THE EFFECT OF GROUP STATUS ON MORAL RELATIVISM AND THE STIGMATIZATION OF MENTAL ILLNESS: A SOCIAL DOMINANCE THEORETICAL MODEL

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This dissertation created a model to be used to explore the effect of dominant group status on stigmatization of mental illness and moral relativism, and the interactive effect of dominant group status on stigmatization of mental illness through moral relativism. The model was conceptualized according to social dominance theory. Latent variables were created to measure moral relativism and stigmatization of mental illness. The latent measures were conceptualized according to current theories in the fields of moral relativism and stigmatization. During statistical analyses the latent measure for moral relativism was found to be unreliable. The study then became confirmatory-exploratory in nature by first comparing the fit indices of three alternate models with single-measure latent variables. The model that best fit the data was then used to conclude the exploratory research on the effect of group status on moral relativism and stigmatization of mental illness. The model was not supported by the data based on fit index and standardized residual scores.
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CHAPTER 1
INTRODUCTION

The goal of this dissertation was to develop a model based on social dominance theory that would explain the effect a respondent’s societal group status has on moral relativism and on stigmatization of mental illness, and to assess the interactive effects of group status and moral relativism on the stigmatization of mental illness. A conceptual model was created to include four sociodemographic variables (race, gender, education, and region) to measure group status, the latent construct of moral relativism, and the latent construct of stigmatization of mental illness. The conceptual model was tested through structural equation modeling, which is appropriate for testing theoretical models that contain latent variables such as moral relativism and stigmatization of mental illness, and for estimating directional relationships between variables.

Statement of Problem

Individuals with mental illness not only suffer the symptoms of their disorder but must also battle the effects of being stigmatized by society. The oppressive results of stigmatization include: exclusion from the rest of society; limited access to resources; reduced level of autonomy; limited access to housing and employment; lack of medical care; and institutionalization in psychiatric or penal facilities (Lawrie, 1999; Link & Phelan, 2001; Corrigan and Shapiro, 2010; Corrigan & Watson, 2002).
Academic literature heavily documents the stigmatization associated with mental illness. Most recent studies reaffirm that even with efforts to reduce the stigma, it still exists and is prevalent in society (Couture & Penn 2003; Graham, Elaine, Aliya & Elanor, 2008; Parcesepe & Cabassa, 2012; Pescosolido, Martin, Long, Medina, Schnittker, 2008; Phelan, Link, Stuve, & Pescosolido, 2000; Watson, Ottati, & Corrigan, 2003). Many Americans are frequently wrong about the cause of mental illness (Martin, Pescosolido & Tuch, 2000; Pescosolido et al., 2010; Schnittker, 2008) and characterize individuals with mental illness as being dangerous (Corrigan, Markowitz, Watson, Rowan & Kubiak, 2003; Martin et al., 2000). Most Americans favor a degree of social distance from individuals with mental illness thus creating another stigmatizing factor (Corrigan, Edwards, Green, Diwan, & Penn, 2001; Martin et al., 2000; Pescosolido, et al, 2010).

Some studies focus on the characteristics of those who stigmatize mental illness. For example, men (Corrigan & Watson, 2007) and people who scored high in narcissistic personality traits (Arikan, 2005) were more likely to stigmatize individuals with mental illness. On the contrary, agreeableness and openness to new experiences predicted a lesser degree of stigmatization of people with mental illness (Brown, 2012).

A recent study by Bizer, Hart, and Jekogian (2012) examined the concepts of belief in a just world, social dominance orientation, negative attitudes about mental illness and self-reported intent to discriminate against people with mental illness. The authors created and empirically supported a causal model in which belief in a just world impacts social dominance orientation, which then impacts negative attitudes about mental illness, which finally impacts intent to discriminate against individuals with mental
illness. The authors state that although research has already established that belief in a just world and social dominance orientation separately can predict prejudice against individuals with mental illness, they were the first to empirically test this link and the first to test the assumptions of social dominance theory as they apply to stigmatization of mental illness.

Like belief in a just world, moral relativism is a personality trait often considered to be a worldview (Emerson, 1996). The term moral relativism describes the rejection of any absolute moral truths, and decision making based on situations independently, without consideration of stereotypes or prejudices (Quintelier & Fessler 2012). Research has shown that most Americans tend to have a perspective of moral relativism (Dawson-Tunik & Stein, 2004; Rigney & Kearl, 1994) and that moral relativism is increasing in the population (Dawson-Tunik & Stein, 2004). Correlations have been found between moral relativism and: gender (Skitka, 2010), political ideology (Rigney & Kearl, 1994; Skitka, 2010) and political candidate support (Iyer, Graham, Koleva, Ditto, & Haidt, 2010).

Moral relativism is theoretically and empirically inversely associated with a desire to require all members of society to adhere to a set standard of rules and norms (Lammers & Stapel, 2009). Individuals who deviate from the norms of society are seen by non-relativists as a threat to its structure. A person with low levels of moral relativism is more likely to oppress a subordinate group who deviates from the norm, such as those with a mental illness, to prevent them from changing the societal structure and to reduce their access to society’s resources (Lammers & Stapel, 2009; Quintelier & Fessler, 2012; Wong, 1984). Research has found that a dominant, more powerful
position in society is positively correlated with a level of moral reasoning that demands a stricter obedience to societal rules (Lammers & Stapel, 2009).

The theoretical framework for this dissertation was based on social dominance theory which is often used in the study of subordinate groups (Sidanius, Deveraux & Pratto, 1992) and was created intently for the purpose of explaining oppression in society and answering why oppression is so difficult to eradicate (Sidanius & Pratto, 1999). By integrating elements of seven different theories, social dominance theory examines inequality of groups in society from individual and structural levels and can be utilized by researchers in many previously unrelated fields of study (Sidanius et al., 1992). The theory is general enough that it can be applied across cultures, historical eras, and varying types of conflicts (Sidanius et al., 1992). The theory identifies the dynamic processes that create and maintain group based inequality so that modifications can be thoughtfully designed to instill equality (Sidanius, Pratto, van Laar & Levin, 2004).

Statement of Purpose

This study created a model that analyzed the stigmatization of mental illness by looking at it from a structural level (group status), and an individual level (moral relativism). It then tested the model of this interaction based on social dominance theory.

The theoretical model represented the effect of group status on moral relativism and on the stigmatization of mental illness, and then the effect of group status on
stigmatization of mental illness through moral relativism. A conceptualized model was most appropriate for this type of study which aimed to integrate multiple-level latent and observed variables and then present the results in a manner that most clearly illustrated the comprehensive scope of the research (Bizer et al., 2012). This model was intended to add to the understanding of how group-based social hierarchy influences moral relativism and the stigmatization of mental illness.

Previous studies have already found that a respondent’s dominant group status in society predicts a positive correlation with his or her stigmatization of mentally ill individuals (Bizer et al., 2012) and a negative correlation with a perspective of moral relativism (Lammers & Stapel, 2009). Knowing how a person’s position of dominance interacts with his or her level of moral reasoning, and then affects the stigmatization of mental illness, can provide new insight into the pervasiveness of the problem.

Significance of Study

Though similar to the recent study by Bizer et al. (2012), this study differed by using group status as indicated by sociodemographics instead of a measure of social dominance orientation. According to theory and empirical studies, a significant correlation exists between group status and social dominance orientation. Members of dominant groups are more likely to have a social dominance orientation (Sidanius & Pratto, 1999). The use of sociodemographics as indicators of group membership not only further expanded on current understanding, but knowledge of these
sociodemographics could have real-world benefits when a social dominance orientation measure is not practical.

If supported, this dissertation’s theoretical model would add to the findings of the previous Bizer et al. (2012) study by revealing that group status has an effect on a worldview type of personality trait (moral relativism) and on stigmatization of mental illness and, that a worldview type of personality trait (moral relativism) affects the relationship between group status and stigmatization of mental illness. The result of the combination of group status and moral relativism is even more important when considering that most public moral decisions are made in situations of unequal power distribution (teacher/pupil, judge/defendant, doctor/patient, etc.) and that the combination of the characteristics of dominance and moral relativism can affect a person’s impartiality (Lammers & Stapel, 2009).

Practically, it was hoped that any information gained from this dissertation would add to efforts to de-stigmatize mental illness. The ultimate goal in studying social dominance should be to reveal that subordination exists, so that it may be corrected (Sidanius & Pratto, 2011)

General Research Questions

1. What is the direct effect of group status on moral relativism?
2. What is the direct effect of group status on stigmatization of mental illness?
3. What is the indirect effect of group status on stigmatization of mental illness through moral relativism?
Summary

Stigmatization of mental illness is a consistent and widespread problem in society. Through the creation of a theoretical model based on social dominance theory, this dissertation tested the effect group status has on moral relativism and on stigmatization of mental illness; and also the interactive indirect effect of group status and moral relativism on the stigmatization of mental illness.

Chapter 2 presents a literature review of the main components of this dissertation. A background in social dominance theory describes the theoretical basis for this research. Reviews of stigmatization of mental illness and of moral relativism provide a more in-depth scope of the endogenous variables that were studied as well as conceptual definitions of moral relativism and stigmatization that were used to create the measurement indices. Chapter 2 introduces the conceptual model and hypotheses used in the study.

Chapter 3 explains the research process that was used for this study. The dataset is described and all endogenous and exogenous variables are identified. The construction of the latent variables, moral relativism and stigmatization of mental illness, are explained and the index variables identified. The final section of this chapter gives a detailed description of the analytic design that was used to conduct the research.

Chapter 4 describes the data analysis portion of the dissertation. The data was analyzed with univariate statistics, bivariate statistics, multivariate statistics and structural equation modeling. Any statistical problems that were identified during the study and their resolutions are explained in this section. Finally, the results of the
structural equation modeling are evaluated according to how well the model is supported by the data.

Chapter 5 discusses the findings of the study. Hypotheses are examined as to whether they were supported by the data and practical implications of the study results are discussed. Limitations of the study are described. Suggestions are made for future research based on the results of this study. Finally, a short summation of the dissertation is presented.
CHAPTER 2
REVIEW OF RELATED LITERATURE

Research regarding stigmatization of mental illness is plentiful in academic literature in the social sciences, particularly sociology. Moral relativism, while not widely represented, is also found in social science research. In their study, which is similar to this dissertation, Bizer et al. (2012) repeatedly asserted that no previous studies examined a social dominance theoretical model of predicting stigmatization of mental illness, with the introduction of a mediating personality variable. The present study tested a similar model of social dominance theory and the stigmatization of mental illness with the introduction of the personality variable moral relativism. Moral relativism is the perspective that no absolute principles of right and wrong exist, but that every situation must be judged individually. Moral relativism is an element of moral reasoning and an indicator of how a person makes judgments and decisions. This chapter presents an overview of the existing academic literature on social dominance theory, stigmatization of mental illness and moral relativism.

Social Dominance Theory

Social dominance theory is a modern addition to the field of social conflict theories. In sociology, conflict theories focus on the divisiveness within a society rather than on a society’s unity and cooperation. Conflict theorists believe divisions in society are caused by the differential distribution of resources, power, authority, status, etc.
(Collins, 1994). Social dominance theory only applies to societies which have an excess of resources. The basis of the theory is that individuals and groups compete for these resources; when one group attains a disproportionately large amount of the resources, they are then able to use this power to dominate subordinate groups and to create a hierarchical social structure. To maintain this group based hierarchy, the dominant group establishes social institutions that function to uphold the hierarchical structure that keeps the dominant group in power.

 Origins

 Social psychologists Jim Sidanius and Felicia Pratto (1999), after arguing that there was a lack of a comprehensive theory of societal conflict, stereotyping, and oppression, created social dominance theory as a model to explain discrimination and inequality in society. The theory was designed with the intent to answer two questions thought to be important to social science: 1.) Why do members of societal groups oppress and discriminate against members of other societal groups? 2.) Why are oppression and discrimination so difficult to eradicate in a society (Sidanius & Pratto, 1999)?

