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Exploring the Relationship of Social Dominance Orientation, Symbolic Ableism, and Support for Mitigation Implementation with Exposure to a Health Threat

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LOYOLA UNIVERSITY CHICAGO

EXPLORING THE RELATIONSHIP OF SOCIAL DOMINANCE ORIENTATION,
SYMBOLIC ABLEISM, AND SUPPORT FOR MITIGATION IMPLEMENTATION WITH
EXPOSURE TO A HEALTH THREAT

A THESIS SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
MASTER OF ARTS

PROGRAM IN APPLIED SOCIAL PSYCHOLOGY

BY
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Dedicated to my family,
Mom, Dad, Derek, and Hannah.

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ABSTRACT

Social Dominance Theory (Sidanius & Pratto, 1999) proposes that groups of individuals in society are organized in social hierarchies that place dominant groups at the top of the hierarchy and subordinate, disadvantaged groups at the bottom. Research on prejudice, discrimination, and intergroup relations has largely focused on sexism and arbitrary-set hierarchies (e.g., race), leaving the idea of a health hierarchy largely neglected. Recently, Raoul (2023) presented the theoretical framework of a health-based social hierarchy, and the present study is an application of this framework. The aims of this study were to a) replicate previous findings by Raoul (2023) that found significant associations between Social Dominance Orientation (SDO) and symbolic ableism and support for hierarchy-attenuating and hierarchy-enhancing policies, and b) explore the relationship between SDO and support for mitigation implementation, with the prediction that the health threat manipulation utilized in this study could weaken these associations. Participants were recruited online on CloudResearch Connect ($n=391$). Standardized SDO composite scores were significantly associated with all but one outcome measure. In sum, higher SDO was associated with higher symbolic ableism, higher support for hierarchy-enhancing policy, lower support for hierarchy-attenuating policies, lower overall mitigation support, and lower concern for the health of others. Threat condition assignment and the SDO by Threat interaction were not associated with any of the outcomes, indicating that the health threat manipulation was unsuccessful. Finally, symbolic ableism significantly mediated, at least partially, the relationship of SDO on mitigation support. The results of this study provide valuable insight from an ableism and health hierarchy perspective by further supporting the evidence that such a hierarchy exists in society.

INTRODUCTION

The COVID-19 pandemic revealed diverse responses among people in the United States: some attempted to “flatten the curve” and protect others who were especially vulnerable to the virus, whereas some valued foremost their personal freedoms and focused on these freedoms at the expense of others’ health, especially those most vulnerable (e.g., immuno-compromised individuals and those otherwise unwell). One way to understand this difference is through the lens of Social Dominance Theory and the existence of a health-based social hierarchy in which individuals higher on the health hierarchy are allocated more positive social value than those who are lower on the health hierarchy.

Social Dominance Theory proposes that groups of individuals in society are organized in social hierarchies that place dominant groups at the top of the hierarchy and subordinate, disadvantaged groups at the bottom. Examples of social hierarchies are gender and age, with men and adults being the dominant groups in these cases. Other examples include an arbitrary-set hierarchy that varies across societies due to what groups are judged culturally dominant and subordinate. In the United States, an example is the existence of a race hierarchy in which White Americans are considered by society to be at the top of the hierarchy and Black Americans are considered at to be on the bottom.

Recently proposed and previously unaddressed by Social Dominance Theory, is the existence of a health-based hierarchy (Raoul, 2023). The existence of a health-based hierarchy demonstrates ableism in our society in which those individuals with better health outcomes and

access to healthcare are placed at the top of this hierarchy and individuals with lesser health outcomes and access are placed at the bottom.

The purpose of the present study was to apply the theoretical framework of a health-based hierarchy to investigate the potential link between level of Social Dominance Orientation (SDO), a measure of an individuals' support for social hierarchy, and support for others in a health-hierarchy situation. In this study, the outcome of interest was the support for various measures to mitigate the impact of an impending hypothetical airborne pandemic to try to gain insight to some of the phenomena that occurred during the COVID-19 pandemic. Additionally, a health threat manipulation intervention was created as an attempt to influence participants to either experience no threat to their sense of being healthy individuals or to experience a threat to their sense of being healthy individuals depending on their random assignment. The aims of this study were to a) replicate previous findings by Raoul (2023) that found significant associations between SDO and symbolic ableism and support for hierarchy-attenuating and hierarchy-enhancing policies, and b) explore the relationship between SDO and support for mitigation implementation, with the goal that the health threat manipulation utilized in this study could weaken these associations.

Social Dominance Theory

“All human societies tend to be structured as systems of group-based social hierarchies”, and Social Dominance Theory (SDT) proposes that these group-based social hierarchies have at least one each of a dominant group at the top of the hierarchy and subordinate group at the bottom of the hierarchy (Sidanius and Pratto, 1999, p. 31). The dominant group(s) disproportionately possess more positive social value than the subordinate group(s), with classifications of positive social value including wealth, social status, political authority and power, and quality health care. Alternatively, the subordinate group(s) disproportionately possess more negative social value than the dominant

group(s), like low social status, low wealth, low power, negative sanctions such as incarceration, and poor health care. SDT postulates that there are three group-based social hierarchies: an age system, a gender system, and an arbitrary-set system. To illustrate, the age system consists of middle-aged adults having a disproportionately large amount of social power, and in the gender system, men have a disproportionately large amount of social power. The arbitrary-set system is unique from the previously mentioned systems in that it consists of many various socially constructed group distinctions. These group distinctions are much more flexible in terms of what classifies for membership as it differs between societies and can be situational, unlike the age and gender hierarchies which seem to be universal. Additionally, there is often more intensity and scope in terms of the brutality that is experienced within these systems. Finally, arbitrary-set systems only occur in societies in which there is sufficient economic surplus as the surplus provides the opportunity for the development of specialized social roles unlike in hunter-gatherer societies where survival is put above all else. Examples of memberships that would fall under arbitrary-set systems are race, ethnicity, religion, nationality, or “any other socially relevant group distinction that the human imagination is capable of constructing” (Sidanius & Pratto, 1999, p. 33).

With the synthesis of SDT, Sidanius and Pratto (1999) aimed to “identify the various mechanisms that produce and maintain this group-based social hierarchy and how these mechanisms interact” (p. 32). This includes what they describe as hierarchy-enhancing (HE) forces and hierarchy-attenuating (HA) forces. Additionally, they describe legitimizing myths which “consist of attitudes, values, beliefs, stereotypes, and ideologies that provide moral and intellectual justification for the social practices that distribute social value within the social system” (p. 45). There are both HE and HA legitimizing myths. Examples of HE legitimizing myths include the Protestant work ethic and other ideas that suggest that “each individual occupies the position along the social status continuum

that he or she has earned and therefore deserves”, which emphasizes the idea that social hierarchy is “fair, legitimate, natural, and perhaps even inevitable” (p. 46). Whereas HE legitimizing myths are those that exacerbate group-based social inequality, HA legitimizing myths are the opposite in that they promote the opposite: group-based social anti-egalitarianism (Sidanius & Pratto, 1999).

