1999


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Judgements of Responsibility for HIV-Infection:

A Test of Weiner's Social Motivation Theory in the Context of the AIDS Epidemic

by

Janet L. Mantler

A Dissertation
Submitted to the College of Graduate Studies and Research
through the Department of Psychology
in Partial Fulfilment of the Requirements for
the Degree of Doctor of Philosophy at the
University of Windsor

Windsor, Ontario, Canada

1999

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ABSTRACT

The present study tested the ability of Weiner's (1993a, 1995a, 1995b, 1996) social motivation model to explain Canadians' and Netherlands' willingness to engage in prosocial behaviours toward people living with HIV and lung cancer. Participants were 207 Canadian and 97 Netherlander undergraduate psychology students who responded to a scenario involving a boy or man living with HIV or lung cancer. Overall, participants from both countries responded similarly and positively. Participants were relatively more positive toward those who acquired the illness through passive routes (i.e., blood transfusion, mother-to-infant-transmission, unknown cause) rather than active routes (i.e., smoking, sex, injection-drug use), but type of disease had little effect on responses. In other words, responses were based on the perceived morality of behaviour rather than on the type of illness. In support of Weiner's theory, participants who thought that the person in the scenario had control over the way in which his illness was acquired also judged him to be more responsible for his illness. Moreover, participants who judged the affected male to be more responsible tended to respond with less sympathy and more negative affect, which, in turn, predicted lower levels of prosocial behaviour. Weiner's model was improved, however, by the addition of blame as a distinct construct. Moreover, pre-existing social attitudes (e.g., attitudes toward gay men, belief in a just world, etc.) had a direct influence on emotions and behaviours. These findings indicate that AIDS education and prevention programs may be able to reduce attributions of culpability for HIV-infection by targeting personal prejudices and making it explicit that cultural, political, and social factors influence behaviour.
All models are wrong, but some are useful.

G. E. P. Box
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CHAPTER 1

Introduction

The AIDS epidemic is approaching the end of its second decade and much is understood about the disease. Nonetheless, when people who are infected with HIV reveal their status, it is common to wonder how they became infected. For example, on February 16, 1996, heavyweight prizefighter Tommy Morrison held a press conference to announce that he was retiring from professional boxing because he had tested positive for HIV. Media reports of Morrison’s disclosure (e.g., Hoffer, 1996; Vecsey, 1996) concentrated on his acknowledgement that he had engaged in an excessive number of unprotected heterosexual encounters, while failing to note that his retirement may have been premature because of the very low risk of HIV transmission during contact sports.

In a similar manner, it is well known that “Magic” Johnson claimed to have a plethora of female sex partners, and that Arthur Ashe became infected through contaminated blood products. Other people who have been infected through “socially acceptable” (Murphy-Berman & Berman, 1993) means such as Ryan White, who was infected through contact with blood products, and Kimberley Bergalis, who claimed to be infected through dental procedures, have been promoted as celebrities. The public reaction to White, Bergalis, Morrison, and Johnson has been overwhelmingly sympathetic (“Covering the epidemic,” 1996), whereas the reaction to well-known HIV-infected gay men, such as swimmer Greg Louganis, singer Freddie Mercury, and Broadway composer and lyricist Jerry Herman, has been considerably more laissez-faire.
Societal Reactions to AIDS

Initial confusion over issues of AIDS susceptibility, cause, transmission routes, and disease progression enabled people to impose a variety of inaccurate stereotypes on people living with HIV and AIDS (PHAs), which have proven to be resistant to change. Although HIV has the same transmission routes as Hepatitis B (another viral infection), it is more often labelled as a sexually transmitted disease, implying that those who are HIV-positive are personally responsible for their infection because they did not change their self-indulgent and risky lifestyle (Albert, 1986; Gilman, 1988; Nelkin & Gilman, 1988). Many people regard AIDS as retribution for deviant lifestyles involving homosexuality, promiscuity, prostitution, and injection-drug use (Echabe & Rovira, 1989; Herek, 1990; Herek & Capitanio, 1993; Melody, 1994; Nisbet & McQueen, 1993; Patton, 1986; Seltzer, 1993).

In the Western world, people tend to distance themselves from the perceived danger of disease by viewing ill people as “bad” and therefore “different” (Altman, 1986; Gilman, 1988). They locate the cause of illnesses in features unique to the sick person, such as distinctive behaviours or emotional dispositions (Crawford, 1994; Finerman & Bennett, 1995; Gilman, 1988), without regard for the situational and cultural context (Herek, 1990). People with diseases can then be placed in distinct categories and fear is reduced simply by avoiding or controlling these "risk groups" (Gilman, 1988; Gilmore & Somerville, 1994).

Because AIDS is loaded with much cultural significance, there is a greater need to categorize PHAs than people with other diseases. Fear of AIDS can be reduced by
judging particular out groups to be responsible for its spread (Nelkin & Gilman, 1988). In North America, gay men are blamed the most because they were the first to be identified with AIDS (Albert, 1986; Gilmore & Somerville, 1994; Schiller, Crystal, & Lewellen, 1994; Watney, 1989), although promiscuous people, injection-drug users, and prostitutes are also blamed (Echabe & Rovira, 1989; Nisbet & McQueen, 1993). By contrast, in Sweden, HIV is most strongly associated with recent immigrants (Danziger, 1999).

The stigma that was previously attached to marginalized groups (e.g., hostility toward gay men) is often transferred to PHAs (Herek, 1990), resulting in a double stigma. In North America, PHAs are stigmatized to a considerably greater extent than people with other serious illnesses (Crawford, 1996; Weiner, Perry, & Magnusson, 1988). People perceive PHAs as more tense, delicate, dangerous, foolish, worthless, and unpredictable than people with heart problems or cancer (Walkey, Taylor, & Green, 1990). PHAs are judged to be more responsible and blameworthy for their illness and less deserving of sympathy compared to people with leukemia (Connors & Heaven, 1995; Crawford, Humfleet, Ribordy, Ho, & Vickers, 1991; Kelly, St. Lawrence, Smith, Hood, & Cook, 1987a, 1987b; Levin & Chapman, 1993; St. Lawrence, Husfeldt, Kelly, Hood, & Smith, 1990; Strasser & Damrosch, 1992), heart disease, cancer, or diabetes (Katz, Hass, Parisi, Astone, & McEvaddy, 1987). Many people believe that PHAs are more dangerous to others than are people with leukemia, and more deserving of quarantine, job loss, or death (Crawford et al., 1991; Kelly et al., 1987a, 1987b; Strasser & Damrosch, 1992). People are less willing to interact with PHAs as friends, casual acquaintances, or colleagues than they are with people who have other illnesses (Crawford et al., 1991; Fish & Rye, 1991;
Katz et al., 1987; Strasser & Damrosch, 1992). Many prefer to have a greater social
distance from PHAs than from people with cancer, diabetes, or heart disease (Kelly et al.,
1987a, 1987b; St. Lawrence et al., 1990).

Some health professionals also have negative AIDS-related attitudes. For
example, in one study (Yedidia, Barr, & Berry, 1993), physicians were only moderately
willing to help PHAs if given a choice. Rather, they preferred to treat people with
meningitis, hemophilia, colon cancer, epilepsy, gonorrhea, Hepatitis B, alcoholism, or
Alzheimer's disease. In fact, dependency on illegal drugs is the only condition they were
less willing to treat than AIDS. Many nurses and medical students are also resistant to
working with PHAs and, in the extreme, would opt to change specialties to avoid caring
for them (Bliwise, Grade, Irish, & Ficarroto, 1991).

Nonetheless, some positive reactions to PHAs have been noted. For example,
50% of a group of busy students were willing to volunteer to help an HIV-positive student
with his academic work (Penner & Fritzscbe, 1993). Two other studies (Berkowitz &
Nuttall, 1996; Cole & Slocumb, 1994) found that most nurses are willing to care for HIV-
positive patients even if given the opportunity to refuse. Furthermore, people who express
low levels of blame for PHAs also have little anxiety about being infected through social
contact and are likely to resist oppression of social groups associated with AIDS (Clift,

Stigma, prejudice, moral taboos, and fear have hampered proactive responses to
the AIDS epidemic (Connor & Kingman, 1988). Individuals who feel threatened by AIDS
have proposed coercive responses to the epidemic, such as mandatory testing, public
tattooing, mandatory reporting of HIV-status, and quarantine of HIV-positive people (Clift et al., 1990; Connors & Heaven, 1995; Superville, 1997), despite the fact that these sorts of measures have proven to be ineffective throughout history (Herek, 1990; Schiller et al., 1994). Supporters of such coercive measures ignore pragmatic solutions. Explicit sex-education and needle-exchange programs have been rejected because they are considered to sanction immoral behaviours (Brandt, 1987). Hence, according to Connor and Kingman (1988), parents do not discuss condom use with their children -- believing that the children will abstain from sex before marriage; officials refuse to give needles to injection-drug users -- thinking that drug users will stop injecting drugs; and authorities avoid using the word *homosexual*-- hoping that gay men will disappear. Instead of acknowledging the status quo, people are asked to change their behaviour, despite the fact that behaviour is affected by a number of complex external forces (Brandt, 1987).

Public response may be determined, at least in part, by how someone becomes infected with HIV. There is a clear distinction between those who are not perceived to be responsible for their infection because they engaged in "normal" and therefore less controllable behaviour (e.g., visiting the dentist, mother-to-infant transmission), and those who are perceived to be responsible because they engaged in non-normative and therefore more controllable behaviours (e.g., homosexual sex, injection-drug use) (Albert, 1986; Bailey, Reynolds, & Carrico, 1989; Clift et al., 1990; D'Angelo, McGuire, Abbott, & Sheridan, 1998; Nisbet & McQueen, 1993; Schellenberg, Keil, & Bem, 1995; Sheehan, Lennon, & McDevitt, 1989). Infection through controllable and non-normative behaviour leads to interpretations that the PHA is irresponsible and that AIDS is "self-
inflicted" (Nisbet & McQueen, 1993). Compared with people infected through uncontrollable routes, people infected through controllable routes are thought to be more responsible for their infection, more deserving of their illness, and more blameworthy (Albert, 1986; Bailey et al., 1989; Clift et al., 1990; D'Angelo et al., 1998; Hunter & Ross, 1991; Keil & Schellenberg, 1998; St. Lawrence et al., 1990). Expressions of sympathy and offers of help tend to be reserved for the "innocent victims" (Albert, 1986; Battegay et al., 1991; Borchert & Rickabaugh, 1995; Clift et al., 1990), in keeping with the norm of social responsibility (Lerner, 1980), which suggests that people help those who are considered to be deserving of help but not those who are held responsible for their condition.

Making Attributions for Behaviour

The way people respond to PHAs is one example of how people need to know the reason for an unusual or negative event in order to react to it (Kelley, 1967). Attribution theory proposes that people use information about the agent's behaviour, the immediate circumstances, and beliefs about typical behaviour in similar situations to interpret the event (Harvey & Weary, 1981; Kelley & Michela, 1980). Attributions can be made to something within the person, such as their ability or motivation, or to something about the situation, such as the physical or social circumstances surrounding the event (Heider, 1958).

In an ideal world, one could form attributions by observing the agent in a number of different circumstances. In the real world, however, there is often only a single observation of behaviour. People must rely on their observations of the agent's present
action, presuming that the agent is acting in accordance with his or her intentions or disposition (Jones & Nisbett, 1972). Moreover, the impact of behaviour is so strong that the influence of the situation is often ignored, or at the very least, underestimated (Heider, 1958), unless there is an obvious external or common cause for the event (Kelley, 1967). Thus, most attributions are dispositional (Ross, 1977). Causal attributions give meaning to the event, which becomes the reality to which the person responds (Heider, 1958; Kelley & Michela, 1980).

Weiner's Theory of Social Motivation

Weiner's (1993a, 1995a, 1995b, 1996) social motivation theory represents a contemporary reading of attribution theory. Weiner suggests that observers search for causation and judge those who are stigmatized or in need of help. Such judgements are initiated by a desire to understand the cause of a negative event in order to determine the appropriate reaction. When observers believe that a person has caused his or her problem, they feel angry and do not feel obligated to provide help. By contrast, if they perceive that the person in need had no control over the situation, they are more sympathetic and willing to become involved.

This attribution process, which occurs after observing an event but before responding to it, is thought to take place in two distinct phases (Weiner, 1995a, 1995b). The first stage involves attributions of causal controllability and assignment of responsibility. The second stage involves the emotional and behavioural reactions that result from judgements of responsibility.
Controllability and Responsibility. According to Weiner (1993a, 1995a, 1995b, 1996), after witnessing a positive or negative event that requires an evaluative response, observers first decide if they believe that the agent was able to control the cause of the event. If the event is perceived to have a situational cause, there is no need to continue the process. If personal controllability is established, however, observers consider whether the agent intentionally produced the effect. If the outcome was obviously unintended, then the agent is not judged to be responsible and the process stops. If the effect is perceived to be both controllable and intentional, then responsibility is assigned. The assignment of responsibility initiates social action.

Controllability is not synonymous with responsibility (Weiner, 1995a). Controllability is an attribution about whether a person is causally connected to an event. Responsibility is a judgement about whether the person “should have” or “should not have” behaved in a particular manner, shifting the focus from the event to the person. There are situations where an act is controllable, but -- because of mitigating circumstances or good intentions -- the person is not considered to be responsible. It can be difficult, however, to prove the existence and the degree of mitigating circumstances. Although some observers may accept the person’s reasons for acting and absolve the agent of responsibility, others may disagree and continue to hold the person responsible.

Anger, Sympathy, and Action. Judgements of responsibility result in emotional reactions that determine behaviour (Weiner, 1993a, 1995a, 1995b, 1996). If the agent is considered to be responsible, then the observer reacts with anger because the person “should have” behaved differently. Conversely, if the person is not considered to be
responsible for the negative event because of external, uncontrollable, or mitigating circumstances, the observer feels sympathetic.

Emotion is the bridge between judgements of responsibility (the cognitive response) and behavioural intentions. Anger and sympathy push the observer to take action appropriate to the perceived meaning of the situation. Sympathy reduces the likelihood of punishment and increases prosocial responses, such as willingness to help. By contrast, anger spurs aversive behaviour such as aggression, punishment, or rejection.

In sum, Weiner's theory of social motivation posits that an observer engages in a causal search following an event. If it is determined that the cause is external, uncontrollable, or due to mitigating circumstances, the agent is not judged to be responsible and the observer responds with sympathy, which leads to willingness to help. If the cause is determined to be personal and controllable and there are no mitigating circumstances, the agent is judged to be responsible and the observer responds with anger, which decreases willingness to help. More simply, the model is:

![Diagram showing Attribution of Controllability, Judgement of Responsibility, Anger or Sympathy, and Willingness to Help]

**Empirical Support for Weiner's Theory of Social Motivation**

In an early study of the social motivation model (Weiner, 1980a), undergraduate students read a scenario in which a person stumbles and falls in a subway car. In one version, the person was apparently drunk (controllable cause); in another version he was
apparently ill (uncontrollable cause). Participants had more anger, less pity, and less willingness to help when the act was perceived to be controllable, but more pity, less anger, and more willingness to help when the act was perceived to be uncontrollable. Similar results were found when the scenario involved a student asking to borrow class notes, either because he had gone to the beach and missed class (controllable cause) or because he had eye problems and was unable to take notes in class (uncontrollable cause) (Weiner, 1980b; Schmidt & Weiner, 1988). Again, greater perceptions of controllability were associated with reduced likelihood of help-giving, greater anger, and less pity.

The applicability of Weiner's social motivation theory has been examined in a variety of other hypothetical situations. Meyer and Mulherin (1980) gave participants scenarios in which an acquaintance who had missed work for either controllable or uncontrollable reasons asked to borrow money to pay the rent. They found that when the need for money was due to controllable rather than uncontrollable causes, participants reported more anger, less empathy, and less willingness to give money. Betancourt (1990) found that when a student needed help with an experiment, attributions of control for the need for help led to greater feelings of disgust and lower levels of empathy, which, in turn, reduced helpfulness. In an investigation of violence in conflict situations (Betancourt & Blair, 1992), participants read a scenario in which two male students had a stone-throwing competition. The student who was losing became frustrated and either intentionally or unintentionally threw a rock that shattered the windshield of his opponent’s car. Participants reported more anger and willingness to retaliate violently when the rock-thrower was perceived as having control over the negative outcome.
In a similar vein, Zucker and Weiner (1993) found that when poverty was perceived to be the result of social causes, poor people were not considered to be responsible for their plight and participants had more pity, more willingness to give personal help, and greater support for welfare programs. When personal factors were perceived to be the cause, poor people were considered to be more responsible and participants were angry and less willing to help.

Most recently, Weiner and his colleagues (Graham, Weiner, & Zucker, 1997) examined the social motivation model within the context of attitudes toward punishment. Again, perceived controllability for a crime was related to greater attributions of responsibility, more anger, less sympathy, and more severe punishment for the crime, whereas a lack of control predicted weaker judgements of responsibility, more sympathy, less anger, and more lenient punishment.

Weiner’s social motivation theory has also been applied to reactions to people with various stigmas (Weiner et al., 1988). Stigmas perceived to have a mental-behavioural origin (e.g., AIDS, child abuse, drug abuse, obesity) were compared to stigmas with a physical or somatic origin (e.g., Alzheimer's disease, blindness, cancer, heart disease, paraplegia). In contrast to physical stigmas, onset of mental-behavioural stigmas were perceived to be under the stigmatized person’s control. People with mental-behavioural stigmas were perceived to be more responsible and more blameworthy for their condition. As predicted, participants reacted to people with mental-behavioural stigmas with less liking, less pity, more anger, and less willingness to help than they did to people with physical stigmas.
In general, these studies reveal strong negative correlations between sympathy and controllability/responsibility and strong positive correlations between anger and controllability/responsibility. Further, correlations between affective responses (sympathy, anger) and helpfulness are stronger than the correlations between controllability/responsibility and helpfulness.

Social Motivation and AIDS

Relatively early in the AIDS epidemic, Weiner (Weiner et al., 1988) examined reactions to PHAs from the perspective of his social motivation theory. He reported that PHAs were considered to be responsible for their infection, deserving of anger, and undeserving of pity, personal assistance, or charity. Nonetheless, judgements of responsibility for stigmas were altered by information about causal controllability. Relative to a man who contracted HIV from promiscuous sex (controllable source), a man who contracted HIV from a blood transfusion (uncontrollable source) was judged to be less responsible and more worthy of pity and help. In fact, participants were as willing to help him as they were to help a person with any physical stigma. By contrast, they were less willing to help a man infected with HIV through controllable means than anyone other than child abusers. In short, perceived controllability had a stronger effect for AIDS than for other diseases.

Graham, Weiner, Giuliano, and Williams (1993) manipulated perceived controllability by examining reactions to five routes of HIV-transmission. They found that a person infected through a blood transfusion was considered to be least responsible, followed by those infected through monogamous heterosexual sex. People infected
through promiscuous heterosexual sex and homosexual sex were perceived to have about the same level of responsibility, whereas people infected through injection-drug use were judged to be most responsible. Anger toward PHAs followed the same pattern, being lowest for the blood transfusion group and highest for injection-drug users, whereas ratings of sympathy had the opposite pattern.

Pullium (1993) also reported that there was greater sympathy and willingness to help a PHA infected through uncontrollable means (infection from a blood transfusion or dental procedures) than there was for a PHA infected through controllable routes. Similarly, Borchert and Rickabaugh (1995) found that HIV-infection from injection-drug use was perceived to be the most controllable route of infection and that such cases were considered to be the least deserving of sympathy and help. Dooley (1995) reported that infection through a blood transfusion was considered to be uncontrollable, whereas infection from heterosexual sex was controllable, but less so than infection from homosexual sex or injection-drug use. Perceived lack of control was directly related to more pity and to less anger, and pity predicted willingness to help.

**Issues in Social Motivation Research**

Weiner's (1993a, 1995a, 1995b, 1996) theory of social motivation has received considerable empirical support. Nonetheless, most of the studies that have supported the social motivation model were conducted by Weiner or his colleagues (e.g., Graham & Weiner, 1991; Graham et al., 1993; Graham et al., 1997; Meyer & Mulherin, 1980, Reisenzein, 1986; Schmidt & Weiner, 1988; Weiner et al., 1988; Weiner, 1980a, 1980b; Zucker & Weiner, 1993). Moreover, none of these studies incorporated all of the social
motivation variables as hypothesized (i.e., controllability, responsibility, anger, sympathy, outcome behaviour) and many reported equivocal support for the model. For example, Betancourt (1990), Betancourt and Blair (1992), Meyer and Mulherin (1980), Reisenzein (1986), and Zucker and Weiner (1993) found links between some factor in the eliciting situation and subsequent affect or behaviour, which suggests that factors outside of Weiner’s model account for some of the variance in outcome measures.

Of the five studies of reactions to PHAs based on social motivation theory (i.e., Borchert & Rickabaugh, 1995; Dooley, 1995; Graham et al., 1993; Pullium, 1993; Weiner et al., 1988), none included all of the hypothesized variables and none provided clear support for Weiner’s theory. Instead, some studies excluded variables such as responsibility (e.g., Dooley, 1995) or behaviours (e.g., Graham et al., 1993) or used composite measures for emotions (e.g., Borchert & Rickabaugh, 1995). Further, only Dooley (1995) incorporated path-analytic techniques. She reported that most of the associations between variables followed the hypothesized pattern, except that anger was unrelated to willingness to help. Hence, although there appears to be support for Weiner’s model, the complete model remains to be tested, especially within the context of the AIDS epidemic. Such a test would also resolve a number of theoretical issues.

**Behavioural Outcomes.** Weiner (1996) maintains that his model “provides a basis for a theory of social conduct that transcends content domains” (p. 212), yet the majority of the social motivation studies have assessed only willingness to help an agent following a negative event (Borchert & Rickabaugh, 1995; Dooley, 1995; Graham & Weiner, 1991; Meyer & Mulherin, 1980; Pullium, 1993; Reisenzein, 1986; Schmidt & Weiner, 1988;
Weiner, 1980a, 1980b; Weiner et al., 1988; Zucker & Weiner, 1993). Moreover, these helping behaviours generally require personal involvement such as lending class notes (Schmidt & Weiner, 1988), accompanying a person to the hospital (Dooley, 1995), or giving a subway seat to a stranger (Reisenzein, 1986).

A variable measuring support for help from authorities or institutions was included in four studies (Borchert & Rickabaugh, 1995; Pullium, 1993; Weiner et al., 1988; Zucker & Weiner, 1993), but only Zucker and Weiner (1993) distinguished institutional from personal help. They found that agreement with welfare payments (i.e., institutional help) was negatively associated with judgements of responsibility and political conservatism, but positively associated with pity and relatively independent of anger. Hence, contrary to Weiner's belief that his model generalizes widely, it may explain personal helping behaviours better than it explains support for help from institutions such as governments or hospitals.

Many of the studies of reactions to PHAs have focussed on social rejection rather than on willingness to help. People prefer greater social distance from PHAs, especially PHAs infected through sex or drug use, than from most other ill people (Crandall, Glor, & Britt, 1997; Crawford et al., 1991; Fish & Rye, 1991; Katz et al., 1987; Kelly et al., 1987a, 1987b; Leiker, Taub, & Gast, 1995; St. Lawrence et al., 1990; Strasser & Damrosch, 1992). Understanding social distance is one means of discerning subtle prejudice toward PHAs (Hagendoorn & Kleinpenning, 1991) that may not be expressed in other situations, for a variety of reasons. In fact, effect sizes for social distance measures tend to be stronger and more reliable than effect sizes for overt prejudice measures.
(Crawford, 1996). If Weiner is correct in assuming that his model of social motivation explains many behaviours, it should be able to explain greater desire for social distance just as well as it explains personal helping behaviours. Unfortunately, no social motivation study has included a measure of preferred social distance.

