

AN ATTRIBUTIONAL ANALYSIS OF STIGMA ONSET AND OFFSET

BY

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presented to the University of Manitoba
in partial fulfillment of the
requirements for the degree of*

MASTER OF ARTS

*in the
Department of Psychology*

*Winnipeg, Manitoba
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Abstract

Researchers have pointed to a number of characteristics of stigma which seem to determine an observer's responses to the stigmatized individual. Stigma characteristics such as visibility (concealability), reversibility, risk to the observer, extent of incapacity, preventability (onset controllability), interference with communication, physical basis, mental/behavioral basis, and possibility of death have all been identified as important (Jones et al, 1984; Katz, 1979; Shears & Jensema, 1969; Sloan & Gruman, 1983; Welner, Perry & Magnusson, 1988). From among these, preventability or onset controllability of the stigma has been noted as a powerful influence upon responses to the stigmatized. Attribution theory provides a conceptual and theoretical framework for analysis and prediction of responses when controllability is a major issue. Welner, Perry & Magnusson (1988) have demonstrated that the attributional analysis of stigmas whose onset controllability have been manipulated can lead to significantly different responses. However, when individuals make judgments about the stigmatized person their responses are more than likely based upon offset controllability as well as onset controllability of the stigma. No research to date has examined the effect of offset controllability upon cognitive, affective and behavioral responses of the observer.

The present study extends the research of Welner et al. (1988) by manipulating offset controllability as well as onset controllability. Subjects read about 10 stigmas within scenarios manipulating the onset

controllability X offset controllability of each stigma. There were six dependent measures to assess cognitive, affective and behavioral responses. The factorial design [onset controllability (onset controllable, onset uncontrollable) X offset controllability (offset controllable, offset uncontrollable) X stigma type (physical, mental/behavioral)] allowed for planned comparisons on responses. The repeated measures effect on stigma type showed a significant difference between physical and mental/behavioral stigma on each of six dependent measures (blame, anger, pity, assistance, contribution and charity).

There was strong support for the hypothesis that onset controllability of stigmas will effect blame, anger, pity, assistance, charity, and monetary contributions. The main effect for onset controllability was confirmed on five out of six variables. Onset controllable stigmas elicited more blame and anger, and less pity, charity, and contributions. Onset controllability of stigmas did not affect the willingness to give assistance. There was weaker support for the hypothesis that offset controllability of stigmas would effect blame, anger, pity, assistance, charity, and monetary contributions. The main effect for offset controllable stigmas demonstrated significant effects for pity and assistance. The offset controllability of stigmas did not result in a significant effect for blame, anger, charity, and monetary contributions. There were significant interaction effects between stigma type and offset controllability for blame, anger, and charity. There were significant

Interaction effects between stigma type and onset controllability for blame and charity. These results demonstrate strong support for the use of Weiner's attributional model of observers' reactions to stigmatized individuals.

There are implications from these findings for organizations soliciting funds on behalf of the stigmatized individuals. Charity organizations may be able to increase donations by emphasizing the uncontrollable aspects of the onset of the condition as long as the negative effect on the stigmatized individual is taken into consideration and reduced as much as possible. Emphasizing an uncontrollable offset will increase feelings of pity and a willingness to assist. The stigma type effects suggest that there will be greater difficulty in accomplishing this with mental/behavioral stigmas than with physical stigmas.

Introduction

Overview

Research into stigmatization attempts to understand the basis on which individuals are marked by society. It also examines the effect that marking has upon the actor in responding to the marked (stigmatized) individual (Goffman, 1963; Jones et al., 1984; Katz, 1979). Although the topic has not been extensively studied, down through history the process and effects of stigmatization have been a common experience within day-to-day life. We have all responded to people based upon some characteristic or condition they possess. The perceived characteristics of the mark will arouse emotional responses in the observer that may affect subsequent behavioral responses.

The Greeks initiated the use of the term stigma in referring to any bodily mark or brand which indicated that its bearer was a slave or a criminal. The bearer of the mark was thus openly exposed to disgrace. The stigmatizing condition was made evident to all who came into contact with the marked individual. This was done to ensure that the rights of the individual were limited by all members of society. Access to commodities, social circles, employment, and education have long been limited by this stigmatizing process.

Today society does not place physical marks or brands on individuals to limit their access to goods and services. However, societal consensus defines what will be a stigmatizing characteristic or condition. For example, in some African societies scars are carved

death have all been identified as important (Jones et al., 1984; Katz, 1979; Shears & Jensema, 1969; Sloan & Gruman, 1983). Each of these can influence cognitive, affective and behavioral responses either alone or by interacting with one or several other factors.

Welner et al., (1988) and Brickman et al., (1982) emphasize the individual's control over the onset and the offset of the stigmatizing condition. Onset controllability refers to the preventability of a stigma (Jones et al., 1984). The cause of the stigma is examined by the observer to determine whether the actor was at fault in creating the stigmatizing condition. Offset controllability is defined in terms similar to reversibility. If the actor can take action to reverse the condition, the condition is labeled offset controllable.

Brickman et al. (1982) suggested four theoretical models which predict helping responses based on responsibility for the problem and its solution.¹ The moral model holds the actor responsible for the problem and its solution. Help-givers are considered responsible for providing assistance by facilitating motivation in the actors. The compensatory model does not hold the actor responsible for the problem but considers them responsible for the solution. In the medical model individuals are neither held responsible for the problem or its solution. Responsibility for the problem is viewed in the medical model as being beyond the control of the individual. The

¹The term responsibility as used here is taken to imply that the onset of the problem and its solution is considered controllable by the individual (see Fincham & Jasper, 1980; Hamilton, 1978; and Shaver, 1985 for discussion on the interpretations for the term responsibility).

enlightenment model maintains that the actor is responsible for the onset of the problem but not for its solution. Although Brickman et al. are suggesting general models to which individuals may adhere in responding to needs, they do emphasize the influence of onset and offset controllability in making judgments to help. Brickman et al. have suggested that within our society there is a highly developed sense of the importance of onset and offset controllability of a problem. Various philosophical and theoretical views are maintained for determining the assignment of responsibility for the problem as well as the appropriate reactions of potential help-givers.

Onset controllability may interact with offset controllability and other stigma characteristics to produce a pattern of responses. The cognitive response of blame and affective responses such as anger and pity may vary according to the effects of onset and offset controllability. These responses may then determine behavioral responses. If the observer does not blame the individual with the problem or condition and experiences pity for the individual they may be more likely to help the person with a problem, give them financial assistance, or believe that charity organizations should help (Weiner et al., 1988).

The purpose of this study is to examine the cognitive, affective and behavioral responses of observers when onset controllability and offset controllability are varied. In addition, onset controllability and offset controllability are expected to interact with the type of stigma in producing responses. Understanding the individual's

perceptions about how stigmas vary on these characteristics and understanding the individual's cognitive, affective and behavioral reactions to those stigmas may help us predict those reactions under a given set of circumstances. Such research may help us to have a greater understanding of interpersonal relationships with the stigmatized. This knowledge is critical for those in the helping professions. It may also assist us in putting together educational material to inform the public about disorders and the needs of the stigmatized individual.

Basic Issues & Approaches in Studying Stigma Characteristics

Several different approaches have been used to examine the effects of stigmas upon the cognitive, affective and behavioral responses of observers. Stigmas have been studied to identify characteristics which cut across a variety of stigmas and predict an observer's responses (Jones et al., 1984; Katz, 1979; Shears & Jensema, 1969; and Sloan & Gruman, 1983). The Just-World hypothesis (Lerner & Miller, 1970) has been used to explain reactions to the stigmatized in terms of the observer's need for self-protection. Self-protection is maintained by the belief that bad things only happen to those who deserve them. The predictive power of this hypothesis, however, has been questioned by Sloan and Gruman (1983). Factors that reflect the controllability of the stigma may be of greater value in determining the responses of observers. In this section each of these topics will be examined.

Shears and Jensema (1969) examined the social acceptability of

various characteristics or conditions. To measure the social acceptability of these conditions subjects rated each on the Bogardus Social Distance Scale (Bogardus, 1925). Subjects were instructed to use their own stereotype of the condition as their reference point. Subjects rated their acceptance of individuals with one of the following ten conditions: (1) blindness, (2) deafness, (3) mental retardation, (4) physical handicap (wheelchair), (5) Cerebral Palsy (spastic), (6) homosexuality, (7) mental illness, (8) amputee (arm or leg), (9) severe stuttering, and (10) harelip. The results indicated that as the degree of intimacy increased the number of subjects willing to accept the stigmatized individual decreased. Shears and Jensema (1969) noted that an apparent grouping of conditions took place. They used these groupings of the conditions to identify possible common characteristics within the groups. The amputee, the wheelchair patient, and the blind person were considered the most acceptable. People who were deaf, who stuttered, or who had a harelip comprised the second group. The least acceptable were the mentally ill, the retarded, and the homosexual. Two features were used to characterize the most acceptable conditions: visibility of the condition, and a physical basis to the condition. The least accepted group was comprised of the less visible conditions and contained two mental disabilities. A similar grouping of conditions was found in Weiner et al. (1988). Factor analysis of their data yielded two groups of stigmas: physical conditions and mental/behavioral conditions. Shears and Jensema suggested that the intermediate

grouping, characterized by individuals who were deaf, who stuttered or had a harellp, was most influenced by ability (or lack of ability) to communicate in addition to visibility. Because these results are based on a very limited number of stigmatizing conditions, they may not be generalizable to other conditions. Further study is needed to determine whether other factors, such as controllability, might have greater predictive power across a wide variety of conditions and responses.

Across conditions, subjects in Shears and Jensema (1969) study consistently replied negatively to the question: " Would you be willing to marry someone with this condition?" Shears and Jensema suggest that two characteristics of deviant conditions may cause this result: (1) the day to day difficulty in managing life activities, and (2) the irreparable nature of the disability. These factors would determine expectations for future success on a variety of levels. Most importantly, it may influence expectations concerning one's ability to care for oneself. If the individuals cannot manage day to day activities and the condition is not likely to change, then it is unlikely that they would be considered capable of participating in many of the responsibilities inherent in the marriage relationship. Of the six dimensions identified as visibility, interference with communication, social stigma, reversibility, extent of incapacity, and difficulties imposed on dally living routine, Shears and Jensema suggested that reversibility, extent of incapacity, and difficulties imposed on dally living routine are most influential in closer levels

of intimacy. However, these three dimensions might also be extremely important at low levels of intimacy when individuals are making judgments concerning the appropriateness of interventions and employability of the marked individual.

Sloan and Gruman (1983) suggested that reactions to ill people are based on the possibility of fatality from the illness, the individuals experience with friends or relatives having the condition, feeling at risk from the condition, knowledge of the cause of the condition, and the effectiveness of treatment. Jones et al. (1984), Shears & Jensema (1969) and Sloan & Gruman's (1983) have identified the following characteristics: visibility (concealable), reversibility (course), risk (peril), preventability (origin), interference with communication (disruptiveness), and fatality (prognosis). On the other hand, Katz (1979) studied stigmas which varied on four characteristics: visibility, threat, potential for sympathy and pity arousal, and apparent responsibility of the possessor. Varying stigmas on these four characteristics, Katz demonstrated that stigmas are capable of eliciting both hostile and sympathetic responses from observers. Thus Katz suggested that there is a basic ambivalence toward marginal groups. This means that responses to stigmas are not always negative but, rather, have the capacity to be either positive or negative depending on their perceived characteristics.