Social Dominance Orientation

Social Dominance Orientation (SDO) is defined as “one’s degree of preference for inequality among social groups” (Pratto et al., 1994). This includes the degree of desire and support the individual feels toward group-based hierarchy “and the domination of ‘inferior’ groups by ‘superior groups” (Sidanius & Pratto, 1999, p. 48). Additionally, SDO is a generalized measure, so, SDO “pertains to whatever group distinctions are salient within a given social context”, and these group distinctions can vary widely due to an infinite amount of “potential distinctions between groups of human beings” (p. 48). SDO likely has direct and pervasive influences on many social ideologies, LMs, and public policies that attenuate and enhance group-based hierarchy which, in turn, impacts group-based hierarchy overall. There is a significant relationship between SDO and an individual’s gender, personality, “temperamental dispositions”, background, socialization factors, and “one’s membership in and identification with arbitrary, highly salient, and hierarchically organized arbitrary-set groups” (Sidanius & Pratto, 1999, p. 49).

Individual levels of SDO have been found to have accurate predictive value within various domains, for example, attitudes toward social ideologies and policies, intergroup behaviors, generalized prejudice among a variety of denigrated groups, and even individuals’ life choices such as whether their job occupation is group-based hierarchy attenuating or enhancing (Pratto et al., 1994; Lee et al., 2011, Ho et al., 2015). In turn, this illustrates the role that SDO has in societal oppression as well as its interaction “with societal and institutional forces to produce and reproduce systems of

social inequality” (Ho et al., 2015). Moreover, the existence of SDO allows for the understanding of a “dynamic model of human oppression” which, in other words, consists of individuals low or high in SDO playing different roles in attenuating or enhancing inequality (Pratto et al., 1994).

While SDO proved to be powerful as a single-dimensional construct, Ho et al. (2012) establishes the two complementary dimensions within SDO, SDO-Dominance (SDO-D) and SDO-Egalitarianism (SDO-E), and provides predictive validity of both of these dimensions. SDO-D is defined as an individual’s “preference for some groups to dominate others” while SDO-E is an individual’s “preference for nonegalitarian group relations”. SDO-D and SDO-E represent different types of prejudice and consequently predict different types of prejudice among individuals. In other words, the bidimensional classification illustrates that aggression and discrimination stem from different aspects of SDO. SDO-D includes old-fashioned racism and aggressive intergroup phenomena, essentially the side of prejudice that is more overt and violent. SDO-E includes more subtle forms of prejudice such as conservatism, legitimizing ideologies such as Protestant work ethic, exclusivity, and opposition to redistributive social policies. SDO-D and SDO-E are strongly correlated to one another but are conceptually distinct constructs. Establishing both dimensions was important to illustrate that both dimensions “predict qualitatively different intergroup phenomena”, thus improving the overall SDO measure (Ho et al., 2012). This research led to the updated and current version of the SDO scale the SDO₇ presented in Ho et al. (2015).

Symbolic Ableism

Social oppression against disabled people, otherwise known as ableism, is extremely salient in our society, and decades of research describe the economic, social, environmental, and psychological disadvantages that impact disabled people due to this oppression (Friedman & Awsumb, 2019). Ableism occurs both overtly and covertly like how prejudice operates in the

oppression of other groups. The field of psychology's research on covert prejudice has largely consisted of the prejudice of people of color and women, however, this literature and its theories can be applied to subtle disability prejudice as it can be identified as a social minority group analogous to those from previous research. Thus, Friedman and Awsumb utilized this opportunity by developing the Symbolic Ableism Scale (SAS). The SAS was adapted from the preexisting Symbolic Racism Scale (SRS), capitalizing on the similarities of subtle prejudice as aforementioned. Symbolic ableism is a focus for this study as it is a fairly new construct that had not been used in conjunction with SDO until recent work by Raoul (2023), where it was found that symbolic ableism and SDO were positively correlated.

A Health Hierarchy

Social dominant and ableist attitudes are both undoubtedly prevalent issues in the United States. A way of understanding these attitudes together is through the lens of a health hierarchy. Recently, Raoul (2023) proposed, what has previously been unaddressed thus far, a theory which establishes an additional arbitrary-set hierarchy of a health-based social hierarchy based on individuals' health and wellness status. Overall, this work garnered evidence supporting a "robust relationship between SDO, health beliefs and attitudes toward sick individuals, suggesting the existence of a social hierarchy based on health". Additionally, results suggest that sick individuals are more likely to experience prejudice and discrimination from those high in SDO, and they are also more likely to experience systemic injustices. The dominant group in this hierarchy consists of those with better health outcomes and access to healthcare than the disadvantaged group. Just as other social hierarchies, it consists of its own set of LMs and hierarchy-enhancing and hierarchy-attenuating forces. Important to note is that even though health outcomes are largely influenced by race and gender in the United States, the health hierarchy still functions and is maintained as its own

hierarchy with intersections of other hierarchies such as race and gender. That is, it was demonstrated that the health hierarchy operates as its own specific hierarchy, and isn't just an application of racial prejudice, for example (Raoul, 2023).

In sum, SDO was found to be negatively related with health-oriented beliefs, health consciousness, and health worry, and positively related with a chance health locus of control, a powerful others health locus of control, and symbolic ableism (Raoul, 2023). Additionally, higher level of SDO predicted higher level of support for HE policies and lower level of support for HA policies (e.g., private versus universal healthcare, respectively). Finally, high level of SDO was related to higher blame and dislike of an unwell target irrespective of health behaviors. In other words, the actual behaviors of the target had no influence on how much dislike or blame someone higher in SDO felt toward a target that had a poor health outcome; simply being sick was all that was needed for the target to be viewed unfavorably regardless of other details regarding the target's health behaviors (Raoul, 2023).

A primary focus for the present study is applying the findings related to SDO being negatively related to health-oriented beliefs; higher levels of SDO were found to be associated with placing lower value on engagement in health behaviors (Raoul, 2023). Based on these findings, it seems individuals with high SDO may have a psychological essentialist view of health. Psychological essentialism is “a belief that people possess an immutable underlying natural essence that makes up who they are, and these characteristics remain stable and are shared amongst all members of a group” (Raoul, 2023; Neufeld, 2022). Additionally, Anna Rosa (2018) found a positive correlation between SDO and pseudo-scientific health beliefs, which may indicate that individuals feel as if their health is not in their control and is simply up to fate (Raoul, 2023). Taking these findings in combination, in terms of personal health beliefs, those high in SDO may tend to think that health

behaviors are not important, do not have an impact on their actual health status, and perhaps possess a feeling of invincibility, which can be applied to the COVID-19 pandemic regarding mitigation implementation such as vaccination, masking, and quarantining to protect the populations who were most vulnerable (Raoul, 2023).

Hypotheses

Empathy Intervention

Raoul (2023) utilized a perspective-taking task intervention aimed to increase empathy among participants as an attempt to decrease blame and dislike of an ill target, which showed to be unsuccessful. These tasks can backfire and be difficult to implement so more research is needed, however, the present study aimed to see if individuals can be influenced in a different type of intervention by using a health threat manipulation.

