increased? A Complex but Important Question.

Abstract

Respectfulness is demanded of doctors and predicts more positive patient health-related outcomes but research is scarce on ways to promote it. This study explores two ways to conceptualize unconditional respect from medical students, defined as respect paid to people on the basis of their humanity, in order to inform strategies to increase it. Unconditional respect conceptualized as an attitude suggests that unconditional respect and conditional respect are additive, whereas unconditional respect conceptualized as a personality trait suggests that people who are high on unconditional respect afford equal respect to all humans regardless of their merits. One-hundred and eighty one medical students completed an unconditional respect measure then read a description of a respect-worthy or a non-respect-worthy man and indicated their respect towards him. The study found a main effect for unconditional respect and a main effect for target respect-worthiness but no interaction between the two when respect paid to the target was assessed, supporting the attitude-based conceptualization. This suggests that unconditional respect can be increased through relevant interventions aimed at increasing the relative salience to doctors of the human worth of individuals. Interventions to increase unconditional respect are discussed.

Introduction

Medical professionals have a professional and ethical obligation to treat patients with respect (General Medical Council 2015). Moreover, research shows that respect from medical professionals is of major concern to patients (Thorne et al. 2013); it is important for positive patient experiences (Carroll et al. 2007; Matthews and Callister 2004), patient satisfaction, adherence to medical advice, trust, help-seeking and self-esteem (Blanchard and Lurie 2004; Beach et al. 2005; Clucas and St Claire 2010). Despite this, disrespectful communication and attitudes from doctors feature in a rising number of patient complaints in countries such as Australia and the UK (Powis 2015). A priority is therefore to increase respectfulness of medical professionals but very little research has focused on ways to do this.

An impediment to such research is the multifaceted nature of *respect*, which generates different ways of operationalising it and consequently, different methodological approaches to increase it. We have identified three relevant types of respect in the philosophical and psychological literature. The first, achieved respect, is respect paid to people on the basis of their accomplishments or merits, such as their conformity to valued standards of conduct, their moral integrity, fortitude of character or concern about others' welfare (Darwall 1977). The second, status respect, is respect paid to people on the basis of their social position (Lalljee, Laham, and Tam 2007). Both of these can be considered as forms of "conditional respect". Because the amount of respect paid results from the perceiver's evaluations of the merits or position of the target person, achieved respect and status respect fit the definition of attitudes (see Ajzen, 1988). Indeed, writers generally agree that respect paid from one person to another is a kind of attitude (Honneth 1995; Sennett 2003), such that positive respect involves evaluating an individual as valuable and deserving of careful attention and proper consideration (see Dillon 2010; Parse 2006). Furthermore, such an evaluation has cognitive, behavioural and affective components (Hendrick and Hendrick 2006; Jackson, Esses, and Burris 2001), analogous to perceiving the person as having respect-worthy attributes, acting in a way that acknowledges the attributes that make the person valuable, and experiencing the person as valuable, respectively (see Dillon 2010). From this perspective, researchers who wish to increase levels of achieved and status respect paid to patients by doctors might focus on increasing the relative salience to doctors of respect-worthy attributes in patients and turn to the rich tradition of attitude change theory and research for guidance (see Briñol and Petty 2011). However, this is likely to be challenging because of lack of opportunity for some groups to demonstrate some respect-worthy qualities, such as self-sufficiency because of

social disadvantage (Sennett, 2003), and vulnerability to doctors' stereotypes. For instance, negative attitudes of medical students or medical professionals have been demonstrated towards homeless people (Masson and Lester, 2003) and patients engaging in self-destructive behaviours have been perceived as wasting healthcare resources (Najman, Klein and Munro, 1982; Saunders et al. 2011).