Proponents of the Just-World hypothesis would predict that the bearer of a mark (the victim) would be rejected and derogated by the observer as a self-protection measure. According to Lerner's

Just-World hypothesis, people need to believe that what occurs in the world is just and, therefore, people only get what they deserve (Lerner & Miller, 1978). As a result, the more severe a disease, the more the victim would be derogated and rejected. Sloan and Gruman (1983) found this to be generally true. However, they also found that the responses to cancer did not follow this prediction.

They hypothesized that another variable, not allowed for in the Just-World hypothesis, must be included to predict responses to victims. Sloan and Gruman (1983) examined the effect of preventability of the condition upon responses. Victims of unpreventable diseases were derogated less than those with preventable diseases. This was contrary to the prediction proposed by the Just-World hypothesis, namely, people derogate victims in order to defend themselves from the belief that it could happen to them. If self-protection was the dominant issue the psychic stress associated with the possibility of having a disease should increase as the controllability of the disease decreases. According to the Just-World hypothesis, victims would be blamed for the onset of an unpreventable disease in order to protect the observer from the thought that the condition might befall them. The result would be an increase in derogation of the victim as controllability decreases. The preventability or origin dimension (Sloan & Gruman, 1983; Jones et al., 1984) is an important source of responses to the stigmatized individual. When an individual is considered responsible for their stigmatizing condition they will be treated less favorably than

Individuals who have had no control over the condition's onset (Farina, Holland, & Ring, 1966; Levine & McBurney, 1977).

The studies on characteristics of stigmas present many possibilities for research and direct application to the mundane. However, they do not provide either empirical or conceptual frameworks for making predictions about possible cognitive, affective and behavioral responses to the stigmatized. Because the preventability or controllability factor has been demonstrated to be a strong determinant of reactions to the stigmatized, a theory that provides a significant conceptual linkage between controllability and observer's responses would be a useful framework for this research.

Attribution Theory

General Introduction. Attribution theory examines the controllability, stability, and locus of causality of outcomes. Consequently, it may have greater predictive power than other theoretical approaches. Attribution theorists believe the perceived cause of an outcome to be an important factor in determining the actors' cognitive, affective, and behavioral responses (see Figure 1).

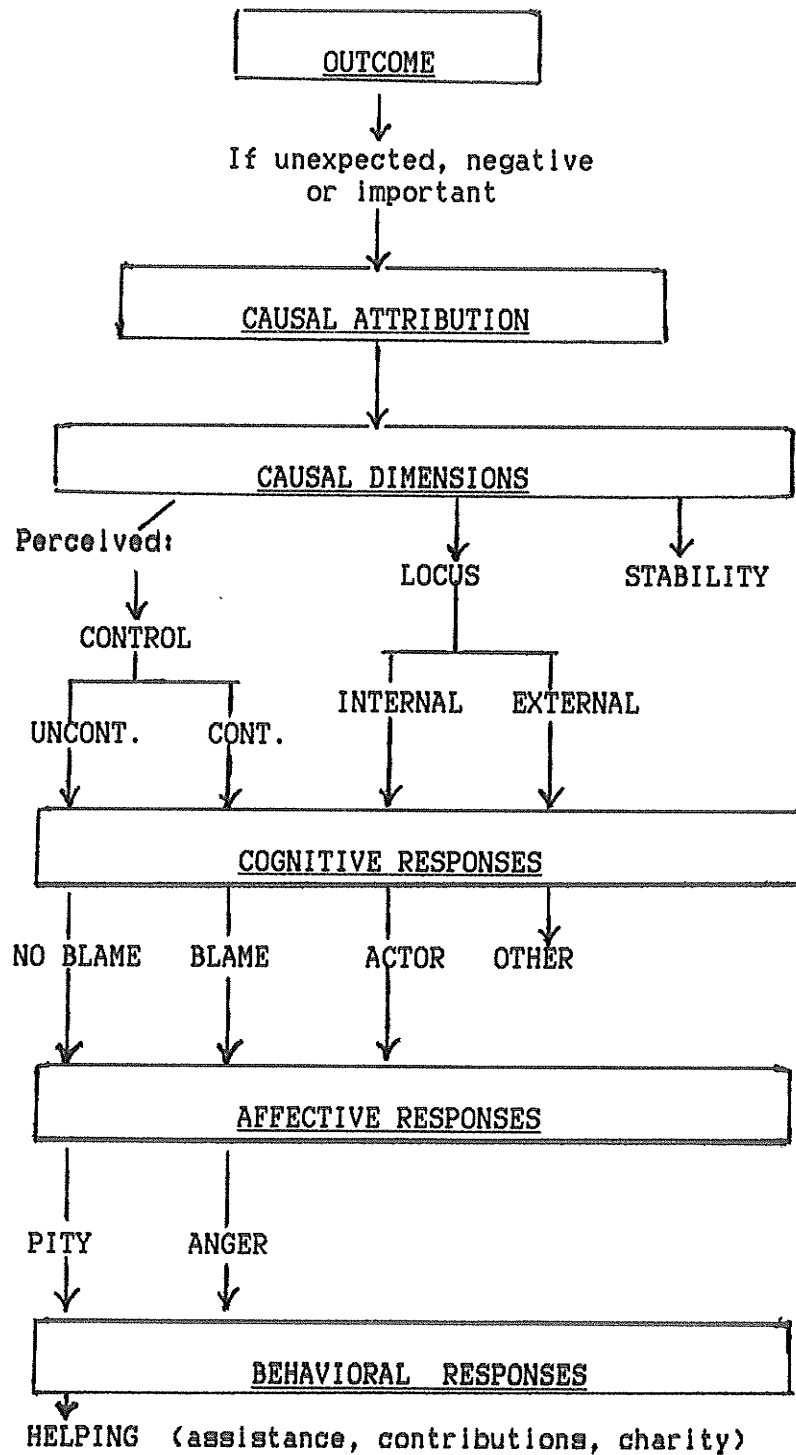
Werner (1980) suggests a three dimensional system for classifying attributions. This three dimensional system emphasizes the locus, the stability, and the controllability of a cause. The locus of a cause places responsibility for an outcome either with the individual (internal) or with someone or something outside the individual (external) experiencing the outcome. The second dimension, stability, is used to distinguish between causes which fluctuate and those which

remain relatively constant. The third dimension of causality is controllability. It differentiates between a cause which is controlled by someone in contrast to one which cannot be controlled by anyone. Attribution theory lends itself very well to the analysis and prediction of responses to an outcome in which the controllability of that outcome is a major issue. Within attribution theory, predictions are made and outcomes are analyzed based upon the controllability of the cause of that outcome, the stability of the condition, and the locus of causality. This is useful in the analysis of reactions to the stigmatized person considered as an outcome. Hence, attribution theory provides the empirical and conceptual frameworks necessary for examining responses to the stigmatized.

Helping Behavior. The usefulness of attributional analysis of helping responses to the stigmatized has been demonstrated. It has been found that the perceived cause of a need can be a very important factor in determining whether aid will be given (Barnes, Ickes, & Kidd, 1979; Ickes & Kidd, 1976; Meyer & Mulherin, 1980; Reisenzein, 1986; Weiner, 1986). If the outcome examined by the observer is considered to be a negative outcome, then the attributional process is all the more certain to be engaged. A need can be and frequently is viewed as a negative outcome, i.e., as a failure. North American society places high value on being able to provide for one's own needs and on maintaining control over all areas of one's life. When a failure occurs the individuals involved become highly motivated to find the cause, that is, to engage the attributional process.

Figure 1

Flow chart of the Attribution Model.



Observers will then respond to the need based upon their perception of the cause, the resulting conclusions of their attributional search.

Weiner (1980) found that an individual who appeared drunk was perceived by observers to have control over the cause of their condition. The scenarios presented to the subjects described a fallen person as either carrying a bottle of alcohol or carrying a cane. Perceived controllability of the cause of the fall was a major factor in determining responses. The subjects were asked to report what their three most dominant affective responses would be if they were on the subway with this person when they fell. The drunken individual engendered negative reactions within the observers due to the individual's lack of exerting or engaging the appropriate control over their behavior. The individual's lack of exerting appropriate control, when it was within the realm of possibility, resulted in decisions by the observers not to give help. An individual who appeared ill was perceived as lacking the ability to exert control over the cause of their condition and thus aroused positive affective reactions and decisions to give help. More than 25% of the subjects reported negative affect such as anger toward the drunk, but less than 3% of the subjects responded negatively toward the ill person.

Meyer and Mulherin (1980) asked subjects to imagine an acquaintance approaching them with a need for money to pay their rent. The cause of the need was manipulated by providing information about the needy person's employment record. The results suggested that controllability of the cause was the most influential factor in

determining whether aid was given. This was mediated by the affect which the attribution aroused. Causes of a need or a failure that were perceived to be controllable by the actor gave rise to anger, no pity, and neglect, whereas perceived uncontrollable causes of failure generated pity, little anger, and assistance (Weiner, 1980; Weiner, 1985; Weiner et al., 1988). Stable, controllable causes resulted in the greatest anger and the least concern for giving aid.

Weiner et al. (1988) enlarged the scope of this work by examining both the affective and behavioral responses of observers to ten stigmas in two experiments. In Experiment I, ten unmanipulated stigmas (Alzheimer's Disease, blindness, cancer, heart disease, paraplegia, Vietnam War syndrome, AIDS, child abuse, drug abuse and obesity) were rated for how much pity, anger, liking, and blame were experienced toward the stigmatized individual. Behavioral measures were taken by asking the subjects how willing they would be to assist, and how much they would be willing to give to this individual. Subjects were also asked to rate how much five interventions (medical treatment, technical job training, welfare, psychotherapy, and professional training/higher education) would give this person a more satisfactory life. Stigmas were grouped according to whether they had a physical basis or a mental/behavioral basis. The physical stigmas were generally considered by subjects to be less controllable and more stable than the mental/behavioral stigmas. The two groups differed significantly on affective and behavioral measures. Onset-uncontrollable stigmas were associated with reactions of pity,

liking, and no anger and with decisions to help. Onset-controllable stigmas were associated with reactions of no pity, little liking, anger and with decisions not to help.

The second experiment presented subjects with the same stigmas in scenarios written to manipulate their onset controllability. Each scenario was followed immediately by the same dependent measures used in Experiment I. The pattern of affective and behavioral responses was based on the onset controllability (onset controllable, onset uncontrollable), the stability (stable, unstable) of the stigma's cause and the type of stigma (physical, mental/behavioral).

Controllability of the onset of the stigma refers to whether the cause of the stigma was under the control of the individual. For example, a controllable onset may involve an individual who drove recklessly and became crippled in the resulting car accident. The onset would have been uncontrollable by the individual if the person had been struck from behind while stopped at a red light. The locus of causation was internal in both these scenarios.

Weiner et al. (1988) defined the stability of a stigma in terms of its reversibility. In this study, stability was not manipulated in the scenarios. Instead, a stability rating was assigned to the stigma based on subjects' responses to the question: "How changeable is [the individual's] condition?" According to attribution theory, the stability of stigmas will determine expectations concerning the future effectiveness of various helping behaviors. Therefore, the perceived stability of a stigma will influence the observer's decisions

concerning the appropriateness of a particular intervention.

In some cases the stigmatized were held responsible for their condition and blamed for it, yet the stigma was not considered amenable to change. This led Welner et al. to suggest a difference exists between stigma onset and offset expectations as proposed by Brickman et al. (1982). Although the stability and the controllability of the onset of stigmas have been studied and the expected pattern of results is now predictable, an observer's affective and behavioral responses have not been measured with the manipulation of both onset controllability and offset controllability.