Masculinity Threat

Fragile masculinity can be defined as a state of “anxiety among males who feel that they are failing to meet cultural standards of masculinity” (DiMuccio & Knowles, 2020). Studies that induce manhood threat, which is essentially “insinuating that the participant is high in femininity”, result in threatened men displaying “a consistent set of physiological, cognitive, attitudinal, and behavioral responses”. These responses include increased “anxiety-related thoughts, aggressive ideation, discomfort and anger, gender-role related stress, higher cortisol levels, cardiac vagal withdrawal” and even “increased justification of social inequality, less support for gender equality, and more benevolent sexism”, among other things. So, in other words, inducing manhood threat “backfires” by causing more masculine behavior such as engaging in more aggressive beliefs and behaviors (DiMuccio & Knowles, 2020).

The present study aimed to see whether inducing a personalized health threat among participants would lead to more engagement in low SDO type thinking, or if it would “backfire” in the same way as masculinity threats do.

Present Study

The present study is an application of the health hierarchy theoretical framework and the ableism and SDO relationship by acting as a complement to the studies conducted in Raoul (2023). I predicted to find evidence for a health threat relationship between high level of SDO and ableism and consequently level of support toward mitigation implementation.

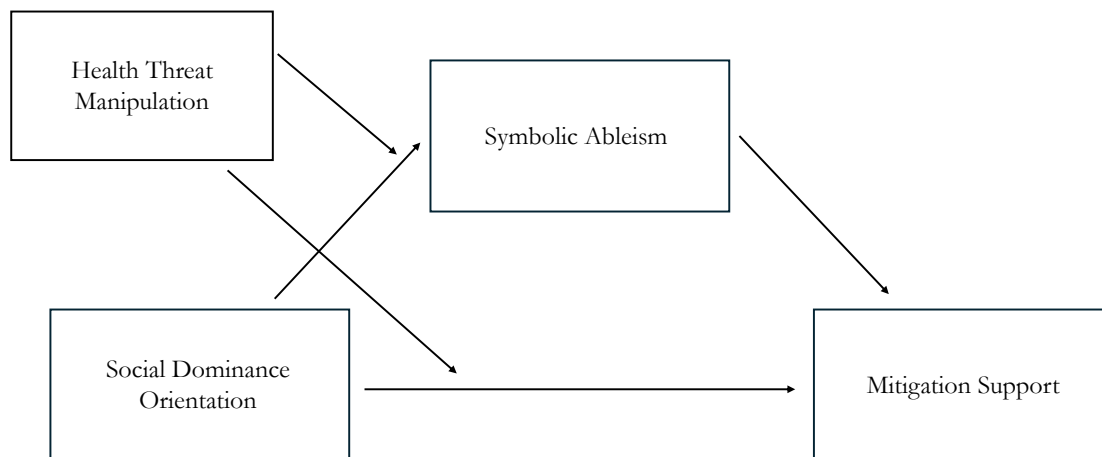
There are several expectations and hypotheses I had for this study. My first hypotheses were that I would replicate findings from Raoul (2023) in that there would be significant associations between SDO and symbolic ableism and health hierarchy-attenuating and hierarchy-enhancing policies. More specifically, I expected that those high in SDO would have significantly higher levels of symbolic ableism than those low in SDO, and those high in SDO would be significantly less supportive of health hierarchy-attenuating policies and significantly more supportive of health hierarchy-enhancing policy than those low in SDO. Additionally, I expected to find a significant association between SDO and the outcome variable of interest in this study: mitigation support. I predicted that those high in SDO would be significantly less supportive of mitigation implementation than those low in SDO.

Next, I predicted that symbolic ableism would mediate the relationship between SDO and support for mitigation implementation; specifically, there would be a positive correlation between SDO and symbolic ableism and a negative association between ableism and mitigation support.

Finally, overall, I expected a significant moderated mediation model. However, there are two possible outcomes that I expected could happen, which I will call the support hypothesis and the

backfire hypothesis. Under the support hypothesis, in the no-threat condition, those high in SDO would display higher levels of symbolic ableism and lower mitigation support. In the threat condition, those high and low in SDO would show similar levels of symbolic ableism and mitigation support. Under the backfire condition, I expected the same pattern as in the no-threat condition above, but a much more pronounced difference in the threat condition. The backfire condition can be compared to the same pattern seen in fragile masculinity (DiMuccio & Knowles, 2020), in which being exposed to a high health threat would actually increase levels of symbolic ableism and decrease levels of support for mitigation implementation.

Figure 1. Hypothesized moderated mediation model.



METHOD

Participants

Four hundred participants were recruited through the online crowdsourcing platform CloudResearch Connect in exchange for one dollar and fifty cents as compensation. Participants had to be at least 18 years of age and live in the United States to be included in the study. After eliminating participants for incomplete data, failed attention checks, and failed manipulation checks, the sample was reduced to three hundred and ninety-one participants. Participants were 71% white, 54.5% male, and had a mean age of 38.04 years ($SD=11.45$). 42.5% of participants held a bachelor's degree and 46.8% thought of themselves as a Democrat.

Instruments

Social Dominance Orientation Scale

Social Dominance Orientation (SDO), “one’s degree of preference for inequality among social groups”, and consequently the SDO scale was first presented by Pratto et al. (1994) as an addition to SDT. They “postulated that there is an important individual difference in general for group domination” leading to the development of SDO. Further, they described that SDO is best described as “a general social-attitudinal orientation or implicit value relevant to intergroup relations”. Additionally, Pratto et al. (1994) distinguishes SDO as a unique construct separate from those that are similar such as interpersonal dominance, conservatism, and authoritarianism during its development. SDO was found to be “a significant predictor of social and political attitudes pertaining to intergroup relations and also of hierarchy roles”. In the validation process, the SDO scale was distributed to 45 samples with 18,741 total respondents from 11 nations (Sidanius &

Pratto, 1999). Ultimately, the sixth version of the scale became the finalized measure. The scale consisted of 16 items rated on a seven-point Likert scale from very negative to very positive, with items 9-16 being reverse coded.

More recently, in Ho et al. (2015), the SDO scale was updated, and now it is the seventh edition of the scale is the most up-to-date version. The seventh edition of the scale moved away from being unidimensional and was adapted to adequately capture the dominance (SDO-D) and egalitarianism (SDO-E) subdimensions of SDO than the previous version of the scale.. Like the previous SDO scale, the updated scale was validated and is “psychometrically sound”. The SDO₇ consists of 16 items rated on a seven-point Likert scale from strongly oppose to strongly favor. There are four items each for the four different constructs of pro-trait dominance, con-trait dominance, pro-trait antiegalitarianism, and con-trait antiegalitarianism. See Appendix A for full scale.

Health Threat Manipulation

The health threat manipulation starts by instructing participants to fill out questions relating to their personal health: “The following questions will assess your health and risk factors that may increase your likelihood of developing a health condition based on new research findings of previously overlooked warning signs. This questionnaire was developed by Harvard Medicine, and we will be using their same scoring system. After answering the questions, you will receive the result of your health assessment in the form of a percentile.” These questions were chosen to be intentionally somewhat obscure and unexpected. For example, “Do you have any plants or animals in your home?”, “Do you take over-the-counter medication when you have a cold?”, and “Do you tend to have chapped lips?”. Questions like these were chosen to try to increase the believability of a participant’s result. In other words, participants are not able to obviously tell if their answer would

be good or bad since it is somewhat obscure. Additionally, I framed the questions as being developed by Harvard Medicine assessing overlooked warning signs based on new research to try to make this manipulation as believable as possible.