**Emotions.** Consistent with appraisal theories of emotion (Deci, 1996; Frijda, 1986, 1993; Scherer, 1997), Weiner (1993a, 1995a, 1995b, 1996) believes that emotional reactions are driven by the observers’ cognitive appraisal of the event, and that emotions motivate overt behavioural responses. Accordingly, only sympathy and anger are included in his model. Sympathy may involve an awareness of a positively-valued person’s suffering and a desire to approach the person in order to alleviate his or her pain (Heider, 1958; Frijda, 1986; Roseman, Antoniou, & Jose, 1996; Wispé, 1991). Sympathy differs from empathy, which is the ability to understand a person’s pain without the urge to help the person (Wispé, 1991). Thus, sympathy motivates the observer to approach and to help, even at a personal cost (Dijker, Kok, & Koomen, 1996).

Anger is a reaction to an aversive event for which someone else is held responsible or blameworthy (Dijker et al., 1996; Frijda, 1993). Anger can also be experienced when social or moral norms have been violated (Dijker et al., 1996; Frijda, 1993; Ickes, 1996; Scherer, 1997). These violations may upset observers’ view of the world (Frijda, 1993; Roseman et al., 1996). Hence, the degree of anger should be related to the difference between what the situation is and what it “should” be (Ferguson & Rule, 1983; Rule & Ferguson, 1984). In this manner, some routes of HIV-transmission (i.e., injection-drug use or promiscuous sex, especially homosexual sex) violate the social norms of many
conservatives, authoritarians, or people who hold fundamentally-religious views. Although the observers are not physically harmed, they experience anger because of the perceived moral transgression. Anger gives rise to a desire to regain control, often through aggression or retaliation (Dijker et al., 1996; Frijda, 1986; Roseman et al., 1996; Rule & Ferguson, 1984).

Although Weiner (1993a, 1995a, 1995b, 1996) posits that anger is the direct, negative counterpart to sympathy, sympathy is always a response to a person (Wispé, 1991), whereas anger can be a response to an act or an event (Roseman et al., 1996). When examining reactions to stigmatized people, it may be more useful to contrast sympathy with contempt. Contempt is experienced in situations similar to those that provoke anger, but it is directed solely at the agent, who is viewed as someone of low personal value (Frijda, 1986; Roseman et al., 1996; Scherer, 1997). Contempt has a much stronger moral component than anger (Scherer, 1997) and leads to the desire to reject or withdraw from the agent (Frijda, 1986; Roseman et al., 1996). Hence, it may be better to test contempt, rather than anger, as a counterpart to sympathy for situations involving moral evaluations of people, such as reactions to PHAs.

**Cognitions.** Weiner (1993a, 1995a, 1995b, 1996) emphasizes that controllability and responsibility are distinct predictors of emotional reactions. He excludes blame from his social motivation model because he believes that blame is a blend of the cognitive component of responsibility and the affective component of anger and thus does not warrant independent status. According to Weiner, blame and responsibility may be used interchangeably for negative events, but blame cannot be used in positive situations.
Most attribution theorists distinguish between the constructs of controllability, responsibility, and blame. In general, it is agreed that in the attribution sequence, causal controllability needs to be established first (Jaspars, Hewstone, & Fincham, 1983; Shaver, 1985, 1996). Attributions of controllability are a means of establishing a simple relationship between agent and event. Controllability is a dichotomous variable: something either is or is not a causal agent and there may be more than one casual agent for an event (Shaver, 1985; Shaver & Drown, 1986).

People move from attributing controllability to assigning responsibility out of a need to hold agents accountable for the outcomes of their actions (Fincham & Jaspars, 1980; Jaspars et al., 1983; Shaver, 1985, 1996). The stronger the causal link between the agent and the event, the greater the likelihood that he or she will be judged responsible (Fincham & Jaspars, 1980; Fincham & Roberts, 1985; Heider, 1958; Shaver, 1985, 1996; Shaver & Drown, 1986; Shultz & Schleifer, 1983). For a person to be judged responsible, however, the act must be perceived to have been intentional, voluntary, and performed with some foreknowledge of the potential consequences of the action (Ferguson & Rule, 1983; Fincham & Jaspars, 1980; Shaver, 1996). Responsibility is a continuous variable that reflects the extent to which the agent can be judged (Shaver & Drown, 1986).

Whereas judgements of responsibility are based on actual behaviour, blame is based on observers' perceptions of what the agent ought to have done (Harvey & Rule, 1978; Heider, 1958). Blame is an evaluative response (Rule & Ferguson, 1984; Shaver, 1996), a judgement of moral responsibility or moral liability (Kelley, 1971; McGraw, 1987). The degree of blame may depend on interactions between the degree of
responsibility and the perceived seriousness of the consequences, beliefs about the agent's past and potential actions, and the importance of the norm perceived to be violated (Albert, 1986; Ferguson & Rule, 1983; Kelley, 1971; Rule & Ferguson, 1984; Shaver, 1985; Shaver & Drown, 1986).

The pattern of relations between causal controllability, responsibility, and blame differs as a function of situational factors. According to Critchlow (1985), attributions of causal controllability are weaker than judgements of responsibility, which in turn may be weaker than judgements of blame. The degree of blame, however, may depend on the perceived seriousness of the offense. For example, Critchlow (1985) found that for actions such as interrupting or insulting another person, the agent was considered to be responsible for the event, but not particularly blameworthy. For more serious actions such as robbery or vandalism, the agent was judged to be equally responsible and blameworthy. Bell, Feraios, and Bryan (1990) reported that judgements of blame were slightly lower than judgements of responsibility for HIV-infection, whereas blame was equal to responsibility for people who died from a drug overdose. Mean ratings for responsibility and blame have been found to be similar for physical stigmas; by contrast, ratings of blame are considerably higher than ratings of responsibility for cases of child abuse, drug abuse, and HIV-infection (Weiner et al., 1988). Judgements of responsibility may be lower when HIV-infection results from contact with blood products than from controllable or unspecified sources (Strasser & Damrosch, 1992; Weiner et al., 1988), but all PHAs -- regardless of the source of infection -- are targets for some blame and stigmatization (Keil & Schellenberg, 1998; Pryor & Reeder, 1993).
Nonetheless, attributional research has often treated controllability, responsibility, and blame interchangeably (Fincham & Jaspars, 1980; Harvey & Rule, 1978; Shaver & Drown, 1986; Shultz & Schleifer, 1983). For example, both Reisenzein (1986) and Schmidt and Weiner (1988) claimed that they assessed controllability, but their scales contained items assessing control, responsibility, and personal fault. Similarly, Weiner and his colleagues (Weiner et al., 1988) used measures of responsibility and blame as indices of control, whereas Zucker and Weiner (1993) used controllability and blame items as indices of responsibility. Only one social motivation study (Graham et al., 1997) included separate and distinct measures of controllability and responsibility in a path model; participants considered these two constructs to be different.

Although Weiner (1993a, 1995a, 1995b, 1996) excludes blame from his social motivation model, there is considerable evidence to suggest that blame differs from responsibility and that it may be the final and essential component in the attribution sequence (Kelley, 1971; Shaver, 1996) that drives behaviour. This complete sequence has not been tested in terms of reactions to PHAs. For these reasons, it is important to examine the unique influence of controllability, responsibility, and blame on potential reactions to PHAs. Blame is likely an important mediator of the effect of judgements of responsibility on emotional reactions.

**Individual Differences.** Weiner's social motivation model (Weiner, 1993a, 1995a, 1995b, 1996) may be useful in predicting situations in which a person might experience anger and choose not to help, but it does not explain why some people choose to help in spite of their attributions or emotional reactions (Deci, 1996). People may instinctively
react to a negative situation in a manner consistent with their values or culturally-influenced attitudes (Batson, 1996; Deci, 1996; Feather, 1996; Harvey, Ho, & Miller, 1996).

Weiner (1993b) admits that individual differences could affect behaviours, but believes that such effects are mediated by attribution variables. The social motivation studies that have tested for influences above and beyond those hypothesized by Weiner's model have found evidence for the influence of factors outside of the model that directly influence emotional reactions and help-giving (Betancourt & Blair, 1992; Graham et al., 1997; Reisenzein, 1986; Schmidt & Weiner, 1988; Zucker & Weiner, 1993). For example, political conservatism has a direct effect on endorsement of welfare policies, unmediated by attributional or emotional variables (Zucker & Weiner, 1993). Similarly, beliefs regarding the effectiveness of punishment as a deterrent of crime directly affect preferred levels of punishment severity (Graham et al., 1997). Gender-role socialization may also have an impact; compared with men, women are generally more willing to help (Amato, Ho, & Partridge, 1985; Borchert & Rickabaugh, 1995; Dooley, 1995; Pullium, 1993; Quigley & Tedeschi, 1996). Such non-attributional predictors of behaviour are most likely to be situation-specific, which is especially important for AIDS-related situations because of the strong association of AIDS with moral issues.

Having a negative attitude toward gay men is the most consistent predictor of negative AIDS-related attitudes and behaviour. People who are more hostile toward gay men tend to have more fear of AIDS (Bouton et al., 1989; Kunkel & Temple, 1992; Pleck, O'Donnell, O'Donnell, & Snarey, 1988; Royse & Birge, 1987; Young, Gallaher, Belasco,

Negative attitudes toward gay men are also predictive of desire for greater social distance from PHAs (Dupras et al., 1989; Royse & Birge, 1987), less willingness to help a colleague who has AIDS (Sheehan et al., 1989), and greater levels of support for coercive AIDS-policies.

People with higher levels of authoritarianism also tend to have relatively high levels of blame for PHAs (Keil & Schellenberg, 1998; Larsen, Elder, Bader, & Dougard, 1990; Witt, 1989, 1990) and are likely to endorse punitive AIDS-related policies (Peterson, Doty, & Winter, 1993). Authoritarians base their attitudes on how people ought to act -- not on how they do act -- and they approve of controlling people (especially those who are unconventional) through punishment. Furthermore, they tend to be prejudiced in general, disliking all people who are different from members of their ingroup (Altemeyer, 1981; Altemeyer & Hunsberger, 1992).

Similarly, compared to people with liberal political views, people who are politically conservative tend to have greater fear of AIDS, more support for coercive AIDS policies, less support for AIDS education, less accurate knowledge of AIDS information, and greater belief in the distinction between innocent and blameworthy PHAs (Bouton et al., 1989; Keil & Schellenberg, 1998; Price & Hsu, 1992; Schellenberg et al., 1995; Young et al., 1991).
Although the association between conservative values and AIDS-related attitudes has been examined in some detail, no one has examined the effect of humanitarian values on reactions to PHAs. Such democratic ideals are associated with liberalism and positive racial attitudes (Katz & Hass, 1988). It is likely that people who are concerned for social justice may be more willing to provide assistance to PHAs regardless of the perceived responsibility for HIV-infection (Feather, 1996).

Religiosity is also associated with AIDS-related attitudes. People who endorse fundamentalist religious beliefs tend to be concerned about the “lifestyle” that contributes to AIDS (Magruder, Whitbeck, & Ishii-Kuntz, 1993; Melody, 1994) and to advocate coercive AIDS policies and prohibition of certain immoral behaviours (e.g., sex outside of marriage) rather than pragmatic AIDS-education programs (Nisbet & McQueen, 1993). People who are very religious tend to have the least accurate AIDS knowledge, the most fear of AIDS, and the most negative attitudes toward PHAs (Bouton et al., 1989; Echabe & Rovira, 1989; Henry et al., 1990; Johnson, 1987; Leiker et al., 1995). People who hold more fundamentalist religious views believe that there is only one true religious doctrine with essential truths (not necessarily Christian) that must be followed according to traditional practices (Hunsberger, 1995). They tend to accept cultural stereotypes uncritically and to discriminate against those who are perceived to threaten their values (Altemeyer & Hunsberger, 1992).

People with a stronger belief in a just world also have more negative attitudes toward PHAs (Bush, Krebs, & Carpendale, 1993; Glennon & Joseph, 1993) and prefer greater social distance from PHAs (Connors & Heaven, 1990). Believing that people “get
what they deserve" may allow one to maintain a sense of personal efficacy (Lerner & Miller, 1978; Rubin & Peplau, 1975), but it also may also lead people to be hostile or unsympathetic to victims whose suffering is not easily alleviated (Rubin & Peplau, 1975).

Finally, relatively strong negative AIDS-related attitudes have been found among heterosexual men compared to heterosexual women (Anderson, 1992; Bouton et al., 1989; Clift et al., 1990; Connors & Heaven, 1990; D'Angelo et al., 1998; Fish & Rye, 1991; Herek, 1994; Herek & Capitano, 1993, Kunkel & Temple, 1992; Leiker et al., 1995; Schellenberg et al., 1995; Spears, Abrams, Sheeran, Abraham, & Marks, 1991) and among older people (Berkowitz & Nuttall, 1996; Johnson, 1987; Leiker et al., 1995; Nisbet & McQueen, 1993; Price & Hsu, 1992; Royse & Birge, 1987). By contrast, having contact with someone who is HIV-positive is a strong predictor of positive AIDS-related attitudes and actions (Henry et al., 1990; O'Donnell, O'Donnell, Pleck, Snarey, & Rose, 1987).

According to Weiner (1993b), the effect of situational influences and individual differences (e.g., gender, hostility toward gay men and lesbians) on reactions to PHAs are mediated by attributional variables and should, therefore, be incorporated into the earliest stage of his model. It is equally plausible, however, that people react according to their pre-existing biases in spite of their rational thoughts regarding an event. Hence, social attitudes may directly influence behaviours and emotions over and above the role of cognitions (i.e., attributions of controllability and responsibility).
Cross-cultural Generalization. Weiner (1996) believes that his model of social motivation has universal application and suggests that it is so robust that "if a culture or group or situation is found in which these relations do not hold, or are reversed, then this could serve as a springboard for ... great insight into that culture, group, or situation" (p. 212). Nonetheless, tests of the cross-cultural generalizability of his model have yielded equivocal results. For example, Chinese students were as likely as Americans to agree that if a person caused his or her problem, they would be angry and that this anger would guide their reactions to the person (Stipek, Weiner, & Li, 1989). The Chinese students were more likely than the Americans, however, to feel pity for the person in need and to have more concern for others than for themselves. Similarly, when Australian adults were asked about their responses to helping victims of a severe bushfire in their community, Weiner's theory was not completely supported (Amato et al., 1985). Specifically, attributions of responsibility were not directly related to sympathy, and sympathy was not related to amount of help. Instead, people with more sympathy or with family or friends who were victims of the fire felt more obligated to help, and feeling obligated was the best predictor of helping.

There is only one published cross-cultural test of Weiner's social motivation model with regard to AIDS (Murphy-Berman & Berman, 1993). American and German undergraduates responded to vignettes in which a labworker or an injection-drug user was infected through an unclean needle. The German students had more pity and warmth for the PHA and were more willing to have scarce resources (e.g., doctors' volunteer time) made available to the PHA. Whereas the American students' responses followed Weiner's
hypothesized cognition→emotion→behaviour pattern, the responses from the German
students were not based on the route of HIV-infection. Hence, Weiner’s model may
provide a better explanation of behaviour in the United States than in other countries.

Results from studies conducted in the United States are often generalized to
Canadians, based on the assumption that people in both countries hold similar attitudes,
especially when contrasted with attitudes of people from other countries (Lipset, 1990).
For example, both Canadians and Americans have comparable levels of support for
women’s and environmental issues and place approximately equal importance on family,
friends, work, and leisure time (Nevitte, 1996). But there are also important cultural,
social, and political differences between Canadians and Americans. For example,
Canadians tend to be less authoritarian and less fundamentally religious than Americans,
but more supportive of euthanasia and homosexual rights (Nevitte, 1996).

The Netherlands is a wealthy, industrialized country that is further left on the
political scale than Canada. The Netherlands has distinguished itself with its inclusive
social programs and longstanding moral, political, and religious tolerance (Dekker &
tend to take a pragmatic approach to social problems (Hessing et al., 1996). For example,
the Netherlands government has taken a non-moralistic stance on hard drug use, and the
focus on harm reduction has resulted in a decrease in the number of young and new
addicts (Buning, Hartgers, van Santen, Verster, & Coutinho, 1988). Netherlands are
more likely than Canadians to suggest that poverty is due to an unjust society or to bad
luck, whereas Canadians are more likely to attribute poverty to laziness. Furthermore,
compared to Canadians, Netherlands tend to be more supportive of homosexual rights and euthanasia (Nevitte, 1996).

The American, Canadian, and Netherlands governments responded differently to the AIDS epidemic. For example, as recently as 1996, the American federal government continued to discriminate against those who were HIV-positive by discharging them, but not others with serious medical conditions, from the military (Herek et al., 1998). The Canadian government has been slower in developing AIDS policies than the Americans, yet has been more pragmatic. In Canada, there has been a refusal to introduce mandatory HIV-testing, opposition to HIV-specific criminal laws and coercive policies, implementation of human-rights tribunals to combat AIDS-related discrimination, and relatively early establishment of needle-exchange programs and anonymous testing sites (Jürgens, 1996).

The Netherlands government responded quickly to the AIDS epidemic by implementing pragmatic AIDS policies (Dekker & Ester, 1993). It countered the coercive actions of other European countries (e.g., forced testing of marginalized groups in Greece, Ireland, Italy, Britain, Denmark, and Portugal) with information that mass testing is counterproductive. Instead, Netherlands concentrated their efforts on aggressive prevention campaigns that focused on general information and pro-active interventions for groups involved in high-risk activities (Dekker & Ester, 1993). By 1984, needle-exchange programs were introduced (Buning et al., 1988).

Further differences between cultures can be found in knowledge of HIV and AIDS. There is little documentation of AIDS knowledge among Canadians, but it can be
assumed that levels are similar to those of Americans because of the extensive influence of the America media. In 1987, AIDS knowledge in the United States was low (LeBlanc, 1993), but by 1995 most high-school and university students had moderate to high levels of knowledge (Carey, Morrison-Beedy, & Johnson, 1997; Imperato, 1996; Shapiro, Radecki, Charchian, & Josephson, 1999). By contrast, in 1987, 95% of Netherlands had very high levels of AIDS knowledge (Dekker & Mootz, 1992).

Netherlands have very positive attitudes toward gay men and lesbians; they also tend to have more pity than irritation for PHAs and considerable willingness to have contact with PHAs (Dijker et al., 1996). Nonetheless, predictors of AIDS-related attitudes are similar in the Netherlands and North America (Dekker & Mootz, 1992). People who are younger, who have more education, and who are not religious tend to have more instrumental AIDS knowledge, more acceptance of PHAs, and greater opposition to coercive policies. People with more hostility toward gay men, more authoritarian and politically conservative attitudes, and stronger religious beliefs are less accepting of PHAs.

If the Weiner model generalizes across cultures, responses of Canadians and Netherlands should follow the cognition→emotion→behaviour pattern found in American research, even if absolute levels of responses differ (e.g., level of blame for PHAs could be higher in one sample than another). If people react to PHAs on the basis of pre-existing social and political values (Herak et al., 1998), however, there should be considerable differences in the behaviours of Canadians and Netherlands based on their cultural background.
Testing Weiner's Model of Social Motivation

Weiner's (1993a, 1995a, 1995b, 1996) model of socially motivated behaviour is based on the assumption that observers evaluate an agent's actions before reacting to the event. In short, Weiner hypothesizes that when an agent's behaviour requires a response, observers first determine if the agent had causal controllability over the act and performed it intentionally. If so, then the observers determine if there were mitigating circumstances. If not, they judge the agent to be responsible for that act. If observers hold the agent responsible, they respond with anger. Otherwise, they respond with sympathy. In turn, observers' emotions determine their behavioural response. Anger results in negative responses such as punishment or withdrawal of help, whereas sympathy motivates prosocial responses such as willingness to help. The purpose of the present study was to test Weiner's social motivation model within the context of the AIDS epidemic, with specific attention to the theoretical issues noted above. The present research also tested a number of modifications to Weiner's model based on these issues.

Behavioural Outcomes. Although Weiner (1996) hypothesizes that the cognition-emotion sequence precedes many social behaviours, most of the relevant research has examined only personal willingness to help (e.g., Borchert & Rickabaugh, 1995; Dooley, 1995; Graham & Weiner, 1991; Meyer & Mulherin, 1980; Pullium, 1993; Reisenzen, 1986; Schmidt & Weiner, 1988; Weiner, 1980a, 1980b; Weiner et al., 1988; Zucker & Weiner, 1993). Dooley (1995) included a measure of support for institutional help and found that the data supported Weiner's model for willingness to provide personal help, but not for support for providing welfare payments to people in need. Because only Dooley
has examined the relation of Weiner's model to different forms of helping, the present research tested his model as an explanation for support for institutional help for PHAs as well as personal intention to help.

Many AIDS researchers are interested in understanding rejection of PHAs (Crandall et al., 1997; Crawford et al., 1991; Fish & Rye, 1991; Katz et al., 1987; Kelly et al., 1987a, 1987b; Leiker et al., 1995; St. Lawrence et al., 1990; Strasser & Damrosch, 1992) as a means of examining subtle forms of discrimination (Hagendoorn & Kleinpenning, 1991), yet no social motivation study has examined this rejection. Hence, the present research tested the ability of Weiner's social motivation model to explain preferred social distance. If Weiner's model generalizes to many social behaviours, it should explain equivalent and significant proportions of the variance for behaviour (i.e., personal help, support for institutional help, desire for social distance).

**Emotions.** Weiner (1993a, 1995a, 1995b, 1996) includes anger and sympathy as the only emotions in his model. As noted, these emotions may not be direct counterparts because sympathy is directed at people whereas anger can also be directed at events (Dijkier et al., 1996; Frijda, 1986; Roseman et al., 1996; Wispé, 1991). Responses to the AIDS epidemic have typically been based on perceived morality (Albert, 1986; Nelkin & Gilman, 1988) and, as such, the focus has been on the ill people (i.e., stigmatized groups) rather than the illness. Because reactions to AIDS have been moral evaluations of people, it may be more appropriate to measure contempt rather than anger, because contempt is directed at a particular person (Frijda, 1986; Roseman et al., 1996; Scherer, 1997). The role of these three emotions (i.e., sympathy, anger, and contempt) was tested in the
present research. If observers focus on stigmatized groups rather than on behaviour, then levels of contempt and sympathy should have a strong association with variables measuring willingness to help, support for institutional help, and desire for social distance. By contrast, if observers focus more on behaviour rather than the person, anger should have a stronger association with outcome behaviours.

Cognitions. Weiner (1995a) excludes blame from his model of social motivation because he considers blame to be a blend of anger and judgements of responsibility (i.e., not a unique construct). Other attribution researchers (Critchlow, 1985; Heider, 1958; Shaver, 1996) propose that blame is the final, moral evaluation in the attribution sequence. Even though they make a theoretical distinction between the constructs of controllability, responsibility, and blame, however, many attribution researchers use these variables interchangeably (Fincham & Jaspars, 1980; Shaver & Drown, 1986). The present research tested the unique roles of controllability, responsibility, and blame to determine if participants equated blame with responsibility or anger, as proposed by Weiner, or if participants followed the controllability→responsibility→blame sequence in which blame, rather than responsibility, is the most direct predictor of emotional reactions.

Individual Differences. Weiner (1993b) suggests that if individual differences influence behaviour, this influence is mediated by observers' attributions of controllability for the event. Many tests of his social motivation theory found, however, that factors in the eliciting situation influence helping behaviours above and beyond the impact of cognitions (Betancourt & Blair, 1992; Graham et al., 1997; Meyer & Mulherin, 1980; Zucker & Weiner, 1993). Indeed, individual-difference variables, including attitudes
toward gay men and lesbians, authoritarianism, religious fundamentalism, political conservatism, belief in a just world, gender, age, and contact with PHAs, are strongly associated with AIDS-related attitudes and behaviours (Bouton et al., 1989; Bush et al., 1993; Clift et al., 1990; Dupras et al., 1989; Henry et al., 1990; Herek, 1994; Magruder et al., 1993; Nisbet & McQueen, 1993; O'Donnell et al., 1987; Peterson et al., 1993; Royce & Birge, 1987; Schellenberg et al., 1995; Sheehan et al., 1989). The present research tested the role of these individual differences in predicting reactions to PHAs. If Weiner is correct in assuming that the influence of individual differences on behaviour is mediated by cognitions, social attitudes should have a direct effect on attributions of controllability for HIV-infection, but only an indirect effect on behaviours. By contrast, if responses to PHAs are driven by pre-existing personal values (Feather, 1996; Geen, 1996), social attitudes should directly affect cognitions, emotions, and behaviours. It was expected that gender, age, and contact with PHAs would influence social attitudes and behaviours, but they would not have a direct impact on cognitions or emotions.