Objectives

The present study examines the effects of onset and offset controllability of multiple types of stigmas on observers' cognitive, affective and behavioral responses. Reactions to various conditions are based on characteristics such as: the visibility of the stigma; the physical, behavioral, mental or emotional basis of the stigma; the stability of the condition; the individual's ability to control the onset of the condition as well as the individual's ability to control the offset of the condition; the likelihood that the condition will result in death; the risk to the observer through contact with the individual; the degree of incapacitation due to the condition, and the likelihood that the observer may at sometime develop the condition (Jones et al., 1984; Katz, 1979; Shears & Jensema, 1969; Sloan & Gruman, 1983; and Welner et al., 1988).

Attributing the cause of the stigmatizing condition to each or any particular combination of these characteristics results in a pattern of affective and behavioral responses on the part of the observer (see Table 1). These responses are based on the observer's perceptions of how the stigmatizing condition rates within these characteristics rather than objective reality. Therefore, measurement of each stigma's rating on the characteristics of interests have been based on the subject's perceptions rather than their knowledge of the individual conditions. The present study extends Welner et al. (1988) by manipulating offset controllability as well as onset controllability and stigma type.

Hypotheses

The following hypotheses were tested:

Onset controllable stigmas would cause greater blame, greater anger, less pity, less assistance, less charity, and less in monetary contributions than onset uncontrollable stigmas.

Offset controllable stigmas would cause greater blame, greater anger, less pity, less assistance, less charity, and less in monetary contributions than offset uncontrollable stigmas.

In other words, significant main effects were expected for both onset and offset controllability. Because the interaction of onset controllability and offset controllability has not been examined in other research we had no clear predictions concerning their combined effect. In addition, no hypotheses were advanced regarding interactions between controllability and stigma type. However, based

on the results from Weiner et al. (1988) an interaction was expected between onset controllability and stigma type.

Method

Subjects

Subjects were volunteers (134 males, 218 females and 1 no response for sex) from the introductory psychology subject pool at the University of Manitoba. Subjects who participated in this study received one credit towards a research participation requirement for their class. Two hundred and sixty-one subjects were between 17 and 19 years of age, 79 were between 20 and 29 years of age, 8 between 30 and 39, and 3 subjects were between 40 and 49 years of age.

Design

The design was a mixed between-within factorial design, manipulating onset controllability (onset controllable, onset uncontrollable) x offset controllability (offset controllable, offset uncontrollable) x stigma grouping (physical, mental/behavioral) (see Table 1). Onset controllability and offset controllability were between subjects variables and stigma grouping was the within-subject variable. Subjects (N = 353) were randomly assigned to one of the four onset/offset conditions, with the number of subjects per condition as given in Table 1. The ten stigmas were combined into two groups of five stigmas each (see Table 2). Five stigmas having a physical genesis were grouped together and labeled as such. The other five stigmas labeled mental/behavioral were combined based on a commonly held view that they have a more mental or behavioral

Table 1

Design.

| Stigma Groupings | | Onset controllable | | Onset uncontrollable | |
|------------------|-----------------------|--------------------|-------------------|----------------------|-------------------|
| | | Offset control. | Offset uncontrol. | Offset control. | Offset uncontrol. |
| | | subj. 1 n = 89 | subj. 2 n = 87 | subj. 3 n = 90 | subj. 4 n = 87 |
| | physical | | | | |
| | mental/ behavioral | subj. 1 n = 89 | subj. 2 n = 87 | subj. 3 n = 90 | subj. 4 n = 87 |

genesis (Welner, Perry & Magnusson, 1988). Factor analysis of the data of Welner et al. (1988) yielded the two stigma groups: physical conditions and mental/behavioral conditions.

The onset controllability and offset controllability factors were designed as between subject variables to ensure that if subjects were inclined to make any comparisons between stigmas it would be based on their reaction to the stigma within a single condition, thus reducing the chances of subjects' discerning the hypotheses.

Materials

The social perception questionnaire consisted of ten stigmas (see Table 2) presented in scenarios, each followed immediately by six questions concerning emotional and behavioral responses to the

Table 2

Stigmas

| Type | Condition |
|-----------------------|-------------------------------|
| Physical | heart disease |
| | lung cancer |
| | blindness |
| | paralysis from the waist down |
| | facial disfigurement |
| Mental/ Behavioral | obesity |
| | unemployment |
| | sexually transmitted disease |
| | depression |
| | criminal conviction |

stigmatized individual. The ten stigmas were presented to each subject using one of four sets of manipulated scenarios (see Appendix A). The following is an example of the manipulated scenarios:

Barrons has a facial disfigurement. An area of Barrons' face was burned as a result of Barrons' mishandling of chemical agents. If Barrons will agree to plastic surgery the facial tissue can be restored without scarring.
(controllable onset/controllable offset)

Barrons has a facial disfigurement. An area of Barrons' face was burned as a result of Barrons' mishandling of chemical agents. Surgery cannot restore the facial tissue to its original state. (controllable onset/uncontrollable offset)

Barrons has a facial disfigurement. The disfigurement is due to a birthmark on Barrons' face. Plastic surgery can completely remove the mark without scarring.
(uncontrollable onset/controllable offset)

Barrons has a facial disfigurement. The disfigurement is due to a birthmark on the face. The mark is so extensive that plastic surgery cannot remove the mark.
(uncontrollable onset/ uncontrollable offset)

Randomization was used to establish the presentation order for the stigmas and to establish the question order on forms in the initial set. Each form had a counterpart in which the order of stigma presentation was reversed (eg. Form 1-r presented the stigmas in reverse order to Form 1), that created eight forms in all (Forms 1, 1-r, 2, 2-r, 3, 3-r, 4, 4-r).

The dependent measures were six questions assessing subjects' cognitive, affective and behavioral responses on 9 point bi-polar scales (see Appendix B). The six questions and their anchors were: (1) How much pity do you feel for this person? (1 = no pity at all, 9 = a great deal of pity), (2) How much anger do you feel toward this person? (1 = no anger at all, 9 = a great deal of anger), (3) How much do you blame this person for having this condition? (1 = no blame, 9 = a great deal of blame), (4) How willing would you be to personally assist this person with a small problem? (1 = not willing at all, 9 = totally willing), (5) Assume that you are the director of a charity organization and going to dispense some financial collections. How much would you be willing to give to this person? (1 = nothing, 9 = a great deal), (6) How willing would you be to make a personal contribution of money for this individual? (1 = not at all willing, 9 = totally willing). Two questions, How much control did this person have over prevention of the condition? (1 = no control, 9 = total control), and, How much control did this person have over the elimination or cure of this problem? (1 = no control, 9 = total control), served as manipulation checks for onset and offset controllability.

Procedure

Sign-up booklets with a variety of times available in them were used to solicit subjects for the sessions. Experimental conditions were randomly assigned to subjects within each session. Because within each session all conditions were represented any day, time, or session effects would be distributed across conditions. Prior to signing-up for one of the experimental sessions, subjects were told that their involvement would be to complete a social perception questionnaire. They were told that this task would require approximately one hour of their time and that they would receive an experimental credit toward their introductory psychology experiment participation requirement.

Upon arrival at the experimental session the subjects were instructed as to their rights and obligations as research participants (Appendix C). The subjects were then given brief instructions on using IBM sheets to record their answers. Upon completion of the questionnaire the subjects were debriefed. This consisted of a brief explanation of stigmas and the application of attribution theory to this work, followed by a question and answer session (see Appendix D).

Results

In all cases under consideration, Hartley's Fmax tests for homogeneity of variances failed to yield significant differences. Moreover, all F tests are assumed to be robust to violations of the sphericity assumption, if any, since there only two groups under each within-subjects condition. This enables subsequent statistical inference procedures within the ANOVA context as described in

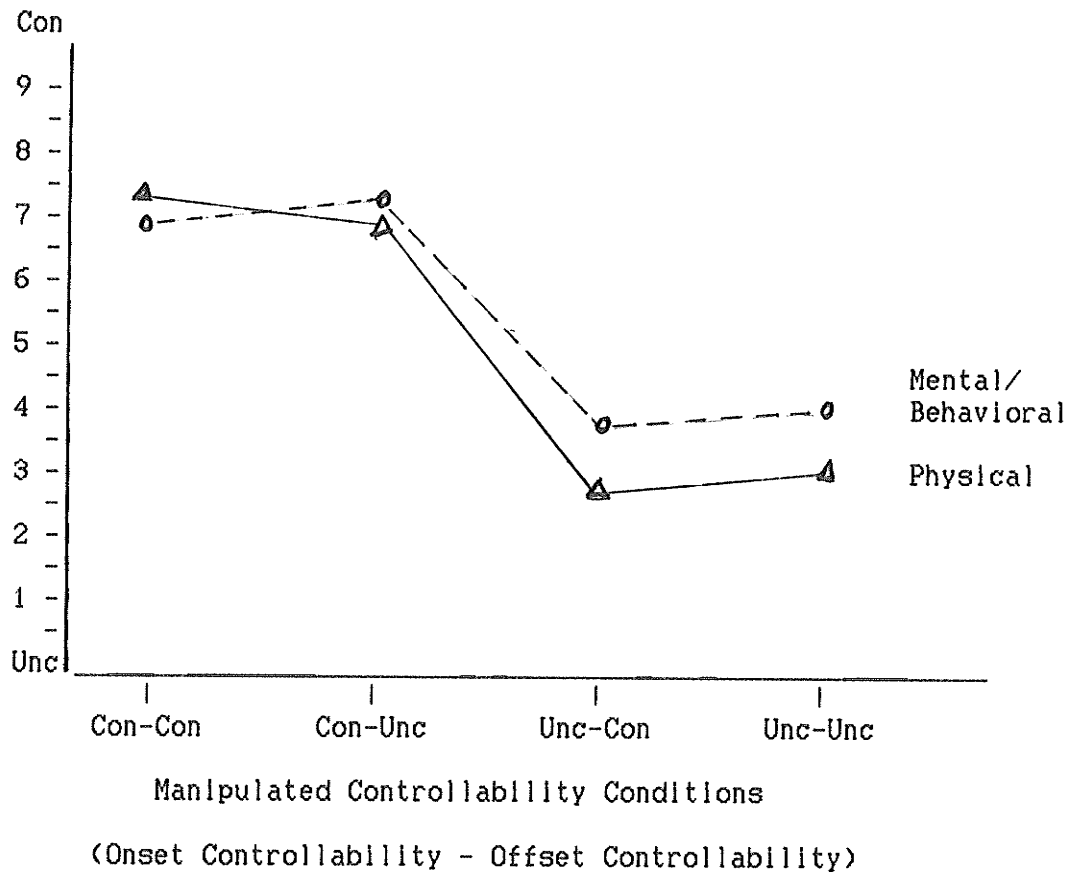
Objectives and Hypotheses.

The results from the manipulation checks demonstrated a successful manipulation of onset and offset controllability (see Figures 2 and 3). Perceived onset controllability and perceived offset controllability were each analyzed using separate 2 (onset: controllable, uncontrollable) x 2 (offset: controllable, uncontrollable) x 2 (stigma type: physical, mental/ behavioral) Analyses of Variance (ANOVAs) with stigma type being a within-subjects variable. Analyses of effects on perceived onset controllability yielded a significant main effect for manipulated onset controllability, $F(1,349) = 1116.97, p < .0001$. There also was a significant repeated measures effect for stigma type, $F(1,349) = 39.60, p < .0001$. Mental/behavioral stigmas ($M = 5.34$) were perceived to be more onset controllable (collapsing across manipulated onset controllability) than physical stigmas ($M = 5.15$). There was a significant interaction effect for stigma type x onset controllability, $F(1,349) = 71.02, p < .0001$ (see Table 3). Mental/behavioral stigmas were perceived to be more onset controllable than physical stigmas when the onset was described as uncontrollable but not when they were controllable. There were interaction effects for stigma type x offset controllability, $F(1,349) = 5.70, p < .01$, and for stigma type x onset controllability x offset controllability, $F(1,349) = 4.08, p < .05$.