 Sidanius and Pratto (1999) felt that while previous theories had provided a means to examine individual elements of societal hierarchy and discrimination, what was needed was an integrated theoretical model that would encompass components from each theory. Their theoretical framework combined the individual, group, institutional and structural levels of analysis (Sidanius & Pratto, 1999). While the theoretical model integrates components of multiple levels of analysis, most of the work
in social dominance theory is from a psychological social psychology perspective. The creators of the theory are both psychologists and most studies of social dominance theory are published in academic journals that have a perspective of psychological social psychology. Social dominance theorists published an article in 2004 to respond to critics of social dominance theory. Criticisms included the assertion of psychological reductionism accusing the theory of reducing every phenomena of society to strictly psychological components (Sidanius et al., 2004).

This study will apply a sociological perspective to social dominance theory in the analysis of stigmatization of mental illness. The sociological variables of sociodemographics will be included in the hypothetical model instead of a personality variable such as social dominance orientation. Social dominance theory, as it was created, is a preferable framework for this model according to the stipulations of the theory that oppression occurs at all levels of society and the different levels interact and reinforce each other to uphold the hierarchical structure of society and continue to keep subordinate groups oppressed. Social dominance theorists conclude that it is this interaction that makes it so difficult to eradicate the oppression of subordinate groups (Pratto et al 1994).

Hierarchies

The basic premise of social dominance theory is that societies are organized into group-based hierarchies with at least one dominant group at the top of the hierarchy and at least one subordinate group at the bottom. In social dominance theory the resources in a society are referred to as positive social values and negative social
values. Positive social values are the materials and symbolic resources a society’s members strive to attain. Examples of positive social values are: high social status, political power, wealth, protection, good housing, good education, good healthcare, etc. Negative social values are resources that are not desirable. Examples of negative social values are: stigmatization, subordination, poverty, disproportionate punishment, poor housing, poor education, poor healthcare, etc. (Pratto, Sidanius & Levin, 2006; Sidanius & Pratto, 1999). The dominant group at the top of the hierarchy possesses a disproportionately greater amount of society’s positive social values and the lower subordinate groups possess a disproportionately larger amount of society’s negative social values.

According to social dominance theory, three hierarchical systems stratify groups in society. The first system is an age system in which older members have dominance over younger members of society. The second system is a gender system in which male members in society are dominant over females. The third hierarchical system is an arbitrary-set system. In the arbitrary-set system, groups are distinguished according to socially constructed characteristics such as ethnicity, religion, region, caste, etc. (Sidanius & Pratto, 1999).

**Social Dominance Orientation**

In social dominance theory, prejudice and discrimination against subordinate groups perpetuate the hierarchical stratification within society. Discrimination is believed to be a part of human nature and while it creates inequality between groups in a society, it also provides dominant groups with the means to survive in times of limited resources.
Historically when resources were not plentiful enough to sustain all of a society, the unequal distribution by the dominant group helped to guarantee that group’s survival (Ratele, 2006).

At the individual level, social dominance theory assesses a person’s desire to sustain the hierarchical domination of one group over subordinate groups. Sidanius and Pratto (2011) refer to this individual characteristic as an individual’s social dominance orientation (SDO). SDO is an attitude toward group relations and a desire to protect the hierarchical structure of society rather than equal relations between groups (Pratto, Sidanius, Stallworth & Malle, 1994). A person with a high SDO is more likely to support hierarchy enhancing legitimizing myths in order to sustain the societal structure. Theoretically, the higher a person’s SDO, the more discrimination he or she will exhibit toward subordinate groups. A person’s own group membership affects his or her level of discriminatory behavior as membership in a dominant group correlates with higher levels of discrimination (Ratele, 2006).

Individuals are guided by their social dominance orientation when they choose which roles they take on in society. Those with a high social dominance orientation assume roles in institutions that allow them to actively perpetuate the oppression of subordinate groups. Individuals with low social dominance orientation choose roles that allow them to promote equality (Pratto et al., 1994).

Social dominance orientation has been correlated with many other individual characteristics and traits. People with high SDO are more likely to be male, Republican, politically and economically conservative, racist and sexist (Pratto et al., 1994). They
are less likely to support gay rights, women's rights, social welfare programs and environmental programs (Pratto et al., 1994).

*Legitimizing Myths*

A dynamic system of mechanisms exists within society that creates and maintains the group-based hierarchy and its inequalities (Sidanius & Pratto, 1999). One such mechanism is the legitimizing myth which is a value, attitude, belief, causal attribution or ideology that is accepted by society and serves to justify either social hierarchy or social equality (Sidanius & Pratto 1999). Legitimizing myths can be either hierarchy-enhancing or hierarchy-attenuating. Hierarchy-enhancing legitimizing myths explain and justify inequalities in society as being moral, just, and necessary. These legitimizing myths promote and perpetuate the hierarchical structure by shaping individual, group and institutional levels of society (i.e. racism, sexism, stereotypes, ‘fate’, nationalism, etc.). Hierarchy-attenuating legitimizing myths contradict hierarchy-enhancing myths and promote group-based equality (i.e. egalitarianism, socialism, humanism, feminism, etc.) (Pratto et al., 2006). Social dominance theory proposes that members of dominant groups are more supportive of hierarchy-enhancing legitimizing myths than hierarchy-attenuating legitimizing myths, and members of subordinate groups are more supportive of hierarchy-attenuating legitimizing myths than hierarchy-enhancing legitimizing myths (Pratto et al., 2006).

Hierarchy-enhancing legitimizing myths function to maintain the hierarchical structure of society and perpetuate the oppressed status of subordinate groups. Because they control the institutions within society, the dominant group is able to
manipulate and disseminate these myths and therefore facilitate the discrimination of subordinate groups (Ratele, 2006). The more the legitimizing myth is accepted by society, the more effective it is. This is referred to as the myth’s power of potency (Sidanius & Pratto, 1999), and when a legitimizing myth is broadly accepted across society, its influence is even stronger and it becomes known as a self-accepted truth (Jackman, 1994).

A legitimizing myth’s power of potency can be influenced by several things. A person with a high social dominance orientation, and therefore a strong desire for domination over subordinate groups, will have a stronger belief in hierarchy-enhancing legitimizing myths. A person with a low social dominance orientation will have a stronger belief in hierarchy-attenuating legitimizing myths. It is the desire for domination and the pervasiveness of hierarchy-enhancing legitimizing myths that create and maintain the stigmatization and oppression of subordinate groups.

**Behavioral Asymmetry**

In addition to legitimizing myths, the group-based hierarchy system is also established and sustained by behavioral asymmetry. Behavioral asymmetry refers to the behavioral exchanges between dominant and subordinate group members that result in better outcomes for the dominant group members (Pratto et al., 2006). There are three major types of behavioral asymmetry: asymmetrical in-group bias, self-debilitating behaviors among subordinates and ideological asymmetry (Pratto, Sidanius & Levin, 2006). Social dominance theory asserts that in addition to the dominant group
oppressing the subordinate group, the subordinate group will sometimes behave in ways that sustain its own oppression (Sidanius & Pratto, 1999).

Asymmetrical in-group bias is the tendency for dominant group members to have stronger in-group bias than subordinate group members. The stronger the legitimizing myths that justify the hierarchical structure of society, the stronger the in-group bias will be for dominant group members. In some instances, asymmetrical in-group bias develops into out-group bias with subordinate group members favoring the dominant group (Pratto et al., 2006). An example of this comes from a study which found that among people who perceive America to be fair and just, members of the White dominant group have stronger in-group bias than do members of subordinate minority groups. Among people who perceive America to be unfair and unjust, members of minority subordinate groups have stronger in-group bias than do members of the White dominant group (Sidanius & Pratto, 1999).

Self-debilitation describes self-destructive and in-group-damaging behaviors. Subordinate group members are significantly more likely to engage in self-debilitation than dominant group members. Examples of destructive behaviors include high rates of: crime, violence, substance abuse and school drop-outs (Pratto et al., 2006). Fueled by the acceptance of legitimizing myths which are often widely known stereotypes in a society, these behaviors can become self-fulfilling prophecies. One study revealed that when the stereotype of women having weaker math skills than men is presented to a group of test-takers, women will score lower than equally qualified men; they also will score lower than equally qualified women who are not presented with the stereotype prior to testing (Spencer, Steele & Quinn, 1999).
Ideological asymmetry describes an important phenomenon in social dominance theory in which individuals with a social dominance orientation who are members of dominant social groups are more likely to support hierarchy-enhancing legitimizing myths than individuals with a social dominance orientation who are members of subordinate social groups. Even though the theory states that a person with a social dominance orientation will be more likely to support hierarchy-enhancing myths and less likely to support hierarchy-attenuating myths, the individual’s group membership in a dominant or subordinate group will have an effect on his or her support for legitimizing myths. The influence of social dominance orientation therefore, is not symmetrical across social groups (Lalonde, Giguère, Fontaine, & Smith, 2007). A study of attitudes about interracial dating (a hierarchy-attenuating practice) found that there is a negative correlation between SDO and support for interracial dating among White dominant group members, but there is no correlation between SDO and support for interracial dating among non-White subordinate group members. These results indicate that in some instances subordinate group membership has a stronger impact on attitude and desire to preserve the hierarchical system than social dominance orientation (Lalonde et al 2007)

**Oppression**

Social dominance theory was developed for the purpose of explaining group based oppression. Its creators believed the answers to oppression are found in the hierarchical structure of society (Sidanius et al, 2004). Once a group is on the top of the hierarchy it is in their best interest to protect and maintain the hierarchical structure to
preserve their dominant position (Sidanius et al, 2004). Legitimating the hierarchical structure and maintaining the status quo in society motivates dominant group members to oppress subordinate groups. Many social dominance theorists assert that stigmatization, racism, sexism, and ethnic prejudices are all tools with which oppression of subordinate groups are legitimized and the hierarchical structure of society is maintained (Crocker et al, 1998; De Oliveira, & Dambrun, 2007; Pratto et al, 1994; Sidanius & Pratto, 1999).

Stigmatization begins with a differentiating characteristic between the individual inflicting the stigma and its recipient. Theories of stigmatization question why certain characteristics are singled out and stigmatized while so many other differentiating characteristics are ignored (Link & Phelan, 2001). Qualities such as eye color, hair color and food preference are usually overlooked as irrelevant, but skin color, gender, and sexual preference are among those characteristics that are often stigmatized (Link & Phelan, 2001). To answer the question of why some differentiating qualities are stigmatized and some are not, social dominance theory looks at the potential threat these differences could pose to the hierarchical structure of society and the distribution of resources (Sidanius & Pratto, 1999).

Social dominance theory asserts that oppressive characteristics of each level of society work together reinforcing each other so that subordinate groups are oppressed by the structure of society as a whole; consequently, the subordinate group’s access to positive social values is limited (Pratto et al, 1994). Individuals with mental illness are considered an out-group who compete with other groups in society for positive social values (Bizer et al. 2012). The stigma of mental illness creates and maintains the
discrimination against mentally ill individuals in society (Link & Phelan, 2001). Elements of stigmatization such as negative stereotypes, prejudice, and discrimination result in less funding allocated to mental health research and medical services. This lack of funding leaves individuals with inadequate care compared to members of society without a diagnosis of mental illness (Link & Phelan, 2001). In addition to inadequate medical care, individuals with mental illness also possess disproportionately high amounts of other negative social values such as poor housing (Corrigan, Larson, Watson, Barr & Boyle, 2006), lack of employment, and segregation (Corrigan & Shapiro, 2010).