Associations among social attitudes were also explored because it is possible that they reflect a single latent construct (e.g., a conventional world-view). Although it has not been tested as a predictor of AIDS-related attitudes, humanitarianism-egalitarianism was included in the cluster of social attitudes to explore the role of liberal values.

**Cross-cultural Comparison.** Weiner (1996) believes that his social motivation theory generalizes to all cultures, in spite of equivocal support (e.g., Amato et al., 1985; Murphy-Berman & Berman, 1993; Stipek et al., 1989). If Weiner's assumption is correct, Canadians' and Netherlands' responses to PHAs should follow his hypothesized
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Cognition-emotion-behaviour sequence. It is possible, however, that cultural differences in personal values and social attitudes (Dekker & Ester, 1993; Hessing et al., 1996; Lipset, 1990) would override this attribution sequence. If this is the case, there should be differences in social attitudes and behavioural reactions based on nationality.

**Illness Comparison.** The final test of Weiner's model of social motivation was to compare its usefulness in explaining reactions to people living with HIV compared to people living with lung cancer. PHAs have been considerably more stigmatized than people with heart disease, leukemia, diabetes, or cancer (Crawford et al., 1991; Kelley et al., 1987a, 1987b; St. Lawrence et al., 1990). If PHAs continue to be more stigmatized, participants should report more blame, more contempt, greater negative affect and less sympathy, and fewer prosocial behavioural responses toward PHAs than toward people with lung cancer.

Reactions to PHAs vary, however, on the basis of perceived agency of HIV-transmission. People who were infected through blood transfusions and infants infected through their mothers are perceived to be "innocent," whereas people infected through sex or drug use are perceived to be blameworthy and less deserving of fair treatment (Bailey et al., 1989; Hunter & Ross, 1991; Keil & Schellenberg, 1998). Observers may be reacting to particular behaviours rather than to the illness. Hence, for both HIV and lung cancer, manipulations altered the way in which the disease was acquired (HIV-transmission: heterosexual sex, homosexual sex, injection-drug use, blood products, and mother-to-infant; lung cancer: smoking or unknown cause). If reactions are made on the basis of beliefs about illness acquisition, participants should respond to smokers who contracted
lung cancer in the same manner as they respond to people infected with HIV through sex or drug use. They should also respond similarly to nonsmokers with lung cancer and to HIV-positive infants and blood-product recipients.

**Summary**

In sum, the present study: (1) tested the usefulness of Weiner's model of social motivation to predict three different behavioural outcomes, and (2) compared the responses of Canadians and Netherlands to people living with HIV and lung cancer. A number of modifications to his model were also tested, including the impact of individual differences (gender, age, contact with PHAs, social attitudes), the role of blame, and a comparison of contempt with anger. The overall design of the study is illustrated in Figure 1.
Figure I. Path Diagram Representing the Design of the Present Study. Modifications and additions to Weiner's Social Motivation Model are in italics.
CHAPTER 2

Method

Participants

Canadian students were recruited from Introductory Psychology classes at the University of Windsor and received course credit for their participation. Participants from the University of Amsterdam\(^1\) were recruited either from Introductory Psychology classes (49%) and received course credit, or from poster advertisements (51%) and were paid five guilders (approximately $3.75). The Netherlands students who received financial remuneration were registered in upper level Psychology courses (44% were in second year, 23% were in third year, and 33% were in fourth year or higher).

Of the 403 participants, 259 were from the University of Windsor (63% female; 91% exclusively heterosexual; 62% white, 21% people of colour, 17% who did not indicate ethnic background) and 144 were from the University of Amsterdam (71% female; 60% exclusively heterosexual; 88% white, 9% people of colour, 3% who did not indicate ethnic background). Both samples had a similar ratio of females to males, which was consistent with the ratio of females to males enrolled in Psychology programs at both universities. In the Winter 1998 semester, 1,310 University of Windsor students (39% male, 61% female) and 452 University of Amsterdam students (30% male, 70% female)

\(^{1}\) National studies of AIDS attitudes in the Netherlands (Dekker & Ester, 1993; Dekker & Mootz, 1992) found that people living in large cities or in rural communities have similar AIDS-related attitudes, which provides support for the comparison of University of Windsor and University of Amsterdam students.
were registered in Introductory Psychology. The Canadian sample had a larger proportion
of students who were exclusively heterosexual, $\chi^2 (1, N = 401) = 54.31, p < .001$, or
people of colour, $\chi^2 (1, N = 356) = 14.39, p < .001$.

The Canadian sample ranged in age from 18 to 45 years ($M = 20.27, SD = 2.77$); the Netherlands sample ranged from 18 to 41 years ($M = 22.01, SD = 3.57$), which was significantly older than the Canadians $t (401) = 5.44, p < .001$. Most of the Canadian participants reported a Christian (47% Catholic, 28% Protestant) religious affiliation; the remainder had an Eastern affiliation (5%), "other" (2%), or none (18%). Most of the Netherlands participants reported having no religious affiliation (66%), with a minority classifying themselves as Catholic (12%), Protestant (16%), Eastern (5%), or "other" (1%). A chi-square test of independence confirmed that the pattern of religious affiliation differed across samples, $\chi^2 (4, N = 398) = 98.42, p < .001$.

Measures

The questionnaire was translated into Netherlands [Dutch] by a staff member of the Vakgroep Sociale Psychology [Social Psychology Workgroup] of the University of Amsterdam. The accuracy of the translation was checked by a Canadian-Netherlands couple who translated the Netherlands version back into English. The original and back-translated versions of the questionnaire were compared and instances of disagreement in the translation were discussed and resolved. The study was cleared by Ethics Review Boards at both universities.

In order for the questionnaire to reflect the Netherlands culture, the name of the main character in the scenarios was changed (William for Canada, Wim for the
Netherlands). Thus, there were two slightly different versions of the questionnaire.

Copies of the Canadian and Netherlands versions of the questionnaire can be found in Appendices A and B. Differences between the two versions are noted below in parentheses.

Scenarios. Each questionnaire had one of seven scenarios: five scenarios involved a male with HIV; two described a male diagnosed with lung cancer (see Appendix C for the full text of the scenarios). The target in the scenarios was male in order to simplify the analyses.

Each participant read and responded to one of seven scenarios. Hence, the basic design was a 2 X 7 (country X scenario) factorial. The scenarios varied according to the way in which the target became afflicted (HIV-infection: mother-to-infant, contact with blood products, heterosexual sex, homosexual sex, or injection-drug use; lung cancer: smoker or nonsmoker). For example, the “heterosexual sex” scenario was as follows:

"William [Wim] is 31 years old and is a bank employee. He has lots of friends and everyone at work likes him. He likes his job, but also enjoys relaxing in the evenings with his new partner, Suzanne, who is HIV-positive. They often watch old movies or go out for dinner. Recently, William has begun to lose weight and to feel tired all the time. He also has a dry, persistent cough, diarrhea, and a fever and has been waking up with night sweats. Suzanne took him to see her physician. William was told that he has tested positive for HIV, the virus that leads to AIDS.” Participants were asked to assume that they knew William quite well and that they had some extra time to volunteer to spend with William.
Consistent with epidemiological studies and HIV-testing protocols, the way in which the illness was acquired was not made explicit. Rather, it was suggested by the information in the scenario. Participants were expected to make an assumption about how the illness was acquired based on this information.

**Behavioural Outcome Measures.** The personal help measure was comprised of 13 items (see Appendix A, pp. 118 - 120, #1-13). Participants rated their answers on 7-point scales, ranging from *Not at all Willing* to *Very Willing*. Two items assessing helping by encouragement were written for the present study (*How willing would you be to give encouragement to William*?). One item (*willingness to donate $5 to William*) was adapted from Murphy-Berman and Berman (1993). The other 11 items were taken from Dooley (1995), who reported that the items met the criteria for reliability but did not report the internal consistency of the scale. The scale items differentiated the intimacy of helping acts (i.e., from social to physical). For example, the least intimate form of helping was to assist William with walking; the most intimate item asked if the participant would help bathe William. The aggregate score for personal help was formed by summing the 13 items, such that higher scores reflected greater willingness to help.

Two scales measured participants’ support for institutional-level help for the target person in the scenario. A single budget-allocation item asked participants to allocate money from a surplus hospital budget to people like William and to people with leukemia, diabetes, and Hepatitis B (Appendix A, p. 121, #6). The second measure consisted of two items (Appendix A, p. 120, #1 - 2) which assessed the extent to which participants agreed that people like William deserve help from governments and medical personnel.
Responses were rated on 7-point Likert-type scales anchored by *Strongly Disagree* and *Strongly Agree*. Higher scores reflected greater support for institutional help. Although these two measures were correlated, $r = .42$, $p < .001$, the correlation was not strong enough to indicate that they were measuring the same behaviour. Because the shared variance was relatively low (< 20%), they were included as separate outcome measures in subsequent analyses.

There were two measures of social distance. The first measure was a 5-item Bogardus scale adapted from Leiker et al. (1995; see Appendix A, p. 120, #1 - 5) who reported alphas ranging from .79 to .86. Two of the items were worded as social-distance statements (*I could refuse to attend a party at which William was also present*) and three were worded as social-acceptance statements (*I could become close friends with William*) and later reverse-scored. For the present study, responses were measured on 7-point scales to be consistent with the other outcome measures. Higher scores indicated greater preferred social distance.

The second measure of social distance (Appendix A, p. 121, #7) presented participants with a diagram representing a dentist's waiting room. An $X$ indicated where William [Wim] was sitting. Participants were asked to mark another $X$ to indicate where they would prefer to sit. The distance between the available chairs increased in increments of approximately 5 mm and ranged from 10 mm to 40 mm. The distance between William and the participant's $X$ indicated his or her preferred social distance. This item had small but significant correlations with each of the individual items from the Bogardus social distance scale (range of .22 to .30, all $g$s < .001) for the Canadian sample. For the
Netherlands sample, however, the dentist office item was correlated only with an unwillingness to become close friends with William \((r = .18, \ p < .05)\). Therefore, this item was not included as an outcome variable in subsequent analyses.

**Cognition and Emotion Variables.** Each of the three cognition variables (controllability, responsibility, and blame) and the three emotion variables (anger, sympathy, and contempt) was measured with four items developed for the present study (Appendix A, pp. 121 - 124, Section 3). For each scale, two items were positively worded \((I \ have \ considerable \ sympathy \ for \ William)\) and two were negatively worded \((I \ do \ not \ feel \ sorry \ for \ William)\). Responses were made on 7-point scales anchored by Strongly Disagree and Strongly Agree. The scores for each variable were summed; higher scores indicated greater levels of the specific cognition or emotion.

The items measuring controllability included personal control, cause, causal controllability, and ability to prevent illness \((#17, 20, 23, 24)\). The items for the responsibility scale included responsibility, accountability, negligence, and liability \((#4, 8, 12, 21)\). The items for the blame scale included blame, fault, deservingness, and guilt \((#3, 7, 15, 22)\). The items assessing anger included anger, irritation, annoyance, and resentment \((#2, 10, 16, 19)\). The items for sympathy included sympathy, pity, feel sorry for, and compassion \((#1, 5, 11, 14)\). Finally, the items for contempt included contempt, disdain, no respect, and worthless \((#6, 9, 13, 18)\).

**Social-Attitude Variables.** Right-wing authoritarianism was measured with a 10-item short form of the Altemeyer (1988) Right-wing Authoritarianism Scale (RWA; see Appendix A, pp. 128 - 129, #20 - 27 and p. 132, # 7 - 8). Participants responded to
statements such as *Obedience and respect for authority are the most important virtues children should learn* on a 9-point Likert-type scale anchored by *Strongly Disagree* to *Strongly Agree*. The Netherlands questionnaire used a 6-point scale, which was later made equal to the 9 point scale\(^2\). Five of the items (3, 7, 8, 9, 10) were reverse scored. Higher scores indicated more authoritarian attitudes. Zanna (1994) reported that this shortened measure has a Cronbach’s alpha of .75 and a correlation of .89 with the original 30-item measure.

Herek’s (1988) Attitudes Toward Lesbians (ATL; see Appendix A, pp. 129 - 130, #30, 32, 35, 36) and Attitudes toward Gay Men (ATG; see Appendix A, pp. 129 - 130, # 28, 29, 31, 33, 34) scales measured hostility toward homosexuals. Participants used 9-point scales to rate their agreement or disagreement with statements such as *I think male homosexuals are disgusting*. The Netherlands sample rated their responses on 7-point scales which were later equated with the 9-point scales rated by the Canadians. Two items in the ATG and one item in the ATL were reverse scored. Scores for each scale were summed and higher scores indicated more negative attitudes. Herek (1988) reports Cronbach alphas of .85 and .87 respectively for these scales. One item (*State laws regulating private, consenting lesbian behaviour should be loosened.*) was excluded from the ATL because it was irrelevant to laws in Canada and the Netherlands.

\(^2\) The range of some of the Likert scales (i.e., for the social-attitudes scales) was inadvertently changed during the translation process for Netherlands questionnaire. Ranges were made equivalent in the preliminary analyses.
Participants' belief in a just world was measured with the 7-item Global Belief in a Just World Scale (GBJW; Lipkus, 1991; See Appendix A, pp. 126 - 127, #1 - 7). Participants responded to items such as *I feel that a person's efforts are noticed and rewarded* on a 6-point scale (no neutral mid-point) anchored by *Strongly Disagree* and *Strongly Agree*. The Netherlands scale used 7-point response options which were later equated to 6 points. All of the items were positively worded. Scores were summed; higher scores reflected a stronger belief in a just world. Lipkus reported that the scale was unidimensional and reliable (alpha = .83).

Katz and Hass's (1988) 10-item Humanitarianism-Egalitarianism Scale (HE; see Appendix A, pp. 127 - 128, #8 - 17) was used to measure participants' concerns for equality and social justice (e.g., *There should be equality for everyone -- because we are all human beings*). Items were rated on a 6-point scale (no neutral mid-point) anchored by *Strongly Disagree* and *Strongly Agree*. A 7-point scale was used with the Netherlands sample and later equated to the 6-point scale. All of the items were positively worded. Scores were summed such that higher scores indicated a stronger humanitarian value-system. Katz and Hass (1988) reported a Cronbach's alpha of .84.

Religiosity was assessed with two measures. Participants were asked to indicate their religious affiliation, later recoded as having or not having a religious affiliation. Respondents' fundamentalism was assessed with the 6-item short form of the Altemeyer and Hunsberger (1992) 20-item religious fundamentalism scale (RF; Jackson & Esses, 1997; see Appendix A, 131 - 132, #1-6). Three items were positively worded and three were negatively worded. Responses to items such as *To lead the best, most meaningful
life, one must belong to the one true religion were made on 9-point scales anchored by Strongly Disagree and Strongly Agree. The Netherlands sample used a 6-point scale which was subsequently equated to a 9-point scale. Higher scores indicated a stronger fundamentalist orientation. Altemeyer and Hunsberger (1992) reported a Cronbach’s alpha of .95 for the long form of this scale; Jackson and Esses (1997) reported a reliability of .88 on the short form and a correlation of .95 between the short and long forms.

Demographics. Participants were asked to provide information about their gender, age, ethnic/cultural background, and sexual orientation (measured with a 7-point scale ranging from Completely Heterosexual to Completely Homosexual; see Appendix A, p. 117). Following previous research (Keil & Schellenberg, 1998; Schellenberg et al., 1995), the sexual-orientation item was subsequently dichotomized as exclusively heterosexual (7 on the 7-point scale) and not exclusively heterosexual (1 - 6). Respondents’ ethnic background was categorized as White, Black, Asian, Hispanic, or other. Participants were also asked about the extent to which the AIDS epidemic had personally affected their lives (no impact = 1, large impact = 7) and the degree of contact they had with an HIV-positive person (no contact = 1, a lot of contact = 7). Finally, they were asked, in comparison with their family, how tolerant they were of others and whether their views were more or less progressive (much less = 1, much more = 7).

Checking Participants’ Level of Understanding. Three items were included at the end of the questionnaire to verify that participants understood the materials and made the inferred assumption about illness acquisition (see Appendix A, p. 132, items 1 - 3). Respondents were first asked if they found the instructions to be clear. Participants who
indicated confusion were dropped from the sample. Participants were also asked to recall what illness (lung cancer or HIV infection) the main character in the scenario had. Finally, participants indicated their belief in how the target in the scenario acquired this illness (response options: mother-to-infant transmission, blood transfusion, heterosexual sex, homosexual sex, injection-drug use, smoking, or unknown). Because the route of illness acquisition was not made explicit in the scenarios, it was possible that the participants' assumptions regarding illness acquisition could differ from the scenario to which they were assigned.

Additional Measures. An additional three items were used to test political conservatism (see Appendix A, p. 127, #18 and #19 and p. 131, #37). These items did not form a reliable scale (Canada: alpha = .52; Netherlands: alpha = .47). The first item, in which participants were asked to choose the most important of four concepts (predetermined to range from conservative to liberal), was unrelated to the other two items. The correlation between the other two items, $r = .36, p < .01$, was not strong enough to infer that they were measuring the same concept. These three conservative items were excluded from the analyses because of the low reliability. It is likely that the people who hold both left-wing and right-wing opinions could interpret each of the statements as supporting their own position. For example, protecting freedom of speech may be considered an important value by people with both right-wing and left-wing politics, but for different reasons (Rosenau, 1992).

A measure of instrumental AIDS/HIV knowledge (Schaalma, Peters, & Kok, 1993; see Appendix A, p. 125 - 127, Section 4) was also included in the questionnaire.
There was a lack of consistency among the items (e.g., more than half of the items had a corrected item-total correlation lower than .20) which may have been a function of the lack of validity of the scale and the difficulty in translation of some items (e.g., *There is still no cure for AIDS* could have been interpreted as *There is still no medicine for HIV-infection*). The knowledge scale was therefore excluded from further analyses.

**Procedure**

A sign-up sheet (see Appendix D) asking for volunteers to participate in a study of reactions to serious illnesses was sent to all Introductory Psychology classes at the University of Windsor before data collection. Respondents were offered a bonus point (1%) toward their final course grade. Participants were tested individually or in small groups ($M = 6$, range 1 - 19).

When the Windsor students arrived at the research location, they were given the questionnaire package and were randomly assigned to one of the seven illness scenarios. The participants first read and signed a consent form (see Appendix E), which was collected and stored separately from the questionnaire.

At the University of Amsterdam, a standard departmental sign-up sheet asking for volunteers from Introductory Psychology courses was posted on the research bulletin board in the lobby of the Psychology Department two weeks prior to the study. Respondents were offered research credit. Additional paid participants from all levels of psychology courses were recruited personally in the cafeteria and by signs posted in the elevators in the psychology building. Participants were tested individually or in small groups ($M = 2$, range 1 - 10).
At the University of Amsterdam, the instructions for the study were given in Netherlands by the experimenter or a Netherlander assistant. Students were randomly assigned to the research conditions. Respondents were given a page describing the study (see Appendix F). Consistent with the University of Amsterdam's research practice, participation implied consent.

Ninety of the participants completed the current study following a brief questionnaire about general attitudes. The attitude study was deemed to be unrelated to the current study and participants reported that it did not affect their responses to the present study.

Respondents in both countries completed the questionnaire beginning with the demographic information, followed by the scenario, the outcome measures, the cognition and emotion items, and finally the individual difference and manipulation check items. When the participants returned the questionnaire to the administrator, they were given a debriefing sheet (see Appendix G for University of Windsor and Appendix H for University of Amsterdam), which included a description of the purpose of the study.
CHAPTER 3

Results

Preliminary Analyses

Missing Data. Mean substitution was used to handle random missing data if no more than two items were missing from a single multi-item scale. Scale scores were not computed for participants missing more than two items.

Eating Response Options Across Samples. Because there were some differences in range between the Likert scales for the Canadian and Netherlands versions of the questionnaire, the response options for the Netherlands version were made equivalent to those used for the Canadian sample. For example, the 7-point response options for the authoritarianism scale on the Netherlands questionnaire were transformed to be equivalent with the 9-point Canadian responses (i.e., \([\text{Netherlands response} - 1] \times \frac{8}{6} + 1 = \text{Canadian response}\)).

Clarity of Instructions. Most (95.5%) of the sample reported that the study instructions were clear (4 and higher on the 7-point scale); 22 participants (7 Canadian, 15 Netherlander) who indicated that they found the instructions confusing (3 or lower on the scale) were dropped from the sample.

Testing the Assumptions Regarding Illness Acquisition. Because information about illness acquisition was never made explicit in the scenarios, participants were asked to judge how the person in the scenario became ill in order to verify that they made the intended inference about how HIV or cancer was contracted. Table 1 lists the number of participants who did or did not make the assumed inference.
Table 1

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Country</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother-to-Infant</td>
<td>Canada</td>
<td>33</td>
<td>4</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>Netherlands</td>
<td>19</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>52</td>
<td>5</td>
<td>57</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>Canada</td>
<td>23</td>
<td>13</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Netherlands</td>
<td>10</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>33</td>
<td>23</td>
<td>56</td>
</tr>
<tr>
<td>Heterosexual Sex</td>
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<td>17</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Netherlands</td>
<td>11</td>
<td>8</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>30</td>
<td>25</td>
<td>55</td>
</tr>
<tr>
<td>Homosexual Sex</td>
<td>Canada</td>
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<td>7</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Netherlands</td>
<td>8</td>
<td>9</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>37</td>
<td>16</td>
<td>53</td>
</tr>
<tr>
<td>Injection-drug Use</td>
<td>Canada</td>
<td>36</td>
<td>0</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Netherlands</td>
<td>17</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>53</td>
<td>1</td>
<td>54</td>
</tr>
<tr>
<td>Lung Cancer - Smoking</td>
<td>Canada</td>
<td>35</td>
<td>0</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Netherlands</td>
<td>13</td>
<td>3</td>
<td>16</td>
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<tr>
<td>Total</td>
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<td>3</td>
<td>51</td>
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<tr>
<td>Lung Cancer - Unknown</td>
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<td>32</td>
<td>4</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Netherlands</td>
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<td>19</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>51</td>
<td>4</td>
<td>55</td>
</tr>
</tbody>
</table>

N = 304, 77, 381

Note. Canada: N = 252; Netherlands: N = 129.

For 20% of the participants, their assumptions of illness acquisition did not match that implied by the scenario. A discriminant function analysis using demographic and social-attitude variables to predict whether participants would make the intended causal
inference was not significant, $\chi^2 (13, N = 322) = 7.97, p = \text{ n.s.}$ In other words, it was not possible to categorize those whose assumptions did or did not match the acquisition route implied in the scenario based on their personal characteristics or individual attitudes.

The proportion of participants who made the intended inference varied across scenarios, $\chi^2 (6, N = 381) = 68.23, p < .001$. The largest discrepancies occurred when the target was implied to have been infected with HIV through a blood transfusion (41% did not match), heterosexual sex (45% did not match), or homosexual sex (30% did not match). Follow-up analyses revealed that, compared with the mother-to-infant condition (the condition with the next highest proportion of non-matches), participants were significantly less likely to match their assumptions to the blood products, $\chi^2 (1, N = 113) = 15.81, p < .001$, heterosexual sex, $\chi^2 (1, N = 112) = 19.21, p < .001$, and homosexual sex, $\chi^2 (1, N = 110) = 8.16, p = .004$, conditions. For the infant, drug-use, and lung cancer conditions, there was no difference in the proportion of participants whose assumptions did not match the condition to which they were assigned (all $\chi^2 s < 3.00$).