Analyses of effects on perceived offset controllability yielded a significant main effect for manipulated offset controllability,

Figure 2

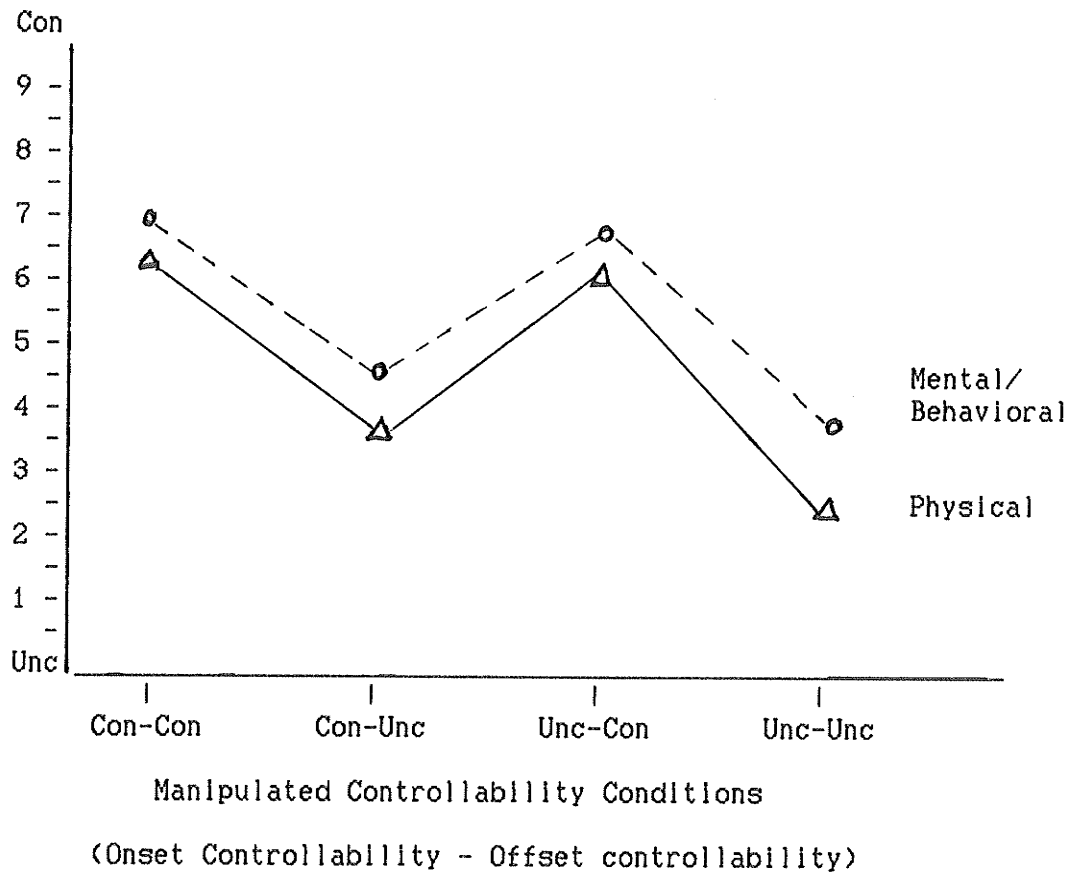
Mean Perceived Onset Controllability as a Function
of Manipulated Controllability and Stigma Type



Note: Con = controllable
Unc = uncontrollable

Figure 3

Mean Perceived Offset Controllability as a Function
of Manipulated Controllability and Stigma Type



Note: Con = controllable
Unc = uncontrollable

Table 3
Perceived Onset Controllability
as a Function of Manipulated Onset
Controllability and Stigma Type

| Stigma Type | Onset | |
|-----------------------|--------------|----------------|
| | Controllable | Uncontrollable |
| Physical | 7.31 c | 2.99 a |
| Mental/ Behavioral | 7.17 c | 3.52 b |

Note. Means with different letters are
significantly different at $p < .01$.

$F(1,349) = 395.21$, $p < .0001$, omega square = 0.53 and a significant repeated measures effect for stigma type, $F(1,349) = 145.83$, $p < .0001$. Mental/behavioral stigmas ($M = 5.63$) were perceived to be more offset controllable than physical stigmas ($M = 4.73$). There was a significant interaction effect for stigma type x offset controllability, $F(1,349) = 21.57$, $p < .0001$ (see Table 4). Mental/behavioral stigmas were perceived to be more offset controllable than physical stigmas when the offset was described as uncontrollable but not when they were controllable. There was a significant interaction effect for stigma type x onset controllability x offset controllability, $F(1,349) = 8.00$, $p < .005$. There were significant onset controllability effects on perceived offset

Table 4
Perceived Offset Controllability
as a Function of Manipulated Offset
Controllability and Stigma Type

| Stigma Type | Offset | |
|-----------------------|--------------|----------------|
| | Controllable | Uncontrollable |
| Physical | 6.39 c | 3.07 a |
| Mental/ Behavioral | 6.96 c | 4.35 b |

Note. Means with different letters are
significantly different at $p < .01$.

controllability, $F(1,349) = 7.18$, $p < .01$ and a significant interaction for offset controllability x onset controllability, $F(1,349) = 9.21$, $p < .003$.

Each of the six dependent variables measuring cognitive, affective and behavioral responses (blame, anger, pity, charity, assistance, and monetary contribution) were analyzed using separate 2 (sex of subject) x 2 (onset: controllable, uncontrollable) x 2 (offset: controllable, uncontrollable) x 2 (stigma type: physical, mental/behavioral) Analyses of Variance (ANOVAs) with stigma type being a within subjects variable. Analyses yielded no effects for sex of subject, therefore, this factor will not be discussed further.

For each of the dependent variables there was a significant

within-subject (stigma type) effect, (see Table 5). The means and effect sizes may be more

Table 5

Means and Repeated Measure F-test on Stigma Type.

| Dependent Variables | Stigma Type | | F (1,349) | Omega & Eta Square |
|---------------------|-------------|-----------------------|-----------|--------------------|
| | Physical | Mental/ Behavioral | | |
| Blame | 4.17 | 4.97 | 153.77 * | 0.30+ 0.31+ |
| Anger | 2.24 | 3.12 | 194.33 * | 0.38+ |
| Pity | 6.31 | 5.08 | 274.60 * | 0.44++ |
| Assist | 7.07 | 6.02 | 348.51 * | 0.50++ |
| Charity | 5.94 | 4.07 | 720.37 * | 0.67++ |
| Contribute | 5.17 | 3.73 | 431.66 * | 0.55++ |

Note. * = $p < .0001$

+ = moderate effect, ++ = large effect

meaningful than F-values since $F(1, \infty) > 3$ are always significant. Physical stigmas elicited less blame and anger, and more pity, assistance, charity, and contributions than did mental/behavioral stigmas.

Hypothesis 1

Main effects were expected for onset controllability, such that stigmas with controllable onsets would elicit more blame, more anger, less pity, less contributions, less assistance, and less charity than those with

uncontrollable onsets.

Blame. The ANOVA yielded a significant main effect for onset controllability, $F(1,349) = 1368.82, p < .01$. Stigmas with controllable onsets ($M = 6.54$) elicited more blame than stigmas with uncontrollable onsets ($M = 2.85$). There was also a significant onset controllability x stigma type interaction, $F(1,349) = 38.71, p < .01$ (see Table 6). Contrasts performed

Table 6
Mean Blame as a Function of Onset
Controllability and Stigma Type

| Stigma Type | Onset | |
|-----------------------|--------------|----------------|
| | Controllable | Uncontrollable |
| Physical | 6.36 a | 1.98 b |
| Mental/ Behavioral | 6.75 c | 3.18 d |

Note. Means with different letters are significantly different at $p < .01$.

using the Neuman-Keuls technique for unequal group sizes (Winer, 1971, pp. 215-218), revealed that for both physical and mental/behavioral stigmas, controllable onset elicited more blame than uncontrollable onset. In addition, mental/behavioral stigmas elicited more blame than physical stigmas, in both the controllable and uncontrollable

onset conditions. The interaction appears to have been significant because the controllable vs. uncontrollable effect is larger for physical stigmas ($6.36 - 1.98 = 4.38$) than for mental/behavioral stigmas ($6.75 - 3.18 = 3.57$).

Anger. There was a significant main effect for onset controllability, $F(1,349) = 156.29, p < .01$. Stigmas with controllable onsets ($M = 3.50$) elicited more anger than stigmas with uncontrollable onsets ($M = 1.84$). There was no interaction between onset controllability and stigma type.

Pity. There was a significant main effect for onset controllability, $F(1,349) = 33.02, p < .01$. Stigmas with controllable onsets ($M = 5.26$) elicited less pity than stigmas with uncontrollable onsets ($M = 6.11$).

Assistance. There was no significant main effect or interaction between onset controllability and stigma type.

Charity. The ANOVA yielded a significant main effect for onset controllability, $F(1,349) = 22.24, p < .01$. Stigmas with controllable onsets ($M = 4.7$) elicited less charity than stigmas with uncontrollable onsets ($M = 5.3$). There was a significant onset controllability x stigma type interaction, $F(1,349) = 7.98, p < .01$ (see table 7). Contrasts revealed that for both physical and mental/behavioral stigmas, uncontrollable onset elicited more charity than controllable onset. More charity was expressed toward individuals with physical stigmas than individuals with mental/behavioral stigmas in both the controllable and uncontrollable onset condition. The interaction appears to have been significant

because the controllable vs. uncontrollable effect was larger for mental/behavioral stigmas ($4.48 - 3.66 = 0.82$) than for physical stigmas ($6.15 - 5.72 = 0.43$).

Contribution. There was a main effect for onset controllability, $F(1,349) = 17.30$, $p < .01$. Stigmas with controllable onsets ($M = 4.1$) elicited less in monetary contributions than stigmas with uncontrollable onsets ($M = 4.8$).

Table 7
Mean Charity as a Function of Onset
Controllability and Stigma Type

| Stigma Type | Onset | |
|-----------------------|--------------|----------------|
| | Controllable | Uncontrollable |
| Physical | 5.72 a | 6.15 b |
| Mental/ Behavioral | 3.66 c | 4.48 d |

Note. Means with different letters are significantly different at $p < .01$.

In summary, five out of six of the hypothesized main effects due to onset controllability were found to be significant. The average Omega square for onset controllability main effect was 0.40. Stigmas with controllable onsets elicited more blame, more anger, less pity, less contributions and less charity than stigmas with uncontrollable onsets. No onset controllability main effect was found on willingness

to lend personal assistance.

Hypothesis 2

Main effects were expected for offset controllability, such that stigmas with controllable offsets would elicit more blame, more anger, less pity, less assistance, less charity and less in monetary contributions than offset uncontrollable stigmas.