A person with a social dominance orientation is theorized to be more likely to have prejudiced attitudes and discriminate against out-groups (Pratto et al., 1994). Empirical studies support this theory, finding that people with high SDO are more likely to exhibit elements of stigmatization including negative stereotyping (Aquino, Steward & Reed, 2005), prejudice (De Oliveira & Dambrun, 2007; Duckitt, 2001) and discrimination (Sidanius, Pratto, & Mitchell, 1994) and to have a strong desire to maintain the status quo of society’s hierarchy (Sidanius & Pratto, 1999). Since the characteristics of SDO serve to legitimize the hierarchical group based structure of society, this stigmatization then becomes the tool with which this legitimation is achieved (Aquino, Steward & Reed, 2005; Jost & Banaji, 1994).

Few studies have examined social dominance theory as it applies to mentally ill members of society. Bizer et al. (2012) referenced the lack of research regarding this relationship in their study as they justify their hypothesis based on theoretical assumptions and previous empirical results regarding other subordinate groups (Bizer
et al. 2012). Earlier studies have found people with a high SDO more likely to be racist and sexist (Pratto et al., 1994) and more likely to oppose gay rights, women’s rights, social welfare programs and environmental programs (Pratto et al., 1994). A study published in 2007 tested the process of stigmatization against people who have a mental illness (Phelan & Basow, 2007). The study did not have a social dominance theoretical perspective but did use an SDO scale to measure a respondent’s desire to be separated from out-groups. This study found SDO to correlate with a desire for social distance from people with mental illness (Phelan & Basow, 2007). Bizer et al. (2012) state that their study found individuals with SDO are more likely to have negative attitudes toward mental illness, and that theirs is the first to empirical test the relationship between social dominance theory and mental illness stigmatizations.

Stigmatization of Mental Illness

Stigma is best known in the field of sociology by the writings of Erving Goffman (1963) who used the term to describe an attribute that makes a person less desirable. Goffman described three forms of stigmatization: abominations of the body, blemishes of individual character, and stigmas of race, nation and religion. Mental illness falls within the second category which includes abnormal behavioral and personality patterns (Goffman, 1963). Stigmatization causes individuals to fear, reject, and discriminate against people with mental illness (Corrigan & Penn, 1999) and results in the individual being excluded from the rest of society; having a reduced level of autonomy; having limited access to housing and employment; receiving inadequate medical care; and
institutionalization in psychiatric or penal facilities (Corrigan and Shapiro, 2010; Corrigan & Watson, 2002; Graham et al, 2008 Lawrie, 1999; Link & Phelan, 2001). Of those in psychiatric and penal facilities, it is not uncommon for the purpose of their incarceration to be social control instead of therapeutic (Corrigan & Watson, 2002). Despite efforts to reduce the stigmatization of mental illness, research repeatedly reveals that it still exists and is prevalent in society (Couture & Penn 2003; Graham et al., 2008; Parcesepe & Cabassa, 2012; Pescosolido et al, 2010; Phelan et al, 2000; Schnittker 2008; Watson et al, 2003).

**Conceptual Definition**

Link and Phelan (2001) argued that the concept of stigma had become vague and presented a comprehensive conceptualization that encompasses its multidisciplinary concepts and is more sociological in nature. They conceptualized stigmatization as the concurrent effect of negative stereotypes and labels, marginalization, loss of status and discrimination. Following this interpretation, Corrigan and Watson (2002) conceptualized stigma as having three components: ignorance/stereotype, prejudice, and discrimination. This conceptualization has been adopted by many other researchers in the study of stigma (Angermeyer & Matschinger 2003; Corrigan & Shapiro, 2010; Graham et al., 2008; Martin & Johnston 2007). For the purpose of this dissertation, this three-component conceptual definition was used to define stigmatization. Ignorance/stereotype was assessed as the belief that mental illness is caused by an individual's own bad character; prejudice was assessed as the
belief that a person with a mental illness is dangerous, and discrimination was assessed as a respondent’s desire for social distance from a person with a mental illness.

Ignorance

Ignorance refers to the lack of accurate and factual knowledge about a stigmatizing condition. Characterizations based on ignorance often turn into stereotypes which are representations used as a reference point when thinking about members of a particular group (Corrigan & Shapiro 2010; Corrigan & Watson 2002). Stereotypes are a form of legitimizing myth known by most members of a society and are used as an efficient means of categorizing information about social groups (Watson et al. 2003). A common stereotypical misconception in society is what causes mental illness. Research shows that many Americans are frequently wrong about the cause of mental illness (Martin et al., 2000; Pescosolido et al., 2010; Schnittker, 2008) This dissertation studied the stereotype that mental illness is caused by an individual’s bad character.

A value held by many in society is the concept of individual responsibility. Attributing mental illness to one’s bad character implies that a person’s condition is within his or her control and holds them personally responsible for his or her own behavior. When mental illness is attributed to genetic or biological causes, the individual is not judged as being responsible for his or her own actions (Weiner, 1995). Judgment that an individual suffers from depression because he or she is lazy is an example of attributing mental illness to bad character. This person is more likely to be held responsible for his or her actions and stigmatized by society than someone who has a mental illness attributed to a biological impairment or traumatic brain injury (Watson et
al, 2005). The stereotype that mental illness is caused by a person’s own bad character can apply to all forms of mental illness, and its support shows very little change over time. According to 1996 data, bad character was blamed for depression 38% of the time and schizophrenia 31% of the time (Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999). Ten years later, respondents were found to blame bad character for depression 32% of the time and schizophrenia 31%, of the time (Pescosolido et al., 2010; Schnittker, 2008).

Prejudice

Jussim, McCauley and Lee (1995) assert that an awareness of a stereotype does not always denote that one agrees with it. They argue that while most people in a society are aware of stereotypes about different groups, not all people accept those stereotypes as true. Prejudice is the acceptance of these stereotypes and an emotional response that shapes an individual’s attitude and judgment toward members of a particular group (Devine, 1989; Hilton & von Hippel, 1996). Prejudice is judgment that goes beyond ignorance of facts and encompasses a negative emotional reaction such as anxiety, fear, hostility, disgust, etc. (Graham et al, 2008).

One such prejudicial judgment is that people who have a mental illness are dangerous. This prejudice is a legitimizing myth that incites feelings of fear in those who believe it (Corrigan et al., 2003). The belief that individuals with mental illness are prone to violence and dangerous is a common prejudice, and research reveals the pervasive acceptance of it among the general public (Link et al. 1999; Martin et al. 2000; Phelan et al 2000). Research has also found that this particular prejudice has increased over time.
One study found that 70% of respondents viewed people with serious mental illness as dangerous (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). According to studies, belief that a person with mental illness is dangerous is an extremely strong emotional motivator leading to further discriminatory action. When individuals perceive a person with mental illness to be a dangerous threat to others, they are more likely to want greater social distance (Corrigan et al, 2001) and be in favor of forced treatment (Corrigan et al., 2003). Furthermore, when the perception of dangerousness exists, endorsement of coercive measures is stronger with the intent not being therapeutic but rather as a form of social control (Watson et al, 2003).

**Discrimination**

The third component of stigmatization is the behavioral aspect of discrimination (Crocker, Major & Steele, 1998). Discrimination is a negative action toward members of a particular group that affects their opportunity for employment, housing, healthcare, socialization, etc. (Graham et al., 2008). Studies have found that people with mental illness are more likely to have a difficult time finding housing (Lawrie, 1999; Link & Phelan, 2001) and are less likely to find employment (Lawrie, 1999; Link & Phelan, 2001).

Because the data used in this dissertation is from an existing survey, it is impossible to measure a respondent’s actual behavior. This study used a measure of a respondent’s self-reporting of his or her likelihood to discriminate against a person with mental illness by avoiding social contact. Studies have revealed that reduced opportunities for socialization exist from the perspective of the individual with mental
illness and the members of society who discriminate against him or her. Studies of individuals with mental illness have found that 60% of them reported feeling rejected or avoided at times (Couture & Penn, 2003), and studies of the general population have found that the majority of respondents wish to avoid social interaction with people with mental illnesses (Corrigan et al. 2001; Link et al. 1999; Martin et al. 2000; Pescosolido et al, 2010). One study found that despite programs to reduce stigmatization, the preference for social distance had not changed from 1996 to 2006 and that the number of respondents unwilling to have someone with a mental illness as a neighbor had actually increased during this time period (Pescosolido et al, 2010).

Moral Relativism

Moral relativism is a perspective of moral reasoning that holds that there is no set of absolute values that can be applied to judge all situations (Pinch, 2008) and that judgments should be reasoned according to the relative context of the situation (Harman, 2012). While some theories of morality argue for consistent basic moral principles (i.e. do not steal, do not harm others, keep your promises, help those who need help, etc.) or for a single principle from which moral rules are derived, (i.e. the Golden Rule), moral relativism discounts the idea of any infallible moral rules that are applicable universally (Harman, 2012). Moral relativists reason that there are multiple frames of reference that determine if something is right or wrong, good or bad, just or unjust (Harman, 2012) and that moral norms are never absolute but are relative to time
and place (Lukes, 2008). Moral relativists have been described in the literature as moralizers, who assess issues from an ideologically neutral perspective (Skitka, 2010).

The perspective of moral relativism involves a cognitive reasoning of all the contributing elements of a specific situation (Lupfer, Cohen, Bernard & Brown, 2001). Developmental theorist Lawrence Kohlberg (1969) analyzed the process by which individuals make moral judgments. Kohlberg created a model of moral development in which he conceptualized three levels of moral reasoning: pre-conventional, conventional and post-conventional. The pre-conventional level is characterized by obedience to moral authority. The conventional level involves adherence to social rules and order. Finally, at the post-conventional level, reasoning is used to judge according to moral and ethical principles of individuals and specific situations (Kohlberg, 1969).

**Conceptual Definition**

Empirical studies of moral relativism are not abundant in academic literature. No agreement exists upon definition or measurement of moral relativism, but most empirical studies include overlapping components. The present study used a three-dimensional schematic definition of moral relativism created by Quintelier and Fessler (2012) which included a relative belief in right and wrong, acceptance of personal variations in moral standards, and tolerance of behaviors that conflict with one’s own moral value system. As is the case with most theory and research of moral relativism, there are overlapping dimensions with this construct and other definitions used in previous studies. One such sociological study by Emerson (1996) examined moral relativism as it intervenes between religion and attitudes toward abortion. In his
publication, Emerson explained that moral relativism is defined in many different ways theoretically and empirically, but he asserted that the underlying notions of all the differing definitions and terminologies are describing the same concepts. Among the concepts he believed are found in every definition for moral relativism are the presence or absence of absolute standards of right and wrong and the variation of moral standards from person to person. In another study, sociologists Rigney and Kearl (1994) sought to develop a map of the prevalence of moral relativism in America. Like Emerson (1996), Rigney and Kearl (1994) also acknowledge the multitude of definitions for moral relativism and the concepts they encompass. Their conceptual definition of moral relativism was created through analysis of theories of the societal and individual progression and development of moral reasoning. These theories were examined to support their two-dimensional concept of moral relativism made up of a relative definition of right and wrong and definitions of morality varying from person to person (Rigney and Kearl, 1994).

Quintelier and Fessler (2012), whose three-dimensional schematic definition is used in this dissertation, premised their publication with a critique of current theoretical and empirical work on moral relativism. They describe a disconnect between theory and research caused by theorists underutilizing the empirical data in theory creation and researchers not applying the theoretical distinctions that define moral relativism to their studies. The authors sought to bridge the gap between theories of moral relativism and empirical studies by addressing the problem and by introducing a working definition of moral relativism they believe adequately encompasses the variety of concepts related to it. Three components comprise their definition: right and wrong, scope, and tolerance.
The first component refers to the belief that right and wrong are relative to an individual’s moral view. The second component, scope, is the acknowledgement of variations in moral views. Tolerance, the final component, is the absence of regulation of others’ behaviors.