The third relevant type of respect, unconditional respect, is respect paid to people on the basis of their humanity, which makes them of fundamentally equal worth to each other (Lalljee et al. 2007; Lalljee et al. 2009). It results from the belief that all humanity is rational, autonomous and self-determining and therefore inherently respect-worthy (Kant 1964/1785; Downie and Telfer 1969; Kristjansson 2007; Lalljee et al. 2007). Based on these theoretical descriptions, it would seem that unconditional respect results directly from the perceiver's value system (in our case, from the doctor's fundamental beliefs that all patients are worthy because they are human, as opposed to any evaluations of his/her patient's individual merits or status). This conceptualisation implies that unconditional respect fits the definition of a *personality* trait (see Ajzen, 1988). Indeed, researchers have found people who are high on unconditional respect are also high on related, yet different traits such as agreeableness, perspective-taking and empathic concern (Lalljee et al. 2007). From this perspective, researchers who wish to increase levels of respect paid to patients by doctors might therefore turn to theories of personality change for guidance. However, they will find that personality traits are typically less malleable than attitudes (Ajzen 2005) and so they might have to rely on encouraging candidates who value human worth to apply for medical school and/or selecting such individuals, which may be somewhat impractical.

In an alternative conceptualization, unconditional respect is viewed as an *attitude*, in the same manner as achieved and status respect, but the relevant attitude object is at a higher level of abstraction, specifically, its level is "humanity" as opposed to individual people. Medical professionals high on unconditional respect perceive humanity in their patients more strongly and/or evaluate it more favourably. From this perspective, strategies to increase levels of unconditional respect paid to patients by medical professionals might, after all be based on attitude theory and research. For instance, interventions could focus on increasing the relative salience to doctors of the human worth of individuals.

To our knowledge, no studies have been designed to distinguish between the personality and attitude based conceptualizations of unconditional respect, yet increasing unconditional respect is likely to be a promising approach to increasing respect towards all

humans, including those with demerits. Because of the potential benefits to patient wellbeing of finding ways to increase the respect their doctors pay to them, our specific research aim is to address this gap in the literature by exploring which conceptualization of unconditional respect is better supported by empirical data from medical students.

The personality-based conceptualization of unconditional respect implies an interactive relationship between the unconditional respect of a perceiver and the merits/status of the person perceived in predicting the amount of respect paid: perceivers high on unconditional respect will pay all humans a high level of respect, regardless of the person's merits/status, whereas perceivers low on unconditional respect will pay a high level of respect only when they perceive that the persons' achievements/status merit it. Thus, in this personality-based conceptualization, high unconditional respect would over-ride conditional respect in the sense that it predicts equal respect to all humans regardless of their merits. On the other hand, the attitude-based conceptualization of unconditional respect implies an additive relationship between the unconditional respect of a perceiver and the merits/status of the person perceived in predicting the amount of respect paid to the person: perceivers high on unconditional respect will pay all people more respect than will perceivers who are low on unconditional respect and will also independently pay more respect to persons when they perceive that the persons' achievements/status merit it. Our study is therefore designed to test for an interactive vs an additive relationship between unconditional and conditional respect.

Our subsidiary research aim is to explore possible differences in the relationships of *cognitive, affective and behavioural* responses of respect to the target person's achievements/status and the perceiver's unconditional respect. The relationship between cognitive, affective and behavioural responses of respect has not previously been examined. Although we expect the response types to correlate, there may also be differences between them (Eagly and Chaiken, 1998), for example because there are more social pressures on behaviours than on thoughts or feelings (Ajzen, 2005).

Methods

Participants

A convenience sample of 181 medical students from a university in the UK comprised 44 (24.3 per cent) first years, 91 (50.3 per cent) second years, 16 (8.8 per cent) third years and 30 (16.6 per cent) fourth years. Ninety-five (52.5 per cent) were female, 74 (40.9 per cent) were males and 12 (6.6 per cent) did not indicate their sex. Most participants were British

(152, 84 per cent). A convenience sample was appropriate given that the study was designed to explore psychological processes that are generally assumed to be universal within cultures.