Blame. There was no significant main effect for offset controllability. There was a significant interaction between offset controllability and stigma type, $F(1,349) = 15.09, p < .01$ (see Table 8). Contrasts revealed that offset controllability had no effect on blame for mental/behavioral stigmas

Table 8

Mean Blame as a Function of Offset

Controllability and Stigma Type

| Stigma Type | Offset | |
|-----------------------|--------------|----------------|
| | Controllable | Uncontrollable |
| Physical | 4.32 a | 4.02 b |
| Mental/ Behavioral | 4.85 c | 5.08 c |

Note. Means with different letters are significantly different at $p < .01$.

(4.85 is not significantly less than 5.08). Physical stigmas with controllable offsets elicited more blame than physical stigmas with

uncontrollable offsets ($4.32 > 4.02$).

Anger. There was no significant main effect for offset controllability. There was a significant offset controllability x stigma type interaction $F(1,347) = 5.52, p < .02$ (see Table 9). Physical stigmas with controllable offsets elicited slightly (but not significantly) more anger than physical stigmas with uncontrollable offset. Conversely, mental/behavioral stigmas with controllable offsets elicited slightly (but not significantly) less anger than mental/behavioral stigmas with uncontrollable offsets. Thus, the interaction was significant because the controllable vs. uncontrollable effect was reversed for physical and mental/behavioral stigmas.

Table 9
Mean Anger as a Function of Offset
Controllability and Stigma Type

| Stigma Type | Offset | |
|-----------------------|--------------|----------------|
| | Controllable | Uncontrollable |
| Physical | 2.28 a | 2.19 a |
| Mental/ Behavioral | 3.03 b | 3.20 b |

Note. Means with different letters are significantly different at $p < .01$.

Table 10

Mean Charity as a Function of Offset
Controllability and Stigma Type

| Stigma Type | Offset | |
|-----------------------|--------------|----------------|
| | Controllable | Uncontrollable |
| Physical | 5.98 a | 5.88 a |
| Mental/ Behavioral | 3.84 b | 4.30 c |

Note. Means with different letters are
significantly different at $p < .01$.

controllability main effect. Stigmas with controllable offsets elicited less pity and less assistance than stigmas with uncontrollable offsets. There were no significant offset controllability main effects on blame, anger, charity or contribution.

There were no onset controllability x offset controllability interaction effects on the six cognitive, affective and behavioral measures or on perceived onset controllability. There was a significant onset controllability x offset controllability interaction on perceived offset controllability.

Discussion

Weiner's attribution model (see Figure 1) was used as a framework for prediction and analyses of subjects' responses to individuals suffering from different stigmatizing conditions based upon the manipulated controllability of the onset and offset of those conditions. According to the model, the perceived controllability of the identified cause will affect observers' attributions of responsibility (blame), and affective responses (pity and anger). Those cognitive and affective responses will then influence behavioral responses such as the willingness to give assistance, dispense charity funds, or give a personal monetary contribution on behalf of the individual. I will discuss the resulting effects of the onset controllability, offset controllability, and stigma type manipulations. Generalizability of the results must be tempered by the fact that 74% of the subjects were 17 to 19 years of age, 22% were 20 to 29 years, and only 3% were 30 to 49 years old. Due to the relative youth and lack of life experiences of this sample it must be noted that the results may not be generalizable to other relatively older and more experienced groups. In addition, the judgments of university students may not represent the attitudes and judgments of less academically oriented individuals who have spent time analyzing and studying peoples' reactions to themselves and others.

Onset Controllability Effects

There was strong support here for Weiner's proposition that onset controllability influences attributions of responsibility (i.e., blame), the affect experienced (e.g., anger or pity), and the

behavioral responses associated with an event. Stigmas with a controllable onset elicited more blame, more anger, less pity, less charity and less in monetary contributions. The willingness to give assistance did not vary with onset controllability. It appears that when one is directly confronted with another's need and asked to assist with a small problem, aid will be given no matter whether the stigma's onset was controllable or not. Willingness to give assistance was high in both onset conditions (controllable $M = 6.55$, uncontrollable $M = 6.51$). However, the controllability of the onset did affect whether the subject would be willing to distribute charity funds or contribute personally on behalf of the stigmatized individual. It appears that people are less likely to distribute money to individuals with onset controllable stigmas even if they would assist personally with a small problem. This difference in the two types of response (i.e., personal assistance, monetary assistance) may originate in several different sources, one of which may reflect students' relatively limited financial resources as opposed to the ability to volunteer some direct personal assistance with a small problem. Another explanation for the willingness to lend personal assistance to an individual with a small problem regardless of whether the onset was controllable or uncontrollable may be the close proximity to the one in need and to the need itself. To dispense charity funds or to donate money to a charity usually provides no immediate contact with the individual in need. Perhaps because of this the perceived onset characteristics and cause of the need become more important in determining the response to a charity's plea for

donations. If this is a viable explanation then charity organizations have two possible methods of increasing charity donations. The first, based on the finding that subjects were more willing to dispense charity donations and to make personal contributions for individuals whose condition was onset uncontrollable, is to emphasize the uncontrollable characteristics of the condition's onset (or the blamelessness of the victim) where applicable and thus motivate the observer to get involved through a charitable donation. Although emphasizing the uncontrollability of the condition may motivate the observer to give donations, as noted by Welner et al. (1988), this approach can have negative effects on the stigmatized individuals. The stigmatized individuals' willingness to take responsibility for their actions in regard to their condition may decrease if the condition is seen as uncontrollable. Second, donation levels should be greater when a charity's public service announcements and fund raising programs are personalized by including an individual with the condition of interest. This supports the present trend to make the disabled more visible in campaigns for charitable donations and for equal access to facilities and opportunities. Charities frequently use children as visible representatives of individuals with the targeted condition. This approach uses both methods of appealing to potential contributors. The child's presence not only personalizes the appeal but also utilizes the innocence of childhood to emphasize the perception of blamelessness of the victim.

In summary, the first hypothesis, that a controllable onset will elicit more blame, more anger, less pity, less assistance, less

charity, and less in monetary contributions was supported in all cases except for provision of assistance. This demonstrates strong support for the use of Weiner's attribution model of observers' reactions to stigmatized individuals.

Offset Controllability Effects

There was weaker support for the hypothesis that offset controllability would influence the observers' responses. Blame, anger, contributions and charity did not vary with offset controllability. However, (while reporting moderately high levels of pity and willingness to assist) offset controllable stigmas elicited significantly less pity and assistance than offset uncontrollable stigmas. The onset of the stigmatizing condition brings about a change in the individual's life. The change usually is unexpected and negative. This engages the attributional process which determines the corresponding emotional and behavioral responses. Offset controllability does not usually involve the unexpected and thus the motivation behind emotional and behavioral responses may be lower than for stigma onset. This may decrease response levels and the response differences between controllable and uncontrollable offsets. However, the responses of pity and willingness to assist appear to demonstrate greater motivational ties to controllability of the offset.

Stigma Type Effects

The stigmas used in this study were grouped into two stigma categories: physical and mental/behavioral. Mental/behavioral stigmas elicited more blame, more anger, less pity, and less willingness to respond with a positive behavior than did physical stigmas when

responses were collapsed across onset and offset conditions and across stigmas within each group (physical and mental/behavioral). The greater blame and anger toward those with mental/behavioral stigmas indicated a tendency to hold them more responsible for their situation.

The tendency to hold individuals with mental/behavioral stigmas more responsible for their situation is consistent with a main effect for stigma type on the measures of perceived onset and offset controllability. Mental/behavioral stigmas were considered to be more onset and offset controllable than physical stigmas regardless of manipulated controllability. The finding that individuals with mental/behavioral stigmas are held more responsible for the onset of the condition replicates the findings of Weiner, Perry, and Magnusson (1988). Weiner et al. (1988) found that unmanipulated mental/behavioral stigmas were considered to be more controllable than physical stigmas. They hypothesized that, for the stigmas used in their study, the individuals were perceived as being morally weak because they had not initiated a response which could have prevented their present condition. As suggested earlier by Brickman et al. (1982) the case in which an individual is held responsible for a problem and for its solution is considered to be a moral problem. In the moral model of responsibility help-givers are considered responsible for providing assistance by facilitating motivation in the individual. The individual with the problem carries responsibility for onset of the condition, as well as, its offset. Because mental/behavioral stigmas are considered to be controllable the

observer experiences little pity and little drive to give assistance.

The difference in perceived controllability based on stigma type explains the stigma type effect on affective and behavioral responses. The affective and behavioral responses to the stigmatized individual mirrors or imitates the responses to stigmas based upon the onset controllability of the stigma. This effect is due to the perception of the stigma's inherent controllability.

Interactions between Stigma Type and Controllability

There was an interaction effect between stigma type (based upon the stigma type's perceived controllability) and onset controllability. Due to this interaction mental/behavioral stigmas and physical stigmas were perceived to be equally controllable when their onset was described as controllable. When the stigmas' onsets were described as uncontrollable mental/behavioral stigmas were perceived as more onset controllable than physical stigmas. In the subject's mind there may be no such thing as a completely uncontrollable mental/behavioral condition.

Although the perception of controllability of mental/behavioral stigmas could be altered somewhat they were still considered to be more controllable than physical stigmas. In situations in which the individual was not in fact responsible for the stigma, those individuals with mental/behavioral stigmas were still seen as having more control over the stigma's onset than individuals with physical stigmas. These judgments of responsibility led to more blame, more anger, less pity, and less assistance, charity, and contributions in the case of mental/behavioral stigmas.

Although perceived controllability of the stigmas' offset decreased when the stigmas were described as offset uncontrollable, the mental/behavioral stigmas were not as amenable to change in that direction as were the physical stigmas. In situations in which the victim was, according to the scenario, not responsible for the continuation of the stigma, subjects still saw victims of mental/behavioral stigmas as more in control of the stigma offset than victims of physical stigmas.

Why should people perceive mental/behavioral stigmas to be more controllable and thus hold the victims more responsible for their stigmas? In our culture the word "behavior" is often synonymous with controllable action. It is a manner of conducting oneself. To behave means to conduct oneself in a proper manner, a manner defined by the society in which one lives. Behavior addresses that part of our life which we do normally control. Often a circumstance in which we find ourselves is brought about by an action we could have controlled.

Perhaps, individuals with mental/behavioral stigmas were perceived as not choosing to behave in the manner required to resolve or alleviate their condition. They may be perceived to be continuously choosing not to change and thus by ongoing failure remain in their present condition. In the minds of the subjects mental/behavioral stigmas may represent a continuing pattern of lack of self-control, carelessness, or laziness. Everyday there is more evidence that the person isn't trying hard enough, and is therefore responsible for his/her own fate.

Physical stigmas are viewed as being caused by either something

totally beyond the control of the stigmatized individual (eg. a birth mark) or to the victims' past behavior. Sometimes that behavior was a single behavior and at other times a behavior that continued for sometime but is no longer engaged in (eg. smoking). The action led to an identifiable "event" (e.g., paralysis, scar, discovery of cancer, heart attack, etc.). The physical stigmas that stem from a behavior are viewed as coming into existence in the moment of that event but exist beyond that time without the participation of the stigmatized individual.

Often in the case of a behavior an observer will make the "fundamental attribution error" attributing others' behavior to internal controllable causes, such as, motives, attitudes, and desires while underestimating the extent to which their behavior is caused by uncontrollable situational factors. In the case of the mental/behavioral stigmas used in this experiment (e.g., overeating, criminal behavior, depression, etc.) people may have attributed the continuation of these behaviors to the personal characteristics (i.e., personal weaknesses) of the individual. Victims of physical stigmas are held less responsible because, at least in some cases, they may be due to a single past event.