Right and Wrong

Quintelier and Fessler’s (2012) first dimension, that right and wrong are not the same universally but are dependent on personal viewpoints, is also found in other studies of moral relativism. Emerson (1996) included the belief in relative values of right and wrong as one of his dimensions of moral relativism. Rigney and Kearl (1994) consider this variable to be the primary concept in their two-dimensional scale of moral relativism. They provide theoretical explanations for this dimension on societal and individual levels. On the societal level, Rigney and Kearl (1994) compare the dimension of right and wrong to Emile Durkheim’s ([1893] 1995) concept of anomie. According to Durkheim, as societies modernize and become more densely populated the moral order of the society also changes. Mechanical solidarity, characterized by strong communal bonds based in family, church and community, gives way to organic solidarity in which members of society do not have strong bonds to their communities. Organic solidarity leads to a condition called anomie in which there is no longer a coherent moral order in society (Durkheim, [1893] 1995) Rigney and Kearl (1994) believe anomie relates to their dimension of moral relativism in which right and wrong are not determined by a strong moral order but are relative to the situation. On an individual level, Rigney and Kearl (1994) and Quintelier and Fessler (2012) describe the theories of key moral
developmental theorists who all attribute the highest levels of moral maturity to an individual’s acceptance of relative standards of right and wrong (Kohlberg, 1969; Perry, 1968; & Gilligan, 1982). Rigney and Kearl (1994) illustrate the concept of a relative perception of right and wrong with phrases in American culture such as: “Who’s to say what’s right or what’s wrong,” “What’s right for you may not be right for me” and “It’s all relative. There are no absolutes.” (p. 24). They believe phrases such as these represent this perspective of moral relativism.

Scope

Scope, the second dimension of moral relativism, describes the acceptance of variations of moral values from person to person (Quintelier & Fessler, 2012). The variation of moral values is found in other studies as an element of moral relativism (Emerson, 1996). It is also the second dimension of Rigney and Kearl’s (1994) two-dimensional definition. Again, the authors analyze this dimension from societal and individual theoretical perspectives. On a societal level, the authors compare this dimension of moral relativism to Durkheim’s ([1893] 1995) theory of modernization. According to Durkheim, the lack of a cohesive moral order in organic solidarity leads to a condition called egoism in which society’s members, because they no longer have a shared standard of moral values, must rely on themselves and their own resources for moral judgments (Durkheim [1893] 1995). On an individual level, the loss of a cohesive moral order and the resulting egoism causes moral value systems to be motivated by
Rigney and Kearl (1994) describe a moral relativist as a person who agrees that
morality is a personal matter.

*Tolerance*

Tolerance, the third dimension of moral relativism, implies that the variations in
moral views cannot be eliminated, regulated or punished. A relativist observer will not
be motivated to stop or regulate the action, or desire that the actor be punished, even if
the behavior goes against the observer’s own moral values (Quintelier & Fessler, 2012).
The concept of tolerance is included as one of the dimensions of Emerson’s (1996)
conceptual definition of moral relativism. The concept of punishing individuals who
break moral rules is the basis for Kohlberg’s (1969) pre-conventional level of moral
reasoning. In the first two stages of his theory of development, children classify
behaviors as right or wrong according to which behaviors are punished and which
behaviors are rewarded. At the lowest levels of moral maturity an absolute application of
punishment for moral transgressions is made without consideration of the particular act
relative to individual and situation (Kohlberg, 1969). Rigney and Kearl (1994) purport the
importance of tolerance to moral relativism believing it to be crucial on a societal level
where it is required for differing cultures to coexist. They go on to say that tolerance is a
necessary component for morally relativist judgments which require individuals to be
tolerant and respectful of differing views (Rigney & Kearl, 1994).

Quintelier and Fessler (2012) provide an example that encompasses all three of
the dimensions of moral relativism: right and wrong, scope and tolerance. In the
example the authors describe two women who are both pregnant, Claudia and Susan. Claudia is a pro-choice activist who believes that abortion is morally permissible and has an abortion. Susan is a pro-life activist who believes abortion is morally unacceptable and carries her baby to term. According to the first dimension of moral relativism that right and wrong are relative and not absolute, it is morally acceptable for Claudia to have an abortion since it does not conflict with her moral values of right and wrong, but it would be wrong for Susan, whose moral values consider abortion unacceptable. According to scope, the second dimension of moral relativism, a relativist would deem the value systems of both Claudia and Susan as legitimate. Quintelier and Fessler (2012) stated that their third dimension, tolerance, would deem the observer’s moral value system inconsequential and would not motivate the observer to act in a way to regulate either woman’s behavior.

Social Dominance

In a study by Lammers and Stapel (2009) the relationship between social dominance and moral relativism was applied to moral reasoning, showing how power affects moral reasoning, The study theorizes and empirically shows, according to social dominance theory, that the higher the level of power an individual has, the less likely he or she is to have a perspective of moral relativism. The goal of dominant groups is to sustain the hierarchical structure that keeps them in a more powerful position. One way to maintain the status quo is by insisting on a strict adherence to established moral rules instead of accepting an ambiguous moral standard such as moral relativism (Lammers & Stapel, 2009).
Social dominance theorists believe there is more to moral reasoning than just the internal process theorized by Kohlberg and that external social and cultural contexts also influence a person’s moral reasoning. People in higher levels of power according to their social group are more likely to make moral judgments based on strict moral rules that stabilize the hierarchy. Accordingly, individuals whose social group puts them in lower levels of power are more likely to make judgments based on specific characteristics to a situation (Lammers & Stapel, 2009).

The perspective of moral relativism would be counter to the goals of a dominant group member who desires to maintain the status quo of society and thus his or her position in the hierarchy of groups. Members of dominant groups are most likely to have a social dominance orientation which indicates their desire to maintain the structure of society (Sidanius & Pratto, 1999). A person with SDO who wished to maintain his or her position in society would support hierarchy enhancing legitimizing myths and would want all members of society to follow the same rules and norms in order to preserve the structure (Jackman & Muha, 1984; Pratto et al, 1984). Desire for an absolute standard of what is right and what is wrong is contradictory to the desire of a moral relativist who can accept the existence of differing sets of values without either set being wrong (Quintelier & Fessler, 2012).

Statement of Hypotheses

The hypotheses for this study were based on social dominance theory and were conceptualized in a model illustrated in Figure 1, a theoretical model of the influence of
group status and moral relativism on stigmatization of mental illness. In the model, four sociodemographic variables (race, gender, education, and region) affect two latent variables (moral relativism and stigmatization of mental illness). Each of the latent variables were constructed of observable index variables. The effects of these index variables were hypothesized as paths from each of the sociodemographic variables to moral relativism and to stigmatization of mental illness. Another effect was hypothesized as a path from moral relativism to stigmatization of mental illness.

Through the hypothesized model, the study assessed whether group status correlated with moral relativism and with stigmatization of mental illness directly. Next, the study tested the indirect effect of group status has on stigmatization or mental illness through moral relativism.

Hypotheses 1a, 2a, 3a, 4a, and 5a were represented in the model as paths from the sociodemographic variables to moral relativism. These hypotheses were theorized according to social dominance theory which states members of dominant groups will be less likely to have a perspective of moral relativism. A perspective of moral relativism and judgment without universal truths would jeopardize the status quo of the hierarchical system that allows the dominant group its status. Dominant group members are more likely to judge based on absolute truths of right and wrong. In a society, these truths would be a part of its hierarchy enhancing legitimizing myths by which the dominant group members would want every member of society to abide. On the other hand, members of subordinate groups, it is theorized, would be more likely to have a perspective of moral relativism and more willing to question the status quo that keeps their group oppressed (Sidanius & Pratto, 1999).
Hypothesized social dominance theoretical model of the influence of demographics and moral relativism on stigmatization of mental illness. According to the arbitrary-set hierarchy of social dominance theory, members of dominant groups will be more likely to stigmatize individuals with mental illness. Individuals with mental illness make up a subordinate group of society in the group based hierarchy and are oppressed by the dominant group. Members of society with mental illness pose a perceived threat to the status quo by not following the norms of society; they evoke fear from the dominant group; and they are an out-group competing for resources within society such as healthcare (Corrigan, 2002). Theories have been supported empirically.
that dominant group members will have a bias against out-group members because out-group members are competing for a larger share of society’s resources and dominant group members have a higher social dominance orientation (Bizer et al 2012).

Conversely, members of subordinate groups have been found to have less of a bias against out-group members because they share a commonality of being subordinated and they will thus be less likely to stigmatize against an out-group (Corrigan, 2002).

Previous studies have found that social dominance theory can be used to predict higher levels of traditional and symbolic racism (Sidanius et al. 1992), sexism (Pratto et al., 1994; Sidanius, 1993; Sidanius & Pratto 1993; Sidanius, Pratto & Bobo, 1994) and homophobia (Whitley & Lee 2000).

Hypothesis 1a: Respondents who are White will be less likely to be moral relativists than respondents who are non-White.

Hypothesis 1b: Respondents who are White will be more likely to stigmatize mental illness than respondents who are non-White.

The first two hypotheses were based on the social dominance theory that White Americans have a dominant position in the group based hierarchy system and non-White Americans are a subordinate group. The dominant/subordinate, Black/White distinction is neither based on race or skin color on their own merits, nor is it based on population numbers. Instead social dominance theory assumes dominant and subordinate groups based on their level of power and the distribution of positive and negative social values in society (Sidanius & Pratto, 2011).
Since the colonization of the United States, a hierarchy of racial groups has existed. White Americans continually possess a disproportionately larger amount of positive social value in American society while non-White races possess a disproportionately larger amount of negative social value (Sidanius & Pratto, 2011). In addition to a disparity in the distribution of resources, African-Americans are viewed as marginalized in society as compared to Caucasian Americans who are seen as owning the nation (Sidanius & Pratto, 1999) and African-Americans are viewed as being less American than Caucasian Americans (Devos & Banaji, 2005).

Caucasians are considered to hold a more dominant hierarchical group status than minorities (Jost, Glaser, Kruglanski, & Sulloway, 2003; Levin et al, 2009) Studies have found that Caucasians have a higher social dominance orientation than minorities (Levin et al., 2009) and have stronger support for group based hierarchy (Levin & Sidanius, 1999; Levin, Sidanius, Rabinowitz, & Federico, 1998; Levin et al, 2009;).

The research on the stigmatization of subordinate groups by minorities has been mixed. African-Americans are found more likely to have a prejudice against homosexuals (Herek, 2000) but are less likely to oppose another minority integrating into their neighborhood and less likely to believe stereotypes about other groups (Bobo & Zubrinsky, 1996). Some studies have shown that minorities, especially African-Americans, are more likely to stigmatize mental illness (Phelan et al, 2000; Schnittker, Freese & Powell, 2000; Silva de Crane & Spielberger, 1981). Still, other research has found African-Americans less likely to stigmatize mental illness (Corrigan et al., 2001) and more likely to be open to mental health care than Caucasians (Schnittker et al, 2000). The tendency not to stigmatize a subordinate group is hypothesized to be due to
the shared prejudice minority group members feel with oppressed groups (Corrigan & Watson, 2007).

**Hypothesis 2a:** Male respondents will be less likely to be moral relativists than female respondents.

**Hypothesis 2b:** Male respondents will be more likely to stigmatize mental illness than female respondents.

The second stratification system within the hierarchy of social dominance theory is a gender system in which male members in society are dominant over females. The theory states that men will hold the more dominant position in the hierarchy, possessing more of society’s positive social value and having a higher social dominance orientation than women (Sidanius & Pratto, 1999). Years after the original 1999 publication of their theory, Sidanius & Pratto (2011) reconfirmed this gender stratification stating that the evidence to support gender stratification is considerable and consistent and repeated in studies across cultures.