A three-dimensional frequency (log-linear) analysis revealed a significant three-way interaction between nationality, scenario, and match of assumptions to scenario, $Q^2 (6, N = 381) = 18.12, p = .006$. Chi-square tests of independence (performed separately for each scenario) uncovered a significant interaction between nationality and match of assumptions for the HIV-homosexual scenario, $\chi^2 (1, N = 53) = 6.15, p = .013$, and for the lung cancer-smoking scenario, $\chi^2 (1, N = 51) = 6.97, p = .008$. Compared with Canadians, Netherlands were less likely to connect HIV-infection to homosexuality and lung cancer to smoking. The interaction was nonsignificant for the other five scenarios.
Because it is impossible to know how the ‘non-matching’ participants interpreted the scenarios, they were excluded from subsequent analyses. Hence, the final sample included 207 Canadians and 97 Netherlands.

**Associations Among Behavioural Outcome Measures**

An examination of the six pairwise correlations between the four outcome variables (i.e., personal help, institutional help, budget allocation, and social distance; see Table 2) separately for the two nationalities revealed that 11 of the 12 correlations were significant, the exception being the correlation between the social-distance and budget-allocation measures for the Netherlands sample. To determine whether the behavioural-outcome variables were representative measures of prosocial behaviour (to be used in the subsequent path analysis of the Weiner model of social motivation), the four variables were submitted to a principal components analysis (PCA; criterion: eigenvalue > 1; varimax rotation). Personal help, institutional help, desire for social distance, and budget allocation strongly loaded on the principal component (.83, .81, -.74, and .55, respectively), which accounted for 55% of the variance. Hence, the variables appear to be similar measures of a larger construct (i.e., prosocial behaviour).

**Table 2**

<table>
<thead>
<tr>
<th></th>
<th>Personal Help</th>
<th>Institutional Help</th>
<th>Budget Allocation</th>
<th>Social Distance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Help</td>
<td></td>
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<td>.26*</td>
<td>-.38***</td>
</tr>
<tr>
<td>Institutional Help</td>
<td>.56***</td>
<td></td>
<td>.31**</td>
<td>-.25*</td>
</tr>
<tr>
<td>Budget Allocation</td>
<td>.27***</td>
<td>.46***</td>
<td></td>
<td>.01</td>
</tr>
<tr>
<td>Social Distance</td>
<td>-.63***</td>
<td>-.50***</td>
<td>-.18**</td>
<td></td>
</tr>
</tbody>
</table>

**Note.** The correlations for the Canadian sample (N = 207) are below the diagonal and for the Netherlands sample (N = 97) are above the diagonal. * p < .05. ** p < .01. *** p < .001.
Associations Among the Cognition and Emotion Variables

The next set of analyses examined whether participants differentiated between the constructs of controllability, responsibility, and blame, and between blame, contempt and anger. In the present study, original Likert-response items (i.e., 4 per construct) were developed as indicators of controllability, responsibility, blame, anger, contempt, and sympathy. The cognition and emotion items (see Appendix I for the correlation matrix of these items) were submitted to a PCA (varimax rotation) to determine whether the resulting factor structure would map onto the constructs. Items measuring anger, contempt, and sympathy were expected to load onto orthogonal (i.e., independent) latent components, whereas items measuring controllability, responsibility, and blame were expected to correlate with the same component. The disdain item was dropped from the analysis because many of the Canadian participants did not understand the word and the Netherlands translation of disdain was the same as contempt.

The initial PCA with a six-factor structure (to match the six constructs) was difficult to interpret: 11 of the cognition items and a single contempt item loaded most highly onto the first component; three anger items loaded onto the second component; contempt, blame, and anger items loaded onto the third component; two sympathy items were loaded onto each of the fourth and fifth components; and a single contempt item loaded onto the sixth component.

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The principal components analyses were also performed using an oblique rotation. The results for the oblique rotation were almost identical as for the orthogonal rotation except that lack of respect had a slightly stronger correlation with contempt in the oblique rotation than in the orthogonal rotation.
A subsequent exploratory PCA (criterion: eigenvalue > 1.00; varimax rotation) yielded a readily interpretable four-factor structure (see Table 3). All of the cognition items (i.e., those measuring controllability, responsibility, and blame) loaded strongly onto the principal component. The four anger items, two contempt items, and one sympathy item loaded onto the second component. This component was relabeled as a negative affect factor. Three of the four sympathy items loaded onto the third component. The

<table>
<thead>
<tr>
<th>Variable</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
</tr>
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<tbody>
<tr>
<td>Accountable</td>
<td>.88</td>
<td>.16</td>
<td>-.13</td>
<td>.11</td>
</tr>
<tr>
<td>Caused</td>
<td>.88</td>
<td>.11</td>
<td>.00</td>
<td>.01</td>
</tr>
<tr>
<td>Preventable</td>
<td>.87</td>
<td>.10</td>
<td>-.09</td>
<td>-.01</td>
</tr>
<tr>
<td>Negligent</td>
<td>.84</td>
<td>.14</td>
<td>-.12</td>
<td>.00</td>
</tr>
<tr>
<td>Controllable</td>
<td>.83</td>
<td>.13</td>
<td>-.07</td>
<td>-.01</td>
</tr>
<tr>
<td>Fault</td>
<td>.81</td>
<td>.19</td>
<td>-.09</td>
<td>.00</td>
</tr>
<tr>
<td>Responsible</td>
<td>.81</td>
<td>.23</td>
<td>-.10</td>
<td>-.03</td>
</tr>
<tr>
<td>Blameworthy</td>
<td>.78</td>
<td>.21</td>
<td>-.08</td>
<td>-.04</td>
</tr>
<tr>
<td>Liable</td>
<td>.73</td>
<td>.15</td>
<td>-.21</td>
<td>.23</td>
</tr>
<tr>
<td>Guilty</td>
<td>.73</td>
<td>.23</td>
<td>-.19</td>
<td>.05</td>
</tr>
<tr>
<td>Deserving</td>
<td>.51</td>
<td>.42</td>
<td>-.15</td>
<td>.07</td>
</tr>
<tr>
<td>Irritated</td>
<td>.47</td>
<td>.39</td>
<td>-.40</td>
<td>.01</td>
</tr>
<tr>
<td>Resent</td>
<td>.09</td>
<td>.77</td>
<td>-.09</td>
<td>.01</td>
</tr>
<tr>
<td>Annoyed</td>
<td>.11</td>
<td>.69</td>
<td>-.11</td>
<td>.30</td>
</tr>
<tr>
<td>Worthless</td>
<td>.08</td>
<td>.69</td>
<td>.03</td>
<td>.03</td>
</tr>
<tr>
<td>No respect</td>
<td>.18</td>
<td>.60</td>
<td>-.15</td>
<td>.03</td>
</tr>
<tr>
<td>Angry</td>
<td>.35</td>
<td>.52</td>
<td>-.12</td>
<td>-.39</td>
</tr>
<tr>
<td>Compassion</td>
<td>.36</td>
<td>.48</td>
<td>.09</td>
<td>-.11</td>
</tr>
<tr>
<td>Pity</td>
<td>-.25</td>
<td>-.63</td>
<td>.39</td>
<td>.00</td>
</tr>
<tr>
<td>Sympathy</td>
<td>-.01</td>
<td>.15</td>
<td>.79</td>
<td>-.17</td>
</tr>
<tr>
<td>Feel Sorry For</td>
<td>-.17</td>
<td>-.36</td>
<td>.66</td>
<td>.20</td>
</tr>
<tr>
<td>Contempt</td>
<td>-.23</td>
<td>-.26</td>
<td>.63</td>
<td>-.05</td>
</tr>
</tbody>
</table>

Variance Explained

|          | 41% | 11% | 6%  | 5%  |

Note. N = 304.
actual *contempt* item loaded separately on the final component. This finding indicates that the cognition items were indeed strongly related regardless of whether they were designed to measure blame, responsibility, or controllability. Although the emotion items did not load exactly as expected, the solution uncovered interpretable negative-affect, sympathy, and contempt factors that were used in subsequent analyses.

**Differences Between the Cognition Variables**

Although the individual cognition items loaded onto the same latent factor and the correlations between the controllability, responsibility, and blame scales were high \((r_s > .79; \text{ see Table 4})\), such correlations do not preclude the possibility of differences among the scales. It is possible that controllability ratings could be higher than blame ratings, despite their strong positive association. Further, if controllability, responsibility, and blame address different domains, the pattern of correlations between these constructs and behaviours, emotions, and attitudes should be different. By contrast, if these constructs are the same, the strength of the correlations should be the same. The three constructs were measured on identical scales, which allowed for direct comparisons.

**Table 4**

**Inter-item Correlations Between the Cognition and Emotion Variables**

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>Responsibility</th>
<th>Blame</th>
<th>Sympathy</th>
<th>Negative Affect</th>
<th>Contempt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>.82***</td>
<td>.79***</td>
<td>-.26*</td>
<td>.35**</td>
<td>.24*</td>
<td></td>
</tr>
<tr>
<td>Responsibility</td>
<td>.89***</td>
<td>.85***</td>
<td>-.22*</td>
<td>.37***</td>
<td>.28**</td>
<td></td>
</tr>
<tr>
<td>Blame</td>
<td>.79***</td>
<td>.88***</td>
<td>-.31**</td>
<td>.48***</td>
<td>.42***</td>
<td></td>
</tr>
<tr>
<td>Sympathy</td>
<td>-.29***</td>
<td>-.36***</td>
<td>-.39**</td>
<td>-.44***</td>
<td>-.31**</td>
<td></td>
</tr>
<tr>
<td>Negative Affect</td>
<td>.48***</td>
<td>.57***</td>
<td>.65***</td>
<td>-.37***</td>
<td>.43***</td>
<td></td>
</tr>
<tr>
<td>Contempt</td>
<td>.18*</td>
<td>.20**</td>
<td>.20**</td>
<td>-.06</td>
<td>.20**</td>
<td></td>
</tr>
</tbody>
</table>

**Note.** Correlations for the Canadian sample \((N = 207)\) are below the diagonal and correlations for the Netherlands sample \((N = 97)\) are above the diagonal.

* \(p < .05\). ** \(p < .01\). *** \(p < .001\).
A mixed-design ANOVA with one between-subjects variable (nationality) and one within-subjects variable (construct: controllability vs. responsibility vs. blame) found no interaction between nationality and construct and no main effect of nationality. The lack of an interaction indicates that differences between means on the controllability, responsibility, and blame scales were similar for Canadians and Dutchers. A main effect of construct confirmed that participants' ratings were higher for some cognition scales than for others, $F(2, 604) = 155.16, p < .001$. Subsequent analyses revealed that attributions of controllability ($M = 14.70, SD = 7.40$) were higher than judgements of responsibility ($M = 12.58, SD = 6.82$), $t(304) = 9.95, p < .001$, and blame ($M = 10.20, SD = 5.57$), $t(304) = 16.43, p < .001$, and that responsibility judgements were higher than blame judgements, $t(304) = 12.32, p < .001$. In general, participants considered the targets to be more responsible than blameworthy for their illness, but more in control of whether they became ill than responsible.

The three cognition scales also had an interesting and systematic pattern of associations with the outcome, emotion, and social-attitude variables. As shown in Table 5, blame had the strongest correlations with other variables, followed by judgements of responsibility, and then by attributions of controllability. Absolute values of the correlations between controllability, responsibility, and blame and the other research variables were submitted to a Friedman test (i.e., the nonparametric equivalent of a repeated-measures ANOVA; $t$ has a non-normal distribution) to determine whether these observations were statistically reliable. The analysis confirmed that the three sets of correlations differed in magnitude, $\chi^2(2, N = 304) = 25.04, p < .001$. Follow-up
Wilcoxon matched-pairs signed-rank tests (normal approximations) revealed that the correlations between blame ratings and the outcome, emotion, and social-attitude variables were higher than those for responsibility ratings, $z = 3.18, p = .0015$, which in turn, were higher than those for the controllability ratings, $z = 3.06, p = .002$. Indeed, blame ratings had the highest correlations for each of the variables, and each of the responsibility correlations was higher than its controllability counterpart.

Table 5
Correlations of Cognitive Variables with Behaviour, Emotion, and Social-Attitude Variables

<table>
<thead>
<tr>
<th>Behavioural Outcome Variables</th>
<th>Controllability</th>
<th>Responsibility</th>
<th>Blame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Help</td>
<td>-.31***</td>
<td>-.37***</td>
<td>-.42***</td>
</tr>
<tr>
<td>Institutional Help</td>
<td>-.37***</td>
<td>-.41***</td>
<td>-.49***</td>
</tr>
<tr>
<td>Budget Allocation</td>
<td>-.14*</td>
<td>-.18**</td>
<td>-.21***</td>
</tr>
<tr>
<td>Social Distance</td>
<td>.29***</td>
<td>.32***</td>
<td>.41***</td>
</tr>
<tr>
<td>Emotion Variables</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sympathy</td>
<td>-.29***</td>
<td>-.34***</td>
<td>-.37***</td>
</tr>
<tr>
<td>Negative Affect</td>
<td>.43***</td>
<td>.50***</td>
<td>.60***</td>
</tr>
<tr>
<td>Contempt</td>
<td>.21***</td>
<td>.23***</td>
<td>.24***</td>
</tr>
<tr>
<td>Social Attitudes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authoritarianism</td>
<td>.05</td>
<td>.05</td>
<td>.11</td>
</tr>
<tr>
<td>Attitude toward Gay Men</td>
<td>.17**</td>
<td>.21***</td>
<td>.28***</td>
</tr>
<tr>
<td>Attitude toward Lesbians</td>
<td>.10</td>
<td>.13*</td>
<td>.19**</td>
</tr>
<tr>
<td>Just World Belief</td>
<td>.13*</td>
<td>.16**</td>
<td>.22***</td>
</tr>
<tr>
<td>Religious Fundamentalism</td>
<td>.04</td>
<td>.06</td>
<td>.07</td>
</tr>
<tr>
<td>Humanitarian Ethic</td>
<td>-.13*</td>
<td>-.14*</td>
<td>-.22***</td>
</tr>
</tbody>
</table>

Note. $N = 304$.

* $p < .05$.  ** $p < .01$.  *** $p < .001$.

As a further test of the roles of the cognition variables, a series of multiple regressions was run for each of the behavioural outcome variables (i.e., personal help, institutional help, budget allocation, and social distance) to examine the unique contributions of controllability, responsibility, and blame. For personal help, support for
institutional help, and desire for social distance (see Table 6), blame explained a significant unique proportion of the variance with controllability and responsibility held constant. Neither controllability nor responsibility explained a significant unique proportion of the variance with the other two cognitive variables held constant. These results add support to the hypothesis that blame is a construct distinct from responsibility. Thus, although the three cognition scales were highly correlated, these findings indicate that the constructs increased in associative strength with the outcome variables as participants moved from attributions of controllability, to judgements of responsibility, to decisions regarding blame. Because of this clear and interpretable hierarchy, the three separate cognition scales were retained for further analyses.

Table 6
Unique Effects of the Cognition Variables on Behavioural Outcomes

<table>
<thead>
<tr>
<th></th>
<th>Personal Help</th>
<th>Institutional Help</th>
<th>Budget Allocation</th>
<th>Social Distance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique effects: $\eta^2$</td>
<td>.0019</td>
<td>.0002</td>
<td>.0020</td>
<td>.0001</td>
</tr>
<tr>
<td>Controllability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsibility</td>
<td>.0013</td>
<td>.0004</td>
<td>.0011</td>
<td>.0022</td>
</tr>
<tr>
<td>Blame</td>
<td>.0392***</td>
<td>.0738***</td>
<td>.0098</td>
<td>.0688***</td>
</tr>
<tr>
<td>Combined effects:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$R^2$</td>
<td>.174</td>
<td>.240</td>
<td>.044</td>
<td>.173</td>
</tr>
<tr>
<td>F</td>
<td>21.10***</td>
<td>31.65***</td>
<td>4.55**</td>
<td>20.97***</td>
</tr>
</tbody>
</table>

* $p < .05$. ** $p < .01$. *** $p < .001$.

Associations among the Social-Attitude Variables

The next set of analyses examined associations among the social-attitude scales (i.e., Attitudes Toward Gay Men, Attitudes Toward Lesbians, Authoritarianism, Global Belief in a Just World, Religious Fundamentalism, and Humanitarian-Egalitarianism) in
order to understand the implications of these relations for testing Weiner’s social
motivation model. Each of the scales was relatively unidimensional (see PCA of all
individual attitude items — Appendix J). As expected, attitudes toward gay men and
attitudes toward lesbians were strongly correlated (see Table 7) and had a similar pattern
of correlations with the emotion, cognition, and outcome variables (see correlation matrix
— Appendix K). Authoritarianism and religious fundamentalism were also strongly
related, although the shared variance was less than 38%. The remaining correlations
among the social-attitude scales were low to moderate.

Table 7
Correlations of Social-Attitude Scales

<table>
<thead>
<tr>
<th></th>
<th>ATG</th>
<th>ATL</th>
<th>HE</th>
<th>GBJW</th>
<th>RF</th>
<th>RWA</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATG</td>
<td></td>
<td>.70***</td>
<td>-.30**</td>
<td>.27**</td>
<td>.44***</td>
<td>.48***</td>
</tr>
<tr>
<td>ATL</td>
<td>.86***</td>
<td></td>
<td>-.22**</td>
<td>.10</td>
<td>.39***</td>
<td>.38***</td>
</tr>
<tr>
<td>HE</td>
<td>-.31***</td>
<td>-.21**</td>
<td></td>
<td>-.10</td>
<td>-.05</td>
<td>-.15</td>
</tr>
<tr>
<td>GBJW</td>
<td>.25***</td>
<td>.23**</td>
<td>-.22**</td>
<td></td>
<td>.15</td>
<td>.22*</td>
</tr>
<tr>
<td>RF</td>
<td>.42***</td>
<td>.41***</td>
<td>.06</td>
<td>.01</td>
<td></td>
<td>.56***</td>
</tr>
<tr>
<td>RWA</td>
<td>.41***</td>
<td>.46***</td>
<td>.02</td>
<td>.09</td>
<td>.61***</td>
<td></td>
</tr>
</tbody>
</table>

Note: The correlation coefficients are below the horizontal for the Canadian sample
(N = 207) and above the horizontal for the Netherlands sample (N = 97).
* p < .05. ** p < .01. *** p < .001.

To determine if the six social-attitude scales reflected a single underlying construct
that could be used in subsequent tests of the Weiner model, the six scales were submitted
to a PCA (criterion: eigenvalues >1; oblique rotation). The humanitarian-egalitarianism
scale was recoded for this analysis to reflect lower humanitarian ethic for ease of
interpretation. Religious fundamentalism, authoritarianism, and attitudes toward lesbians
and gay men formed the first component (47.7% of the variance; loadings = .81, .84, .84,
.83 respectively), and lower humanitarian ethic and belief in a just world formed a second
component (20.7% of the variance; loadings = .80, .62, respectively). These components suggest that social attitudes have two distinct dimensions ($r = .14$), the first reflecting hostility toward people different from oneself and the second reflecting a general negative world-view. This pattern is contrary to the expectation that all of the social attitudes would reflect a single underlying construct.

**Means, Standard Deviations, and Reliabilities for all Research Scales**

The means and standard deviations for the behavioural outcome, cognition, emotion, and social-attitude variables are listed in Table 8. In general, participants had favourable responses to the target person in the scenarios. The majority (76%) said that they were very willing to help the ill person, although willingness to help decreased as the physical intimacy of the helping acts increased. For example, 89% of participants were very willing to listen to the ill person and 72% were very willing to call an information hotline on his behalf, but only 27% were very willing to help him bathe. Moreover, 89% of the sample were very supportive of medical and government help for the person.

Seventy-six percent of the sample allocated a “fair” amount of the fictitious hospital budget to “people like William,” with “fair” considered to be proportional to the overall budget (i.e., 20 - 25% depending on whether the participants allocated funds to four or five illnesses). Participants also expressed considerable sympathy (77% were above the midpoint) and relatively low levels of contempt (66% were below the midpoint) and negative affect (98% were below the midpoint) toward the ill person.

The internal reliabilities (as measured by Cronbach’s alpha) for both samples were very similar, although slightly lower for the Netherlands sample for many of the variables,
most likely because of the smaller sample size. All of the scales had acceptable internal consistency (.60 or greater; see Table 8).

Table 8
Means, Standard Deviations, and Cronbach’s Alpha for Research Scales by Nationality

<table>
<thead>
<tr>
<th>Scale</th>
<th>Possible Range</th>
<th>Canada Mean</th>
<th>Canada SD</th>
<th>Canada Alpha</th>
<th>Netherlands Mean</th>
<th>Netherlands SD</th>
<th>Netherlands Alpha</th>
</tr>
</thead>
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<tr>
<td>Behavioural Outcome Variables</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Help</td>
<td>13 - 91</td>
<td>74.29</td>
<td>14.64</td>
<td>.94</td>
<td>72.55</td>
<td>11.62</td>
<td>.89</td>
</tr>
<tr>
<td>Institutional Help</td>
<td>2 - 14</td>
<td>12.39</td>
<td>2.19</td>
<td>.79</td>
<td>11.66</td>
<td>2.07</td>
<td>.74</td>
</tr>
<tr>
<td>Budget Allocation</td>
<td>0 - 100</td>
<td>23.30</td>
<td>9.20</td>
<td>--</td>
<td>22.10</td>
<td>8.22</td>
<td>--</td>
</tr>
<tr>
<td>Social Distance</td>
<td>5 - 35</td>
<td>9.93</td>
<td>5.16</td>
<td>.74</td>
<td>9.54</td>
<td>3.85</td>
<td>.60</td>
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<td>Cognition Variables</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Controllability</td>
<td>4 - 28</td>
<td>15.24</td>
<td>8.14</td>
<td>.92</td>
<td>13.55</td>
<td>6.69</td>
<td>.85</td>
</tr>
<tr>
<td>Responsibility</td>
<td>4 - 28</td>
<td>13.00</td>
<td>7.21</td>
<td>.91</td>
<td>11.69</td>
<td>5.85</td>
<td>.84</td>
</tr>
<tr>
<td>Blame</td>
<td>4 - 28</td>
<td>10.43</td>
<td>5.90</td>
<td>.81</td>
<td>9.71</td>
<td>4.78</td>
<td>.77</td>
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<tr>
<td>Emotion Variables</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sympathy</td>
<td>3 - 21</td>
<td>16.02</td>
<td>3.48</td>
<td>.61</td>
<td>17.66</td>
<td>2.67</td>
<td>.68</td>
</tr>
<tr>
<td>Negative Affect</td>
<td>7 - 49</td>
<td>13.62</td>
<td>6.23</td>
<td>.82</td>
<td>15.09</td>
<td>5.42</td>
<td>.75</td>
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<tr>
<td>Contempt</td>
<td>1 - 7</td>
<td>2.89</td>
<td>1.73</td>
<td>--</td>
<td>1.65</td>
<td>.97</td>
<td>--</td>
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<td>Social-Attitude Variables</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authoritarianism</td>
<td>10 - 90</td>
<td>49.24</td>
<td>11.87</td>
<td>.70</td>
<td>34.13</td>
<td>9.93</td>
<td>.71</td>
</tr>
<tr>
<td>Attitude toward Gay Men</td>
<td>5 - 45</td>
<td>20.62</td>
<td>13.03</td>
<td>.94</td>
<td>11.16</td>
<td>7.37</td>
<td>.86</td>
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<tr>
<td>Attitude toward Lesbians</td>
<td>4 - 36</td>
<td>14.22</td>
<td>9.50</td>
<td>.90</td>
<td>7.41</td>
<td>4.58</td>
<td>.68</td>
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<td>Belief in a Just World</td>
<td>7 - 42</td>
<td>20.64</td>
<td>6.23</td>
<td>.81</td>
<td>19.33</td>
<td>5.50</td>
<td>.79</td>
</tr>
<tr>
<td>Religious Fundamentalism</td>
<td>9 - 54</td>
<td>21.48</td>
<td>12.65</td>
<td>.88</td>
<td>13.65</td>
<td>9.09</td>
<td>.83</td>
</tr>
<tr>
<td>Humanitarian Ethic</td>
<td>10 - 60</td>
<td>48.84</td>
<td>6.86</td>
<td>.83</td>
<td>46.55</td>
<td>5.67</td>
<td>.76</td>
</tr>
</tbody>
</table>

Note. Canada: N = 207; Netherlands: N = 97.