Materials and measures

1. Two vignettes describing a thirty-five year-old white English male target¹ from a middle-class family were created to operationalise worthy and non-worthy conditions of achieved and status respect. In the Respect-worthy condition, the man had been in long term employment as a teacher and did volunteering (to operationalise self-sufficiency and “giving back to others” (see Sennett 2003)); he liked exercising and had healthy habits (to operationalise “psychological and moral depth” (see Crossley 2000)), he was fair and loyal with pupils (to operationalise living up to his personal standards (see Hill 1982)), honest and reliable with his wife (see Frei and Shaver 2002) and never violent (see Sprott 1955). In the Non-respect-worthy condition, he was described with the mirror demerits (e.g. unemployed, not bothered with volunteering etc...). The vignettes were matched for appearance, length and language and included (the same) picture of the man’s face and shoulders at a forty-five degree angle. He had a neutral facial expression.

2. The 12-item *Unconditional Respect for Persons scale: RfP* scale (Lalljee et al., 2007) was used to measure unconditional respect (UR). Items are rated on a Likert scale from 1 (strongly disagree) to 6 (strongly agree) with total scores ranging from 12 to 72. Examples of items include “because we are all human, everyone should be treated with respect” and “someone who has committed an awful crime no longer has the right to be treated decently” (reverse coded). The scale has good internal consistency (median Cronbach’s alpha of .75 in ten samples) and good convergent, discriminant and predictive validity at interpersonal and group levels amongst several different cultures, including the UK, India and the United Arab Emirates (see Lalljee et al. 2007). Standardized Cronbach Alpha was .80 in the present sample.

3. Visual analogue scales (VAS) (from “very unlikely” at zero cm on the left to “very likely” at ten centimetres on the right) were created to measure the three manifestations of paid respect (Paid Respect), including nine behaviours, six beliefs and eight feelings of respect towards the target (see Table 1). VAS were chosen over Likert scales because they are easy and quick to use and generally preferred by raters and can be considered interval (see Hasson and Bengt 2005). Cronbach’s alpha tests and item-total correlations were carried out to establish the internal reliability of these measures. Item-total correlations for beliefs and

feelings of respect were all above .3 but two behaviours of respect had item-total correlations below .3: “you would hold him responsible if he missed an appointment”, “you would tend to not make eye contact” and were therefore dropped. Standardized Cronbach Alphas for each set of items was .83, .88 and .88 respectively, indicating that the measures had good internal consistency. A scale from 0 to 10 for each measure was created by averaging scores over the relevant item set.

Validation of the Paid Respect measurement model

Confirmatory Factor Analysis (CFA) was carried out to confirm that the items making up the three measures all related to the latent construct of respect, and therefore that the measures were valid. A bifactor model postulating that variation in the items is explained by a general factor (here respect), as well as grouping factors (here behavioural, cognitive and affective aspects of responding) that explain item covariance over and above the general factor, was a good fit to the data ($X^2(165) = 246.21, p < .001, CFI = 0.96, TLI = 0.95, RMSEA = 0.05 (0.03, 0.06), SRMR = 0.04$)². Inspection of the model parameters showed that all items loaded significantly on (i.e. correlated significantly with) the general factor (loadings ranged between .36 (Behaviour 2) and .87 (Feeling 2)), which supported that all three measures related to respect.