After answering the questions, they were randomly assigned a result of either a high or low chance of developing a health condition; this result will have no relation to how the participant answered the questions. The result will be phrased as “Your results show that you are in the top/bottom 20% likelihood of developing a serious health condition, so you are considered to be very high/low risk”. The result included an image of a normal bell curve with an arrow pointing to their respective result to try to evoke a feeling of officiality. This manipulation served to elicit a personalized feeling of threatened health – or the opposite, no threat to their health – within the participant before answering questions relating to symbolic ableism and support for protective initiatives. See Appendix B for complete health threat manipulation materials.

Symbolic Ableism Scale

The Symbolic Ableism Scale (SAS) is presented by Friedman & Awsumb (2019) as a validated measure of subtle prejudice of disabled individuals. Disabled people are still socially devalued, yet no such measure previously existed for measuring implicit attitudes of ableism. Previously, ableism research focused more on overt prejudice. However, in modern day society, prejudice, stereotypes, and discrimination commonly occur both overtly and covertly, with this certainly occurring with ableism in addition to other types of prejudiced attitudes such as racism. With societal progression in social justice issues, people have become more reluctant to display more overt forms of prejudice and discrimination. So, the SAS was developed to prompt further research in the covert prejudice of symbolic ableism.

The development of the SAS was inspired by and an adapted version of the Symbolic Racism Scale (SRS). Symbolic racism describes the more implicit, conservative attitudes individuals hold that they may not even recognize as opposed to explicitly racist ideals. Examples of symbolic racist attitudes include thinking “racial discrimination is no longer a serious issue”, “disadvantaged Black people are just unwilling to take responsibility for their lives”, and “the special treatment of Black people is not justified”. Moreover, the distinction of symbolic attitudes from other attitudes is the expression of “symbols” such as “opposition to busing or opposing affirmative action”.

The SAS items consist of 13 statements such as: “Discrimination against disabled people is no longer a problem in the United States”, “If disabled people would just try harder they would be as well off as nondisabled people”, and “Disabled people are demanding too much from the rest of society”. There are also reverse keyed statements, for example, “It is easy to understand the anger of disabled people in America” and “Hard work offers little guarantee of success for disabled people”. These items are rated by participants on a seven-point Likert scale from strongly disagree to strongly agree. These items touch on the four different themes of individualism, recognition of continuing discrimination, empathy for disabled people, and excessive demands. See Appendix C for full scale.

Support for Mitigation Implementation and Health Hierarchy Policy

Next, the participants were asked to “Imagine there is a new pandemic caused by an airborne respiratory virus with a 5% fatality rate. Select how much you would favor or oppose the implementation of each of the following mitigation initiatives to protect yourself and others by selecting a number 1 to 7 on the scale below.” A list of protective initiatives inspired by mitigation procedures from the COVID-19 pandemic was provided and were ordered from least to most restrictive. Participants were asked to rate each item on a seven-point Likert scale from strongly oppose to strongly favor. The items include do nothing/no intervention, everyone can continue

normally but immunocompromised and vulnerable populations can stay home, everyone can continue normally but immunocompromised and vulnerable populations can have special accommodations, mask mandates, quarantining when symptomatic, quarantining after exposure, vaccine mandates, closing businesses, and stay at home orders for everyone. In addition to these questions, we also asked participants to indicate the level of concern they would feel for others in the scenario of this new pandemic on a seven-point Likert scale.

We also asked the participants to indicate how much they favor or oppose Medicare for all, private health insurance, universal healthcare, and unlimited paid sick leave on a seven-point Likert scale. These questions serve to gauge participant's attitudes toward health hierarchy-enhancing and hierarchy-attenuating policies on a broader level than simply a pandemic scenario. See Appendix D for complete mitigation and health hierarchy support measures.

Procedure

The survey for this study was constructed and distributed via Qualtrics. On CloudResearch Connect, participants were provided an anonymized link to complete the survey. The main sections of the survey completed include, in order, informed consent, the SDO scale, the randomized health threat manipulation, the SAS, an attention check question, questions regarding support for the implementation of protective mitigation initiatives, a manipulation check, demographic information, and a debriefing informing them their health quiz results were randomized and unfounded. Both the SDO scale and SAS had high reliability in this sample, with Cronbach's Alpha values of 0.949 and 0.873, respectively. All analyses were conducted in SPSS after data collection was complete.

RESULTS

Group Assignment, Social Dominance Orientation, and SDO by Threat

Several multiple regression analyses were completed to determine if group assignment, SDO, and SDO by threat interaction were significant predictors of symbolic ableism, both overall mitigation support and support of individual mitigation measures, and support of health hierarchy enhancing and attenuating policies. Before completing these analyses, a standardized Z-score of composite SDO variable and a SDO by Threat variable were created. The SDO by Threat variable was created by multiplying each participant's standardized SDO composite score by the value of their group assignment: -1 for high risk and +1 for low risk.

Predicting Symbolic Ableism

The multiple regression analysis predicting symbolic ableism was significant $F(3, 387) = 49.450, p < 0.001$; overall, the independent variables account for approximately 27.7% of the variance in symbolic ableism as suggested by the R Square value (0.277). However, standardized SDO ($t[387] = 12.017, p < 0.001$) was the only significant predictor of symbolic ableism with a standardized beta weight of $b = 0.526$. Group assignment ($t[387] = -1.035, p = 0.302$) and SDO by Threat interaction ($t[387] = 0.567, p = 0.571$) were not significant predictors of symbolic ableism.

Predicting Mitigation Support

A composite score of mitigation support was created to use for analysis. The nine separate mitigation procedures listed to gauge mitigation support were organized from least restrictive to most restrictive, from do nothing/no intervention to stay at home orders for everyone. Each procedure was given a weight value for its level of restriction, so “do nothing/no intervention” was

given a weight of -4 and “stay at home orders for everyone” was given a weight of +4. Then, each value that participants gave when indicating how much they would favor or oppose the implementation of each procedure on a scale of 1 to 7 was multiplied by the weight value. Finally, the average of all of the new weighted responses was computed to give each participant a composite score to indicate their overall level of mitigation support.

Multiple regression analyses were performed for both the composite score of mitigation support as well as for each separate mitigation procedure to determine if group assignment, SDO, and SDO by Threat were significant predictors of mitigation support. In addition, level of concern for the health of others in the hypothetical pandemic scenario was assessed using the same predictors.

Overall Mitigation Support. The multiple regression analysis predicting overall mitigation support was significant $F(3, 387) = 20.051, p < 0.001$; overall, the independent variables account for approximately 13.5% of the variance in mitigation support as suggested by the R Square value (0.135). However, standardized SDO ($t[387] = -7.511, p < 0.001$) was the only significant predictor of mitigation support with a standardized beta weight of $b = -0.360$. Group assignment ($t[387] = -1.002, p = 0.317$) and SDO by Threat ($t[387] = 0.338, p = 0.736$) were not significant predictors of mitigation support.