In conclusion, there is in general fairly strong support for Weiner's theory that there is a connection between controllability, attributions of responsibility, affective reactions, and behavioral responses. The effect of offset controllability did not yield as strong support for Weiner's attribution model as did the effect of onset controllability. It could be an artifact of the particular

manipulation scenarios or it could be that it is more difficult to alter one's belief concerning the offset controllability of some stigmas. It could be that judgments of the original cause are the most important in influencing our responses. The observer might think that, if the person had not engaged in a particular behavior or activity offset controllability would not be an issue. Offset controllability appears to be of secondary importance in influencing our behavior.

Examination and application of these results must take into account the possible restrictions on generalizability which emanate from the sample and method used. The majority of the sample were relatively young, inexperienced students who represent an academically oriented population. Their responses may differ from individuals who do not have corresponding drives and goals. The responses of sampled students may have been affected by the questioning of personal attitudes which takes place within the university setting. Further research needs to draw samples from a wider variety of settings and examine whether differences exist between university and non-university students. Also, in future work on this topic it may be advantageous to examine a variety of mediums for presentation of the stigmatized individual in an attempt to increase the real life quality of the encounter of the experiment's subjects with the stigmatized individual. However, using actors or photographs as alternative presentation methods may introduce competing variables (eg. sex of the stigmatized and relative attractiveness to the experimental subject) which will decrease controllability.

References

- Barnes, R. D., Ickes, W. & Kidd, R. F. (1979). Effect of the perceived intentionality and stability of another's dependency on helping behavior. Personality and Social Psychology Bulletin, 5, 367-372.
- Bogardus, E. S. (1925). Measuring Social Distance. Journal of Applied Sociology, 2, 299-308.
- Brickman, P., Rabinowitz, V. C., Karuza, Jr., J., Coates, D., Cohn, E., & Kldder, L. (1982). Models of helping and coping. American Psychologist, 37, 368-384.
- Farina, A., Holland, C. H., & Ring, K. (1966). The role of stigma and the set in interpersonal interaction. Journal of Abnormal Psychology, 71, 421-428.
- Finchman, F. D. & Jaspers, J. M. (1980). Attribution of responsibility: From man the scientist to man as lawyer. In Leonard Berkowitz (Ed.), Advances in Experimental Social Psychology Vol.13 (pp. 81-138). N. Y.: Academic Press.
- Goffman, E. (1963). Stigmas: Notes on a spoiled identity. New York: Simon & Schuster.
- Hamilton, V L. (1978). Who is responsible? Toward a social psychology of responsibility attribution. Social Psychology, 41, 316-328.
- Ickes, W. J., & Kidd, R. F. (1976). An attributional analysis of helping behavior. In J. H. Harvey, W. J. Hicks, & R. F. Kidd (Eds.), New Directions in Attribution Research Vol. 1 (pp. 311-334). N. J.: Erlbaum.

- Jones, E. E., Farina, A., Hastorf, A. H., Markus, H., Miller, D. T., & Scott, R. A. (1984). Social stigma. New York: Freeman.
- Katz, I., (1979). Some thoughts about the stigma notion. Personality and Social Psychology Bulletin, 5, 447-460.
- Lietz, J. J. (1981). Ranking social stigma: Would you want one for a friend? Perceptual and Motor Skills, 53, 353-354.
- Levine, J. M. & McBurney, D. H. (1977). Causes and consequences of effluvia: Body odor awareness and controllability as determinants of interpersonal evaluation. Personality and Social Psychology, 3, 442-445.
- Lerner, M. J., & Miller, D. T. (1978). Just world research and the attribution process: Looking back and ahead. Psychological Bulletin, 85, 1030-1051.
- Meyer, J. P., & Mulherin, A. (1980). From attribution to helping: An analysis of the mediating effects of affect and expectancy. Journal of Personality and Social Psychology, 39, 201-210.
- Reisenzein, R. (1986). A structural equation analysis of Weiner's attribution-affect model of helping behavior. Journal of Personality and Social Psychology, 50, 1123-1133.
- Shaver, K. G. (1985). The Attribution of Blame: Causality, Responsibility, and Blameworthiness. New York: Springer-Verlag.
- Shears, L. M. & Jensen, C. J. (1969). Social acceptability of anomalous persons. Exceptional Children, 36, 91-96.
- Sloan, R. P. & Gruman, J. C. (1983). Beliefs about cancer, heart disease, and their victims. Psychological Reports, 52, 415-424.

- Weiner, B. (1979). A theory of motivation for some classroom experiences. Journal of Educational Psychology, 71, 3-25.
- Weiner, B. (1980). A cognitive (attribution) - emotion - action model of motivated behavior: An analysis of judgments of help-giving. Journal of Personality and Social Psychology, 39, 186-200.
- Weiner, B. (1985). An attributional theory of achievement motivation and emotion. Psychological Review, 92, 548-573.
- Weiner, B. (1986). An Attributional Theory of Motivation and Emotion. New York: Springer-Verlag.
- Weiner, B., Perry, R. P., & Magnusson, J. L. (1988). An attributional analysis of reactions to stigma. Journal of Personality and Social Psychology, 55, 738-748.
- Weiner, B. J. (1971). Statistical Principles in Experimental Design. (2nd ed.). New York: McGraw-Hall.

Appendix A

SCENARIOS

1. onset controllable X offset controllable

D. Scott has developed Lung Cancer. Diagnosis suggests that the cancer was brought on by excessive smoking. It has been caught early. If D. Scott agrees to surgery and chemotherapy the condition can be reversed.

R. Smith is paralyzed from the waist down. Smith was in an automobile accident for which he/she was at fault. If Smith agrees to surgery and physiotherapy functioning can be restored.

M. Bridge has become excessively overweight. Excessive eating and lack of exercise have been the primary contributors to the obesity. If M. Bridge will alter eating habits and exercise habits the weight will be lost.

F. Lee has developed heart disease. The diagnosis indicates that the disease is due to the patients excessive smoking and high cholesterol diet. If Lee agrees to surgery and a change in diet the condition can be reversed.

C. Lake is unemployed. Lake caused an accident on the job. This led to his/her dismissal. C. Lake could have taken another position with less responsibility at the company.

D. Barrons has a facial disfigurement. An area of D. Barrons' face was burned as a result of the mishandling of chemical agents. If D. Barrons will agree to plastic surgery the facial tissue can be restored without scarring.

V. Fleming has contracted a sexually transmitted disease. Fleming did not practice safe sex. The condition can be reversed with the administration of medication.

R. Jones is blind. R. Jones was not wearing protective eye guards while cutting cement on a road repair crew. Cement chips lodged in Jones' eyes causing blindness. If Jones agrees to surgery vision can be restored.

M. Taylor has developed severe depression. Taylor is unhappy in a high pressure job. A change of jobs and a reduction in stress can cause the depression to gradually disappear.

J. Matthews is a convicted criminal. Matthews chose to steal instead of working at a regular paying job. Matthews has been offered help to rehabilitate himself/herself.

2. onset controllable X offset uncontrollable

D. Scott has developed Lung Cancer. Diagnosis suggests that the cancer was brought on by D. Scott's excessive smoking. The cancer is too advanced to be reversed through surgery or chemotherapy.

R. Smith is paralyzed from the waist down. Smith was in an automobile accident for which he/she was at fault. Surgery and physiotherapy cannot restore functioning.

M. Bridge has become excessively overweight. Excessive eating and lack of exercise have been the primary contributors to the obesity. A pituitary tumor has developed and weight loss is impossible.

F. Lee has developed heart disease. The diagnosis indicates that the disease is due to the patient's excessive smoking and high cholesterol diet. The condition led to congestive heart failure and cannot be reversed.

C. Lake is unemployed. Lake caused an accident on the job. The resulting disability will prevent him/her from ever working again.

D. Barrons has a facial disfigurement. An area of D. Barrons' face was burned as a result of mishandling of chemical agents. Surgery cannot restore the facial tissue to its original state.

V. Fleming has contracted a sexually transmitted disease. Fleming did not practice safe sex. The condition cannot be reversed.

R. Jones is blind. R. Jones was not wearing protective eye guards while cutting cement on a road repair crew. Cement chips lodged in her/his eyes causing blindness. The eyes were damaged beyond repair.

M. Taylor has developed severe depression. A chemical imbalance in the brain created by the recreational use of drugs caused the depression. Treatment cannot correct the problem.

J. Matthews is a convicted criminal. Matthews chose to steal instead of working at a regular paying job. Matthews has developed a compulsion to steal and no longer has the ability to stop.

3. onset uncontrollable X offset controllable

D. Scott has developed Lung Cancer. Diagnosis suggests that the cancer was brought on by exposure to secondhand smoke. If D. Scott agrees to surgery and chemotherapy the condition can be reversed.

R. Smith is paralyzed from the waist down. The injury occurred when Smith's automobile was struck from behind while Smith was stopped at a red light. If Smith agrees to surgery and physiotherapy the functioning can be restored.

M. Bridge has become excessively overweight. A thyroid condition caused the weight problem. If Bridge agrees to surgery, the condition can be corrected and the weight lost.

F. Lee has developed heart disease. The diagnosis indicates that congenital factors led to heart problems. If F. Lee agrees to surgery the condition can be corrected.

C. Lake is unemployed. The company where C. Lake worked has closed down. C. Lake could take another position at an associated company.

D. Barrons has a facial disfigurement. The disfigurement is due to a birthmark on the face. Plastic surgery can completely remove the mark without scarring.

V. Fleming has contracted a sexually transmitted disease. V. Fleming unknowingly contracted the disease from his/her spouse. The condition can be reversed with the administration of medication.

R. Jones is blind. As she/he passed a road repair crew that were cutting cement, chips entered Jones' eyes and caused blindness. If he/she agrees, surgery can repair the eyes and restore vision.

M. Taylor has developed severe depression. A chemical imbalance due to illness has caused the depression. If he/she accepts medical treatment for the precipitating cause, the depression will disappear.

J. Matthews is a convicted criminal. Matthews had little to eat when growing up and was taught to survive on the street by stealing. Matthews has been offered a program of rehabilitation.

4. onset uncontrollable X offset uncontrollable

D. Scott has developed Lung Cancer. Diagnosis suggests that the cancer was brought on by exposure to secondhand smoke. The cancer is too advanced to be reversed through surgery or chemotherapy.

R. Smith is paralyzed from the waist down. The injury occurred when Smith's car was struck from behind while he/she was stopped at a red light. Surgery and physiotherapy cannot restore functioning.

M. Bridge has become excessively overweight. A pituitary tumor caused the weight gain. The condition can not be reversed.

F. Lee has developed heart disease. The diagnosis indicates that congenital factors lead to congestive heart failure. The condition can not be reversed.

C. Lake is unemployed. The company where he/she worked has closed down. Because of Lake's advanced age and outdated skills he/she is unemployable.

D. Barrons has a facial disfigurement. The disfigurement is due to a birthmark on the face. The mark is so extensive that plastic surgery cannot remove the mark.

V. Fleming has contracted a sexually transmitted disease. V. Fleming unknowingly contracted the disease from his/her spouse. The condition can not be reversed.

R. Jones is blind. As Jones passed a road repair crew that were cutting cement, chips entered Jones' eyes and caused blindness. The eyes were damaged beyond repair.

M. Taylor has developed severe depression. An inoperable brain tumor has caused the depression. Nothing can be done to reverse this condition.

J. Matthews is a convicted criminal. Matthews had little to eat when growing up and was taught to survive on the street by stealing. Matthews has developed a compulsion to steal and no longer has the ability to stop.