There was also evidence that the behavioural items represented a domain specific factor that accounted for unique variance in the items over the general factor. All behavioural items, except for item 2, loaded significantly on the behaviour factor (loadings ranged between .39 and .50), which explained 10% of the common variance across these items. Evidence that cognitive and affective items represented domain specific factors was weaker, with many of the items loading highly on the general factor (loadings over .62) such that little unique variance was left for the specific factors. Only three of the six belief items (1, 3 and 6) loaded significantly on the cognitive factor (loadings ranged between .40 and .51) and two of the affective items (3 and 5) loaded significantly on the affective factor (loadings of .50 and .49). The cognitive and affective factors each explained 6% of the common variance across the items (Stucky & Edelen, 2014). Overall, this suggested that beliefs and feelings more strongly reflect the general factor of paid respect than behaviours. Nonetheless, we decided to keep the distinction between all three measures of respect because the bifactor model with these three grouping factors was the best fit for the data² and because it also allowed us to explore the relationships between the other research variables (target respect-worthiness and unconditional respect) and each of the three responses of respect. Indeed, the

distinction between the classes of responses is considered conceptually important for attitude theory and research even though prior factor analyses of attitudinal responding have not always clearly differentiated between them (Eagly & Chaiken, 1998).

Procedure

Ethical clearance was obtained from the University of Bristol Centre for Hearing and Balance Studies Ethics Committee, which ensured that the study followed the principles in the Declaration of Helsinki.

Two questionnaire types were assembled, one with the vignette describing the patient as respect-worthy followed by VAS and the other with the vignette describing the target as non-respect-worthy followed by VAS. Subsequently, an RfP Scale was inserted before or after each vignette and VAS in counterbalanced order.

The two questionnaire types (Respect-worthy/Non-respect-worthy) were pseudo-randomly distributed to medical students between lectures, with distribution of the two questionnaire types following a set sequential order. Participation was anonymous and voluntary and generally took about fifteen minutes. Participants were invited to imagine that they were meeting the target described and indicate likely behaviours, beliefs and feelings of respect they would pay towards him (see Elizur, Neumann, and Bawer 1986).

Statistical strategy for main analysis

A two-level latent-outcome multivariate response linear regression model was used (see Garson 2013; Heck, Thomas, and Tabata 2013) to examine the effect of UR and Respect-worthiness on Paid Respect as well as the interactions between UR and Respect-worthiness (Respect-worthy/Non-respect-worthy), Respect-worthiness and Paid Respect Manifestation (Behaviours/Beliefs/Feelings of respect), and UR and Paid Respect Manifestation. This model was chosen in preference to repeated measures ANCOVA because ANCOVA has a more restrictive assumption of homogeneity of regression slopes (Kwok et al., 2008). The two-level multivariate response model was devised to denote one underlying latent construct of paid respect (Heck et al., 2013). The measurement model at level 1 consisting of the three measures of respect nested within individuals was defined using the repeated dialog box in SPSS MIXED. An index variable named "Paid Respect Manifestation" was used to identify the measures of behaviours, beliefs and feelings as three measures of the latent construct of

respect (Heck et al., 2013). To aggregate the three measures of respect into one construct, the intercept term at the lowest level was excluded (Heck et al., 2013).

The participant was treated as a level 2 unit (Heck et al., 2013). At level 2, the three individual-level predictors were UR, Respect-worthiness, and Participant Sex. Participant Sex was added as a predictor since female medical students have been shown to score higher on empathy than their male counterparts (Bylund and Makoul 2002) and preliminary analysis of the data using a 2 (Participant Sex: Male/Female, between-subjects) X 3 (Paid Respect Manifestation: Behaviours/Beliefs/Feelings of respect, within-subjects) mixed ANOVA on Paid Respect showed a significant effect of Participant Sex with females ($M = 6.82, SD = 1.55$) paying more respect to the target than males ($M = 6.33, SD = 1.47$), $F(1, 167) = 4.18, p = .042$ ($\eta_p^2 = .025$). Preliminary analyses also showed no difference in Paid Respect according to Medical School Year and no interaction between Medical School Year and Paid Respect Manifestation so data were collapsed over Medical School Year. UR, Respect-worthiness, Participant Sex, Paid Respect Manifestation and the interactions were entered as fixed terms. The full factorial model was first tested with all main effects and same and cross level interactions for the four fixed terms. Only significant interaction terms were retained in the model with the exception of the interaction terms of interest. To facilitate interpretation of the intercepts, the predictors were centered (UR at the sample mean, Respect-worthiness and Participant Sex by coding the categories as -1 and + 1). Behaviours of respect were set as the reference category for Paid Respect Manifestation. Coefficients were estimated using Restricted Estimated Maximum Likelihood (REML). An unstructured covariance structure was used to describe the relationships among the three respect manifestation measures within individuals as this matrix fitted the data best based on the -2 Restricted Log Likelihood and Akaike's Information Criterion (AIC) indicators (Heck et al., 2013). The statistical assumptions of normality, linearity and multicollinearity were met.