Mitigation Measure: Do nothing/No intervention. The multiple regression analysis predicting approval of no intervention was significant $F(3, 384) = 29.743, p < 0.001$; overall, the independent variables account for approximately 18.9% of the variance of approval as suggested by the R Square value (0.189). However, standardized SDO ($t[384] = 9.223, p < 0.001$) was the only significant predictor of approval with a standardized beta weight of $b = 0.430$. Group assignment

($t[384] = 0.587, p = 0.558$) and SDO by Threat ($t[384] = -0.035, p = 0.972$) were not significant predictors of approval of no intervention.

Mitigation Measure: Everyone can continue normally, but immunocompromised and vulnerable populations can stay home. The multiple regression analysis predicting approval of allowing vulnerable populations to stay home was significant $F(3, 387) = 4.799, p = 0.003$; overall, the independent variables account for approximately 3.6% of the variance of approval as suggested by the R Square value (0.036). However, standardized SDO ($t[387] = 3.490, p < 0.001$) was the only significant predictor of approval with a standardized beta weight of $b = 0.176$. Group assignment ($t[387] = 0.944, p = 0.346$) and SDO by Threat ($t[387] = -1.028, p = 0.305$) were not significant predictors of approval of allowing vulnerable populations to stay home.

Mitigation Measure: Everyone can continue normally, but immunocompromised and vulnerable populations can have special accommodations. The multiple regression analysis predicting approval of allowing vulnerable populations to have special accommodations was not significant $F(3, 387) = 0.574, p = 0.633$. Standardized SDO ($t[387] = 1.095, p = 0.274$), group assignment ($t[387] = -0.301, p = 0.764$) and SDO by Threat ($t[387] = -0.821, p = 0.412$) were not significant predictors of approval of allowing vulnerable populations to have special accommodations.

Mitigation Measure: Mask mandates. The multiple regression analysis predicting approval of mask mandates was significant $F(3, 387) = 26.833, p < 0.001$; overall, the independent variables account for approximately 17.2% of the variance of approval as suggested by the R Square value (0.172). However, standardized SDO ($t[387] = -8.713, p < 0.001$) was the only significant predictor of approval with a standardized beta weight of $b = -0.408$. Group assignment ($t[387] = -$

0.929, $p = 0.353$) and SDO by Threat ($t[387] = 0.065$, $p = 0.948$) were not significant predictors of approval of mask mandates.

Mitigation Measure: Quarantining when symptomatic. The multiple regression analysis predicting approval of symptomatic quarantining was significant $F(3, 387) = 18.283$, $p < 0.001$; overall, the independent variables account for approximately 12.4% of the variance of approval as suggested by the R Square value (0.124). However, standardized SDO ($t[387] = -7.302$, $p < 0.001$) was the only significant predictor of approval with a standardized beta weight of $b = -0.352$. Group assignment ($t[387] = -0.309$, $p = 0.758$) and SDO by Threat ($t[387] = 0.355$, $p = 0.723$) were not significant predictors of approval of symptomatic quarantining.

Mitigation Measure: Quarantining after exposure. The multiple regression analysis predicting approval of quarantining after exposure was significant $F(3, 386) = 25.893$, $p < 0.001$; overall, the independent variables account for approximately 16.8% of the variance of approval as suggested by the R Square value (0.168). However, standardized SDO ($t[386] = -8.580$, $p < 0.001$) was the only significant predictor of approval with a standardized beta weight of $b = -0.404$. Group assignment ($t[386] = -1.021$, $p = 0.308$) and SDO by Threat ($t[386] = 0.755$, $p = 0.451$) were not significant predictors of approval of quarantining after exposure.

Mitigation Measure: Vaccine mandates. The multiple regression analysis predicting approval of vaccine mandates was significant $F(3, 385) = 17.344$, $p < 0.001$; overall, the independent variables account for approximately 11.9% of the variance of approval as suggested by the R Square value (0.119). However, standardized SDO ($t[385] = -7.077$, $p < 0.001$) was the only significant predictor of approval with a standardized beta weight of $b = -0.343$. Group assignment ($t[385] = -0.446$, $p = 0.656$) and SDO by Threat ($t[385] = 0.177$, $p = 0.860$) were not significant predictors of approval of vaccine mandates.

Mitigation Measure: Closing businesses. The multiple regression analysis predicting approval of closing businesses was significant $F(3, 387) = 13.276, p < 0.001$; overall, the independent variables account for approximately 9.3% of the variance of approval as suggested by the R Square value (0.093). However, standardized SDO ($t[387] = -6.237, p < 0.001$) was the only significant predictor of approval with a standardized beta weight of $b = -0.306$. Group assignment ($t[387] = -0.183, p = 0.855$) and SDO by Threat ($t[387] = 0.351, p = 0.726$) were not significant predictors of approval of closing businesses.

Mitigation Measure: Stay at home orders for everyone. The multiple regression analysis predicting approval of stay at home orders was significant $F(3, 386) = 13.716, p < 0.001$; overall, the independent variables account for approximately 9.6% of the variance of approval as suggested by the R Square value (0.096). However, standardized SDO ($t[386] = -5.909, p < 0.001$) was the only significant predictor of approval with a standardized beta weight of $b = -0.290$. Group assignment ($t[386] = -1.688, p = 0.092$) and SDO by Threat ($t[386] = -0.136, p = 0.892$) were not significant predictors of approval of stay at home orders.

Level of Concern for the Health of Others. The multiple regression analysis predicting level of concern for the health others in the given pandemic scenario was significant $F(3, 387) = 28.030, p < 0.001$; overall, the independent variables account for approximately 17.9% of the variance of concern as suggested by the R Square value (0.179). However, standardized SDO ($t[387] = -8.943, p < 0.001$) was the only significant predictor of concern with a standardized beta weight of $b = -0.417$. Group assignment ($t[387] = 0.276, p = 0.783$) and SDO by Threat ($t[387] = -0.850, p = 0.396$) were not significant predictors of level of concern for the health of others.

Predicting Support of Health Hierarchy Enhancing and Attenuating Policies

Medicare for All. The multiple regression analysis predicting support for Medicare for all was significant $F(3, 386) = 43.440, p < 0.001$; overall, the independent variables account for approximately 25.2% of the variance in support as suggested by the R Square value (0.252). However, standardized SDO ($t[386] = -11.362, p < 0.001$) was the only significant predictor of support with a standardized beta weight of $b = -0.507$. Group assignment ($t[386] = 1.326, p = 0.186$) and SDO by Threat ($t[386] = 0.185, p = 0.853$) were not significant predictors of support for Medicare for all.

Universal Healthcare. The multiple regression analysis predicting support for universal healthcare was significant $F(3, 384) = 40.803, p < 0.001$; overall, the independent variables account for approximately 24.2% of the variance in support as suggested by the R Square value (0.242). However, standardized SDO ($t[384] = -10.859, p < 0.001$) was the only significant predictor of support with a standardized beta weight of $b = -0.489$. Group assignment ($t[384] = 1.309, p = 0.191$) and SDO by Threat ($t[384] = -0.886, p = 0.376$) were not significant predictors of support for universal healthcare.