Research has previously been conducted to look at the effect of gender on moral relativism and stigmatization toward mental illness. While studies about moral relativism and gender are sparse and have shown the relationship with gender to be insignificant (Rigney & Kearl, 1994), the theory that men will be more likely to stigmatize mental illness has been empirically established (Corrigan & Watson, 2007).

**Hypothesis 3a:** The more years of education a respondent has, the less likely he or she is to be a moral relativist.
Hypothesis 3b: The more years of education a respondent has, the more likely he or she is to stigmatize mental illness.

This present study assessed educational level as a determinant of dominant or subordinate group membership. A positive correlation exists between educational level and job status, which could place an individual in a position to control the structure of society. There is also a positive correlation between higher level of education and higher socioeconomic status (Kugler, Cooper & Nosek, 2010). Because a person with more years of education has more power and higher socioeconomic status, he or she would be a dominant group member.

A four year longitudinal study found that while years in college correlated with respondents being more liberal, more egalitarian and less racist, there is no change in status legitimizing orientation from beginning college to graduation (Levin et al 2009). Another study found no correlation between college education and opposition to egalitarian ideals (Kugler et al., 2010).

The hypotheses regarding level of education were supported in the literature by many studies. One such study revealed that even though well-educated individuals are more likely to support racial integration ideology, they were found to be no more likely to endorse policies that would lead to the realization of those ideals (Berinsky, 2004; Jackman, 1978).

Research has also revealed that individuals with higher education are just as likely to display intolerance for out-groups as individuals with lower educational levels (Jackman & Muha, 1984; Sullivan, Piereson, & Marcus, 1982). Although some theorists perceive advanced education as an experience that opens the mind, in the vein of
social dominance theory, education is also viewed as a key mechanism by which individuals learn the values expected of them by society and time spent in higher education may actually reinforce a person’s commitment to societal norms (Jackman & Muha, 1984).

Hypothesis 4a: Region of respondent will have no correlation to moral relativism.
Hypothesis 4b: Region of respondent will have no correlation to stigmatization of the mental illness.

In social dominance theory literature no theoretical basis exists to believe that region of the United States would have a correlation to moral relativism or stigmatization of mental illness. There is also no theoretical basis to assume that individuals from certain regions would have social dominance over other regions. When region is used as a variable in social dominance research, it is most often divided into southern states and non-southern states.

This region variable in this study classifies respondents into being from the southern region of the United States or being from a non-Southern region of the United States. The hypotheses for region expected there to be no correlations.

Hypothesis 5: Moral relativism will have a positive correlation with stigmatization of mental illness.

Hypothesis 5 was represented on the model as the path from moral relativism to stigmatization of mental illness. This hypothesis was also based on assumptions of social dominance theory, which states that members of dominant groups will be less
likely to have a perspective of moral relativism. Members of dominant groups are theorized to score low in degree of moral relativism and likely to have a social dominance orientation and a willingness to oppress subordinate members of society to preserve the status quo. Conversely, a person who does possess a perspective of moral relativism would be theorized not to have a social dominance orientation and is more likely to embrace ideals such as egalitarianism. He or she would be less likely to stigmatize members of subordinate groups because he is not motivated to oppress these individuals in order to preserve the status quo (Lammers & Stapel, 2009).

The methodology and statistical analyses used to test the hypothetical model are described in Chapter 3 and Chapter 4. Results of these statistical tests were interpreted to determine if the data supported the model and the hypotheses. A discussion of the results and their implications is provided in Chapter 5.
CHAPTER 3

METHODOLOGY

This dissertation utilizes existing data from the General Social Survey to test a hypothetical model based on social dominance theory. The method used to test the model is structural equation modeling with LISREL, a statistical software program designed specifically for structural equation modeling. This chapter details the sample, variables and statistical design of this study.

Sample

The data used in this study is from the 2006 General Social Survey (GSS), which is used to “take the pulse” of America by measuring demographic trends, behaviors, and attitudes of a broad range of subjects. The GSS collects data from respondents nationwide and utilizes address information from the United States Postal Service and sophisticated mapping software to ensure the likelihood of all possible addresses in the United States being included in the random sample. The GSS has been in existence for almost forty years, and many of the questions remain unchanged since that time. In 2006, the GSS was fielded for the 26th time. The GSS maintains rigorous standards by employing 150 prestigious social scientists to review the questions on the instrument each year, and data is gathered from 43 different countries biennially. Additionally, questions on the GSS are periodically rotated to test for replication of previous study findings making it a trend survey. In 2006, the GSS
This study included 5,084 variables and included 51,020 respondents. Survey respondents used in this study are English-speaking persons, 18 years old or older, live in the United States, and are not currently institutionalized. Full probability sampling was used in the 2006 GSS survey (Davis, Smith & Marsden, 2009).

Endogenous Variable – Stigmatization of Mental Illness

Because stigmatization of mental illness is a characteristic that cannot be observed and directly measured a latent variable was constructed. The index variables were chosen based on the conceptual theory of stigma developed by Corrigan and Watson (2002) and used by many social science researchers. The theory consists of three different concepts that make up stigmatization: ignorance/stereotype, prejudice and discrimination (Angermeyer & Matschinger 2003; Corrigan & Shapiro, 2010; Graham et al., 2008; Martin & Johnston 2007). For the purpose of this dissertation, this three-dimensional conceptual definition was used to measure stigma.

Ignorance/stereotype was assessed as the belief that mental illness is caused by an individual’s own bad character; prejudice was assessed as the belief that a person with a mental illness is dangerous, and discrimination was assessed as a respondent’s willingness to socialize with a person with a mental illness, a respondent’s willingness to have a person with a mental illness as a neighbor, and a respondent’s willingness to work on a job with a person with a mental illness.

The five questions that made up the index variable of stigmatization were all part of a special mental health section of the GSS. Survey questions in this section are
based on twelve vignettes describing conditions that depict various mental illnesses (schizophrenia, depression, alcohol addiction, drug addiction). GSS interviewers are instructed to present, at random, one of the twelve cards to the respondent. The vignettes were created based on the *Diagnostic and Statistical Manual of Mental Disorders, DSM-IV* (Link et al. 1999). The observable variables will be measured by five questions from the GSS.

*Bad Character: Situation Caused by Own Bad Character*

This variable assessed the ignorance/stereotype element within the definition of stigmatization by measuring if a respondent erroneously attributed mental illness to bad character. This variable has previously been used in the literature as a measure of attitude and perception of mental illness, specifically attitude about the cause of mental illness and its symptoms (Link et al. 1999; Schnittker, Freese & Powell, 2000).

The variable was measured by responses to Question 942A. Now I want to ask you some specific questions about (John/Mary). In your opinion, how likely is it that (John/Mary)’s situation MIGHT be caused by his/her own bad character? Responses from this numeric variable were recoded as, 1 – *not at all likely*, 2 – *not very likely*, 3 – *somewhat likely*, 4 – *very likely*. A strong agreement with the statement indicated a strong likelihood of stigmatization of mental illness.

*Dangerous: How Likely X Violent Toward Other People*

This variable assessed the element of prejudice within the concept of stigmatization by measuring if a respondent believed a person with mental illness was
dangerous and could hurt other people. This variable has been previously used in research to measure a perception of dangerousness (Link et al, 1999; Schnittker et al., 2000)

The variable was measured by responses to Question 657. In your opinion, how likely is it NAME would do something violent toward other people? Responses from this numeric variable were coded as: 1 – *not at all likely*, 2 – *not very likely*, 3 – *somewhat likely*, 4 – *very likely*. A strong agreement with the question indicated a strong likelihood of stigmatization.

_Socialization: How Willing Respondent Would Spend Time Socializing with X_

This variable assessed the element of discrimination within the concept of stigmatization by measuring a respondent’s self-reported likelihood that they would want to socialize with a person with mental illness. This variable has been previously used in research to measure a perception of social distance (Link et al, 1999; Schnittker et al., 2000).

The variable was measured by responses to Question 656b. How willing would you be to spend an evening socializing with NAME? Responses from this numeric variable were coded as: 1 – *definitely willing*, 2 – *probably willing*, 3 – *probably unwilling*, 4 – *definitely unwilling*. A strong willingness indicated a lower likelihood of stigmatizing mental illness.
Neighbor: How Willing Respondent Would Be to Have X as a Neighbor

The variable assessed the element of discrimination within the concept of stigmatization by measuring a respondent’s self-reported likelihood that they would or would not be willing to have a person with a mental illness as a neighbor. This variable has been previously used in research to measure a perception of social distance (Link et al, 1999; Schnittker et al., 2000).

The variable was measured by responses to Question 656a. How willing would you be to move next door to NAME? Responses from this numeric variable were coded as: 1 – definitely willing, 2 – probably willing, 3 – probably unwilling, 4 – definitely unwilling. A strong willingness indicated a lower likelihood of stigmatizing mental illness.

Coworker: How Willing Respondent Would Be to Work With X on a Job

This variable assessed the element of discrimination within the concept of stigmatization by measuring a respondent’s self-reported likelihood that they would be willing to work on a job with a person with a mental illness. This variable has been previously used in research to measure a perception of social distance (Link et al, 1999; Schnittker et al., 2000).

The variable was measured by responses to Question 656d. How willing would you be to have NAME start working closely with you on a job? Responses from this numeric variable were coded as: 1 – definitely willing, 2 – probably willing, 3 – probably unwilling, 4 – definitely unwilling. A strong willingness indicated a lower likelihood of stigmatizing mental illness.
Endogenous Variable – Moral Relativism

Because moral relativism is a characteristic that cannot be observed and directly measured, a latent variable was constructed. The index variables were chosen based on the schematic definition of moral relativism created by Quintelier and Fessler (2012) which states that moral relativism is comprised of three components: right and wrong, scope, and tolerance. Three questions from the GSS were used to measure each of these three elements of moral relativism. Together they made up the index measure of a respondent’s moral relativism. Each of the index variables had been used previously in empirical work to measure the concept of moral relativism (Voas, & Ling, 2010; Barker & Tinnick, 2006; Emerson, 1996, Greeley, 1993).

*Black / White: Respondent Agrees Right and Wrong Not Black and White*

This variable from the GSS survey was used to measure the right and wrong element of the moral relativism schematic. The variable has previously been used in the literature as an indicator of a perspective of moral relativism (Barker & Tinnick, 2006; Emerson, 1996; Nickell & Herzog, 1996; Rigney & Kearl, 1994; Voas, & Ling, 2010). It has been used specifically as a measurement of a respondent’s degree of acceptance of absolute standards of right and wrong (Rigney & Kearl 1994).

The variable was measured by responses to Question 374. Please consider the following statements and tell me whether you agree strongly, agree somewhat, disagree somewhat, or disagree strongly with each statement. B. Right and wrong are not usually a simple matter of black and white; there are many shades of gray. Responses to this numeric variable were coded as 1 – *agree strongly*, 2 – *agree somewhat*, 3 – *disagree*
somewhat, 4 – disagree strongly. A strong agreement with the statement indicated a strong degree of moral relativism.

**Personal Morality: Respondent Agrees That Morality is a Personal Matter**

This variable from the GSS survey was used to measure the scope element of the moral relativism schema. The variable has previously been used in the literature as an indicator of a perspective of moral relativism (Emerson, 1996; Rigney & Kearl, 1994). It has been used specifically as a measurement of whether a respondent agrees that right and wrong is an individual judgment or whether judgments should be made according to a societal standard of right and wrong.