Results

Preliminary analyses

Chi-square and T-tests confirmed that there were no differences between the respect-worthy and non-respect-worthy groups in terms of participant sex, year of study, nationality (British/non-British) and UR score.

Descriptives and correlations

The means and standard deviations for behaviour, belief and feeling manifestations of Paid Respect as well as for average Paid Respect are shown in Table 2, broken down by Respect-worthiness and Participant Sex. The mean UR score for the full sample was 60.45 ($SD = 6.80$, range = 34-72) ($N = 173$) and 60.33 ($SD = 6.76$, range = 34 to 72) for participants who indicated their sex ($N=163$).

All scores for behaviour, belief and feeling manifestations of Paid Respect and UR inter-correlated significantly, although correlations involving UR were smaller in magnitude (see Table 3).

Coefficients and significance tests for the main analysis

The fixed-effect estimates from the final model are summarised in Table 4. The model indicates that the intercept (mean value of Paid Respect) across Respect-worthy and Non-Respect-worthy conditions and across males and females at the mean value of UR was 7.05 for Behaviours, 6.74 for Beliefs and 6.08 for Feelings. The table indicates that UR and Respect-worthiness were significant predictors of Paid Respect (respectively estimate = .08, $p < .001$ and estimate = .70, $p < .001$). When participants' UR scores increased by 1, their Paid Respect increased by .08 and participants afforded higher Paid Respect to the Respect-worthy compared to the Non-Respect-worthy target. The interaction between UR and Respect-worthiness was not significant. The interaction between UR and Paid Respect Manifestation was also not significant, indicating that the relationships between UR and each manifestation of Paid Respect were similar. However, there was a significant interaction between Respect-worthiness and Paid Respect Manifestation, in that Respect-worthiness was more strongly related to Feelings compared to Behaviours (estimate = .54, $p < .001$), and Beliefs compared to Behaviours (estimate = .32, $p < .001$). Follow-up analyses confirmed that Respect-worthiness was significantly related to each manifestation of Paid Respect (for Behaviours ($N = 162$): $B = .70$, $SE = .09$, $t = 7.66$, $p < .001$; for Beliefs ($N = 162$): $B = 1.04$, $SE = .09$, $t = 10.88$, $p < .001$; for Feelings ($N = 163$)²: $B = 1.25$, $SE = .08$, $t = 16.26$, $p < .001$). While Participant Sex was no longer a significant predictor of Paid Respect, there was a significant interaction between Respect-worthiness and Participant Sex (estimate = .21, $p = .005$), with Respect-worthiness being more strongly related to Paid Respect in females compared to males. Follow-up analyses confirmed that Respect-worthiness was a significant predictor of Paid Respect for females (estimate = .93, $SE = .11$, $p < .001$) and males (estimate

= .44, $SE = .15$, $p = .006$). The model explained 58 per cent of the variation in average Paid Respect scores (see Peugh, 2010).