Unlimited Paid Sick Leave. The multiple regression analysis predicting support for unlimited paid sick leave was significant $F(3, 387) = 29.945, p < 0.001$; overall, the independent variables account for approximately 18.8% of the variance in support as suggested by the R Square value (0.188). However, standardized SDO ($t[387] = -9.188, p < 0.001$) was the only significant predictor of support with a standardized beta weight of $b = -0.423$. Group assignment ($t[387] = -1.369, p = 0.172$) and SDO by Threat ($t[387] = 0.113, p = 0.910$) were not significant predictors of support for unlimited paid sick leave.

Private Health Insurance. The multiple regression analysis predicting support for private health insurance was significant $F(3, 386) = 10.759, p < 0.001$; overall, the dependent variables

account for approximately 7.7% of the variance in support as suggested by the R Square value (0.077). However, standardized SDO ($t[386] = 5.613, p < 0.001$) was the only significant predictor of support with a standardized beta weight of $b = 0.278$. Group assignment ($t[386] = -0.028, p = 0.978$) and SDO by Threat ($t[386] = 0.025, p = 0.980$) were not significant predictors of support for private health insurance.

The Trust and Agreement of Health Assessment Results Based on Group Assignment

Due to group assignment not being a significant predictor of symbolic ableism, mitigation support, or support of health hierarchy enhancing and attenuating policies, an independent samples t-test was completed to determine if trust and agreement of participants' health assessment results were significantly different based on their random assignment condition of high or low risk, as this could be an explanation as to why the manipulation was unsuccessful. In other words, this analysis aimed to determine how much participants valued and believed their health assessment result depending on their group assignment to see if this varied significantly between the two groups.

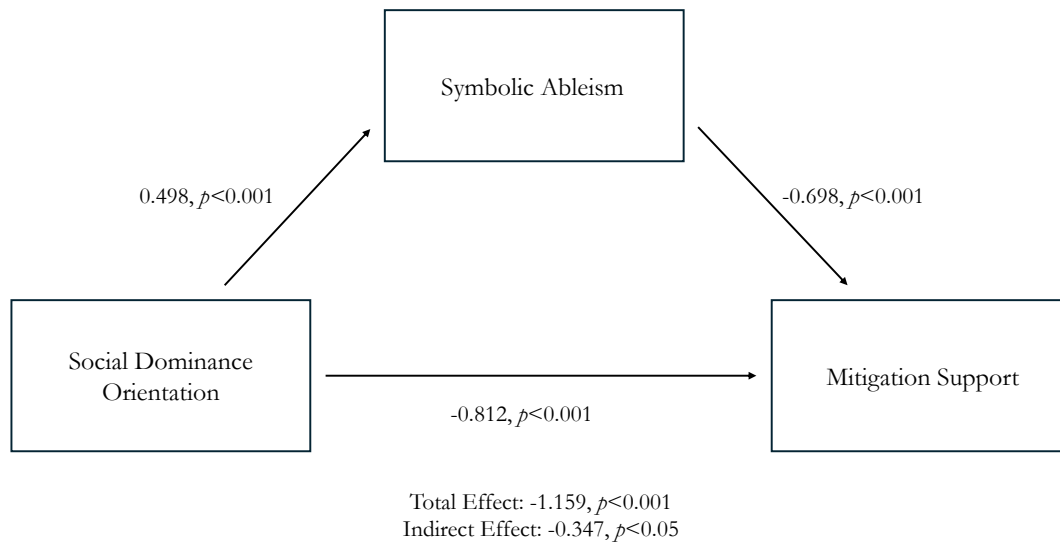
Group assignment was found to have significant main effects on average trust and average agreement. Participants assigned to the low risk condition agreed more with their health assessment results ($M = 4.70, SD = 1.618$) than did those assigned to the high risk condition ($M = 2.81, SD = 1.514$), $t(383) = -11.814, p < 0.001, d = -1.205$. Participants assigned to the low risk condition had more trust in their health assessment results ($M = 4.02, SD = 1.726$) than did those assigned to the high risk condition ($M = 2.52, SD = 1.459$), $t(375) = -9.017, p < 0.001, d = -0.930$.

Symbolic Ableism as a Mediator of Social Dominance Orientation on Mitigation Support

Following Hayes' PROCESS Procedure via bootstrapping using the SPSS Macro, the effect of SDO on mitigation support mediated by symbolic ableism was analyzed using the PROCESS mediation Model 4 with 5,000 bootstrap samples (Figure 2). Like the multiple regression analyses,

the standardized composite Z-score of SDO variable and the mitigation support composite score variable were used for this analysis. Results of this analysis indicated that symbolic ableism significantly mediated, at least partially, the relationship of SDO on mitigation support; the indirect effect coefficient was -0.3474 and the 95% Confidence Intervals were [-0.5502, -0.1476] indicating that the indirect effect is significant since zero is not contained within the range of the CIs.

Figure 2. Results of symbolic ableism as a mediator of SDO on mitigation support.



DISCUSSION

This study aimed to explore the influence of a health threat manipulation on attitudes toward mitigation support and its interactions with Social Dominance Orientation (SDO) and symbolic ableism. The primary goals of this study were to gather more evidence to contribute to the establishment of a health-based social hierarchy as posited by Raoul (2023) and to test a threat manipulation as a moderator of SDO on symbolic ableism and mitigation support. Raoul (2023) tested an empathy manipulation to attempt to decrease blame and dislike of an ill target which was unsuccessful, so a threat manipulation was chosen in this study as an attempt to change participants' attitudes utilizing a different approach. Overall, I originally predicted a significant moderated mediation model based on the findings of Raoul (2023) and other research encompassing Social Dominance Theory; my hypothesis was that for participants high in SDO, when exposed to the threat condition, would have significantly different levels of symbolic ableism and mitigation support as compared to those high in SDO not exposed to the threat. I expected that, among those high in SDO, the threat condition would either a) decrease symbolic ableism and increase mitigation support or b) cause a backfire effect, increasing symbolic ableism and decreasing mitigation support. I also predicted to find main effects of SDO on symbolic ableism and mitigation support, and a significant mediation model in which there would be a positive correlation between SDO and symbolic ableism and a negative association between ableism and mitigation support.

Unfortunately, the health threat manipulation was not successful in changing participants' attitudes toward mitigation implementation support as intended. This likely occurred because those who were assigned to the high health threat condition did not find their randomized health

assessment result to be trustworthy or in agreeance with their personal belief of their risk; both of these factors were rated significantly lower as compared to those who were assigned to the low health threat condition. Thus, it would seem to be expected that the manipulation group assignments would not influence the participants in a substantial way. This result is not entirely surprising and can be explained generally by motivated reasoning in which one interprets information in a self-serving way, as well as interpreting health information more specifically (Sherman et al., 2000). Health information, especially when this information is aimed to increase perceptions of personal risk, can result in defensiveness and resistance to acceptance in order to protect one's self-image; this still tends to occur even if the health information in question has high personal relevance to the individual receiving this information (Sherman et al., 2000).