The variable was measured by responses to Question 374. Please consider the following statements and tell me whether you agree strongly, agree somewhat, disagree somewhat, or disagree strongly with each statement. D. Morality is a personal matter and society should not force everyone to follow one standard. Responses to this numeric variable were coded as 1 – agree strongly, 2 – agree somewhat, 3 – disagree somewhat, 4 – disagree strongly. A strong agreement with the statement was interpreted as a strong degree of moral relativism.

**Punish Sinners: Respondent Agrees That Sinners Must Be Punished.**

This variable from the GSS survey was used to measure the element of tolerance in the schema of moral relativism. This variable has previously been used in the literature as an indicator of a perspective of moral relativism and moral rigidity. (Emerson, 1996; Greeley, 1993).
The variable was measured by responses to Question 374. Please consider the following statements and tell me whether you agree strongly, agree somewhat, disagree somewhat, or disagree strongly with each statement. A. Those who violate God’s rules must be punished. Responses from this numeric variable were recoded as 1 – disagree strongly, 2 – disagree somewhat, 3 – agree somewhat, 4 – agree strongly. A strong disagreement with the statement was interpreted as a strong degree of moral relativism.

Exogenous Variables – Sociodemographics

This dissertation used group status as indicated by sociodemographics to represent dominance according to social dominance theory. There is a significant positive correlation between group status and social dominance orientation according to the theory and empirical studies (Sidanius & Pratto, 1999). The use of sociodemographics as indicators of group membership could further expand on current understanding, and have real-world benefits when a social dominance orientation measure is not practical.

Race: Race of Respondent

This variable was measured by response to Question 24. What race do you consider yourself? Responses from this numeric variable were recoded as 1 – non-White 2 – White.
Gender: Code Respondents Sex

This variable “sex” is not a question for the respondent but was coded by the interviewer. Responses from this numeric variable remained as coded as: 1 – female
2 – male.

Education: Highest Year of School Completed.

This variable was measured by response to the question, What is the highest grade in school that you finished and got credit for? Responses for this variable were coded as values of 0 – 20 for the years of education the respondent had completed.

Region: Region of Interview

This variable is also an item from the GSS. The responses for this variable were recoded to specify only Southern and non-Southern regions of the country. Region was coded as 1 – Southern region and 2- Non-southern region. The Southern region included the South Atlantic, West South Central and East South Central regions of America. The non-Southern region included the regions of New England, Middle Atlantic, East North Central, West North Central, Mountain and Pacific. The division of America into regions representing the South and non-South is a widely used method in social science research (Emerson, 1996, Greeley, 1993). Demographically, Americans from the south do not differ from the rest of the country. The level of ideological differences between the south and the rest of the country is what drives researchers to use this division of regions in America (Kuklinski, Cobb & Gilens; 1997). The states that made up the Southern region for this study included Arkansas, Oklahoma, Louisiana,
Texas, Kentucky, Tennessee, Alabama, Mississippi, Delaware, Maryland, West Virginia, Virginia, North Carolina, South Carolina, Georgia, Florida, and the District of Columbia.

Statistical Design

Structural equation modeling is a statistical method of estimating directional and non-directional relationships between variables in a hypothesized model. It was especially appropriate for this study because of its ability to measure a model consisting of latent factors causally linked to observable, measurable indicators, and for its ability to assess the overall fit of a model to a data set. It is also preferable for its capacity to measure parameters and errors within a model, and to allow for modifications of the model after data analysis (Bohrnstedt & Knoke, 1994). The statistical design of this study consisted of univariate analysis, bivariate analysis, multivariate analysis, and structural equation modeling.

Univariate Analysis

Univariate analysis was used to test variables alone for their own qualities that are not dependent on another variable. The variables for this study were obtained from the General Social Survey's 2006 data file and originally contained 1,259 variables and 4,510 respondents. The data set was downloaded into Statistical Package for the Social Science (SPSS) Statistics GradPack version 17.0 from the National Opinion Research Center website. Data reduction and some of the descriptive analysis was done in SPSS.
before the dataset was imported to LISREL 9.10 Student Edition for the remaining analysis and structural equation modeling.

Demographic data was obtained to describe the respondents in the sample. Exploratory statistics and box plots were used to assess the normality of variables. Descriptive statistics were performed to establish characteristics of the sample including mean, standard deviation, skewness and kurtosis. These univariate statistics serve to confirm the assumption of normality that is necessary for structural equation modeling (Boomsma, 2000).

*Bivariate Analysis*

Bivariate analysis involves the testing of two variables for their effect on each other. Pearson’s product moment correlation (Pearson’s r) is a measure of association of interval ratio on variables (Babbie, 2004). Pearson’s r was conducted for every latent variable against every observable variable. Pearson r correlation coefficients were examined for their insight into the direction and strength of relationships between two variables. A two-tailed statistical test of hypothetical inference was used because it tests hypotheses in more than one direction, which is beneficial when the researcher does not have much information about alternate hypotheses (Bohrenstedt & Knoke, 1994).

*Structural Equation Modeling*

The structural equation model was tested by LISREL with the maximum likelihood method of estimation. Statistical equation modeling estimates parameter
values and makes approximations with the goal of using the data to maximize the likelihood of model fit (Bohrnstedt & Knoke, 1994). Maximum likelihood was chosen for this study because it is the preferred method of estimation in studies with samples of several hundred and with multivariate normality (Boomsma, 2000). In addition to path approximations, LISREL conducted correlation matrices, and measures of fit. The model was evaluated based on results of goodness of fit testing, residual matrices and modification indices (Schermelleh-Engel, Moosbrugger, & Müller, 2003)
CHAPTER 4
DATA ANALYSIS

This chapter presents the results of the data analysis performed to test the theoretical model. First, the univariate techniques that included descriptors of the sample and the dataset are given, followed by results of bivariate testing such as cross tabulation and correlation. Regression and other forms of multivariate statistical pretesting are also described. The procedure of structural equation modeling is detailed as it was applied to test the study model.

Univariate Statistics

Univariate statistics are processes that are executed on one variable by itself. Examples of univariate statistics done for this study are, mean, standard deviation, skewness, kurtosis, minimum frequency, maximum frequency, z-score, p-value, and chi-square. Descriptive statistics were also done on the respondent sample. Frequencies and percentages of the study sample are listed in Table 1. The sample population was predominantly White (83.2%) and female (56.2%). Amount of education completed ranged from 2 years to 20 years and a large majority of the sample had finished 12 years or more of education (87.7%). Respondents were surveyed in Southern and non-Southern regions of the country. The non-Southern regions had 656 respondents, and only 436 respondents were from the southern region of the country.
The data was then examined for missing values with listwise deletion. Listwise deletion is a multiple regression analysis that removes all cases that are missing any single case of variable data. This is preferable for regression analysis when comparisons are necessary (Bohrnstedt & Knoke, 1994). After listwise deletion, the sample size became 1,092.

Table 1

**Sociodemographic Variable Frequencies & Percentages**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-White</td>
<td>183</td>
<td>16.8%</td>
</tr>
<tr>
<td>White</td>
<td>909</td>
<td>83.2%</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>614</td>
<td>56.2%</td>
</tr>
<tr>
<td>Male</td>
<td>478</td>
<td>43.8%</td>
</tr>
<tr>
<td><strong>Region</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-South</td>
<td>656</td>
<td>60.1%</td>
</tr>
<tr>
<td>South</td>
<td>436</td>
<td>39.9%</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>.2%</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>.1%</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>.1%</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
<td>.5%</td>
</tr>
<tr>
<td>7</td>
<td>5</td>
<td>.5%</td>
</tr>
<tr>
<td>8</td>
<td>10</td>
<td>.9%</td>
</tr>
<tr>
<td>9</td>
<td>20</td>
<td>1.8%</td>
</tr>
<tr>
<td>10</td>
<td>41</td>
<td>3.8%</td>
</tr>
<tr>
<td>11</td>
<td>49</td>
<td>4.5%</td>
</tr>
<tr>
<td>12</td>
<td>303</td>
<td>27.7%</td>
</tr>
<tr>
<td>13</td>
<td>103</td>
<td>9.4%</td>
</tr>
<tr>
<td>14</td>
<td>169</td>
<td>15.5%</td>
</tr>
<tr>
<td>15</td>
<td>54</td>
<td>4.9%</td>
</tr>
<tr>
<td>16</td>
<td>168</td>
<td>15.4%</td>
</tr>
<tr>
<td>17</td>
<td>51</td>
<td>4.7%</td>
</tr>
<tr>
<td>18</td>
<td>66</td>
<td>6.0%</td>
</tr>
<tr>
<td>19</td>
<td>15</td>
<td>1.4%</td>
</tr>
<tr>
<td>20</td>
<td>29</td>
<td>2.7%</td>
</tr>
</tbody>
</table>
Descriptive univariate statistics established characteristics of the sample data including mean, standard deviation, skewness and kurtosis. Exploratory statistics, box plots and stem and leaf diagrams were used to assess the normality of variables. One variable was discovered to be skewed. The variable black/white had a skewness measure of 1.078. This level was outside the range of what is considered to be acceptable (-.1 to .1). The coefficient of determination $R^2$ was used to perform a square root transformation that created a new variable by adjusting the previous value based on the variable's lowest value (Osborne, 2010).

Table 2

*Descriptive Statistics of Study Variables*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exogenous – Sociodemographic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>1.83</td>
<td>.37</td>
<td>-.78</td>
<td>1.18</td>
</tr>
<tr>
<td>Gender</td>
<td>1.44</td>
<td>.50</td>
<td>.25</td>
<td>-1.94</td>
</tr>
<tr>
<td>Education</td>
<td>13.78</td>
<td>2.70</td>
<td>-.03</td>
<td>.66</td>
</tr>
<tr>
<td>Region</td>
<td>1.40</td>
<td>.49</td>
<td>.41</td>
<td>-1.83</td>
</tr>
<tr>
<td><strong>Endogenous – Moral Relativism</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black / White</td>
<td>1.64</td>
<td>.25</td>
<td>.81</td>
<td>-.12</td>
</tr>
<tr>
<td>Personal Morality</td>
<td>1.95</td>
<td>.87</td>
<td>.58</td>
<td>-.44</td>
</tr>
<tr>
<td>Punish Sinners</td>
<td>2.35</td>
<td>1.02</td>
<td>.14</td>
<td>-1.10</td>
</tr>
<tr>
<td><strong>Endogenous – Stigmatization of Mental Illness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bad Character</td>
<td>2.31</td>
<td>.10</td>
<td>.22</td>
<td>-1.01</td>
</tr>
<tr>
<td>Dangerous</td>
<td>2.41</td>
<td>.85</td>
<td>.12</td>
<td>-.58</td>
</tr>
<tr>
<td>Socialization</td>
<td>2.31</td>
<td>.90</td>
<td>.31</td>
<td>-.65</td>
</tr>
<tr>
<td>Neighbor</td>
<td>2.17</td>
<td>.84</td>
<td>.51</td>
<td>-.17</td>
</tr>
<tr>
<td>Coworker</td>
<td>2.59</td>
<td>.95</td>
<td>-.01</td>
<td>-.94</td>
</tr>
</tbody>
</table>

*N = 1092*
Bivariate Statistics

Bivariate statistics were conducted in preparation for structural equation modeling. Pearson’s $r$ was conducted on every variable in the study to test for degree and direction of any correlations that already exist in the data. (Table 3)