Discussion

Main effects of both Unconditional Respect and Respect-worthiness on Paid Respect were found with no interaction between the two, despite the study being sufficiently powered to detect such an interaction (Maas and Hox 2005). This additive pattern supports our conceptualization of unconditional respect as an attitude towards a high order category such as humanity, as opposed to a personality trait. This is encouraging because it suggests that interventions could be used to cultivate unconditional respect drawing on almost one hundred years of attitude research (Briñol and Petty 2011; Wood 2000). Such interventions might focus on increasing the saliency of human worth to medical students and professionals and could in turn improve the respect experience of non-respect-worthy people in medical consultations. This would be of benefit, for example, to people at the bottom of the social economic ladder who may be disadvantaged when it comes to demonstrating the respect-worthy qualities of being self-sufficient, giving back to others and working to the limits of their abilities and who may be more likely to experience disrespect (Sennett 2003). Indeed, negative attitudes from medical students have been reported towards various patient groups (e.g. Masson and Lester 2003) and the main effect of respect-worthiness confirms that people who display fewer respect-worthy characteristics are likely to receive less respectful attitudes from their doctors.

The finding that participants paid more respect to the target when he was described as having respect-worthy qualities compared with non-respect-worthy qualities supports the idea that conditional respect can be conceptualized as an attitude directed towards a person based on perceptions that s/he possesses respect-worthy achieved qualities. Moreover, the finding provides some empirical support for achieved qualities proposed in the literature as likely to make a person respect-worthy (c.f. Sennett 2003; Crossley 2000; Hill 1982; Spratt 1955) and for the relevance to professional interpersonal relationships of achieved qualities identified by Frei and Shaver (2002) in the context of close relationships. The study also showed a significant effect of Respect-worthiness on all three manifestations of Paid Respect, although Respect-worthiness was more strongly related to Feelings and Beliefs than Behaviours. It is positive if doctors intend to behave with respect towards patients even if they perceive few respect-worthy qualities in them, although there is also the possibility that patients perceive a

mismatch, perhaps experiencing the respectful communication as non-genuine and feeling less respected as a result.

The finding that paid respect increased when participants scored higher on unconditional respect is consistent with past findings that people who scored high on unconditional respect were more likely to report acting respectfully towards disrespectful targets (Chopra 2006, as cited in Lalljee et al. 2007). However, the present study adds to existing literature in that unconditional respect is also manifest in reports about feelings and beliefs of paid respect. This further supports our conceptualization of unconditional respect as a respectful attitude towards a human, rather than just a behavioural inclination to act with respect. Indeed, prior to these findings, unconditional respect could have been considered a behavioural inclination to act with respect derived from a favourable attitude towards the general behaviour of treating people with a basic level of respect, seeing this to be the morally right action, without necessarily believing the person to be inherently worthy and feeling respect for the person. This congruency also suggests that respectful communication resulting from high levels of unconditional respect is more likely to be perceived as genuine.

Existing validated scales could not be used to measure behaviours, beliefs and feelings of respect because, to our knowledge there are only two validated scales that measure respect and they both focus on romantic relationships (Hendrick and Hendrick 2006; Frei and Shaver 2002) and were unsuitable for this study. The three measures used here each had good internal reliability, related to one latent construct of respect and showed evidence of construct validity since, consistent with prior research, female medical students scored higher on them than male medical students (Bylund and Makoul 2002). Whilst the sample size was sufficient to address the main aims of the study, the number of participants was somewhat lower than is often recommended for the confirmatory factor analysis that was used to validate the underlying structure of the paid respect measures. However, small sample robust estimates using the swain function (Herzog, Boosma and Reinecke, 2007) were used for several of the indices (as explained in the footnotes²).