Due to the manipulation being nonsignificant in its associations, the hypothesized moderated mediation model was not able to be analyzed. Even though the manipulation was unsuccessful, the results from this study still provide valuable information from an ableism and health hierarchy standpoint to further the literature on this topic; the results support the evidence of the existence of a health-based social hierarchy and are consistent with previous findings. The results also provided insight to some of the phenomena that occurred during the COVID-19 pandemic.

Symbolic ableism significantly mediated, at least partially, the relationship of SDO on mitigation support. Additionally, there were significant associations of SDO on symbolic ableism, overall mitigation support, eight out of nine mitigation measures, level of concern for the health of others in a pandemic scenario, and support for health hierarchy attenuating and enhancing policies. Higher levels of SDO were associated with higher levels of symbolic ableism, lower levels of overall mitigation support, lower concern for the health of others in a pandemic scenario, and lower support for hierarchy-attenuating policies and higher support for hierarchy-enhancing policy. For

the individual mitigation measures, higher levels of SDO were associated with lower support for mask mandates, quarantining when symptomatic, quarantining after exposure, vaccine mandates, closing businesses, and stay at home orders for everyone. Conversely, higher levels of SDO were associated with higher support of doing nothing and allowing everyone to continue normally but vulnerable populations can stay home.

Limitations and Future Directions

A clear limitation of this study is that the manipulation was unsuccessful in that participants did not seem to be convinced of the health assessment result truly applying to them, especially when assigned to the high risk condition. The actual cause is unknown, but it is likely that participants were motivated to protect their self-image by resisting the threatening health information; this could have been a large contributing factor to the lack of success of the manipulation.

Another limitation of this study is that even though symbolic ableism was found to be a significant mediator of SDO on mitigation support, we cannot assume causation due to the methods used in this study. In other words, we can assume that symbolic ableism is associated with these factors, but we cannot determine a true direction or cause of this relationship. Nonetheless, linking symbolic ableism to these constructs is valuable knowledge in regard to supporting the evidence of the existence of a health-based social hierarchy.

Moving forward, either utilizing an entirely new type of intervention or restructuring the already attempted empathy or threat interventions could potentially result in a successful manipulation. For example, Sherman et al. (2000) found that pairing threatening health messages with self-affirmation increased acceptance of the health message, so perhaps utilizing a similar method could have made the manipulation in this study more successful. Testing interventions in this research area could shed light on how to increase support of vulnerable populations and

members placed low on the health hierarchy, which would be valuable information in the event of a new health emergency as well as for pursuits to decrease ableism and health-based prejudice and discrimination.

Coda

Research on prejudice, discrimination, and intergroup relations has largely focused on sexism and arbitrary-set hierarchies (e.g., race), leaving the idea of a health hierarchy largely neglected. Recently, Raoul (2023) presented the foundation of a health-based social hierarchy. The results of the present study add to the evidence of a health hierarchy and provide insight to attitudes influencing ableism that have been overlooked in past research and theory. This study found significant links of Social Dominance Orientation to symbolic ableism, health hierarchy-attenuating and hierarchy-enhancing policies, and support for others in a health-hierarchy influenced situation. More specifically, it provided insight to the various responses that were seen during the COVID-19 pandemic in the United States. Although more work is necessary to understand the complete functioning of the health hierarchy, the results of this study further indicate that such a hierarchy exists.

APPENDIX A

SOCIAL DOMINANCE ORIENTATION (SDO₇) SCALE

Instructions: Show how much you favor or oppose each idea below by selecting a number from 1 to 7 on the scale below. You can work quickly; your first feeling is generally best.

1	2	3	4	5	6	7
Strongly oppose	Somewhat oppose	Slightly oppose	Neutral	Slightly favor	Somewhat favor	Strongly favor

Pro-trait dominance:

1. Some groups of people must be kept in their place.
2. It's probably a good thing that certain groups are at the top and other groups are at the bottom.
3. An ideal society requires some groups to be on top and others to be on the bottom.
4. Some groups of people are simply inferior to other groups.

Con-trait dominance:

5. Groups at the bottom are just as deserving as groups at the top.
6. No one group should dominate in society.
7. Groups at the bottom should not have to stay in their place.
8. Group dominance is a poor principle.

Pro-trait anti-egalitarianism:

9. We should not push for group equality.
10. We shouldn't try to guarantee that every group has the same quality of life.
11. It is unjust to try to make groups equal.
12. Group equality should not be our primary goal.

Con-trait anti-egalitarianism:

13. We should work to give all groups an equal chance to succeed.
14. We should do what we can to equalize conditions for different groups.
15. No matter how much effort it takes, we ought to strive to ensure that all groups have the same chance in life.
16. Group equality should be our ideal.

Note: The con-trait items should be reverse-scored before computing a composite scale mean

APPENDIX B

HEALTH THREAT MANIPULATION

Instructions: The following questions will assess your health and risk factors that may increase your likelihood of developing a health condition based on new research findings of previously overlooked warning signs. This questionnaire was developed by Harvard Medicine, and we will be using their same scoring system. After answering the questions, you will receive the result of your health assessment in the form of a percentile.

1. When do you usually have your largest meal of the day?

- Morning
- Midday
- Evening

2. What has been your average bedtime in the last six months?

- Before 8 p.m.
- Between 8 p.m. & 11p.m.
- After 11 p.m.

3. How often have you taken post-lunch naps on average in the last six months?

- Rarely
- Sometimes
- Often

4. How often do you take over-the-counter medication when you have a cold?

- Rarely
- Sometimes
- Often

5. What has your average mood been like in the last six months?

- Cheerful
- Content
- Irritable
- Gloomy

6. What is your typical form of transportation?

- Public Transit
- Car
- Walking/Biking

7. Do you live in a city, suburb, or rural area?

- City
- Suburb
- Rural area

8. What is the climate like where you live?

- Tropical
- Dry
- Temperate
- Continental

9. Do you have any plants or animals in your home?
Plants
Animals
Both
Neither
10. Do you suffer from colds more than once a year?
Yes
No
11. How often do you feel tired or exhausted?
Rarely
Sometimes
Often
12. Do you regularly take medication?
Yes
No
13. How often do you spend time outdoors?
Rarely
Sometimes
Often
14. Do you tend to have chapped lips?
Rarely
Sometimes
Often
15. Do you have a diagnosed health condition of any kind?
Yes
No
16. How often do you have contact with a lot of people?
Rarely
Sometimes
Often
17. How often are you exposed to stressful situations?
Rarely
Sometimes
Often
18. If you experience symptoms for a week or more, do you visit a doctor?
Rarely
Sometimes