Between-Country Differences for Individual Differences

The AIDS epidemic had a greater impact on the lives of the Netherlands (M = 3.19, SD = 1.65) than the Canadians (M = 2.69, SD = 1.55, t(302) = 2.56, p = .011, although both samples had relatively little personal contact with someone who is HIV-positive. Only 3% of both samples had a great deal of contact with a PHA (i.e., scoring a
6 or 7 on a 7-point scale). One-sample t-tests revealed that participants in both samples considered themselves to be more tolerant (Canada: \( M = 4.88, SD = 1.24, t(206) = 10.25, p < .001 \); Netherlands: \( M = 5.13, SD = 1.07, t(96) = 10.47, p < .001 \)) and more progressive (Canada: \( M = 5.14, SD = 1.13, t(205) = 14.51, p < .001 \); Netherlands: \( M = 5.11, SD = 1.02, t(96) = 10.76, p < .001 \)) than their families.

To determine if there were differences between the social attitudes of the Canadians and the Netherlands, the six social-attitude items (see Table 8 for the means and standard deviations) were submitted to a multivariate analysis of variance (MANOVA), which revealed a significant difference between groups, Wilks \( \Lambda = .67 \), \( F(6, 292) = 24.16, p < .001 \). Subsequent univariate analyses revealed that, compared to the Netherlands, the Canadians had stronger authoritarian attitudes, \( t(300) = 10.86, p < .001 \), more hostility toward gay men, \( t(300) = 6.67, p < .001 \), more hostility toward lesbians, \( t(301) = 6.69, p < .001 \), more fundamental religious beliefs, \( t(301) = 5.46, p < .001 \), and a stronger humanitarian ethic, \( t(302) = 2.80, p = .005 \). In short, the Canadians were more extreme across the measures.

**Differences based on Nationality, Illness, and Agency**

If AIDS continues to be more stigmatized than other illnesses, participants should have more positive behaviours, thoughts, and feelings toward a person with lung cancer than toward a person infected with HIV. Responses to an ill person are also likely to vary according to the ill person's perceived agency (i.e., the way in which the illness was acquired). For example, participants were expected to react more positively toward a person who acquired an illness through "passive" means (e.g., a nonsmoker with lung
cancer; a person infected with HIV through blood products or mother-to-infant transmission) rather than “active” means (e.g., a smoker with lung cancer; a person infected with HIV through sex or drug use). Such factors could also vary according to nationality. Accordingly, three-way (nationality X illness X agency) MANOVAs were conducted separately for the behavioural outcome variables, the cognition variables, and the emotion variables. Means and standard deviations are listed in Table 9.

The MANOVA for the behavioural outcome variables revealed no interactions. A main effect of illness, Wilks Λ = .92, F (4, 289) = 6.33, p < .001, stemmed primarily from the fact that participants allocated more hospital funds to people with HIV than to people with lung cancer, F (1, 292) = 20.52, p < .001. A main effect of agency was also significant, Wilks Λ = .95, F (4, 289) = 3.54, p = .008. Participants were more supportive of institutional help, F (1, 292) = 12.93, p < .001, and allocated more hospital funds, F (1, 292) = 6.34, p = .012, to people who acquired their illness through “passive” rather than “active” means. The main effect of nationality was not significant.

For the cognition variables, there were no two- or three-way interactions between variables and no main effects of nationality or illness. The main effect of agency was significant, Wilks Λ = .44, F (3, 294) = 124.90, p < .001. Participants attributed lower levels of controllability, responsibility, and blame when the target person was perceived to have acquired his illness through “passive” rather than “active” means, Fs (1, 296) = 355.15, 261.98, 148.25, respectively, ps < .001.
Table 9
Means and Standard Deviations by Illness, Agency, and Nationality for Behavioural Outcomes, Cognition, and Emotion Variables

<table>
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<tr>
<th>Variable</th>
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<th>Lung Cancer</th>
<th>CDA</th>
<th>NL</th>
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Note. Canada: N = 207; Netherlands: N = 97.
As in the previous analyses, the MANOVA for the emotion variables uncovered no interactions. There was a main effect of nationality, Wilks $\Lambda = .78$, $F(3, 279) = 27.00$, $p < .001$. Compared to the Canadians, Netherlands displayed higher levels of sympathy, $F(1, 281) = 14.41$, $p < .001$, higher levels of negative affect, $F(1, 281) = 4.72$, $p = .031$, but lower levels of contempt, $F(1, 281) = 41.81$, $p < .001$. The main effect of agency was also statistically reliable, Wilks $\Lambda = .97$, $F(3, 279) = 3.12$, $p = .026$. Respondents had more negative affect toward targets who acquired their illness through "active" instead of "passive" routes, $F(1, 281) = 8.49$, $p = .004$. The main effect of illness was not significant.

In summary, the lack of interactions between nationality and illness or agency points to the similarities in response patterns across the two samples. The only between-country difference to emerge was for emotional reactions. Consistent with the hypotheses, agency was a significant predictor of responses for all groups of variables. Type of illness was a significant predictor of behaviours, but not of cognitions and emotions. Because there were no interactions of nationality and cognitions, emotions, or behaviours, the Canadian and Netherlands samples were combined for subsequent analyses ($N = 304$).

**Unique Contributions of Social-Motivation and Individual-Difference Variables to Behavioural Outcomes**

The next set of analyses tested whether the behavioural outcome variables were better predicted by the social-motivation or individual-difference variables. Social-motivation theory predicts that angry or sympathetic responses toward a person involved
in a negative event should be the only variables to exert a direct influence on the likelihood of helping behaviours. It was hypothesized, however, that individual differences would also have a direct impact on behaviour. Situational influences were expected to be mediated by emotions. Separate multiple regression analyses (conducted for each behavioural outcome; see Appendix L for full analyses) examined the unique contribution of three blocks of variables: (1) an emotion block, which included the negative-affect and sympathy variables, (2) an individual-difference block, which consisted of scores on the two social-attitudes factors (hostility toward others and negative world-view), and gender; and (3) a scenario block, which included the two variables associated with the design of the scenarios (agency and illness). The regression analyses examined the extent of the unique contribution of each block of variables (rather than the individual variables) while holding constant the variance accounted for by the other blocks. If Weiner is correct, only the emotion block should be significant because social attitudes and the details provided by the scenario should be mediated by the participants’ emotional responses.

**Personal Help.** The regression analysis showed that the three blocks of variables accounted for 46% of the variance in willingness to provide personal help, $R = .675$, $F(7, 288) = 33.79, p < .001$. The unique contribution of the emotion block was significant, $R^2 = .12, F(2, 283) = 32.04, p < .001$. The individual-difference block also

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*Although it had been hypothesized that age and contact with PHAs would affect emotional and behavioural reactions to the target person, these measures had limited variance. Only 3% of the sample had contact with PHAs and only 7% of the sample was 25 years or older. Hence, the age and contact variables were excluded from the regression analyses and path analyses.*
accounted for a significant unique proportion of the variance, $R^2 = .11$, $F (3, 283) = 19.16$, $p < .001$. The scenario block did not make a unique contribution and accounted for less than 1% of the variance.

**Institutional Help.** The regression model accounted for 36% of the variance in support for institutional help, $R = .596$, $F (7, 283) = 22.27$, $p < .001$. Similar to the previous analysis, the emotion block accounted uniquely for 14% of the variance, $F = (2, 283) = 30.58$, $p < .001$. The individual-difference block accounted uniquely for 4% of the variance, which was also significant, $F (3, 283) = 6.01$, $p < .001$. The scenario block accounted for less than 1% of the variance, which was not significant.

**Budget Allocation.** The regression analysis on the allocation of hospital funds showed that the three blocks of variables accounted for 15% of the variance, $R = .388$, $F (8, 280) = 7.09$, $p < .001$. The unique contribution of the emotion block was significant, $SR^2 = .03$, $F (2, 280) = 5.64$, $p = .004$. For this outcome, the scenario block accounted for a highly significant unique proportion of the variance, $SR^2 = .06$, $F (2, 280) = 10.47$, $p < .001$, whereas the individual-difference block explained 1% of the variance.

**Social Distance.** The emotion, individual difference, and scenario blocks accounted for 42% of the variance in desire for social distance from the target person, $R = .651$, $F (7, 283) = 29.67$, $p < .001$. Similar to the first two analyses, the unique contribution of the emotion block was significant, $SR^2 = .15$, $F (2, 283) = 37.34$, $p < .001$. The unique contribution of the individual-difference block was also significant, $SR^2 = .07$, $F (3, 283) = 11.31$, $p < .001$. The scenario block did not make a unique contribution and accounted for less than 1% of the variance.
**Summary.** The emotion block of variables contributed significant unique amounts of variance for each of the four regression analyses, which supports Weiner's hypothesis that emotions are the best predictors of helping behavior toward a person experiencing a negative event. Nonetheless, individual-differences were significant in three of the four analyses and the illness-type/illness-acquisition variables were significant in the fourth, supporting the argument that influences outside of Weiner's model are important in explaining behavior. These results lend support to the hypothesis that pre-existing personal factors may influence behavior above and beyond the cognition→emotion→behavior sequence proposed by Weiner.

**Unique Contributions of Cognition and Individual-Difference Variables to Emotional Reactions**

In his theory of social motivation, Weiner hypothesized that only cognitions, specifically judgements of responsibility, directly influence emotional reactions. Any influence of situational or individual-difference factors would be mediated by cognitions. It was hypothesized, however, that pre-existing personal factors, such as social attitudes, would affect both cognitive and emotional reactions. Information about the illness acquisition was not expected to have a direct influence on emotions. Separate multiple regression analyses (conducted for each emotion variable: sympathy, negative affect, and contempt; see Appendix M for full analyses) examined the unique contribution of three blocks of variables: (1) a cognition block (i.e., responsibility); (2) an individual-difference block (i.e., hostility toward others, general world view, and gender; and (3) a scenario block (i.e., agency and illness). The regression analyses examined the unique contribution
of each block of variables while holding constant the variance accounted for by the other blocks. If Weiner is correct, only the responsibility block should be significant because the influence of gender, social attitudes, and the details provided by the scenario should be mediated by the participants' cognitive evaluations.

**Sympathy.** The three blocks of variables accounted for 19% of the variance in sympathy for the target person, $R = .437$, $F (6, 291) = 11.46, p < .001$. Responsibility contributed a unique proportion of the variance, $SR^2 = .07$, $F (1, 291) = 23.46, p < .001$. The individual-difference block also accounted for a significant unique proportion of the variance, $SR^2 = .04$, $F (3, 291) = 5.32, p = .001$, as did the scenario block, $SR^2 = .02$, $F (2, 291) = 4.13, p = .017$.

**Negative Affect.** The regression model accounted for 40% of the variance in negative affect, $R = .630$, $F (6, 291) = 31.29, p < .001$. The cognition block was highly significant and accounted uniquely for 14% of the variance, $F (1, 291) = 64.40, p < .001$. The individual-difference block accounted uniquely for 10% of the variance, which was also highly significant, $F (3, 291) = 15.88, p < .001$. The scenario block was also significant and accounted for 2% of the variance, $F (2, 291) = 5.79, p = .003$.

**Contempt.** The regression analysis showed that the cognition, individual-difference, and scenarios blocks accounted for 16% of the variance in contempt for the target person, $R = .404$, $F (6, 287) = 9.35, p < .001$. Similar to the first two analyses, the unique contribution of the cognition block was significant, $SR^2 = .05$, $F (1, 287) = 16.42, p < .001$. The unique contribution of the individual-difference block was also significant, $SR^2 = .07$, $F (3, 287) = 7.79, p < .001$, as was the unique contribution of the scenario
block, $\text{SR}^2 = .03$, $F (2, 287) = 5.77$, $p = .004$.

**Summary.** As expected, the cognition block (i.e., responsibility) consistently explained a significant proportion of the variance for each of the emotion variables. Contrary to Weiner's theory, however, the scenario and individual-difference blocks also explained significant unique proportions of the variance for each of the emotions. Hence, there was support for the hypothesis that emotional reactions would be predicted by factors other than judgements of responsibility.

**Path Analysis of Weiner's Social Motivation Model**

The final set of analyses included tests of Weiner's social motivation model and proposed modifications to his model. As stated previously, Weiner believes that if observers attribute controllability to a particular agent, then they will also likely judge the agent to be responsible for the event. If they judge the person to be responsible, they will react with more anger and less sympathy. If they are angry, they are less likely to help the agent, whereas if they are sympathetic, they are more likely to help the person.

Although Weiner believes that his model is applicable to most social behaviours, it is most often used to explain helping behaviour. The previous regression analyses revealed similar patterns of predictors of each outcome behaviour (i.e., personal help, support for institutional help, budget allocation, and social distance), supporting Weiner's theory. An earlier PCA revealed that these behaviours may represent a latent *prosocial behaviour* component. Hence, *prosocial behaviour* was used as a single outcome variable in the overall test of Weiner's model. If Weiner's model predicts the composite measure of prosocial behaviour, it would provide considerable support for his hypothesis.
The path models were tested with the maximum likelihood method of EQS (Bentler, 1995), a software program used for structural equation modelling. This modelling technique compares raw data to hypothesized causal models. EQS provides estimates for multiple linear equations, path coefficients ($R$) for each of the hypothesized relations, and several goodness-of-fit indices. For example, if the model provides a good fit to the data, the LISREL Goodness of Fit index (GFI) and the Comparative Fit Index (CFI) should be .9 or greater (maximum: 1.0) and the Root Mean Square Error of Approximation (RMSEA) should be less than .1.

**Weiner’s Model of Social Motivation.** Weiner’s model provided a good explanation of prosocial behaviour toward an ill person, GFI = .981, CFI = .987, RMSEA = .080. All of the hypothesized paths between variables were highly significant (see Figure 2). Attributions of controllability predicted stronger judgements of responsibility, which in turn predicted greater negative-affect and less sympathy. Stronger negative-affect subsequently predicted less prosocial behaviour, whereas stronger sympathy predicted more prosocial behaviour. The strong relations between the emotions and the composite measure of prosocial behaviour suggests that Weiner’s social motivation model could be used to explain a variety of behaviours.

**Modifications to the Social Motivation Model.** The present study proposed a number of modifications to Weiner’s model (see Figure 3 for the input model). The first modification was the inclusion of contempt. It was expected that contempt, more so than negative affect, would predict less prosocial behaviour. The second modification was the inclusion of blame. Weiner believes that responsibility has a direct influence on
Figure 2. Test of Weiner's Social Motivation Model on the Composite Measure of Prosocial Behaviour

Sympathy → Responsibility → Controllability

Prosocial Behaviour

Negative Affect

-0.333***

-0.544***

0.230***

0.454***

0.878***
emotions, but the present study proposed that responsibility influences blame, which in turn increases contempt and negative affect but decreases sympathy. Third, Weiner believed that factors external to his model (e.g., illness acquisition and individual differences) would be mediated by the cognition–emotion sequence. It was expected, however, that negative social attitudes (i.e., hostility toward others, negative world-view) would directly affect not only stronger attributions of controllability, but also emotions and willingness to perform prosocial behaviours. Demographic variables (i.e., gender, age, nationality, and contact with PHAs) were hypothesized to be directly related to behaviour as well as social attitudes, but as noted earlier, age and contact with PHAs had little variance and were, therefore, excluded. Further, the lack of interaction of nationality with cognitions, emotions, or behaviours indicated that Canadians’ and Netherlands’ attribution patterns were similar, negating a need to test for differences. Hence, only the influence of gender on the social motivation model remained to tested. It was expected that, compared with men, women would have more positive social attitudes and would be more willing to engage in prosocial behaviours. Agency was expected to have a direct effect on only attributions of controllability. In sum, the variables in the final test of the model included: (1) individual differences (gender, general hostility, negative world view); (2) agency; (3) cognition variables (controllability, responsibility, blame); (4) emotion variables (sympathy, contempt, negative affect); and (5) prosocial behaviour.
In general, the modifications to the social motivation model provided an adequate explanation for willingness to engage in prosocial behaviour, $GFI = .944$, $CFI = .957$, $RMSEA = .087$. An examination of the specific relations between the variables revealed that, as expected, perceived agency of illness acquisition directly influenced attributions of controllability. Greater control was attributed to targets who were perceived to have willingly engaged in risk-related behaviours (see path coefficients, Figure 4). Further, the paths from gender to social attitudes and to behaviour were significant. Men were more likely than women to be hostile toward others and to have a negative world-view, whereas women were more willing to engage in prosocial behaviours.

As hypothesized, participants with a negative world-view and more hostility toward others made stronger attributions of control and were less willing to engage in prosocial behaviours. The relation of social attitudes to emotions was less consistent. Hostility toward people different from oneself predicted more contempt and less sympathy for the ill person, but did not predict negative affect. Negative world-view predicted negative affect, but was unrelated to contempt and sympathy.

The cognition–emotion sequence was in the predicted direction. Attributions of controllability predicted judgements of responsibility, which predicted higher levels of blame. Blame, in turn, predicted greater contempt and negative-affect and less sympathy. As expected, more sympathy and less negative-affect predicted willingness to engage in prosocial behaviour. Contrary to expectations, contempt was not significantly related to prosocial behaviour.
Summary. The present data supported Weiner's hypothesized cognition→emotion→behaviour theory. Moreover, there was considerable support for many of the proposed modifications to his model. Blame was an important contributor to the attribution sequence, which supported the hypothesis that blame is different from anger and judgements of responsibility. Individual differences were also important contributors to the process. Gender and social attitudes affected not only attributions of controllability, but also emotional and behavioural reactions, suggesting that pre-existing opinions have an important influence on reactions to ill people. Contrary to expectations, contempt was not significantly related to prosocial behaviour. Further, negative affect was a stronger predictor of behaviour than was sympathy. Together, these emotional reactions suggest that participants based their responses on their perceptions about behaviour rather than on their perceptions about stigmatized groups.
Figure 4. Test of Modifications to Weiner's Social Motivation Model: Output Model Indicating Significant Paths in Solid Lines
CHAPTER 4
Discussion

Weiner's Model of Social Motivation

The present study tested the ability of Weiner's (1993a, 1995a, 1995b, 1996) model of social motivation to explain Canadians' and Netherlandes' willingness to engage in prosocial behaviours toward people living with HIV and lung cancer. It was found that, in support of Weiner's theory, participants who attributed less control for illness acquisition made lower judgements of responsibility for the illness. Those who judged the ill person to be less responsible responded with more sympathy and less negative affect, which, in turn, predicted prosocial behaviour. The findings also supported Weiner's (1996) proposal that the cognition→emotion→behaviour sequence is applicable to many social behaviours: emotional reactions equally predicted willingness to provide personal help, support for institutional help, and social contact, behaviours of considerable consequence to PHAs (Crandall et al., 1997; Crawford et al., 1991; Fish & Rye, 1991; Katz et al., 1987; Kelly et al., 1987a, 1987b; Leiker et al., 1995; St. Lawrence et al., 1990; Strasser & Damrosch, 1992).

Emotions

Weiner (1993a, 1995a, 1995b, 1996) suggests that behavioural responses are motivated by two emotions: anger and sympathy. It was hypothesized, however, that contempt would be a more appropriate counterpart to sympathy because contempt involves a moral evaluation of the agent, whereas anger may be more related to the event (Dijker et al., 1996; Frijda, 1986; Roseman et al., 1996; Wispé, 1991). It was expected
that contempt and sympathy should have a stronger association with outcome behaviours if observers focus on stigmatized groups rather than on behaviour. By contrast, if observers focus more on the behaviour, then anger should have a stronger association with behaviours.

Contempt and negative affect were moderately correlated in the present study, which implies that they are related but not the same. Sympathy and negative affect predicted outcome behaviours, but contrary to expectations, participants’ feelings of contempt for the ill person did not predict their behavioural reactions. These findings support Weiner’s contention that anger and sympathy are key motivators and indicate that participants were responding more to their perceptions of particular behaviours than to stigmatized groups.

**Cognitions**

Weiner (1995a) excludes blame from his model of socially motivated behaviour because he believes that blame is a hybrid of anger and judgements of responsibility, whereas other attribution theorists (e.g., Critchlow, 1985; Heider, 1958; Shaver, 1996) propose that blame is the final evaluation in the attribution sequence. The present results supported the latter hypothesis. The addition of blame improved Weiner’s model, which suggests that blame is a unique and valuable factor that needs to be incorporated into the model.

Furthermore, the data revealed a clear hierarchy of cognitive judgements. Participants from both countries made stronger attributions of controllability, moderate judgements of responsibility, and weaker judgements of blame. Participants’ ratings of
controllability, responsibility, and blame showed the opposite pattern to those reported by Critchlow (1985). For behaviours ranging from overeating to robbery, she found that ratings of responsibility and blame were similar and higher than ratings of causality. In the most serious of situations, however, blame had the highest ratings. In the current study, blame had the lowest ratings. Even so, blame had significantly stronger correlations with all of the emotions, behaviours, and social attitudes than either controllability or responsibility. When considered in conjunction with Critchlow’s results, these correlations suggest that blame is the most serious of judgements, reserved for judging the perceived impact of the event. These results support the belief that controllability is a relatively simple yes/no evaluation, responsibility involves the degree of association and agent and event, and blame is a moral, or value-based, judgement (Kelley, 1971; Shaver, 1985; Shaver & Drown, 1986). Hence, if one of the functions of blame is to define who is to be punished for a particular act (Critchlow, 1985; Kroger & Wood, 1998), the observers’ level of blame -- rather than their judgements of controllability or responsibility -- should be the best predictor of their responses.

**Individual Differences**

It was hypothesized that common social attitudes (e.g., authoritarianism, belief in a just world) would reflect a single latent construct, such as conventionalism. Instead, negative attitudes toward gay men and lesbians, religious fundamentalism, and authoritarianism were strongly related, representing a generalized hostility toward people different from oneself, whereas belief in a just world and humanitarian ethic were strongly and negatively associated, representing a general perspective of how the world works.
Moreover, these two dimensions were virtually orthogonal. Hence, previous studies that have found associations between AIDS-related attitudes and authoritarianism, religious attitudes, or prejudice toward gay men have probably tapped into a similar cluster of attitudes.

Weiner (1993b) suggests that the influence of individual differences on behaviours is mediated by cognitive responses, specifically through attributions of controllability. Contrary to his hypothesis, however, factors outside of the cognition→emotion sequence, such as intentions (Murphy-Berman & Berman, 1993), political or retribution beliefs (Graham et al., 1997; Zucker & Weiner, 1993), and gender (Borchert & Rickabaugh, 1995; Dooley, 1995; Pullium, 1993) can have a direct impact on emotions and behaviours. In the present study, it was hypothesized that pre-existing social attitudes would directly influence emotional and behavioural responses to PHAs, and that gender would directly influence behaviour. As expected, women were more willing to engage in prosocial behaviours. Moreover, people with a negative world-view and greater hostility toward others reported less willingness to engage in prosocial behaviour. The direct impact of social attitudes on behaviour suggests that behaviour is affected by pre-existing attitudes in addition to the observer’s interpretation of the situation (Kelley, 1971).

**Cross-cultural differences**

Weiner’s model provided a good account of the Canadian and Netherlands’ responses to people living with HIV and lung cancer, which supports his contention that his theory generalizes across cultures (Weiner, 1996). Nonetheless, the similarities between the two samples could also reflect the increasing globalization of culture (Segall,
Lonner, & Berry, 1998). Young people from Canada and the Netherlands, particularly those enrolled in university psychology programs, are likely to be more similar than would be older people within these cultures. For example, ideas about individualism and personal responsibility may be shared through exposure to American media (e.g., MTV, CNN) and psychology textbooks, which may have shifted younger Netherlands away from adherence to collectivist ideals traditionally typical of Northern European societies to individualistic ideals typical of North America (Hofstede, 1980). Although Weiner’s model appears to generalize across cultures, the present study may provide a “snapshot” of a world in which various cultures are becoming less distinct.