Appendix B

SOCIAL PERCEPTION QUESTIONNAIRE

GROUP 1 - FORM 1

This questionnaire concerns your impression and opinions about some conditions and characteristics of people. The information that you provide here is confidential and will not be released to any other person. Do not put your name on the questionnaire.

This questionnaire is not a test, so there are no right or wrong answers. The validity of the questionnaire depends on your honesty, so please try to give your true thoughts and feelings. Work quickly, and do not omit any question. Thank you for your cooperation.

Record the answers to these first nine (9) questions within
SECTION 3 of your IBM answer sheet.

At the top of this page you have a group number and a form number. Please indicate on the IBM sheet which group and which form you have.

1) GROUP NUMBER

- 1 = group 1
- 2 = group 2

2) FORM NUMBER

- 1 = form 1
- 2 = form 2
- 3 = form 3
- 4 = form 4
- 5 = form 5
- 6 = form 6
- 7 = form 7
- 8 = form 8
- 9 = form 9

While your name should not be on this form, we would like some general information about you, so please respond to the following by indicating the number on the IBM sheet which corresponds to the number of your answer. Continue using section 3 of your IBM sheet.

- 3) SEX 1 = male
 2 = female
- 4) AGE 1 = 19 years or less
 2 = 20 to 29 years
 3 = 30 to 39 years
 4 = 40 to 49 years
 5 = 50 or more years
- 5) ETHNIC ORIGIN
 1 = North America Indian
 2 = Europlan
 3 = Asian
 4 = African
 5 = South American
 6 = Other
- 6) PLACE OF ORIGIN
 1 = Large City (population of 100,000 or more)
 2 = Small City (population - 10,000 to 99,999)
 3 = Town (population - 1,500 to 9,999)
 4 = Rural (population less than 1,500
 includes living on a farm, etc.)
- 7) RELIGION
 1 = Roman Catholic
 2 = Protestant
 3 = Jewish
 4 = Muslim
 5 = Atheist
 6 = Other

8) BIRTH ORDER

In your family, were you

- 1 = an only child
- 2 = the oldest child
- 3 = a middle child
- 4 = the youngest child

9) HOW MANY CHILDREN WERE IN YOUR FAMILY (including you)?

- 1 = One (you were an only child)
- 2 = Two
- 3 = Three
- 4 = Four
- 5 = Five or more

10) UNIVERSITY FACULTY

- 1 = Arts
- 2 = Science
- 3 = Law
- 4 = Education
- 5 = Social Work
- 6 = Nursing
- 7 = Human Ecology
- 8 = Management
- 9 = Other

11) YEAR IN UNIVERSITY

- 1 = FIRST YEAR
- 2 = SECOND YEAR
- 3 = THIRD YEAR
- 4 = FOURTH YEAR

Group 1 - Form 1

A number of questions regarding your thoughts and feelings about a variety of conditions and characteristics will follow. Some will be difficult to answer and you will feel the need for more information or feel uncertain about your answer. Try to give the most accurate answer you can, even though we recognize that this may at times be difficult. There are ten personal characteristics or conditions that we are particularly interested in, and the questions all refer to these conditions. They are heart disease, lung cancer, blindness, paralysis from the waist down, obesity, unemployment, sexually transmitted disease, depression, convicted criminal, and facial disfigurement.

(For the rest of this questionnaire use section 1 of the IBM sheet.)

Answer each of the following questions, indicating your answers within SECTION 1 on the IBM sheet.

Bridge has become excessively overweight. Excessive eating and lack of exercise have been the primary contributors to the obesity. If Bridge will alter eating habits and exercise habits the weight will be lost.

1) How much do you blame this person for this condition?

| no blame at all | | | | | | | | totally blame |
|--------------------|---|---|---|---|---|---|---|------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

2) Assume that you are the director of a charity organization and were going to dispense financial collections. How much would you be willing to give to this person?

| not at all willing | | | | | | | | totally willing |
|-----------------------|---|---|---|---|---|---|---|--------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

3) How willing would you be to personally assist this person with a small problem?

| not at all willing | | | | | | | | totally willing |
|-----------------------|---|---|---|---|---|---|---|--------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

4) How willing would you be to make a personal contribution of money for this person?

| not at all willing | | | | | | | | totally willing |
|-----------------------|---|---|---|---|---|---|---|--------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

Analysis of Stigmas
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5) How much anger do you feel toward this person?

| | | | | | | | | | |
|--------------------|---|---|---|---|---|---|---|---|------------------|
| no anger at all | | | | | | | | | totally angry |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

6) How much plty do you feel for this person?

| | | | | | | | | | |
|-------------------|---|---|---|---|---|---|---|---|---------------|
| no plty at all | | | | | | | | | total plty |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

7) How much control did this person have over prevention of this condition?

| | | | | | | | | | |
|---------------|---|---|---|---|---|---|---|---|------------------|
| no control | | | | | | | | | total control |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

8) How much control did this person have over elimination or cure of this condition?

| | | | | | | | | | |
|---------------|---|---|---|---|---|---|---|---|------------------|
| no control | | | | | | | | | total control |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

Scott has developed Lung Cancer. Diagnosis suggests that the cancer was brought on by excessive smoking. It has been caught early. If Scott agrees to surgery and chemotherapy the condition can be reversed.

9) How much do you blame this person for this condition?

| no blame at all | | | | | | | | | totally blame |
|--------------------|---|---|---|---|---|---|---|---|------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

10) Assume that you are the director of a charity organization and were going to dispense financial collections. How much would you be willing to give to this person?

| not at all willing | | | | | | | | | totally willing |
|-----------------------|---|---|---|---|---|---|---|---|--------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

11) How willing would you be to personally assist this person with a small problem?

| not at all willing | | | | | | | | | totally willing |
|-----------------------|---|---|---|---|---|---|---|---|--------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

12) How willing would you be to make a personal contribution of money for this person?

| not at all willing | | | | | | | | | totally willing |
|-----------------------|---|---|---|---|---|---|---|---|--------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

13) How much anger do you feel toward this person?

| | | | | | | | | | |
|--------------------|---|---|---|---|---|---|---|---|------------------|
| no anger at all | | | | | | | | | totally angry |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

14) How much pity do you feel for this person?

| | | | | | | | | | |
|-------------------|---|---|---|---|---|---|---|---|---------------|
| no pity at all | | | | | | | | | total pity |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

15) How much control did this person have over prevention of this condition?

| | | | | | | | | | |
|---------------|---|---|---|---|---|---|---|---|------------------|
| no control | | | | | | | | | total control |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

16) How much control did this person have over elimination or cure of this condition?

| | | | | | | | | | |
|---------------|---|---|---|---|---|---|---|---|------------------|
| no control | | | | | | | | | total control |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

Jones is blind. Jones was not wearing protective eye guards while cutting cement on a road repair crew. Cement chips lodged in Jones' eyes causing blindness. If Jones agrees to surgery vision can be restored.

17) How much do you blame this person for this condition?

| no blame at all | | | | | | | | totally blame | |
|--------------------|---|---|---|---|---|---|---|------------------|--|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

18) Assume that you are the director of a charity organization and were going to dispense financial collections. How much would you be willing to give to this person?

| not at all willing | | | | | | | | totally willing | |
|-----------------------|---|---|---|---|---|---|---|--------------------|--|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

19) How willing would you be to personally assist this person with a small problem?

| not at all willing | | | | | | | | totally willing | |
|-----------------------|---|---|---|---|---|---|---|--------------------|--|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

20) How willing would you be to make a personal contribution of money for this person?

| not at all willing | | | | | | | | totally willing | |
|-----------------------|---|---|---|---|---|---|---|--------------------|--|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

Analysis of Stigmas
65

21) How much anger do you feel toward this person?

| | | | | | | | | | |
|--------------------|---|---|---|---|---|---|---|---|------------------|
| no anger at all | | | | | | | | | totally angry |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

22) How much pity do you feel for this person?

| | | | | | | | | | |
|-------------------|---|---|---|---|---|---|---|---|---------------|
| no pity at all | | | | | | | | | total pity |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

23) How much control did this person have over prevention of this condition?

| | | | | | | | | | |
|---------------|---|---|---|---|---|---|---|---|------------------|
| no control | | | | | | | | | total control |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

24) How much control did this person have over elimination or cure of this condition?

| | | | | | | | | | |
|---------------|---|---|---|---|---|---|---|---|------------------|
| no control | | | | | | | | | total control |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

Matthews is a convicted criminal. Matthews chose to steal instead of working at a regular paying job. Matthews has been offered help to rehabilitate.

25) How much do you blame this person for this condition?

| no blame at all | | | | | | | | | totally blame |
|--------------------|---|---|---|---|---|---|---|---|------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

26) Assume that you are the director of a charity organization and were going to dispense financial collections. How much would you be willing to give to this person?

| not at all willing | | | | | | | | | totally willing |
|-----------------------|---|---|---|---|---|---|---|---|--------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

27) How willing would you be to personally assist this person with a small problem?

| not at all willing | | | | | | | | | totally willing |
|-----------------------|---|---|---|---|---|---|---|---|--------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

28) How willing would you be to make a personal contribution of money for this person?

| not at all willing | | | | | | | | | totally willing |
|-----------------------|---|---|---|---|---|---|---|---|--------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

Analysis of Stigmas
67

29) How much anger do you feel toward this person?

| no anger at all | | | | | | | | | totally angry |
|--------------------|---|---|---|---|---|---|---|---|------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

30) How much pity do you feel for this person?

| no pity at all | | | | | | | | | total pity |
|-------------------|---|---|---|---|---|---|---|---|---------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

31) How much control did this person have over prevention of this condition?

| no control | | | | | | | | | total control |
|---------------|---|---|---|---|---|---|---|---|------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

32) How much control did this person have over elimination or cure of this condition?

| no control | | | | | | | | | total control |
|---------------|---|---|---|---|---|---|---|---|------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

Lake is unemployed. Lake caused an accident on the job. This led to Lake's dismissal. Lake could take another position with less responsibility at the company.

33) How much do you blame this person for this condition?

| | | | | | | | | | | |
|--------------------|---|---|---|---|---|---|---|---|--|------------------|
| no blame at all | | | | | | | | | | totally blame |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | |

34) Assume that you are the director of a charity organization and were going to dispense financial collections. How much would you be willing to give to this person?

| | | | | | | | | | | |
|-----------------------|---|---|---|---|---|---|---|---|--|--------------------|
| not at all willing | | | | | | | | | | totally willing |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | |

35) How willing would you be to personally assist this person with a small problem?

| | | | | | | | | | | |
|-----------------------|---|---|---|---|---|---|---|---|--|--------------------|
| not at all willing | | | | | | | | | | totally willing |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | |

36) How willing would you be to make a personal contribution of money for this person?

| | | | | | | | | | | |
|-----------------------|---|---|---|---|---|---|---|---|--|--------------------|
| not at all willing | | | | | | | | | | totally willing |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | |

Analysis of Stigmas
69

37) How much anger do you feel toward this person?

| | | | | | | | | | |
|--------------------|---|---|---|---|---|---|---|---|------------------|
| no anger at all | | | | | | | | | totally angry |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

38) How much pity do you feel for this person?

| | | | | | | | | | |
|-------------------|---|---|---|---|---|---|---|---|---------------|
| no pity at all | | | | | | | | | total pity |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

39) How much control did this person have over prevention of this condition?

| | | | | | | | | | |
|---------------|---|---|---|---|---|---|---|---|------------------|
| no control | | | | | | | | | total control |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

40) How much control did this person have over elimination or cure of this condition?

| | | | | | | | | | |
|---------------|---|---|---|---|---|---|---|---|------------------|
| no control | | | | | | | | | total control |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

Taylor has developed severe depression. Taylor is in an unhappy marriage and a high pressure job. If Taylor seeks therapy, makes a change in living habits, and reduces stress the depression can be altered.