Often

19. How often do you urinate in a day, on average?

Less than 4 times in a day

4-8 times in a day

More than 8 times in a day

20. How often do you defecate in a day, on average?

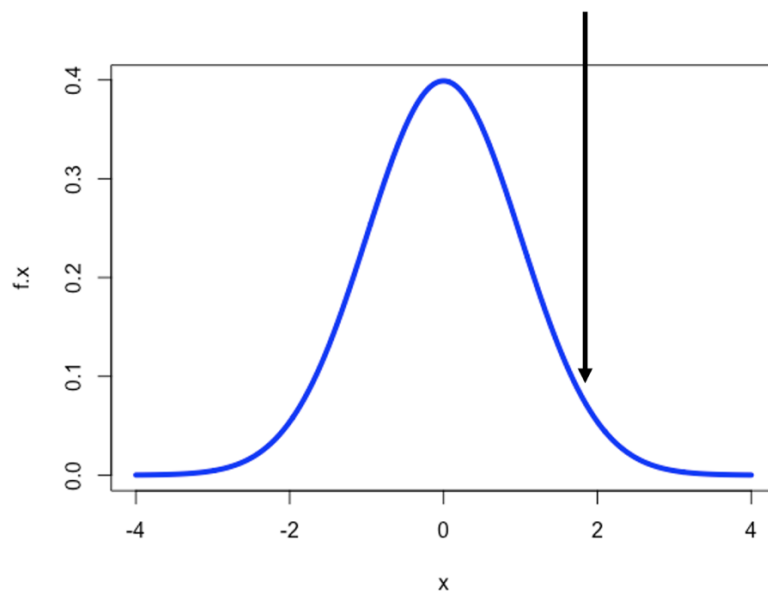
0-1 times in a day

2-3 times a day

More than 3 times a day

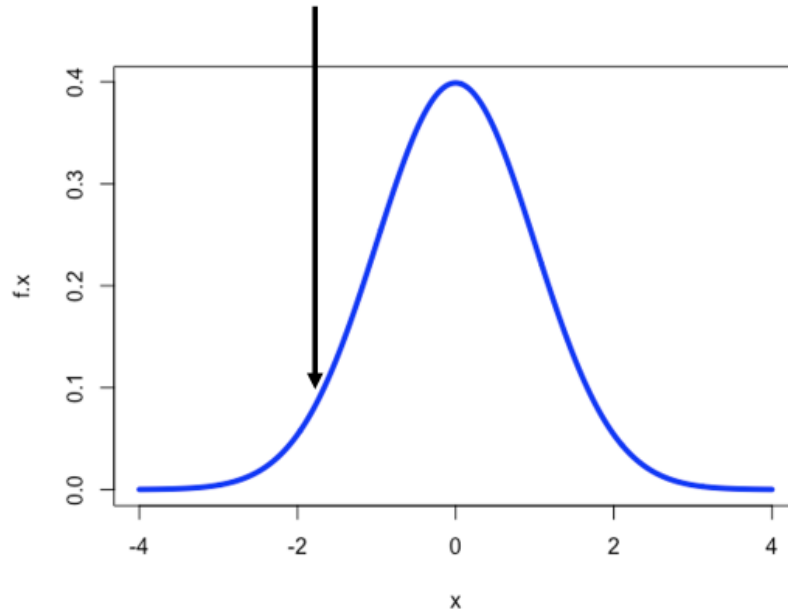
High Risk Condition Result

Your results show that you are in the top 20% likelihood of developing a serious health condition, so you are considered to be **very high risk**.



Low Risk Condition Result

Your results show that you are in the bottom 20% likelihood of developing a serious health condition, so you are considered to be **very low risk**.



APPENDIX C
SYMBOLIC ABLEISM SCALE

Instructions: Show how much you agree or disagree with each statement below by selecting a number 1 to 7 on the scale below.

1	2	3	4	5	6	7
Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree

1. Even if disabled people try hard they often cannot reach their goals. (Reverse keyed)
2. Even if disabled people are ambitious they often cannot succeed. (Reverse keyed)
3. If disabled people work hard they almost always get what they want.
4. Hard work offers little guarantee of success for disabled people. (Reverse keyed)
5. Any disabled person who is willing to work hard has a good chance of succeeding.
6. Discrimination against disabled people is no longer a problem in the United States.
7. If disabled people would just try harder, they would be as well off as nondisabled people.
8. Disabled people are demanding too much from the rest of society.
9. Disabled people should stay hidden.
10. Most disabled people who don't get ahead should not blame the system; they really have only themselves to blame.
11. Over the past few years disabled people have gotten less than they deserve. (Reverse keyed)
12. It is easy to understand the anger of disabled people in America. (Reverse keyed)
13. Disabled people complain too much about their situation in society.

APPENDIX D

MITIGATION AND HEALTH HIERARCHY SUPPORT MEASURES

Instructions: Imagine there is a new pandemic caused by an airborne respiratory virus with a 5% fatality rate. Select how much you would favor or oppose the implementation of each of the following mitigation initiatives to protect yourself and others by selecting a number 1 to 7 on the scale below.

1	2	3	4	5	6	7
Strongly Oppose	Somewhat Oppose	Slightly Oppose	Neutral	Slightly Favor	Somewhat Favor	Strongly Favor

1. Do nothing/No intervention
2. Everyone can continue normally, but immunocompromised and vulnerable populations can stay home
3. Everyone can continue normally, but immunocompromised and vulnerable populations can have special accommodations
4. Mask mandates
5. Quarantining when symptomatic
6. Quarantining after exposure
7. Vaccine mandates
8. Closing businesses
9. Stay at home orders for everyone

Instructions: Select how much you favor or oppose each of the following by selecting a number 1 to 7 on the scale below.

1	2	3	4	5	6	7
Strongly Oppose	Somewhat Oppose	Slightly Oppose	Neutral	Slightly Favor	Somewhat Favor	Strongly Favor

1. Medicare for All
2. Universal Healthcare
3. Private Health Insurance
4. Unlimited Paid Sick Leave

APPENDIX E
OTHER SURVEY MEASURES

Attention Check Question

Instructions: The next question is an attention check. Select the answer “purple” to continue the survey.

The bananas are:

Yellow
Purple
Green
Red

Manipulation Check Questions

Instructions: On a scale of 1-7, how much do you agree with your health assessment result? 1 being definitely don’t agree, 7 being definitely agree.

Definitely don’t agree			Moderately agree		Definitely agree	
1	2	3	4	5	6	7

Instructions: On a scale of 1-7, how much do you trust with your health assessment result? 1 being definitely don’t trust, 7 being definitely trust.

Definitely don’t trust			Moderately trust		Definitely trust	
1	2	3	4	5	6	7

Instructions: What was your result on your health assessment?

Low risk
Medium risk
High risk

Demographic Questions

Instructions: Select your preferred gender identity (select however many apply).

Female
Male
Nonbinary
Genderqueer/androgynous
Genderfluid
Intersex
Transgender
Transsexual
FTM (female-to-male)
MTF (male-to-female)
Prefer not to answer
Other _____

Instructions: Select your racial/ethnic identity (select however many apply).

White
Black or African American
American Indian or Alaska Native
Asian
Native Hawaiian or Pacific Islander
Hispanic or Latino/a/e
Other _____

Instructions: Do you think of yourself as a Republican, a Democrat, an Independent, or something else?

Republican
Democrat
Independent
Other _____
No preference

Instructions: Where would you place yourself on this scale if 1 is extremely liberal and 7 is extremely conservative?

Liberal				Moderate				Conservative				
1		2		3		4		5		6		7

Instructions: What is your highest level of completed education?

Some High School
High School Degree or Equivalent
Some College
Associate's Degree
Bachelor's Degree
Graduate Degree

Instructions: What is your age in years?

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VITA

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