Table 3

**Pearson’s r Correlations**

<table>
<thead>
<tr>
<th></th>
<th>Coworker</th>
<th>Neighbor</th>
<th>Socialization</th>
<th>Dangerous</th>
<th>Bad Character</th>
<th>Black/White</th>
<th>Pers. Morality</th>
<th>Punish Sinner</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coworker</strong></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Neighbor</strong></td>
<td>-0.05</td>
<td>0.60</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Socialization</strong></td>
<td>0.57</td>
<td>0.44</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dangerous</strong></td>
<td>0.37</td>
<td>0.38</td>
<td>0.35</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bad</strong></td>
<td>0.16</td>
<td>0.20</td>
<td>0.15</td>
<td>0.19</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Character</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Black/White</strong></td>
<td>-0.05</td>
<td>0.04</td>
<td>0.00</td>
<td>-0.00</td>
<td>0.03</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pers. Morality</strong></td>
<td>0.02</td>
<td>0.04</td>
<td>0.01</td>
<td>-0.03</td>
<td>-0.02</td>
<td>0.23</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Punish Sinners</strong></td>
<td>-0.06</td>
<td>0.04</td>
<td>-0.05</td>
<td>0.06</td>
<td>0.18</td>
<td>0.15</td>
<td>0.13</td>
<td>1</td>
</tr>
<tr>
<td><strong>Region</strong></td>
<td>-0.02</td>
<td>-0.06</td>
<td>-0.05</td>
<td>0.05</td>
<td>0.05</td>
<td>0.11</td>
<td>0.02</td>
<td>0.24</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>0.05</td>
<td>-0.07</td>
<td>0.02</td>
<td>-0.10</td>
<td>-0.19</td>
<td>0.06</td>
<td>0.01</td>
<td>0.24</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>-0.03</td>
<td>-0.02</td>
<td>-0.02</td>
<td>-0.02</td>
<td>0.07</td>
<td>0.06</td>
<td>-0.07</td>
<td>-0.07</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td>-0.02</td>
<td>-0.11</td>
<td>--0.05</td>
<td>--0.10</td>
<td>--0.12</td>
<td>--0.02</td>
<td>0.05</td>
<td>-0.22</td>
</tr>
</tbody>
</table>

*N = 1092*

*p<0.05, p <0.01*
Cronbach’s alpha is a bivariate statistical test to measure internal reliability of a set of measures. The standard for Cronbach’s alpha is that a score of .8 or .9 is preferred, a score over .7 is acceptable, a score over .5 or .6 is questionable, and anything below 5 is unacceptable (King, Nurcombe, Bickman, Hides, & Reid, 2003). The index measures of the latent concepts of stigmatization of mental illness and moral relativism were tested with Cronbach’s alpha. The index measure for stigmatization of mental illness scored a .72, which is acceptable. The index measure for moral relativism scored a .24 which is unacceptable as a measurement model. Attempts were made to create other index measures of moral relativism based on previous theoretical and empirical works described in Chapter 2. None of the other index measures for moral relativism scored above unacceptable on Cronbach’s alpha reliability testing. Details of the attempts to create a reliable measure for moral relativism are listed in the appendix of this dissertation.

Because no reliable latent measurement of moral relativism could be constructed, the model was re-specified to include a single-measure latent variable for moral relativism. Although a multiple item index measure is best, researchers agree that it is not always feasible and in such cases, single indicators are acceptable (Anderson & Gerbing, 1988; MacCallum & Austin, 2000). For the remainder of the study each of the three indicators was used as a single-measure for the latent variable moral relativism in separate models. The models were treated as alternate models for comparison and were each separately estimated using the maximum likelihood estimation method in structural equation modeling. The models were then compared according to guidelines of structural equation modeling for comparing alternate models for their appropriateness
for representing the sample data. In alternate model comparison it is recommended to use a combination of multiple indicators of goodness of fit to determine selection of most appropriate model. Further implications from the lack of internal reliability of the moral relativism index measure are discussed in Chapter 6.

Multivariate Statistics

Before testing the model of this study with structural equation modeling, regression was used to study the relationship between the sociodemographic variables, moral relativism and stigmatization of mental illness. Covariances were computed for each of the variables paired with the mental illness stigmatization measures, and then with the moral relativism measures. These results are presented in Table 4. The maximum likelihood method of estimation measures the differences in parameters when structural equation modeling attempts to fit the model into the sample covariance matrix (Jöreskog & Sörbom, 1993). Covariance matrices and variable groupings are created from the model and the results of over 25 different fit indices are presented. The maximum likelihood model estimates for the model paths are represented in the model.
Table 4

Covariance Matrix

<table>
<thead>
<tr>
<th></th>
<th>Coworker</th>
<th>Neighbor</th>
<th>Socialization</th>
<th>Dangerous</th>
<th>Bad Character</th>
<th>Black/White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coworker</td>
<td>0.90</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neighbor</td>
<td>0.41</td>
<td>0.70</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Socialization</td>
<td>0.50</td>
<td>0.45</td>
<td>0.81</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dangerous</td>
<td>0.30</td>
<td>0.27</td>
<td>0.26</td>
<td>0.72</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bad Character</td>
<td>0.15</td>
<td>-0.02</td>
<td>-0.01</td>
<td>-0.02</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td>Black/White</td>
<td>-0.01</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.06</td>
<td>0.73</td>
</tr>
<tr>
<td>Region</td>
<td>-0.05</td>
<td>-0.05</td>
<td>-0.12</td>
<td>0.03</td>
<td>-0.01</td>
<td>0.01</td>
</tr>
<tr>
<td>Education</td>
<td>0.12</td>
<td>-0.16</td>
<td>0.04</td>
<td>-0.22</td>
<td>0.04</td>
<td>-0.04</td>
</tr>
<tr>
<td>Gender</td>
<td>-0.01</td>
<td>0.02</td>
<td>-0.01</td>
<td>0.00</td>
<td>-0.01</td>
<td>0.01</td>
</tr>
<tr>
<td>Race</td>
<td>-0.01</td>
<td>-0.05</td>
<td>-0.02</td>
<td>-0.04</td>
<td>0.01</td>
<td>-0.00</td>
</tr>
</tbody>
</table>

N = 1092

p<0.05, p <0.01

Structural Equation Modeling

The maximum-likelihood method of estimation was used via LISREL to perform structural equation modeling for this study. As described earlier, three alternate models with different single-indicator measures for the latent variable moral relativism were tested. The empirical testing results of all three models were analyzed and their goodness of fit measures were compared to each other to determine which model was a better fit for the data. The model that was deemed to be the best match to the data was then analyzed according to the original purpose of this study; the effect of group
status on moral relativism and on stigmatization of mental illness, and then the effect of group status on stigmatization of mental illness through moral relativism.

Alternate Model Comparison

Three separate models were analyzed with structural equation modeling. Each model had a single-indicator measure for the latent variable moral relativism. The three variables: black/white, personal morality and punish sinners were each separately used as the single-indicator measurement. Structural equation modeling was performed with maximum likelihood estimation to determine which of the models best fit the data. The statistical analysis was performed with LISREL and the models were identical except for the single variable used to measure moral relativism. Resulting structural models contained differing coefficients and are illustrated in the following three figures. Figure 2 represents the model that used the black/white variable, Figure 3 represents the model that used the personal morality variable, and Figure 4 represents the model that used the punish sinners variable.

Before the models were analyzed empirically for the relationships of the exogenous and endogenous variables, they were analyzed and compared according to fit indices to determine which model was the most appropriate fit for the data. LISREL provided scores for over 20 fit index tests. Fit index tests are measurements that identify how well a model fits a particular data set. Details about the indices of fit selected for this study are presented in Table 5.
Figure 2. Alternate Model 1 - Black/White
Figure 3. Alternate Model 2 – Personal Morality

*p<0.05, **p<0.01

Chi-Square = 62833.866

df = 24

P-value = 0.00000
When comparing alternate models in structural equation modeling, a combination of multiple indices is recommended (Chau, 1997; Hu & Bentler, 1998; Schermelleh-Engel et al., 2003). There are three different types of fit indices: absolute fit, comparative fit, and parsimonious fit. Absolute fit indices do not take other models or baselines into consideration for comparison. Its measurement is determined by how well one theorized model fits a certain data sample (Jöreskog & Sörbom, 1993). Comparative fit indices, also referred to as relative fit indices, compare the model's chi-square result against a baseline model such as the null hypothesis which assumes the variables are uncorrelated (McDonald & Ho, 2002). Parsimonious fit indices are
variations of comparative fit indices that are adjusted to penalize a model for being too complicated. Parsimony fit indices are also used in model comparison analyses.

The absolute fit tests used in this study are the maximum likelihood chi-square, the root mean square error of approximation, the root mean square residual, and the standardized root mean square residual. The maximum likelihood ratio chi-square is a traditional measurement used to measure overall model fit, but is not deemed accurate for large samples (Jöreskog & Sörbom, 1993). In the model comparison for this study the black/white variable model scored a 6845.89 in the maximum likelihood chi-square test ($x^2$). The variable personal morality had a chi-square of 62893.86 and the variable punish sinners had a chi-square of 63197.94. A chi-square test determines the inappropriateness of a model to the data, therefore a lower score is a more acceptable fit (Schermer-Engel et al., 2003).

The standardized root mean square residual (SRMSR) is thought to be a good absolute measure of fit as well as being sensitive to model misspecifications and is often recommended along with other combinations of comparative fit indices (Hu & Bentler, 1998). The SRMR range deems <.05 to be considered a good fitting model and <.1 to be considered acceptable (Hu & Bentler, 1998). Again, none of the models tested scored in the acceptable range according to SRMSR, black/white scored 0.27 and personal morality and punish sinners each scored 0.31.
Table 5

**Overall Fit Indices**

<table>
<thead>
<tr>
<th>Fit Index Measurements</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Absolute Indexes</strong></td>
<td></td>
</tr>
<tr>
<td>Maximum Likelihood of Chi Square ($x^2$)</td>
<td>lower the better</td>
</tr>
<tr>
<td>Root Mean Square Error of Approximation (RMSEA)</td>
<td>.05 - .08 = adequate fit. ≤.05 = good fit</td>
</tr>
<tr>
<td>Root Mean Square Residual (RMSR)</td>
<td>closer to zero suggests good fit</td>
</tr>
<tr>
<td>Standardized Root Mean Square Residual (SRMSR)</td>
<td>≤ .1 = acceptable; &lt; .05 = good</td>
</tr>
<tr>
<td><strong>Comparative Indexes</strong></td>
<td></td>
</tr>
<tr>
<td>Normative Fit Index (NFI)</td>
<td>&gt;.9 = acceptable fit</td>
</tr>
<tr>
<td>Non-normed Fit Index (NNFI)</td>
<td>&gt;.95 = acceptable fit; &gt;.97 = good fit</td>
</tr>
<tr>
<td>Goodness of Fit Index (GFI)</td>
<td>&gt;.90 = acceptable fit; &gt;.95 = good fit</td>
</tr>
<tr>
<td>Adjusted Goodness of Fit Index (AGFI)</td>
<td>&gt;.85 = acceptable fit; &gt;.90 = good fit</td>
</tr>
<tr>
<td><strong>Parsimony Indexes</strong></td>
<td></td>
</tr>
<tr>
<td>Akaike Information Criterion (AIC)</td>
<td>lower the better</td>
</tr>
<tr>
<td>Expected Cross-Validation Index (ECVI)</td>
<td>lower the better</td>
</tr>
<tr>
<td>90% Confidence Interval for ECVI</td>
<td>lower the better</td>
</tr>
<tr>
<td>Parsimony Goodness of Fit Index (PGFI)</td>
<td>&gt;.90 = acceptable fit; &gt;.95 = good fit</td>
</tr>
</tbody>
</table>
The root mean square error of approximation (RMSEA) is also highly recommended in the literature for the same reasons as the SRMSR, plus providing confidence intervals (Maccullum & Austin, 2000). The root mean squared error adjustment index deems a model’s fit as good at a result of ≤ 05, adequate at .05-.08, mediocre at .08-.10 and not acceptable >.10 (Browne & Cudeck, 1993). All of the models in this study scored in the not acceptable range. The personal morality single-measure variable scored 1.56 and the punish sinners single-measure variable model also scored 1.56. The model using black/white as its single-measure variable, while still scoring not acceptable, had the best RMSEA score of the three alternate models at .52.