Although participants in both samples had similar patterns of responses to people living with HIV and lung cancer, there were notable differences between the Canadians and Netherlands’ level of emotions and social attitudes. Canadians had more contempt, whereas Netherlands had more sympathy and more negative affect for the ill person. Compared with the Netherlands, Canadians also had higher levels of authoritarianism, religious fundamentalism, and hostility toward gay men and lesbians, yet they were more supportive of humanitarian principles. Thus, Canadians may be more extreme in their abstract attitudes toward outgroups, but less extreme when responding to a particular individual.

It is possible that the attitude measures, which were developed in North America, constrained the Netherlands’ responses. Although these students were able to provide responses to the attitude scales, given the opportunity, they may have indicated that some items did not make sense within their culture. For example, after completing the
questionnaire, a few of the Netherlands participants questioned the inclusion of the
Attitudes toward Lesbians and Gay Men scale (Herek, 1988), expressing wonder that
homosexuality should be an issue to anyone. Because 40% of the Netherlands, but only
7% of the Canadians, identified themselves as neither exclusively homosexual nor
heterosexual, it is clear that Netherlands are more likely than Canadians to view sexual
orientation as a continuum rather than a dichotomy. Overall, however, the similarities
between the two cultures in terms of willingness to engage in prosocial behaviour imply
that cognitive and emotional reactions are important determinants of such behaviours, as
Weiner suggests.

Illness versus Behaviours

PHAs are more stigmatized than people with illnesses such as leukemia, cancer,
diabetes, meningitis, cancer, epilepsy, gonorrhea, hepatitis B, and Alzheimer’s disease
(Connors & Heaven, 1995; Crawford et al., 1991; Kelly et al., 1987a, 1987b; Levin &
Chapman, 1993; St. Lawrence et al., 1990; Strasser & Damrosch, 1992; Weiner et al.,
1988; Walkey et al., 1990; Yedidia et al., 1993). Accordingly, it was hypothesized that
participants in the present research would have more negative cognitive, emotional, and
behavioural reactions to PHAs than to people with lung cancer. Contrary to expectations,
however, only one difference between illnesses was uncovered and it was in the opposite
direction. Participants were more supportive of providing extra hospital resources to
people living with HIV than to people with lung cancer.

Assumptions regarding the dichotomy of active versus passive risk-related
behaviours for both HIV-infection and lung cancer were more important determinants of
reactions than were differences between the two illnesses. It is possible that in the early
years of the AIDS epidemic all PHAs were stigmatized, but with more information about
various transmission routes, reactions are now based on the perceived morality of
particular behaviours (D'Angelo et al., 1998; Keil & Schellenberg, 1998). In the present
study, participants had more negative reactions to targets whom they assumed were
infected through intentional participation in risky behaviours. Specifically, they reported
greater levels of negative affect and attributed greater controllability, responsibility, and
blame to people whom they assumed had an active role in acquiring their condition
(through sex, injection-drug use, or smoking) as compared with those who were perceived
to have been passively infected (through a blood transfusion, mother-to-infant
transmission, or an unknown cause). They were also less supportive of hospitals and
medical professionals providing resources to people infected through active routes.

The fact that people infected through heterosexual sex and smoking were included
in the same pattern of reactions as those infected through homosexual sex and injection-
drug use supports the idea that reactions are based less on stigmatized groups (e.g., gay
men, injection-drug users) than on particular behaviours. Further support for the
distinction based on behaviours rather than illness can be drawn from participants' emotional reactions to the target. If reactions are based perceptions of stigmatized
illnesses, people should respond with more contempt, a reaction to the people (Frijda,
1986; Roseman et al., 1996). If, however, reactions are based on perceptions of
behaviours that violate a social norm, people should respond with anger (Dijker et al.,
1996; Frijda, 1993; Ickes, 1996; Scherer, 1997). In the present study, negative affect (a
less intense form of anger) was a stronger predictor of responses to people living HIV and lung cancer than was contempt. Negative affect was related to lack of helpfulness, lack of support for institutional help, and greater desire for social distance, whereas contempt was only related to lower allocations of a hospital budget to people with these illnesses. Hence, HIV-infection was not more stigmatized than cancer in the present experimental context. Instead, participants focused on “blameworthy” behaviours (D’Angelo et al., 1998).

Particular behaviours may be blameworthy, however, only if someone gets “caught.” Powell and his colleagues (Powell, Christensen, Abbott, & Katz, 1998) reported that participants had greater blame for a person who had heterosexual sex and was consequently infected with HIV than for a person who had heterosexual sex and was not infected. These moral judgements may reflect a hindsight bias. Observers believe that the agent should have been aware of the potential risk and taken appropriate precautions, even if the risk became apparent only after the fact. This is especially the case if the individual is perceived to have engaged in promiscuous [heterosexual or homosexual] sex or injection-drug use (Schaalma et al., 1993).

Behaviour change can be difficult because of the inherent pleasure or symbolic meaning of many activities. Although people living in Western cultures have likely internalized messages of personal responsibility for one’s health, many continue to engage in behaviours with known risks for a variety of personal and situational reasons. People are willing to take risks if they perceive the pleasure to outweigh potential costs, if the risk prevention behaviours are too difficult, or if the risk increases the pleasure (Baum &
Posluszny, 1999). Moreover, they may be comfortable living with a double standard, understanding and accepting their own incongruent behaviours while judging others as irresponsible.

Blaming people for their illness based solely on their perceived involvement in particular behaviours may be an unforeseen by-product of the past and present climate in public-health promotion, which frequently placed responsibility for health on the individual (e.g., Ottawa Charter, 1986). Individuals have little ability to act responsibly if certain prerequisites are not in place. Emphasizing personal responsibility served to negate the role of governments, institutions, culture, families, living conditions, emotional stress, and other factors that can prevent responsible actions or even encourage irresponsible actions (Baum & Posluszny, 1999; Herek et al., 1998). In general, observers tend to focus almost exclusively on individual behaviours (Ross, 1977) which causes them to discount information about mitigating circumstances for HIV-infection and continue to blame those infected through sex or injection-drugs. In one study (Keil & Schellenberg, 1998), providing detailed accounts about governmental negligence in disseminating safer-sex information in the early 1980s had little effect on participants’ blame for PHAs.

In the present study, smokers with lung cancer and people living with HIV who were perceived to have been infected through sex or injection-drug use were considered to be relatively unworthy of compassionate treatment. Implicit assumptions about blameworthy behaviours may have an impact on the medical services provided to ill people, despite health-care workers’ beliefs that they are providing unbiased service (Ladany, Stern, & Inman, 1998). When personal bias overrides commitment to treat all
people on the basis of need, it may result in a two-tiered system of care, with children and
blood-product recipients receiving the best treatment and others receiving relatively poor
care. Additional research is required to determine the extent to which this is currently the
situation and whether this implicit bias could be overcome so that all people receive the
help they require.

Assumptions about Illness Acquisition

Participants read scenarios that required them to make assumptions about the
illness-acquisition route based on a description of the target’s behaviour. Epidemiologists
and health professionals use similar information to infer how illnesses are transmitted. For
some scenarios, participants readily made the intended connection between illness and
behaviour, especially if the target person had previously used injection-drugs, was an HIV-
positive child, or was a smoker with lung cancer. Fewer participants made the intended
inference for the other conditions. Almost one half of the participants did not make the
connection between behaviour and transmission for a scenario involving blood products,
heterosexual sex, or homosexual sex. Instead, they indicated that the transmission route
was uncertain. For the homosexual-HIV and smoking-cancer scenarios, more
Netherlands than Canadians were unsure about the way in which the illness was
acquired.

Some participants may have had difficulty connecting particular behaviours to
illness when the behaviours were considered relatively normal. People may avoid thinking
about the prospect that HIV can be transmitted through behaviours in which they are
likely to engage, such as sex. In one study (Powell et al., 1998), when participants
considered themselves to be similar to a target with HIV, they were less blameful of the
target. Participants with negative AIDS-related attitudes distanced themselves from the
target PHA by claiming that they were very different in character, behaviour, and
relationships. Similarly, Netherlanders may be more accepting of homosexuality and
smoking and, thus, less likely than Canadians to presume that these behaviours caused the
target person's illness. The perception may be that what is "normal" is "safe." By
focusing on alternative transmission routes through which others could become infected,
one can avoid acknowledging that he or she is at risk (Nelkin & Gilman, 1988).

**Positive AIDS-Related Attitudes**

Overall, participants' reactions to PHAs were positive. The vast majority of
participants were supportive of medical institutions providing the best service possible and
willing to have social contact with the PHA described in the scenario. Most people were
willing to help the target, although as acts increased in physical intimacy, levels of
helpfulness decreased. Participants were very sympathetic toward the PHA, with little
negative affect and relatively low levels of blame.

Positive reactions toward PHAs may be more of a characteristic of Canadians and
Netherlanders than of Americans, who tend to be more conservative (Lipset, 1990). But
even in the United States, a rapid and dramatic positive shift in attitudes has occurred over
the course of the AIDS epidemic. The early overwhelmingly negative reactions to PHAs
(Connor & Kingman, 1988; Echabe & Rovira, 1989; Herek, 1990; Kelly et al., 1987a,
1987b; Sheehan et al., 1989; Shilts, 1987; Walkey et al., 1990) may have resulted from a
"knee-jerk" need to protect oneself from uncertainty about the virus. With time and
reflection, however, people began to respond with greater concern (Herek et al., 1998). A cursory examination of recent AIDS-related studies (Berkowitz & Nutall, 1996; Borchert & Rickabaugh, 1995; Cole & Slocumb, 1994; Crandall et al., 1997; D'Angelo et al., 1998; Dijker et al., 1996; Harrison, Fusilier, & Worley, 1994; Leiker et al., 1995; Murphy-Berman & Berman, 1993; Powell et al., 1998; Schaalma et al., 1993) indicates that the majority of participants have positive reactions, possibly due to successful education efforts that increased AIDS awareness among the general public. Positive attitudes found in the present research may signal a recent trend among young people who cannot remember a world before AIDS.

Nonetheless, a simple examination of these studies cannot confirm that there is a trend toward increasingly positive responses because of problems with publication lag, the use of different measures, and the lack of information about the mean levels of responses. Although Crawford's (1996) meta-analysis of 21 AIDS-related studies found no difference in AIDS-related attitudes between earlier and later studies, her sample was restricted to studies published from 1986 to 1992. A meta-analysis of the literature documenting reactions to PHAs over the 20 years of the AIDS epidemic could confirm trends or determine if the focus on the differences between those who hold positive and negative attitudes has overshadowed the positive reactions. Longitudinal and multivariate research approaches could also be used to examine the influence of contextual changes in the AIDS-epidemic, such as the development of new drug therapies and shifts in populations who are most at risk (Herek et al., 1998; Powell et al., 1998).
Even if responses to PHAs in social-science research are becoming increasingly positive, it is possible that such responses stem from demand characteristics. As many as 25% of the participants in the present study endorsed negative responses to PHAs, especially toward PHAs whom they believed to have engaged in risky behaviours, and 34% of the participants indicated that they had contempt for the ill person. It is possible that a “significant minority” (Herek & Capitanio, 1997) continues to hold negative AIDS-related attitudes, even though they are aware that expressing hostility toward PHAs is generally considered inappropriate. The awareness of the social norm against appearing to be prejudiced (Adorno, Frenkel-Brunswik, Levinson, & Sanford, 1950; Billig, 1998) may lead to more subtle forms of prejudice toward PHAs similar to modern racism (Dovidio & Gaertner, 1998) and modern sexism (Swim, Aikin, Hall, & Hunter, 1995). In other words, prejudice is likely to become covert as it becomes less acceptable.

Implications

Issues for HIV-Education. Although levels of general AIDS knowledge appear to be high in Western cultures and reactions to PHAs are improving, there is still no cure for AIDS. Given this, it is important to keep the seriousness of HIV-infection in the public consciousness. With the development of effective treatments, HIV-infection may come to be perceived as a manageable chronic illness (Signorile, 1997). Because the short-term consequences of infection may be less serious than in the past, there may be an increase in risk-related behaviours. Recent media reports of the “alarming trend for bare-back sex” (i.e., unprotected anal sex; Protease dis-inhibitors, 1997) have called attention to this potential behaviour change. At the same time, these reports may exaggerate and over-
simplify stories of unprotected anal sex to portray those engaging in it as purposefully spreading HIV. There have been gay men who have had unprotected sex throughout the AIDS epidemic (Odets, 1994), which has not necessarily always been risky. For example, many HIV-negative men in couple relationships have unprotected sex without any possibility of transmitting HIV.

HIV-education must move beyond simple prohibitions such as “always use a condom.” Although these messages have been effective reminders to think about safer-sex behaviour, they also have led to the perception that people who have been infected should have known better and are deserving of punishment (Herek et al., 1998). In the worst case, condom use in non-risky situations could become a burden and result in reduced use in high-risk situations. Further education efforts must also counter inflammatory stories, such as those about bare-back sex, with information and reasoning skills regarding the relative risks and level of protection required in different situations.

It is also important to make it explicit that societal, cultural, and economic forces have considerable impact on individuals' behaviours (Beeker, Guenther-Grey, & Raj, 1998). People need to be given the tools to identify their options and to go against cultural norms, if necessary. Hence, intervention efforts need to be focused at the level of behavioural intentions and at influences on behaviours that are unique to specific groups (Reppucci, Woolard, & Fried, 1999). This can be done by changing social norms, implementing community-based interventions, educating people about diverse populations, and promoting tolerant public policies (Beeker et al., 1998).
Because positive reactions increase with greater amounts of contact with PHAs (Herek & Capitanio, 1997), with increased contact, people should report even more positive responses than noted in the present study. Techniques to promote general tolerance for PHAs could include portrayals of specific individuals living with HIV so that those who do not have personal contact can identify with a "face." Such vicarious contact (i.e., feeling of having a relationship with a public figure due to media exposure) can decrease blame (Herek & Capitanio, 1997). In sum, AIDS-education programs need to discuss the seriousness of HIV-infection and, at the same time, address issues of when and with whom protection is necessary and how to make behaviour changes tolerable.

**The Future of Attribution Models.** Weiner’s model of social motivation and the modifications to it provided a good explanation of the reactions to people living with HIV and lung cancer. Nonetheless, some analyses indicated that the model may be further improved with the addition of new associations between variables. Specifically, perceptions of the way in which an illness is acquired may directly affect emotional responses, and men may be more likely than women to blame the ill person.

It is also important to examine the usefulness of Weiner’s model within a larger context. Heider (1958) suggests that the study of attributions should begin with simplified models of interpersonal relationships, bearing in mind that such relationships are part of a complex gestalt. Weiner’s social motivation theory has illuminated some attribution processes and provided an explanation of reactions to PHAs, but it needs to be determined that these responses occur spontaneously and frequently in order to provide support for the value of the model (Cialdini, 1980).
Traditional attribution models (e.g., Jones & Davis, 1965; Kelley, 1967), including Weiner's model, tend to focus on the individual's actions without regard for the interaction of situational and social factors that may restrict or prompt the behaviours. These models also assume that observers are "naive scientists" (Heider, 1958) who automatically determine causality for events before reacting. It would be more realistic, however, to acknowledge that people hold contradictory opinions (Billig, 1998), such that they may express a belief in one setting but endorse an opposite belief in a different context.

Because they assume that people behave consistently and that attributions are situated in the individual, attribution researchers have typically relied on research methods that do not provide a context. These methods do not consider that people generally tell attribution stories to make a point, justify their own behaviour, or influence others (Edwards & Potter, 1993). By providing more information about the context and motives of the agent and allowing participants to respond freely, researchers may uncover alternative responses that do not necessarily fit the patterns revealed using traditional standardized, quantifiable research questions. Qualitative examinations of the words that people spontaneously choose to describe events may help to uncover a clearer understanding of the extent to which people work through the sequence proposed by Weiner's social motivation model. Such examinations could also highlight the influence of pre-existing norms or context-specific factors. In impersonal settings, when there is time to analyze the event or the need to make justifiable decisions, attribution processes may indeed mirror Weiner's social motivation model. By contrast, in situations with more
personal involvement or greater urgency, personal and contextual factors may have a greater influence.

In sum, future research needs to examine attributions within the larger context of interactions among people, situations, moral values, and historical contexts. Such an endeavour would likely necessitate the use of qualitative research designs (e.g., interviews, recordings of group discussions). Indeed, responses that are more conversational are likely to be more personal, emotional, and realistic than responses to quantitative measures and allow participants to talk about their struggles and inconsistencies.

Limitations

Measures. The present research found considerable similarities between the Netherlands and Canada samples. It is possible that some of the similarities were a function of the measures, which were developed from a North American perspective. As such, the research scales may not have accurately reflected the realities of life in the Netherlands, as indicated by higher levels of internal consistency in some measures for the Canadian than for the Netherlands sample. Subtle differences may have been revealed if more culturally sensitive measures been used. Future cross-cultural attribution and AIDS research needs to be aware of such potential biases and to develop measures that can reveal clearly the points of similarity and difference between the cultures under study (Segall et al., 1998).

Although the use of a hypothetical scenario was consistent with attribution studies, the scenario provided little contextual information about the target person, which may have dampened emotional reactions (e.g., expression of negative affect). For example, the
person who had used injection-drugs was now “clean.” It was unclear how this person’s past and present drug habits affected participants’ reactions. These issues may be resolved in future research by having an ill person tell his or her own story, either live or on videotape, or by interviewing people about their own beliefs and emotional reactions to HIV-related issues.

Although participants made distinctions between controllability, responsibility, and blame in the research setting, it is possible that people do not engage in such complex patterns in everyday exchanges (Kroger & Wood, 1998). Additional research is required to examine the spontaneous attributions of responsibility and blame and to explore the role of each construct in responses to serious situations.

In spite of efforts to check the text of the questionnaire, there were some difficulties with the translation of the questionnaire. Nevertheless, these irregularities appeared to have little effect on the results.

**Participants.** There were fewer participants from the Netherlands than from Canada and this imbalance may have reduced the influence of the Netherlands’ sample in the path models. Although the attribution processes appeared to be similar for both cultures, equivalently large samples are needed to confirm this.

Excluding participants who did not make the assumption of illness acquisition based on implied routes further reduced the sample size. In particular, this attrition affected the blood products, heterosexual sex, and homosexual sex conditions and possibly reduced the power of the results. Nonetheless, the fact that people made the assumption regarding illness acquisition for some behaviours but not others was in itself informative.
It is possible that some of the participants who did not make the intended assumption had a more sophisticated understanding of the multiple possible illness acquisition factors. Although the present data did not reveal such a trend, it may become evident in research that allows participants to explicitly state and justify their assumptions.

In order to have similar samples from Canada and the Netherlands, only undergraduate students were included in the present study. Studies of more representative adult samples could reveal greater variation in responding. Attribution research should also access specific groups (e.g., health care workers, police officers, judges) for whom attributions may have a considerable impact on their responses to particular people.

**Conclusion**

Even though people continue to attribute responsibility and blame to many people living with HIV, there have been changes in the pattern of reactions since the early years of the AIDS epidemic. The present study provided a snapshot of attitudes and reactions to people living with HIV and lung cancer, which suggested that responses to those infected with HIV are becoming more positive. What is of greater importance is the perception of how an illness is acquired. People continue to respond less positively to those whom they believe have actively chosen to engage in perceived high-risk behaviours.

At the same time, the course of the AIDS epidemic continues to change. Development of new drug therapies may ensure that HIV-infection becomes a truly manageable, chronic illness. Attitudes toward AIDS-related issues may continue to improve if education efforts are targeted at specific problems that acknowledge the roles of people and contexts.
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Appendix A

Canadian Questionnaire

SECTION 1: PLEASE TELL US ABOUT YOURSELF.

In this survey we are interested only in what you think and believe. There are no right or wrong answers. Read each item very carefully. For the questions followed by a row of numbers, please circle the number that most closely reflects your answer.

1) Are you male ☐ or female ☐?

2) How old are you? _______

3) What is your ethnic/cultural background? ________________________________

4) What is your religious affiliation (for example: none, Catholic, Protestant, Muslim, etc.)?

5) How would you classify your sexual orientation?

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<th>Completely Homosexual</th>
<th>Completely Heterosexual</th>
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6) Compared with your family, how tolerant of others are you?

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<tr>
<th>Much Less Tolerant</th>
<th>Much More Tolerant</th>
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<tbody>
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<td>1</td>
<td>6</td>
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<td>2</td>
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7) Compared with your family, how progressive are your views?

<table>
<thead>
<tr>
<th>Not very Progressive</th>
<th>Very Progressive</th>
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<tbody>
<tr>
<td>1</td>
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<td>2</td>
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</table>

8) To what extent has the AIDS epidemic had an impact on your life?

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<th>No Impact</th>
<th>Large Impact</th>
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<td>1</td>
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<td>2</td>
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</tbody>
</table>
9) How much contact have you had with a person whom you know is HIV-positive.

<table>
<thead>
<tr>
<th>No Contact</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>A great deal of contact</td>
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SECTION 2: REACTIONS TO SERIOUS ILLNESS

William is ten years old and lives with his mother who is a bank employee. He has lots of friends and everyone at school likes him. He likes to go to school, but also enjoys relaxing in the evenings with his mother. They often play games and read books together. Recently, William has begun to lose weight and to feel tired all the time. He also has a dry, persistent cough, diarrhea, and a fever and is waking up with night sweats. His mother, who recently found out that she is HIV-positive, took her son William to her physician. She was told that William tested positive for HIV, the virus that leads to AIDS.

Assume that you know William quite well and that you have some extra time to volunteer to spend with William. Please answer the following questions about how you might act toward William. Respond by circling the number that best reflects your answer.

How willing would you be:

1) to give encouragement to William?
   Not at all
   Willing
   1 2 3 4 5 6 7
   Very Willing

2) to listen to William and offer advice if he asked for it?
   Not at all
   Willing
   1 2 3 4 5 6 7
   Very Willing

3) to give $5 to William, if you had the extra money?
   Not at all
   Willing
   1 2 3 4 5 6 7
   Very Willing

4) to assist William with walking?
   Not at all
   Willing
   1 2 3 4 5 6 7
   Very Willing
5) to call an information hotline for William? 
Not at all 
Willing 
1 2 3 4 5 6 7

6) to go to the pharmacy to pick up a prescription for William? 
Not at all 
Willing 
1 2 3 4 5 6 7

7) to bring food to William? 
Not at all 
Willing 
1 2 3 4 5 6 7

8) to accompany William to his doctor's office or clinic? 
Not at all 
Willing 
1 2 3 4 5 6 7

9) to do William's laundry? 
Not at all 
Willing 
1 2 3 4 5 6 7

10) to accompany William to a social support meeting for people with a similar condition? 
Not at all 
Willing 
1 2 3 4 5 6 7

11) to help William to eat? 
Not at all 
Willing 
1 2 3 4 5 6 7

12) to help to change William’s bedding? 
Not at all 
Willing 
1 2 3 4 5 6 7
13) to help to bathe William?
Not at all  Very Willing
Willing
1  2  3  4  5  6  7

What are your general opinions about helping people like William?

1) People like William deserve the best possible treatment by doctors, nurses, and all hospital staff.
Strongly Agree
Disagree
1  2  3  4  5  6  7

2) The government should help people like William.
Strongly Agree
Disagree
1  2  3  4  5  6  7

How would you react to the following situations?

1) I could accept William as a visitor to Canada.
Strongly Agree
Disagree
1  2  3  4  5  6  7

2) I could admit William to my street to live within a few doors of me.
Strongly Agree
Disagree
1  2  3  4  5  6  7

3) I could refuse to attend a party at which William also was present.
Strongly Agree
Disagree
1  2  3  4  5  6  7

4) I could not become close friends with William.
Strongly Agree
Disagree
1  2  3  4  5  6  7

5) I could accept William as if he was a member of my family.
Strongly Agree
Disagree
1  2  3  4  5  6  7
6) A local hospital is reviewing its annual budget. After all of the expenses of every department have been met, this hospital has $1 million left over. They have identified four groups of patients that could use some extra support. What percentage of the available money do you think should go to each of the following groups?