The target towards which respect was directed was a young white male and findings might not generalise to older, non-white, female or other categories. In particular, there are likely to be differences in the level of respect paid to different targets and in the achieved qualities attracting respect in different targets. Moreover, unconditional respect may be more prevalent in some cultures than others. Despite this, there is no strong reason to suspect that the main finding of an additive relationship between unconditional respect and conditional

respect on the level of respect paid, supporting a conceptualization of unconditional respect as an attitude, would not transfer. Participants also had the tendency to score on the high end of the unconditional respect scale since only twelve participants (7 per cent) scored at or below “slightly agree” on average (a score of 48 and below), although sixty-four (37 per cent) scored below “agree” on average (a score below 60), perhaps because admission criteria for medical school in the United Kingdom already favour students high on humanism (Medical School Council, 2016). Although the questionnaire was anonymous, a social desirability bias in responding might also have played a role. Despite this there was sufficient variation in scores for significant results to be found. In light of evidence that doctors become less humanistic with more experience in medical settings (Haque and Waytz 2012), there is a need for future longitudinal research to investigate whether there is a shift in the mean of the distribution of scores in doctors as they gain experience.

Medical education and continuing professional development programmes should focus on interventions aimed at increasing levels of unconditional respect among medical students and medical professionals given the importance of respect from medical professionals for optimal medical care and patient health outcomes (Blanchard and Lurie 2004; Beach et al. 2005; Clucas and St Claire 2010). Charles Bailey argued that if one possesses the proper concept of a person – “a rational living with consciousness, reason, intentionality, freedom of choice, responsibility, capacity for suffering and pleasure both physical and mental” - one must logically have respect for others (as cited in Andrews 1976, 141). Possibly, saliency of human worth can be increased by strengthening people’s conception of shared personhood. It is also possible that people who are more inclined to self-categorise as part of the same human family have higher levels of unconditional respect (Laham et al. 2009) and that unconditional respect could be improved by promoting self-categorisation as “one human family”. Further research should investigate whether existing communication skills training already enhances or could enhance unconditional respect by such means. Patient-centred communication skills training may also be helpful in ensuring doctors perceive patients as persons and apply their attitude of unconditional respect to them (Clucas and St Claire 2011).

Notes

¹The status of the target was also manipulated by introducing him as a patient or a professional in a non-medical context. This manipulation was carried out because of indications in the literature that medical students and doctors sometimes depersonalize patients (Dyrbye et al. 2008; Haque and Waytz 2012; Wahlqvist et al. 2005), in which case they would not apply their attitude of unconditional respect to them. However, this factor did not have an effect on Paid Respect and did not interact with UR or respect-worthiness so in the interests of clarity, it is not mentioned further in the paper and the word “target” has been used.

²The fit of each factor model of interest was evaluated using the Tucker-Lewis index (TLI), the comparative fit index (CFI), the root-mean-square error of approximation (RMSEA) with a 90% confidence interval (CI) and the standardised root-mean square residual (SRMR). TLI and CFI values $\geq .90$ and RMSEA and SRMR values $< .08$ indicate acceptable model fit whilst TLI and CFI values $\geq .95$ and RMSEA values $< .06$ and SRMR values $\leq .05$ indicate good model fit (Hu & Bentler, 1999; MacCallum et al, 1996). Small sample robust estimates using the swain function (Herzog, Boosma and Reinecke, 2007) are presented for the following fit indices: CFI, TLI and RMSEA given that larger samples are often advised for CFA. We also evaluated the fit of a one-factor model (postulating that all items are influenced by a single factor) and a two-factor model (postulating two correlated factors – a behavioural and a cognitive/affective factor - explaining variation in the items) but these were a poor fit to the data. The fit of a second-order model, postulating three factors, whose correlations are explained by a higher order factor (unlike the bifactor model for which the general factor and grouping factors are on an equal conceptual footing in explaining item covariance) was also evaluated. The second-order model showed a just acceptable fit on all indices, except the TLI, whose value of .89 was below the .90 threshold for acceptable model fit.