41) How much do you blame this person for this condition?

| no blame at all | | | | | | | | | totally blame |
|--------------------|---|---|---|---|---|---|---|---|------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

42) Assume that you are the director of a charity organization and were going to dispense financial collections. How much would you be willing to give to this person?

| not at all willing | | | | | | | | | totally willing |
|-----------------------|---|---|---|---|---|---|---|---|--------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

43) How willing would you be to personally assist this person with a small problem?

| not at all willing | | | | | | | | | totally willing |
|-----------------------|---|---|---|---|---|---|---|---|--------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

44) How willing would you be to make a personal contribution of money for this person?

| not at all willing | | | | | | | | | totally willing |
|-----------------------|---|---|---|---|---|---|---|---|--------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

Analysis of Stigmas
71

45) How much anger do you feel toward this person?

| | | | | | | | | | |
|--------------------|---|---|---|---|---|---|---|---|------------------|
| no anger at all | | | | | | | | | totally angry |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

46) How much pity do you feel for this person?

| | | | | | | | | | |
|-------------------|---|---|---|---|---|---|---|---|---------------|
| no pity at all | | | | | | | | | total pity |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

47) How much control did this person have over prevention of this condition?

| | | | | | | | | | |
|---------------|---|---|---|---|---|---|---|---|------------------|
| no control | | | | | | | | | total control |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

48) How much control did this person have over elimination or cure of this condition?

| | | | | | | | | | |
|---------------|---|---|---|---|---|---|---|---|------------------|
| no control | | | | | | | | | total control |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

Barrons has a facial disfigurement. An area of Barrons' face was burned as a result of the mishandling of chemicals agents. If Barrons will agree to plastic surgery the facial tissue can be restored without scarring.

49) How much do you blame this person for this condition?

| no blame at all | | | | | | | | totally blame | |
|--------------------|---|---|---|---|---|---|---|------------------|--|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

50) Assume that you are the director of a charity organization and were going to dispense financial collections. How much would you be willing to give to this person?

| not at all willing | | | | | | | | totally willing | |
|-----------------------|---|---|---|---|---|---|---|--------------------|--|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

51) How willing would you be to personally assist this person with a small problem?

| not at all willing | | | | | | | | totally willing | |
|-----------------------|---|---|---|---|---|---|---|--------------------|--|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

52) How willing would you be to make a personal contribution of money for this person?

| not at all willing | | | | | | | | totally willing | |
|-----------------------|---|---|---|---|---|---|---|--------------------|--|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

Analysis of Stigmas
73

53) How much anger do you feel toward this person?

| | | | | | | | | | |
|--------------------|---|---|---|---|---|---|---|---|------------------|
| no anger at all | | | | | | | | | totally angry |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

54) How much pity do you feel for this person?

| | | | | | | | | | |
|-------------------|---|---|---|---|---|---|---|---|---------------|
| no pity at all | | | | | | | | | total pity |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

55) How much control did this person have over prevention of this condition?

| | | | | | | | | | |
|---------------|---|---|---|---|---|---|---|---|------------------|
| no control | | | | | | | | | total control |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

56) How much control did this person have over elimination or cure of this condition?

| | | | | | | | | | |
|---------------|---|---|---|---|---|---|---|---|------------------|
| no control | | | | | | | | | total control |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

Lee has developed heart disease. The diagnosis indicates that the disease is due to the patients excessive smoking and high cholesterol diet. If Lee agrees to surgery and a change in diet the condition can be reversed.

57) How much do you blame this person for this condition?

| no blame at all | | | | | | | | totally blame |
|--------------------|---|---|---|---|---|---|---|------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

58) Assume that you are the director of a charity organization and were going to dispense financial collections. How much would you be willing to give to this person?

| not at all willing | | | | | | | | totally willing |
|-----------------------|---|---|---|---|---|---|---|--------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

59) How willing would you be to personally assist this person with a small problem?

| not at all willing | | | | | | | | totally willing |
|-----------------------|---|---|---|---|---|---|---|--------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

60) How willing would you be to make a personal contribution of money for this person?

| not at all willing | | | | | | | | totally willing |
|-----------------------|---|---|---|---|---|---|---|--------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

Analysis of Stigmas
75

61) How much anger do you feel toward this person?

| | | | | | | | | | |
|--------------------|---|---|---|---|---|---|---|---|------------------|
| no anger at all | | | | | | | | | totally angry |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

62) How much pity do you feel for this person?

| | | | | | | | | | |
|-------------------|---|---|---|---|---|---|---|---|---------------|
| no pity at all | | | | | | | | | total pity |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

63) How much control did this person have over prevention of this condition?

| | | | | | | | | | |
|---------------|---|---|---|---|---|---|---|---|------------------|
| no control | | | | | | | | | total control |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

64) How much control did this person have over elimination or cure of this condition?

| | | | | | | | | | |
|---------------|---|---|---|---|---|---|---|---|------------------|
| no control | | | | | | | | | total control |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

Smith is paralyzed from the waist down. Smith was in an automobile accident for which Smith was at fault. If Smith agrees to surgery and physiotherapy functioning can be restored.

65) How much do you blame this person for this condition?

| no blame at all | | | | | | | | totally blame | |
|--------------------|---|---|---|---|---|---|---|------------------|--|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

66) Assume that you are the director of a charity organization and were going to dispense financial collections. How much would you be willing to give to this person?

| not at all willing | | | | | | | | totally willing | |
|-----------------------|---|---|---|---|---|---|---|--------------------|--|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

67) How willing would you be to personally assist this person with a small problem?

| not at all willing | | | | | | | | totally willing | |
|-----------------------|---|---|---|---|---|---|---|--------------------|--|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

68) How willing would you be to make a personal contribution of money for this person?

| not at all willing | | | | | | | | totally willing | |
|-----------------------|---|---|---|---|---|---|---|--------------------|--|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

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69) How much anger do you feel toward this person?

| | | | | | | | | | |
|--------------------|---|---|---|---|---|---|---|---|------------------|
| no anger at all | | | | | | | | | totally angry |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

70) How much pity do you feel for this person?

| | | | | | | | | | |
|-------------------|---|---|---|---|---|---|---|---|---------------|
| no pity at all | | | | | | | | | total pity |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

71) How much control did this person have over prevention of this condition?

| | | | | | | | | | |
|---------------|---|---|---|---|---|---|---|---|------------------|
| no control | | | | | | | | | total control |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

72) How much control did this person have over elimination or cure of this condition?

| | | | | | | | | | |
|---------------|---|---|---|---|---|---|---|---|------------------|
| no control | | | | | | | | | total control |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

Fleming has contracted a sexually transmitted disease. Fleming did not practice safe sex. The condition can be reversed with the administration of penicillin.

73) How much do you blame this person for this condition?

| | | | | | | | | | |
|--------------------|---|---|---|---|---|---|---|---|------------------|
| no blame at all | | | | | | | | | totally blame |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

74) Assume that you are the director of a charity organization and were going to dispense financial collections. How much would you be willing to give to this person?

| | | | | | | | | | |
|-----------------------|---|---|---|---|---|---|---|---|--------------------|
| not at all willing | | | | | | | | | totally willing |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

75) How willing would you be to personally assist this person with a small problem?

| | | | | | | | | | |
|-----------------------|---|---|---|---|---|---|---|---|--------------------|
| not at all willing | | | | | | | | | totally willing |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

76) How willing would you be to make a personal contribution of money for this person?

| | | | | | | | | | |
|-----------------------|---|---|---|---|---|---|---|---|--------------------|
| not at all willing | | | | | | | | | totally willing |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

Analysis of Stigmas
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77) How much anger do you feel toward this person?

| | | | | | | | | | |
|--------------------|---|---|---|---|---|---|---|---|------------------|
| no anger at all | | | | | | | | | totally angry |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

78) How much pity do you feel for this person?

| | | | | | | | | | |
|-------------------|---|---|---|---|---|---|---|---|---------------|
| no pity at all | | | | | | | | | total pity |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

79) How much control did this person have over prevention of this condition?

| | | | | | | | | | |
|---------------|---|---|---|---|---|---|---|---|------------------|
| no control | | | | | | | | | total control |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

80) How much control did this person have over elimination or cure of this condition?

| | | | | | | | | | |
|---------------|---|---|---|---|---|---|---|---|------------------|
| no control | | | | | | | | | total control |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

Appendix C

Introductory Instructions to Subjects

WELCOME:

"Welcome to experiment stlx."

RIGHTS AND OBLIGATIONS:

"As a research participant you have rights and obligations. You have the right to withdraw from an experiment with out loss of the experimental credit if you are experiencing any unreasonable stress.

You also have the obligation to do your best to attend to the task at hand, give true and accurate answers and not bother your neighbors, for example, by talking."

CONCERNING COMPLETION OF THE SESSION:

"Please listen carefully to all instructions so you do this correctly."

"After completing the questionnaire remain in your seat. At the end of the session, I will give you a brief explanation of the experiment and sign your experimental credit cards. We will all leave at the same time."

USING THE IBM SHEETS:

(While passing out the IBM sheets)

"Do not fill in anything on the IBM sheet except as directed to do so in the questionnaire. Examine the sheet closely it is not the same as the sheets you use for your class tests."

"First, there are four sections as indicated on the left side of the sheet. Find sections one and three, we will be using these

2 sections. Second, the numbering is different. The numbers go across the page rather than down the page."

"Indicate your answers on the IBM sheet only. Please do not make any marks on the questionnaire."

(While passing out the questionnaires)

"Do not open the questionnaire yet. We will read the instruction pages and proceed together."

QUESTIONNAIRE INSTRUCTIONS:

(After subjects possess the required materials.)

"Follow along as I read the instructions on page 1 Now find section 3 on your IBM sheet and answer questions 1 and 2 (Assist anyone who has difficulty finding the location designated for answering these demographic questions)."

(Repeat this for page 2 and completing demographic questions 3 - 11. Proceed with page 4 instructions and direct the subjects to section 1 on the IBM sheet. Ask if there are any questions. When questions are answered allow them to proceed with the questionnaire.)

"Please remain in your seats when you are finished. We will collect the materials and answer questions about this research when everyone has finished."

(Tell the subjects how much time they have to complete the questionnaire.)

Appendix D

DEBRIEFING AND FINAL INSTRUCTIONS

AFTER QUESTIONNAIRES ARE COMPLETED:

"Put the IBM sheet inside the front cover of your questionnaire and leave them on your desks."

DEBRIEFING:

"This study applies attribution theory to the study of stigmas. A stigma is anything that marks an individual, anything that determines responses (usually negative responses) to the person. We are using attribution theory to examine emotional and behavioral reactions to stigmatized individuals."

"Your answers on these questionnaires will help us understand how people respond to individuals with the conditions presented."

"Do you have any questions concerning participating in research or about this research in particular?"

(Question and answer time. Participants are encouraged to ask questions concerning the research.)

"Results on this data should be ready in about four months. If you are interested in the results you can approach the researcher at that time and the general results will be made known to you."

ENDING A SESSION:

"Leave your questionnaires with the IBM sheets in them on the front table and bring your experimental credit card up to be signed, then you may leave. THANK YOU for your participation."