A. People like William  _____
B. People with leukemia  _____
C. People with diabetes  _____
D. People with Hepatitis B  _____
E. Other (please specify)  ___________________________  _____

7) You have an appointment with your dentist. As you enter the dentist’s waiting room you see William. William is sitting in the chair marked with an X. Use an X to mark where you would prefer to sit while you wait for your appointment.

SECTION 3: EMOTIONAL REACTIONS

Sometimes when we are told about a person with a serious illness we have different reactions to that person. We have listed a number of thoughts that you may or may not have had. Please rate your agreement or disagreement with each of the following statements by circling the appropriate number.

1) I feel sympathy for William.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
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</table>
2) I feel anger toward William.
   Strongly
   Disagree
   1  2  3  4  5  6  7

3) It is his own fault that William is ill.
   Strongly
   Disagree
   1  2  3  4  5  6  7

4) William's illness is not a result of his own negligence.
   Strongly
   Disagree
   1  2  3  4  5  6  7

5) I pity William.
   Strongly
   Disagree
   1  2  3  4  5  6  7

6) I feel contempt for William.
   Strongly
   Disagree
   1  2  3  4  5  6  7

7) William does not deserve what happened to him.
   Strongly
   Disagree
   1  2  3  4  5  6  7

8) William should not be held personally liable for his illness.
   Strongly
   Disagree
   1  2  3  4  5  6  7

9) I respect William.
   Strongly
   Disagree
   1  2  3  4  5  6  7
10) William makes me feel irritated.  
   Strongly Agree  
   Disagree  
   1 2 3 4 5 6 7

11) I do not feel sorry for William.  
   Strongly Agree  
   Disagree  
   1 2 3 4 5 6 7

12) William is responsible for his illness.  
   Strongly Agree  
   Disagree  
   1 2 3 4 5 6 7

13) William should not feel worthless.  
   Strongly Agree  
   Disagree  
   1 2 3 4 5 6 7

14) I have no compassion for William.  
   Strongly Agree  
   Disagree  
   1 2 3 4 5 6 7

15) William is to blame for his illness.  
   Strongly Agree  
   Disagree  
   1 2 3 4 5 6 7

16) I am not annoyed by William.  
   Strongly Agree  
   Disagree  
   1 2 3 4 5 6 7

17) William's illness was under his personal control.  
   Strongly Agree  
   Disagree  
   1 2 3 4 5 6 7
18) I feel disdain toward William.  
Strongly Disagree Strongly Agree  
1 2 3 4 5 6 7  

19) I do not resent William.  
Strongly Disagree Strongly Agree  
1 2 3 4 5 6 7  

20) William had no control over the cause of his illness.  
Strongly Disagree Strongly Agree  
1 2 3 4 5 6 7  

21) William is accountable for his illness.  
Strongly Disagree Strongly Agree  
1 2 3 4 5 6 7  

22) William should not feel guilty for being ill.  
Strongly Disagree Strongly Agree  
1 2 3 4 5 6 7  

23) William could not have prevented his illness.  
Strongly Disagree Strongly Agree  
1 2 3 4 5 6 7  

24) It was something that William did that caused his illness.  
Strongly Disagree Strongly Agree  
1 2 3 4 5 6 7  

SECTION 4: AIDS INFORMATION  
How correct or incorrect are the following statements about HIV and AIDS?  

1) People can contract HIV (the virus that causes AIDS) only if they are gay or injection drug users.  
Definitely Incorrect Definitely Correct  
1 2 Don’t Know 3 4 5
2) You can tell from a person’s looks whether or not he or she is infected with HIV.

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<th>Definitely Correct</th>
<th>Definitely Incorrect</th>
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3) You can not contract HIV by kissing.

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4) There is still no cure for AIDS.

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5) Someone who is HIV-positive cannot infect others with AIDS.

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6) When you are infected with HIV it might take years before you become ill because of AIDS.

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7) You can contract HIV by sharing glasses or cups with someone with AIDS.

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8) Everyone who is infected with HIV is aware of it.

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9) You cannot contract HIV by sharing toilets or bathrooms with a person with AIDS.

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10) All HIV-infected people will become ill within a couple of months.

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SECTION 5: PERSONAL OPINIONS

Everyone has different personal views on life and has different social and political attitudes. We would like to know about your opinions on a wide range of questions.

1) People get what they are entitled to have.
   Strongly
   Disagree
   1 2 3 4 5 6

2) A person’s efforts are noticed and rewarded.
   Strongly
   Disagree
   1 2 3 4 5 6

3) People earn the rewards and punishments they get.
   Strongly
   Disagree
   1 2 3 4 5 6

4) People who meet with misfortune have brought it on themselves.
   Strongly
   Disagree
   1 2 3 4 5 6

5) People get what they deserve.
   Strongly
   Disagree
   1 2 3 4 5 6

6) Rewards and punishments are fairly given.
   Strongly
   Disagree
   1 2 3 4 5 6
7) The world is basically a fair place.
   Strongly Agree
   Disagree
   1  2  3  4  5  6

8) One should be kind to all people.
   Strongly Agree
   Disagree
   1  2  3  4  5  6

9) One should find ways to help others less fortunate than oneself.
   Strongly Agree
   Disagree
   1  2  3  4  5  6

10) A person should be concerned about the well-being of others.
    Strongly Agree
    Disagree
    1  2  3  4  5  6

11) There should be equality for everyone -- because we are all human beings.
    Strongly Agree
    Disagree
    1  2  3  4  5  6

12) Those who are unable to provide for their basic needs should be helped by others.
    Strongly Agree
    Disagree
    1  2  3  4  5  6

13) A good society is one in which people feel responsible for one another.
    Strongly Agree
    Disagree
    1  2  3  4  5  6

14) Everyone should have an equal chance and an equal say in most things.
    Strongly Agree
    Disagree
    1  2  3  4  5  6
15) Acting to protect the rights and interests of other members of the community is a major obligation for all persons.

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<th>Strongly</th>
<th>Disagree</th>
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16) In dealing with criminals the courts should recognize that many are victims of circumstances.

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17) Prosperous nations have a moral obligation to share some of their wealth with poor nations.

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18) People should be free to pursue their financial dream, even at the risk of harming someone else.

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19) The freedom to be an individual is more important than equality and human rights.

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20) The way things are going in this country, it's going to take a lot of "strong medicine" to straighten out the troublemakers, criminals, and perverts.

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<th>Disagree</th>
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21) It would be best for everyone if the proper authorities censored magazines and movies to keep trashy materials away from the youth.

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22) There is nothing wrong with premarital sexual intercourse.

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23) Obedience and respect for authority are the most important virtues children should learn.

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24) Once our government leaders and the authorities condemn the dangerous elements in our society, it will be the duty of each patriotic citizen to help stomp out the rot that is poisoning our country from within.

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<th>Strongly Agree</th>
<th>Strongly Disagree</th>
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25) In these troubled times, laws have to be enforced without mercy, especially when dealing with the agitators and revolutionaries who are stirring things up.

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26) The self-righteous "forces of law and order" threaten freedom in our country a lot more than the groups they claim are "radical" and "godless."

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<th>Strongly Agree</th>
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27) A lot of rules regarding modesty and sexual behaviour are just customs which are not necessarily any better or holier than those which other people follow.

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<th>Strongly Agree</th>
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28) Just as in other species, male homosexuality is a natural expression of sexuality in human men.

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<th>Strongly Agree</th>
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29) Male homosexuality is merely a different kind of lifestyle that should not be condemned.

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<th>Strongly Disagree</th>
<th>Strongly Agree</th>
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30) Female homosexuality in itself is no problem, but what society makes of it can be a problem.

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<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
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31) Homosexual behaviour between two men is just plain wrong.

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<th>Strongly Disagree</th>
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32) Lesbians just can't fit into our society.

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<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
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33) Male homosexuality is a perversion.

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34) I think male homosexuals are disgusting.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
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35) Female homosexuality is a sin.

<table>
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<tr>
<th>Strongly Disagree</th>
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36) Lesbians are sick.

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<th>Strongly Disagree</th>
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37) Which one of the following things is most important to you? (Circle only ONE)

A. Maintaining order in the nation.
B. Giving people more say in important government decisions.
C. Maintaining a high level of economic growth in the nation.
D. Protecting freedom of speech.

SECTION 6: RELIGIOUS OPINIONS

Although people's religious beliefs are very personal, we would like to ask you some general questions about what you believe. In the statements below, when we talk about "God," please interpret it to mean the deity of your choice.

1) It is more important to be a good person than to believe in God and the right religion.  
   Strongly Disagree   Strongly Agree
   1  2  3  4  5  6  7  8  9

2) No single book of religious writings contains all the important truths about life.  
   Strongly Disagree   Strongly Agree
   1  2  3  4  5  6  7  8  9

3) "Satan" is just the name people give to their own bad impulses. There really is no such thing as a diabolical "Prince of Darkness" who tempts us.  
   Strongly Disagree   Strongly Agree
   1  2  3  4  5  6  7  8  9

4) To lead the best, most meaningful life, one must belong to the one, true religion.  
   Strongly Disagree   Strongly Agree
   1  2  3  4  5  6  7  8  9

5) When you get right down to it, there are only two kinds of people in the world: the Righteous, who will be rewarded, and the rest, who will not.  
   Strongly Disagree   Strongly Agree
   1  2  3  4  5  6  7  8  9
6) The basic cause of evil in this world is Satan, who is still constantly and ferociously fighting against God.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
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7) People should pay less attention to traditional forms of religious guidance and instead develop their own personal standards of what is moral and immoral.

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<tr>
<th>Strongly Disagree</th>
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</table>

8) Atheists and others who have rebelled against the established religions are no doubt every bit as good and virtuous as those who attend church regularly.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  2  3  4  5  6  7  8  9</td>
<td></td>
</tr>
</tbody>
</table>

SECTION 7

Finally, we would like to ask you a few questions to make sure that you understood this survey.

1) The main character in the story that you read at the beginning of this study had which of the following diseases?
   - Lung Cancer  
   - HIV-infection  

2) How did this person become ill?
   - Mother-to-infant transmission  
   - Blood transfusion  
   - Heterosexual sex  
   - Homosexual sex  
   - Injection drug use  
   - Smoking  
   - Unknown  

3) How clear or confusing did you find the instructions for this study?
   Very Clear  
   Very Confusing  

<table>
<thead>
<tr>
<th>Very Confusing</th>
<th>Very Clear</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  2  3  4  5  6  7</td>
<td></td>
</tr>
</tbody>
</table>
Vragenlijst ‘Reacties op ernstige ziektes’

Deze vragenlijst gaat over hoe mensen reageren op ernstige ziektes. Het betreft een vergelijkend, cross-cultureel onderzoek waaraan meerdere landen deelneemen. Het gaat jouw mening en er zijn geen goede of foute antwoorden.

De vragenlijst bestaat uit 7 delen en met name de latere delen zijn gestandaardiseerde meetinstrumenten waarin je mening wordt gevraagd over soms wat extreme meningen die in sommige landen wel en in andere landen niet aanvaardbaar worden geacht.

Geef gewoon je eigen mening.

Het invullen van de vragenlijst kost zo’n 20-30 minuten.

Succes!
Deel 1: Gegeven over jezelf

In dit onderzoek zijn we geïnteresseerd in wat jij denkt of vindt over een aantal onderwerpen. Er zijn geen goede of foute antwoorden. Bij het beantwoorden van de vragen 5 tot en met 9 wordt je verzocht één cijfer per vraag te omcirkelen, hoe lager het cijfer hoe meer je het woord aan de linkerrand van toepassing vindt, hoe hoger het cijfer, hoe meer je het woord aan de rechterrand van toepassing vindt.

(1) Ben je een man □ of ben je een vrouw □? (Zet een kruisje in het gewenste hokje)

(2) Wat is je leeftijd? ____________ (vul het aantal jaren in)

(3) Wat is je etnische/culturele achtergrond? ____________________________

(4) Wat is je godsdienst? (bijv. katholiek, protestant, moslim, etc., als ‘geen’ schrijf n.v.t.) ____________________________

(5) Wat is je seksuele geaardheid?

<table>
<thead>
<tr>
<th>homoseksueel</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>heteroseksueel</th>
</tr>
</thead>
</table>

(6) Als je jezelf vergelijkt met je familie, hoe tolerant vind je jezelf ten opzichte van anderen?

<table>
<thead>
<tr>
<th>veel minder tolerant</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>veel tolerant</th>
</tr>
</thead>
</table>

(7) Als je jezelf vergelijkt met je familie, hoe progressief kink jij dan tegen de dingen aan?

<table>
<thead>
<tr>
<th>niet zo erg progressief</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>heel erg progressief</th>
</tr>
</thead>
</table>

(8) In hoeverre heeft de AIDS-epidemie invloed gehad op jouw leven?

<table>
<thead>
<tr>
<th>geen invloed</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>grote invloed</th>
</tr>
</thead>
</table>

(9) Hoeveel contact heb je (of heb je gehad) met iemand van wie je weet dat hij/jij HIV-positief is?

<table>
<thead>
<tr>
<th>geen contact</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>heel veel contact</th>
</tr>
</thead>
</table>
Deel 2: Reacties op een ernstige ziekte


Stel je voor dat jij Wim goed kent en dat je wat extra tijd hebt die je met hem door wil brengen. Wij je onderstaande vragen beantwoorden over jouw gedrag ten opzichte van Wim. Omcirkel steed één cijfer per vraag. Hoe lager het cijfer hoe meer je het woord aan de linkerzijde van toepassing vindt, hoe hoger het cijfer, hoe meer je het woord aan de rechterzijde van toepassing vindt.

Hoe bereid zou je zijn om:

(1) Wim aan te moedigen dingen te doen?

<table>
<thead>
<tr>
<th>helemaal niet</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>heel erg</th>
</tr>
</thead>
</table>

(2) te luisteren naar Wim en hem advies te geven als hij er om vraagt?

<table>
<thead>
<tr>
<th>helemaal niet</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>heel erg</th>
</tr>
</thead>
</table>

(3) Wim 10 gulden te geven als je extra geld had?

<table>
<thead>
<tr>
<th>helemaal niet</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>heel reg</th>
</tr>
</thead>
</table>

(4) Wim te helpen met lopen?

<table>
<thead>
<tr>
<th>helemaal niet</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>heel erg</th>
</tr>
</thead>
</table>

(5) een AIDS-informatieliijn te bellen voor Wim?

<table>
<thead>
<tr>
<th>helemaal niet</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>heel erg</th>
</tr>
</thead>
</table>

(6) naar de apotheek te gaan om een recept op te halen voor Wim?

<table>
<thead>
<tr>
<th>helemaal niet</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>heel erg</th>
</tr>
</thead>
</table>

(7) Wim eten te brengen?

<table>
<thead>
<tr>
<th>helemaal niet</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>heel erg</th>
</tr>
</thead>
</table>
(8) met Wim mee te gaan naar z’n dokter of naar het ziekenhuis?

| helemaal niet | 1 | 2 | 3 | 4 | 5 | 6 | 7 | heel erg |

(9) Wim’s was te doen?

| helemaal niet | 1 | 2 | 3 | 4 | 5 | 6 | 7 | heel erg |

(10) met Wim mee te gaan naar een bijeenkomst voor mensen met dezelfde ziekte?

| helemaal niet | 1 | 2 | 3 | 4 | 5 | 6 | 7 | heel erg |

(11) Wim te helpen met eten?

| helemaal niet | 1 | 2 | 3 | 4 | 5 | 6 | 7 | heel erg |

(12) Wim’s bed te verschonen?

| helemaal niet | 1 | 2 | 3 | 4 | 5 | 6 | 7 | heel erg |

(13) Wim te helpen met z’n bad?

| helemaal niet | 1 | 2 | 3 | 4 | 5 | 6 | 7 | heel erg |

Hoe denk je in het algemeen over hulp aan mensen zoals Wim?

(1) Mensen zoals Wim verdienen de beste verzorging van dokters, verpleegsters en de rest van de ziekenjuisstaf

| helemaal niet mee eens | 1 | 2 | 3 | 4 | 5 | 6 | 7 | helemaal mee eens |

(2) De overheid moet mensen als Wim helpen

| helemaal niet mee eens | 1 | 2 | 3 | 4 | 5 | 6 | 7 | helemaal mee eens |

Wat vind je van de volgende bewerkingen?

(1) Ik zou Wim kunnen accepteren als bezoeker aan Nederland

| helemaal niet mee eens | 1 | 2 | 3 | 4 | 5 | 6 | 7 | helemaal mee eens |
(2) Ik zou het niet erg vinden als Wim een paar deuren verderop in mijn straat woonde

<table>
<thead>
<tr>
<th>helemaal niet</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>mee eens</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(3) Ik zou kunnen weigeren naar een feestje te gaan waar Wim ook was

<table>
<thead>
<tr>
<th>helemaal niet</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>mee eens</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(4) Ik zou niet dik bevriend met Wim kunnen zijn

<table>
<thead>
<tr>
<th>helemaal niet</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>mee eens</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(5) Ik zou Wim accepteren alsof hij familie van me was

<table>
<thead>
<tr>
<th>helemaal niet</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>mee eens</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(6) Een ziekenhuis in de buurt bekijkt het jaarlijks budget. Nadat al het geld verdeeld is over de diverse onderdelen blijft er een miljoen gulden over. Er zijn vier groepen patiënten die in aanmerking komen voor dit extra geld. Hieronder kun je aangeven in procented hoe je het geld over de groepen zou willen verdelen. Controleer svp dat he totaal 100% is.

A. Aan mensen zoals Wim
B. Aan mensen met leukemie
C. Aan mensen met suikerziekte
D. Aan mensen met hepatitis B
E. Anderen (vul hieronder in welke)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

% + 100 %
(7) Je hebt een afspraak bij de tandarts. Als je binnenkomt zie je Wim. Wim zit op de stoel waar een kruisje (x) op staat. Geef door middel van een kruisje (x) aan waar jij het liefste gaat zitten terwijl je wacht tot je opgeroepen wordt.

Deel 3: Emotionele reacties

Soms reageren we verschillend op een persoon wanneer we te horen krijgen dat die persoon een ernstige ziekte heeft. Hieronder vind je een aantal gedachten die wel of niet door je hoofd kunnen spelen. Omcirkel steeds één cijfer per vraag. Hoe lager het cijfer hoe meer je het woord aan de linkerkant van toepassing vindt, hoe hoger het cijfer, hoe meer je het woord aan de rechterkant van toepassing vindt.

(1) Ik voel sympathie voor Wim.

helemaal    1   2   3   4   5   6   7  helemaal
mee oneens          mee eens

(2) Ik voel me boos op Wim.

helemaal    1   2   3   4   5   6   7  helemaal
mee oneens          mee eens

(3) Het is Wim's eigen schuld dat hij ziek is.

helemaal    1   2   3   4   5   6   7  helemaal
mee oneens          mee eens
(4) Wim’s ziekte is niet het gevolg van zijn eigen onoplettendheid.

helemaal 1 2 3 4 5 6 7 helemaal
mee oneens

(5) Ik heb medelijden met Wim

helemaal 1 2 3 4 5 6 7 helemaal
mee oneens

(6) Ik voel minachting voor Wim.

helemaal 1 2 3 4 5 6 7 helemaal
mee oneens

(7) Wim verdient het niet wat er met hem gebeurd is.

helemaal 1 2 3 4 5 6 7 helemaal
mee oneens

(8) De ziekte kan Wim niet persoonlijk worden aangerekend.

helemaal 1 2 3 4 5 6 7 helemaal
mee oneens

(9) Ik heb respect voor Wim.

helemaal 1 2 3 4 5 6 7 helemaal
mee oneens

(10) Wim irriteert me.

helemaal 1 2 3 4 5 6 7 helemaal
mee oneens

(11) Het spijt me niet voor Wim.

helemaal 1 2 3 4 5 6 7 helemaal
mee oneens

(12) Wim is zelf verantwoordelijk voor z’n ziekte.

helemaal 1 2 3 4 5 6 7 helemaal
mee oneens
(13) Wim moet zichzelf *niet* waardeloos vinden.

```
helemaal  1  2  3  4  5  6  7  helemaal
mee oneens          mee eens
```

(14) Ik voel niet met Wim mee.

```
helemaal  1  2  3  4  5  6  7  helemaal
mee oneens          mee eens
```

(15) Wim is zelf verantwoordelijk voor zijn ziekte.

```
helemaal  1  2  3  4  5  6  7  helemaal
mee oneens          mee eens
```

(16) Ik erger me *niet* aan Wim.

```
helemaal  1  2  3  4  5  6  7  helemaal
mee oneens          mee eens
```

(17) Wim had zelf controle over z’n ziekte.

```
helemaal  1  2  3  4  5  6  7  helemaal
mee oneens          mee eens
```

(18) Ik voel minachting voor Wim.

```
helemaal  1  2  3  4  5  6  7  helemaal
mee oneens          mee eens
```

(19) Ik heb *geen* hekel aan Wim.

```
helemaal  1  2  3  4  5  6  7  helemaal
mee oneens          mee eens
```

(20) Wim had *geen enkele* controle over zijn ziekte.

```
helemaal  1  2  3  4  5  6  7  helemaal
mee oneens          mee eens
```

(21) Wim is zelf aansprakelijk voor zijn ziekte.

```
helemaal  1  2  3  4  5  6  7  helemaal
mee oneens          mee eens
```
(22) Wim moet zich niet schuldig voelen omdat hij ziek is.

helemaal mee oneens
1 2 3 4 5 6 7

(23) Wim kon niet voorkomen dat hij ziek werd.

helemaal mee oneens
1 2 3 4 5 6 7

(24) De ziekte werd veroorzaakt door iets wat Wim deed.

helemaal mee oneens
1 2 3 4 5 6 7

Deel 4: Informatie over AIDS

Hoe goed of fout zijn volgens jou de volgende beweringen over HIV en AIDS? Omcirkel steeds één cijfer per vraag. Hoe lager het cijfer hoe meer je het woord aan de linkerkant van toepassing vindt, hoe hoger het cijfer, hoe meer je het woord aan de rechterkant van toepassing vindt. De 3 omcirkel je als je het antwoord niet weet.

(1) Mensen kunnen alleen worden geïnfecteerd met het HIV-virus (het virus dat AIDS veroorzaakt) als ze homoseksueel zijn of door intraveneus druggebruik.

helemaal goed
1 2 3 4 5 6 7

(2) Je kan het aan iemand zien als hij of zij HIV-positief is.

helemaal goed
1 2 3 4 5 6 7

(3) Je kan niet geïnfecteerd worden met HIV door iemand te zoeken.

helemaal goed
1 2 3 4 5 6 7

(4) Er is nog steeds geen medicijn tegen AIDS.

helemaal goed
1 2 3 4 5 6 7
Iemand die HIV-positief is kan anderen niet infecteren met AIDS.

(6) Als je HIV-positief bent kan het jaren duren voordat je AIDS krijgt.

(7) Je kunt HIV-positief worden wanneer je uit iemands glas of kopje drinkt.

(8) Iedereen die HIV-positief is beseft dat ook.

(9) Je kan niet HIV-positief wordend doordat je dezelfde WC of badkamer gebruikt als iemand die AIDS heeft.

(10) Alle mensen die HIV-positief zijn worden binnen enkele maanden heel erg ziek.

Deel 5: Eigen meningen

Iedereen heeft z’n eigen kijk op het leven en heeft verschillende sociale en politieke meningen. We willen graag jouw mening over de verschillende vragen die volgen. Om cirkel steeds één cijfer per vraag. Hoe lager het cijfer hoe meer je het woord aan de linkervlak van toepassing vindt, hoe hoger het cijfer, hoe meer je het woord aan de rechterzijde van toepassing vindt.