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Table 1:

Measures of behaviour, belief and feeling manifestations of Paid respect

Items	Source
Behaviours of respect: You would....	
1....be inclined to treat him politely	Frei and Shaver (2002)
2....not take his opinions seriously	Jones (2000); Simon, Lucken, &
3....respect his views	Sturmer (2006); Clucas & St Claire (2010)
4....help him formulate and carry out his plans	Downie and Telfer (1969)
5....listen to him attentively to everything that he says	Clucas (2005); Jones (2000)
6....tend to smile at him	Clucas (2005); Lawrence- Lightfoot (1999)
7....would treat him with respect	
Beliefs of respect: You would...	
1....think that this person deserves to be respected	
2....expect people to listen to him	
3....think of him as a person of worth	
4....think he has much to be proud of	Dillon (2010)
5....not believe him respect-worthy	
6....believe you are superior to him	
Feelings of respect: You would...	
1....find it hard to feel respect for him	
2....admire this person	
3....feel contempt for this person	Dillon (2010)
4....feel pity for the person	
5....despise him	
6....would feel honoured to be with this person	
7....like this person as your neighbour	
8....dislike having him as a colleague	adapted from the social distance scale (Bogardus, 1925, as cited in Fishbein & Ajzen, 1975)

Table 2:

Means and standard deviations for behaviour (N = 178), belief (N = 178) and feeling (N = 179) manifestations of Paid Respect as well as for average Paid Respect (N = 177¹), broken down by Respect-worthiness and Participant Sex

	N ¹	Paid Respect Manifestation			Average
		Behaviours	Beliefs	Feelings	Paid Respect
Respectworthy	89	7.82 (1.18)	7.85 (1.17)	7.38 (.97)	7.68 (1.00)
Females	51	8.16 (1.10)	8.14 (.99)	7.64 (.88)	7.98 (.88)
Males	34	7.34 (1.18)	7.44 (1.28)	7.05 (.98)	7.28 (1.04)
Non-respectworthy	88	6.26 (1.36)	5.54 (1.51)	4.76 (1.16)	5.50 (1.14)
Females	43	6.14 (1.20)	5.53 (1.31)	4.66 (.99)	5.44 (.92)
Males	39	6.35 (1.52)	5.54 (1.59)	4.78 (1.33)	5.51 (1.28)
Females	94	7.23 (1.52)	6.93 (1.74)	6.26 (1.76)	6.82 (1.55)
Males	73	6.80 (1.45)	6.42 (1.73)	6.82 (1.63)	6.33 (1.47)
Total	177	7.04 (1.49)	6.70 (1.77)	6.07 (1.69)	6.60 (1.53)

¹Number of participants with scores for all three manifestations of Paid Respect.

Table 3:

Correlations between manifestations of Paid Respect, average Paid Respect and UR

	1	2	3	4	5
1. Behaviours	1.00				
2. Beliefs	.78	1.00			
3. Feelings	.70	.87	1.00		
4. Average Paid	.88	.96	.93	1.00	
Respect					
5. UR	.40	.37	.31	.39	1.00

Note: All p values $<.001$

Table 4: Model coefficients and significance tests for Level 1 and Level 2 variables predicting Paid Respect across the three manifestations

	Coefficien t	Standard Error	<i>t</i>	<i>df</i>	<i>p</i>
Fixed effects					
Feelings intercept	6.08	.08	79.49	159.37	<.001
Beliefs intercept	6.74	.09	71.05	158.36	<.001
Behaviours intercept	7.05	.09	78.51	161.30	<.001
UR	.08	.01	5.47	170.27	<.001
Respect-worthiness	.70	.09	7.81	160.50	<.001
Respect-worthiness*UR	-.002	.01	-.19	156.76	.850
Sex	-.02	.07	-.30	156.53	.767
Respect-worthiness*Sex	.21	.07	2.86	156.53	.005
Paid Respect Manifestation ¹ *UR					
For Feelings	-.02	.01	-1.23	157.60	.222
For Beliefs	-.002	.01	.19	160.29	.851
Paid Respect Manifestation					
¹ *Respect-worthiness					
For Feelings	.54	.09	6.07	157.12	<.001
For Beliefs	.32	.08	3.98	159.40	<.001

Note. ¹Reference category = Behaviours