Mensen krijgen waar ze recht op hebben.
(2) De moeite die iemand doet wordt opgemerkt en beloond.

helemaal 1 2 3 4 5 6 7
mee oneens

(3) Mensen verdienen de beloning en straf die ze krijgen.

helemaal 1 2 3 4 5 6 7
mee oneens

(4) Mensen die te maken krijgen met tegenslag, hebben zich dat zelf aangedaan

helemaal 1 2 3 4 5 6 7
mee oneens

(5) Mensen krijgen wat ze verdienen.

helemaal 1 2 3 4 5 6 7
mee oneens

(6) Beloning en straf worden eerlijk verdeeld.

helemaal 1 2 3 4 5 6 7
mee oneens

(7) De wereld is over het algemeen best een redelijke plek.

helemaal 1 2 3 4 5 6 7
mee oneens

(8) Je moet aardig zijn voor alle mensen.

helemaal 1 2 3 4 5 6 7
mee oneens

(9) Je moet een manier vinden om mensen te helpen die minder geluk hebben dan jijzelf.

helemaal 1 2 3 4 5 6 7
mee oneens
(10) Mensen moet zich bekomen over het welzijn van anderen.

helemaal 1 2 3 4 5 6 7
mee oneens

(11) Er moet gelijkheid zijn voor iedereen -- tenslotte zijn we allemaal mensen.

helemaal 1 2 3 4 5 6 7
mee oneens

(12) Als mensen niet voor zichzelf kunnen zorgen moeten anderend hen helpen.

helemaal 1 2 3 4 5 6 7
mee oneens

(13) Een goede samenleving is die waarin mensen zich voor elkaar verantwoordelijk voelen.

helemaal 1 2 3 4 5 6 7
mee oneens

(14) Iedereen moet voor wat betreft de meeste dingen gelijke kansen en gelijke rechten hebben.

helemaal 1 2 3 4 5 6 7
mee oneens

(15) Je inspannen voor de rechten en het belang van mensen in je omgeving is een belangrijke verplichting voor iedereen.

helemaal 1 2 3 4 5 6 7
mee oneens

(16) De rechtspraak moet rekening houden met het feit dat veel criminelen ook slachtoffer zijn van omstandigheden.

helemaal 1 2 3 4 5 6 7
mee oneens

(17) Welvarende landen hebben de morele plicht om een deel van hun geld te delen met arme landen.

helemaal 1 2 3 4 5 6 7
mee oneens
(18) Mensen moeten vrij zijn hun financiële dromen waar te maken ook al lopen ze het risico anderen daardoor te benadelen.

helemaal mee oneens

(19) De vrijheid van het individu is belangrijker dan gelijkheid en mensenrechten.

helemaal mee oneens

(20) Zoals het hier gaat in dit land is er een heleboel voor nodig om relschoppers, misdadigers en viezerikken in het gareel te houden.

helemaal mee oneens

(21) Het zou voor iedereen het beste zijn als de overheid zich zou bezighouden met de censuur op tijdschriften en films, zodat echte rommel niet bij jongeren terechtkomt.

helemaal mee oneens

(22) Er is niks mis met seks voor het huwelijk.

helemaal mee oneens

(23) Gehoorzaamheid en respect voor autoriteit zijn de belangrijkste deugden die een kind moet leren.

helemaal mee oneens

(24) Als de overheid gevaarlijke elementen in onze maatschappij aanwijst is het de plicht van elke vaderlandsliedende burger te helpen te zijn het kwaad dat ons land ondermijnt te bestrijden.

helemaal mee oneens
(25) In deze moeilijke tijden is het zaak dat er strak de hand wordt gehouden aan de regels van de wet, vooral als het gaat om volksmenners en revolutionairen die de boel opruiven.

helemaal 1 2 3 4 5 6 7 helemaal mee oneens

(26) De eigengereide handhavers van “recht en orde” zijn veel meer een bedreiging voor de vrijheid in ons land dan de groepen die zij als ‘radicaal’ en ‘goddeloos’ bestempelen.

helemaal 1 2 3 4 5 6 7 helemaal mee oneens

(27) Een groot aantal regels over bescheidenheid en seksualiteit zijn gewoontend die niet noodzakelijkerwijs beter of ‘heiliger’ zijn dan andere gewoonten.

helemaal 1 2 3 4 5 6 7 helemaal mee oneens

(28) Net zo als bij andere diersoorten is homoseksualiteit onder mensen een normale uiting van seks.

helemaal 1 2 3 4 5 6 7 helemaal mee oneens

(29) Homoseksualiteit bij mannen is gewoon een andere levenshouding en zou niet veroordeeld moeten worden.

helemaal 1 2 3 4 5 6 7 helemaal mee oneens

(30) Homoseksualiteit bij vrouwen is op zich geen probleem, maar kan een probleem worden door wat de maatschappij er van maakt.

helemaal 1 2 3 4 5 6 7 helemaal mee oneens

(31) Homoseksualiteit tussen twee mannen is gewoon fout.

helemaal 1 2 3 4 5 6 7 helemaal mee oneens
(32) Lesbiennes horen gewoon niet thuis in de maatschappij.
helemaal 1 2 3 4 5 6 7
mee oneens

(33) Homoseksualiteit bij mannen is onsmakelijk.
helemaal 1 2 3 4 5 6 7
mee oneens

(34) Ik vind homo's weerzinwekkend.
helemaal 1 2 3 4 5 6 7
mee oneens

(35) Homoseksualiteit bij vrouwen is zondig.
helemaal 1 2 3 4 5 6 7
mee oneens

(36) Lesbiennes zijn 'ziek.'
helemaal 1 2 3 4 5 6 7
mee oneens

(37) Selecteer uit de volgende onderwerpen hetgeen jij het belangrijkst vindt (omcirkel er dus één).
A. Orde in de maatschappij handhaven
B. Mensen meer stemrecht geven bij belangrijke regeringsbesluiten
C. Een hoge economische groei handhaven
D. Descherming van de vrijheid van meningsuiting
Deel 6: Meningen over het geloof

Alhoewel het geloof voor mensen nogal persoonlijk is, willen we je wat vragen stellen over hetgeen jij gelooft. Als we het in onderstaande vragen hebben over “God,” vragen we je dit te ‘vertalen’ naar diegene die jij ziet als ‘God.’ Omcirkel steeds één cijfer per vraag. Hoe lager het cijfer hoe meer je het woord aan de linkerkant van toepassing vindt, hoe hoger het cijfer, hoe meer je het woord aan de rechterkant van toepassing vindt.

(1) Het is belangrijker een goed mens te zijn dan to geloven in God of het juiste geloof
to hebben.

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(2) Geen enkel religieus boek bevat alle belangrijke waarheden van het leven.

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(3) “Satan is gewoon een naam die mensen geven aan hun slechte gewoonten. Er
bestaat niet zoiets als de duivelse ‘Prins der Duitsternis’ die ons in verzoeking
brengt.

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(4) Om het beste en waardevolste leven te leiden is het noodzakelijk dat je je bekeert
tot het ene ware geloof.

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(5) Uiteindelijk zijn er twee sorten mensen op de wereld: de “Rechtschapenen,” die
daarvoor beloon worden, en de rest die daarvoor niet beloond zullen worden.

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(6) De voornaamste veroorzaker van het slechte in de wereld is de duivel, die nog
steeds God hevig bestrijdt.

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</table>
(7) Mensen moeten minder aandacht besteden aan de traditionele voorschriften van de kerk en zelf uitmaken wat goed en wat kwaad is.

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mee eens

(8) Achteisten en anderen die gestreden hebben tegen de gevestigde religies zijn zonder twijfel net zo goed en rechtschappen als diegenen die regelmatig naar de kerk gaan.

helemaal niet | 1 | 2 | 3 | 4 | 5 | 6 | helemaal mee eens
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Deel 7

Tenslotte willen we je nog een paar vragen stellen zodat we zeker weten dat je dit onderzoek hebt begrepen.

(1) De hoofdfiguur in het verhaaltje dat je hebt gelezen aan het begin van dit onderzoek leed aan welke ziekte?

- Longkanker □
- HIV-infectie □

(2) Hoe kwam het dat deze persoon ziek werd?

- Overdracht van moeder-naar-kind □
- Bloedtransfusie □
- Heteroseksueel contact □
- Homoseksueel contact □
- Intraveneus druggebruik □
- Roken □
- Onbekende oorzaak □

(3) Hoe duidelijk of verwarrend vond je de instructies bij dit onderzoek?

erg | 1 | 2 | 3 | 4 | 5 | 6 | 7 | heel duidelijk
verwarrend

Dank voor het invullen van de vragenlijst
Appendix C

Scenarios

HIV: Mother-to-Infant

William is 10 years old and lives with his mother who is a bank employee. He has lots of friends and everyone at school likes him. He likes to go to school, but also enjoys relaxing in the evenings with his mother. They often play games and read books together. Recently, William has begun to lose weight and to feel tired all the time. He also has a dry, persistent cough, diarrhea, and a fever and is waking up with night sweats. His mother, who recently found out that she is HIV-positive, took her son William to her physician. She was told that William has tested positive for HIV, the virus that leads to AIDS.

HIV: Blood Products

William is 31 years old and is a bank employee. He has lots of friends and everyone at work likes him. He likes his job, but also enjoys relaxing in the evenings with his new partner, Suzanne. They often watch old movies or go out for dinner. He needs to be careful with some activities. William is a hemophiliac. If he is injured, he needs to be treated with special blood products to help his blood clot. Recently, William has begun to lose weight and to feel tired all the time. He also has a dry, persistent cough, diarrhea, and a fever and is waking up with night sweats. Suzanne took him to see her physician. William was told that he has tested positive for HIV, the virus that leads to AIDS.
**HIV: Heterosexual Sex**

William is 31 years old and is a bank employee. He has lots of friends and everyone at work likes him. He likes his job, but also enjoys relaxing in the evenings with his new partner, Suzanne, who is HIV-positive. They often watch old movies or go out for dinner. Recently, William has begun to lose weight and to feel tired all the time. He also has a dry, persistent cough, diarrhea, and a fever and has been waking up with night sweats. Suzanne took him to see her physician. William was told that he has tested positive for HIV, the virus that leads to AIDS.

**HIV: Homosexual Sex**

William is 31 years old and is a bank employee. He has lots of friends and everyone at work likes him. He likes his job, but also enjoys relaxing in the evenings with his new partner, John, who is HIV-positive. They often watch old movies or go out for dinner. Recently, William has begun to lose weight and to feel tired all the time. He also has a dry, persistent cough, diarrhea, and a fever and has been waking up with night sweats. John took William to see his physician. William was told that he has tested positive for HIV, the virus that leads to AIDS.

**HIV: Injection-drug Use**

William is 31 years old and is a bank employee. He has lots of friends and everyone at work likes him. He likes his job, but also enjoys relaxing in the evenings with his new partner, Suzanne. They often watch old movies or go out for dinner. A number of years ago, William had used injection drugs, but now is clean. Recently, William has begun to lose weight and to feel tired all the time. He also has a dry, persistent cough, diarrhea, and
a fever and has been waking up with night sweats. Suzanne took him to see her physician. William was told that he has tested positive for HIV, the virus that leads to AIDS.

**Lung Cancer: Smoker**

William is 31 years old and is a bank employee. He has lots of friends and everyone at work likes him. He likes his job, but also enjoys relaxing in the evenings with his new partner, Suzanne. They often watch old movies or go out for dinner. William has been a smoker since he was 14. Recently, William has begun to lose weight and to feel tired all the time. He also has a persistent cough and wheezing in the chest and feels feverish. Suzanne took him to see her physician. William was told that he has lung cancer.

**Lung Cancer: Nonsmoker**

William is 31 years old and is a bank employee. He has lots of friends and everyone at work likes him. He likes his job, but also enjoys relaxing in the evenings with his new partner, Suzanne. They often watch old movies or go out for dinner. William has never smoked a cigarette in his life. Recently, William has begun to lose weight and to feel tired all the time. He also has a persistent cough and wheezing in the chest and feels feverish. Suzanne took him to see her physician. William was told that he has lung cancer.
Appendix D

Canadian Sign-up Sheet

Please Participate!

I am a graduate student working on my dissertation in Applied Social Psychology and I need lots of people to volunteer to participate in a study of reactions to serious illness.

You will be asked to read a paragraph about someone who is ill and then to fill out a survey in response to that story.

This study should take approximately 30 minutes and is worth ONE bonus point toward your Psyc 115 or Psyc 116 final grade.

Please sign up for one of the times listed below. On the right hand side of the page, you’ll find a slip of paper with the time and location for which you signed up. Rip off the tag and keep in a place you’ll be sure to check so that you’ll remember to come to the study.

This study will take place in Room 265, Room 265A, or Room 278 of Chrysler Hall South. This is noted on the day for which you sign up and will be posted in the hallway of Chrysler Hall South.

If you need to reschedule your appointment, call me. My name and phone number are listed on the tag.

Looking forward to seeing you there!

Janet Keil
Appendix E

Canadian Consent Form

STUDY OF REACTIONS TO SERIOUS ILLNESS
INFORMATION FOR PARTICIPATION
AND CONSENT FORM

Thank you for agreeing to participate in this study. It will take approximately 30 minutes.

I am a graduate student in Applied Social Psychology at the University of Windsor and this survey will be the basis for my dissertation.

I am interested in learning about your reactions to people with a serious illness. Specifically, you will be asked to read a brief description of someone with a serious illness (either lung cancer or AIDS) and respond to a number of questions about this description. You will also be asked to respond to a number of items about your attitudes toward some social issues, your personal views, and some very general questions about yourself.

Your participation is completely voluntary. If you do not want to answer a particular question, skip it and go on to the next one. You can choose to withdraw at any time. Feel free to ask questions at any point during the research.

This research is completely confidential. You cannot be identified from the answers you provide. Please do not put your name or any identifying information on the questionnaire.

This study has been cleared by the Ethics Committee of the Department of Psychology, University of Windsor. If you have any questions or concerns before or after participating in this survey, please contact any of the following people:

Janet Keil                Principal Investigator  253-4232, ext. 2218
Dr. Stewart Page         Research Supervisor     253-4232, ext. 2215
Dr. Sylvia Voelker       Ethics Committee         253-4232, ext. 2249

If you agree to participate, please sign the consent form below. Please leave the consent form with the researcher. You will receive a copy of the information contained in this form when you hand in the questionnaire.

I have understood this information and freely agree to participate in this research.

_____________________________  ______________________________
Sign your name here.          Today's Date
Appendix F

Netherlands Participation Information

Deze vragenlijst gaat over hoe mensen reageren op ernstige ziektes. Het betreft een vergelijkend, cross-cultureel onderzoek waaraan meerdere landen deelnemen. Het gatt om jouw mening en er zijn geen goede of foute antwoorden.

De vragenlijst bestaat uit 7 delen en met name de latere delen zijn gestandaardiseerde meetinstrumenten waarin je mening wordt gevraagd over soms wat extreme meningen die in sommige wel en in andere landen niet aanvaardbaar worden geacht.

Geef gewoon je eigen mening.

Het invullen van de vragenlijst kost zo'n 20 - 30 minuten.

Succes!
Appendix G

Canadian Debriefing Materials

THANK YOU!

Thank you for participating in this survey. Your responses will remain confidential and you can not be identified from the answers you provided.

Some of you read a story about a man with lung cancer, whereas others read a story about a man or young boy with AIDS. Everyone answered the same questions, always referring to the person in the story.

The purpose of this research is to understand reactions to people with AIDS and how these reactions differ from reactions to people with other diseases, such as lung cancer. We asked you about your emotional responses, such as how much sympathy, anger, and contempt you may feel for the person in the story. We also wanted to understand your cognitive responses, so we asked how much control, responsibility, and blame you feel the person deserved for becoming ill. Finally we wanted to know if some of your social attitudes would predict what you think and feel about the ill person as well as how much you think the person deserves to be helped. We asked about your humanitarian ideals, your attitudes toward homosexuals, your belief in a fair world, your religious beliefs, and your political values.

We will be comparing your answers to answers from people in the Netherlands [Holland] to compare how people in different cultures react to serious illnesses.

This study has been cleared by the Ethics Committee of the Department of Psychology, University of Windsor. If you have any questions or concerns please contact any of the following people:

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Phone</th>
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<tbody>
<tr>
<td>Janet Keil</td>
<td>Principal Investigator</td>
<td>253-4232, ext. 2218</td>
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<td>Dr. Stewart Page</td>
<td>Research Supervisor</td>
<td>253-4232, ext. 2215</td>
</tr>
<tr>
<td>Dr. Sylvia Voelker</td>
<td>Ethics Committee</td>
<td>253-4232, ext. 2249</td>
</tr>
</tbody>
</table>
INFORMATION ABOUT AIDS AND HIV

What is AIDS?

AIDS stands for Acquired Immunodeficiency Syndrome. AIDS is the advanced stage of the disease caused by a virus called HIV - Human Immunodeficiency Virus.

HIV is a virus that can attack and seriously damage the body's immune system, which is its defence against disease and infection.

The average period between infection with HIV and full-blown AIDS is about 10 years.

HIV is usually transmitted in the following ways:

* through unprotected vaginal and/or anal sex.
* by sharing needles or syringes for injecting drugs or steroids.
* by an infected mother to her baby during pregnaancy or at birth.

The risk of being infected through blood transfusions or contact with blood products is extremely low since testing procedures for blood products were put in place in November, 1985.

If you would like more information regarding AIDS and HIV please contact:

AIDS Committee of Windsor
1168 Drouillard Road
Suite B
Windsor, Ontario, N8Y 2R1
(519) 973-0222
1-800-265-4858
Appendix H

Netherlands Debriefing Materials

Bedankt voor het meedoen met dit onderzoek. Je antwoorden zullen vertrouwelijk worden behandeld en je anonimiteit is natuurlijk gewaarborgd.

Sommingen van jullie hebben een kort verhaal gelezen over een man die lijdt aan longkanker, terwijl anderen een verhaal gelezen hebben over een man of over een jongetje die AIDS heeft.

Het doel van dit onderzoek is meer te weten te komen over de reacties die men heeft ten aanzien van mensen met AIDS en over het verschil in reacties ten aanzien van mensen met andere ziekten, zoals bijvoorbeeld longkanker. We hebben je emotionele reacties gevraagd, zoals hoeveel sympathie, kwaadheid, minachting je zou voelen voor de persoon in het verhaal. We wilden ook andere dingen weten, dus vroegen we ook naar hoeveel verantwoordelijkheid en schuld jij vond dat the persoon had voor het krijgen van zijn ziekte. Op het eind wilden we weten of jouw sociale normen en waarden invloed hebben op hetgeen jij denkt en voelt over de zieke persoon en ook in welke mate jij vindt dat de persoon het verdient geholpen te worden. We hebben je gevraagd over hoe je denkt over humanitaire onderwerpen, je houding ten opzichte van homoseksualiteit, je geloof in een rechtvaardige wereld, je religie en je politieke meningen en waarden.

We zullen jouw antwoorden vergelijken met die van mensen in Canada om te kijken hoe mensen in verschillende culturen reageren op ernstige ziekten.

Dit onderzoek voldoet aan de eisen van de Commissie Ethiek van de Faculteit de Psychologie van de Universiteit van Amsterdam en de University of Windsor (Canada). Als je nog vragen hebt kun je contact opnemen met Janet Keil die hier tijdelijke berikbaar is op telefoonnummer 525.6888 (tot en met donderdag 19 februari) daarna op telefoonnummer 525.6891 (van vrijdag 20 februari tot vrijdag 27 februari).
### Appendix 1

**Correlations Between the Individual Cognition and Emotion Items**

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<th>Control</th>
<th>Prevent</th>
<th>Cause</th>
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Correlations between the individual cognition and emotion items, cont'd.

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Note. N = 304.
Note. r > .12, p < .05, r > .16, p < .01.
Appendix J

**Factor Structure of the Social-Attitude Scales**

The latent factor structure of the social-attitude scales (i.e., Attitudes toward Gay Men, Attitudes toward Lesbians, Authoritarianism, Global Belief in Just World, Religious Fundamentalism, and Humanitarian-Egalitarianism) was examined to ensure that each scale was unidimensional and that the scales were not measuring the same latent factor. To do this, all of the individual items from the scales were submitted to a principal components analysis (varimax rotation; see Table J1). The criterion of five factors was used as the ATG and ATL are subscales of Herek’s (1988) Attitudes Toward Gay Men and Lesbians scale.

The results yielded an interpretable factor structure. All of the attitudes toward lesbians and gay men items were highly correlated with a latent factor, as were all of the religious fundamentalism items, the just world belief items, and the humanitarianism items. The only items that did not load as expected were the authoritarianism items; half of these items loaded on a single factor, but four items were correlated with the religious fundamentalism factor and one was not correlated with any factor. Thus, the factor structure of the individual differences items indicates that the scales were relatively independent.
### Table J

**Principal Components Analysis of All Individual Social-Attitude Items**

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**Principal Components Analysis of all Social-Attitudes Items**

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### Variance Explained

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*Note. N = 304.*
Appendix K

Correlations of Social-Attitude Scales with Behavioural Outcome, Emotion, and Cognition Variables

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Note. Canada: N = 207; Netherlands N = 97.
* p < .05, ** p < .01, *** p < .001.
### Multiple Regressions on Behavioural Outcomes

#### Table L.1

**Multiple Regression on Willingness to Provide Personal Help**

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$R = .675$

$R^2 = .455$

**Adjusted $R^2 = .442**

* $p < .05$. ** $p < .01$. *** $p < .001$. 
Table L2

Multiple Regression on Support for Institutional Help

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R = .596
R² = .355
Adjusted R² = .339

* p < .05. ** p < .01. *** p < .001.
Table L3

Multiple Regression on Hospital Budget Allocation

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<th>Variable</th>
<th>B</th>
<th>SE</th>
<th>β</th>
<th>( \beta^2 )</th>
<th>SR²</th>
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<td>Emotion Variables</td>
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</tr>
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<td>.098</td>
<td>-.154</td>
<td>.017*</td>
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<td>.012</td>
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<td>1.036</td>
<td>-.063</td>
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\[ R = .388 \]
\[ R^2 = .151 \]

Adjusted \( R^2 = .129 \)

* \( p < .05 \), ** \( p < .01 \), *** \( p < .001 \).
Table L4  
**Multiple Regression on Desire for Social Distance**

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<th>β</th>
<th>t²</th>
<th>SR²</th>
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<td>.001</td>
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<td>.447</td>
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<td>.250</td>
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<td>.125</td>
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<td>.453</td>
<td>.033</td>
<td>.001</td>
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R = .651  
R² = .423  
Adjusted R² = .409

* p < .05. ** p < .01. *** p < .001.
### Multiple Regressions on Emotional Reactions

#### Table M1
**Multiple Regression on Sympathy**

<table>
<thead>
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<th>Variable</th>
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<th>β</th>
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<th>$R^2$</th>
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<td>.044**</td>
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</table>

$R = .437$

$R^2 = .191$

Adjusted $R^2 = .175$

* $p < .05$. ** $p < .01$. *** $p < .001$. 
<table>
<thead>
<tr>
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<th>β</th>
<th>sr²</th>
<th>SR²</th>
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R = .630  
R² = .397  
Adjusted R² = .384

* p < .05. ** p < .01. *** p < .001.
### Table M3

**Multiple Regression on Contempt**

<table>
<thead>
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<th>Variable</th>
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<th>β</th>
<th>sr²</th>
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<td>.093</td>
<td>-.054</td>
<td>.003</td>
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<td>.006</td>
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<td>Scenario Variables</td>
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</tbody>
</table>

R = .404  
R² = .163  
Adjusted R² = .146

* p < .05.  ** p < .01.  *** p < .001.
VITA AUCTORIS

Janet L. Mantler was born in 1964 in Prince George, British Columbia. She graduated from Prince George Senior Secondary School in 1982. She went to Trinity Western University in Langley, British Columbia where she obtained a Bachelor of Arts (Honours) in Psychology in 1987. In 1993 she received a Master of Arts in Applied Social Psychology from the University of Windsor, Windsor, Ontario. She is presently an Assistant Professor in the Department of Psychology, University of Saskatchewan.