The comparative fit indices often mentioned in the literature include the normed fit index (NFI) and non-normed fit index (NNFI), which is the NFI structured so that large sample sizes are not penalized (Bentler & Bonnett, 1980). The goodness of fit index (GFI) enables a researcher to compare a model against having no model at all, and the adjusted goodness of fit index (AGFI) is the same as the GFI but without penalizing for model complexity (Jöreskog & Sörbom, 1993; McDonald & Ho, 2002).

Measures of parsimony take into account the most simplified qualities of alternate models and assess them accordingly (Schermelleh-Engel et al., 2003). Measures of parsimony include the parsimony goodness of fit index (PGFI) and the expected cross validation index (ECVI). The Aikake (AIC) is a parsimonious fit test that is considered an information criterion test (Schermelleh-Engel et al., 2003).

Information criterion tests are often used for alternate model comparisons because they do well with non-nested, non-hierarchical models that are tested on the same data. There is no specific range for acceptability of fit for information criterion tests.
but lower scores are interpreted as the more acceptable model (Diamantopoulos & Siguaw, 2000). The lowest AIC score in this study was for the model that included the variable black/white as its measure of moral relativism (2271.25). The AIC scores were almost double for the models that included the personal morality variable (5025.00) and the punish sinners variable (5238.54) The ECVI test estimates the discrepancy between the covariance in the structured model and estimates discrepancy in other samples (Browne & Cudeck, 1993). Results of model fit indices of the three alternate models are detailed in Table 6.

Table 6

Comparison of Alternate Model Fit Indices

<table>
<thead>
<tr>
<th>Index</th>
<th>Black/White</th>
<th>Personal Morality</th>
<th>Punish Sinners</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Absolute Indexes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chi-Square ($x^2$)</td>
<td>6845.89</td>
<td>62893.86*</td>
<td>63197.94</td>
</tr>
<tr>
<td>RMSEA</td>
<td>0.52*</td>
<td>1.56</td>
<td>1.56</td>
</tr>
<tr>
<td>RMSR</td>
<td>2.57*</td>
<td>68248.84</td>
<td>71886</td>
</tr>
<tr>
<td>SRMSR</td>
<td>0.27*</td>
<td>0.31</td>
<td>0.31</td>
</tr>
<tr>
<td><strong>Comparative Indexes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NFI</td>
<td>0.95*</td>
<td>1.00*</td>
<td>1.00*</td>
</tr>
<tr>
<td>NNFI</td>
<td>0.93*</td>
<td>1.03*</td>
<td>1.02*</td>
</tr>
<tr>
<td>GFI</td>
<td>0.58</td>
<td>0.05</td>
<td>0.01</td>
</tr>
<tr>
<td>AGFI</td>
<td>0.04</td>
<td>-1.18</td>
<td>-1.27</td>
</tr>
<tr>
<td><strong>Parsimony Indexes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AIC</td>
<td>2271.25*</td>
<td>5025.00</td>
<td>5238.54</td>
</tr>
<tr>
<td>ECVI</td>
<td>6.33*</td>
<td>57.65</td>
<td>57.91</td>
</tr>
<tr>
<td>90% ECVI</td>
<td>6.578*</td>
<td>58.41</td>
<td>58.75</td>
</tr>
<tr>
<td>PGFI</td>
<td>0.25</td>
<td>0.02</td>
<td>0.03</td>
</tr>
</tbody>
</table>

*Indicates best fit
The results of the fit indices concluded that the model with the variable black/white was a more appropriate fit to the data. The scores for black/white deemed it a better fit for the data on 5 out of 12 fit indices.

Model Evaluation

Structural equation modeling was performed with maximum likelihood estimation to test this study’s model on how well it represented the effect of group status on stigmatization of mental illness and on moral relativism; and also the effect of group status on stigmatization of mental illness through moral relativism. The data revealed the direct effects of the sociodemographic group variables on both moral relativism and stigmatization of mental illness. The indirect effects of group status on stigmatization of mental illness through moral relativism were also revealed through statistical analysis.

Direct Effects

The data revealed the direct effects of sociodemographic group status on stigmatization of mental illness. Two effects were significant. There is significant correlation (.11) between region and moral relativism. This indicates that the respondents who live in a non-southern region of the United States are more likely to have a perspective of moral relativism and that respondents who live in the southern region of the United States are less likely to have a perspective of moral relativism. The variable race was found to have a negative relationship (-.10) with the stigmatization of mental illness indicating that respondents who were non-White were more likely to stigmatize mental illness and respondents who were White were less likely to stigmatize
mental illness. Other coefficient results from the model were not statistically significant. The direct effects on moral relativism found that race positively correlated (0.01) and gender positively correlated (0.06). The positive direction indicates that moral relativism correlates with non-whites and women, but the results are not significant.

The direct effects on stigmatization of mental illness were also insignificant. Gender (.01) had a positive effect on stigmatization which indicated that male respondents were more likely to stigmatize mental illness. The relationships between stigmatization of mental illness and race (-.10), education (-.02), and region (-.02) were all negative. The directions of these effects on stigmatization of mental illness indicate that people who are White, have more years of education, and people who live in the south are all less likely to stigmatize mental illness, but only the effect of race reached a level of significance. The model analysis studied the influence of moral relativism on stigmatization of mental illness. The result was a negative relationship, but it was not significant (-.00).
### Table 7

*Structural Equation Modeling Estimates of Direct and Indirect Effects*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Standardized Coefficient</th>
<th>Total Coefficient</th>
<th>SE</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Direct Effect on Moral Relativism</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>0.01</td>
<td>0.02</td>
<td>0.03</td>
<td>0.80</td>
</tr>
<tr>
<td>Gender</td>
<td>0.06</td>
<td>0.09</td>
<td>0.03</td>
<td>2.84</td>
</tr>
<tr>
<td>Education</td>
<td>0.06</td>
<td>-0.00</td>
<td>0.01</td>
<td>-0.00</td>
</tr>
<tr>
<td>Region</td>
<td>0.11</td>
<td>0.16</td>
<td>0.03</td>
<td>5.12</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Direct Effect of Stigmatization of Mental Illness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>-0.10</td>
<td>-0.07</td>
<td>0.03</td>
<td>0.79</td>
</tr>
<tr>
<td>Gender</td>
<td>0.01</td>
<td>-0.04</td>
<td>0.03</td>
<td>2.84</td>
</tr>
<tr>
<td>Education</td>
<td>-0.02</td>
<td>-0.03</td>
<td>0.03</td>
<td>0.00</td>
</tr>
<tr>
<td>Region</td>
<td>-0.02</td>
<td>-0.04</td>
<td>0.03</td>
<td>5.12</td>
</tr>
<tr>
<td>Moral Relativism</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>-0.00</td>
<td>-0.00</td>
<td>0.00</td>
<td>-1.76</td>
</tr>
<tr>
<td>Gender</td>
<td>-0.00</td>
<td>-0.01</td>
<td>0.00</td>
<td>-2.02</td>
</tr>
<tr>
<td>Education</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>-0.00</td>
</tr>
<tr>
<td>Region</td>
<td>-0.01</td>
<td>-0.01</td>
<td>0.01</td>
<td>-2.50</td>
</tr>
</tbody>
</table>

N = 1092  maximum likelihood method of estimation
SE = standard error of total coefficient, t = t-score

**Indirect Effects**

In addition to the direct effects of sociodemographic group status on stigmatization of mental illness and moral relativism, the model also measured the indirect effect of each sociodemographic group status on stigmatization of mental illness through moral relativism. Again, there were no indirect effects that produced significant results. The effects of race, gender and education all measured at a level of 0.00. The effect of region on stigmatization of mental illness through moral relativism only measured at a level of -.01.
In determining if a conceptual model is an appropriate fit for the data, the first step according to structural equation modeling is to evaluate measurement indices of fit. As previously described, while the Black/White model scored better on fit indices than did either of the other alternate models, it did not score well enough in any of the recommended combinations to be considered a good fit or an adequate fit for the data.

An examination of the standardized residual matrices is recommended to identify model misfit (Schermelleh-Engel et al 2003). A model should have a high number of standardized residuals with a value close to zero. This indicates a high correlation between the model and the empirical data. This model had several residuals over 2.0 indicating a poor fit to the data. (Anderson & Gerbing, 1988).
Table 8

*Standardized Residuals Matrix*

<table>
<thead>
<tr>
<th></th>
<th>Coworker</th>
<th>Neighbor</th>
<th>Socialization</th>
<th>Dangerous</th>
<th>Bad Character</th>
<th>Black/White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coworker</td>
<td>-23.37</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neighbor</td>
<td></td>
<td>-23.37</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Socialization</td>
<td>0.70</td>
<td>17.81</td>
<td>-23.37</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dangerous</td>
<td>2.44</td>
<td>-8.67</td>
<td>---</td>
<td>-23.37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bad Character</td>
<td>1.70</td>
<td></td>
<td>---</td>
<td>---</td>
<td>-23.37</td>
<td></td>
</tr>
<tr>
<td>Black/White</td>
<td>-0.55</td>
<td>0.82</td>
<td>1.09</td>
<td>-0.55</td>
<td>1.29</td>
<td>-23.37</td>
</tr>
<tr>
<td>Region</td>
<td>-0.24</td>
<td>0.62</td>
<td>0.12</td>
<td>-0.50</td>
<td>1.84</td>
<td>0.50</td>
</tr>
<tr>
<td>Education</td>
<td>0.51</td>
<td>-1.62</td>
<td>-0.38</td>
<td>-1.27</td>
<td>-6.99</td>
<td>---</td>
</tr>
<tr>
<td>Gender</td>
<td>-0.30</td>
<td>0.50</td>
<td>0.06</td>
<td>-0.43</td>
<td>2.56</td>
<td>-0.83</td>
</tr>
<tr>
<td>Race</td>
<td>-0.20</td>
<td>-0.62</td>
<td>-0.15</td>
<td>-1.43</td>
<td>-3.87</td>
<td>-2.61</td>
</tr>
</tbody>
</table>

N = 1092
CHAPTER 5
CONCLUSION

The goal of this dissertation was to examine the relationship between group membership, the perspective of moral relativism and stigmatization of individuals with mental illness, and to determine if there was an effect on the relationship between sociodemographics and stigmatization, if the path went through moral relativism. These relationships were hypothesized according to social dominance theory and then conceptualized as a model in accordance with structural equation modeling. The method intended to create a model incorporating latent variables to represent moral relativism and stigmatization of mental illness and to test the model through structural equation modeling. This chapter discusses the study process and findings from data analysis followed by study implications, study limitations, and suggestions for future research.

Discussion

It is obvious that the basic underlying principle of social dominance theory alone cannot explain all phenomena within a society. Social dominance theory was the basis of the construction of the conceptual model for this dissertation. The fundamental principles of social dominance theory, along with theories of stigmatization and moral relativism, were specified as the foundation for the model. After conducting the study and analyzing the results, the data did not support the theoretical conceptualizations. First, Quintelier and Fessler’s (2012) schematic theoretical definition of moral relativism as consisting of right and wrong, personal morality and tolerance, was not supported by
the data as a basis for measuring the concept of moral relativism as a latent construct. Second, Corrigan and Watson’s (2002) theory of stigmatization as consisting of ignorance/stereotype, prejudice and discrimination, while passing validity testing to construct a latent index measurement for the variable stigmatization of mental illness, was problematic to the model fitting the data as revealed by the high residual values. Third, social dominance theory, which was the theoretical basis for the conceptual model and the hypotheses, was not supported by the data as a theory to model the relationships between group status, moral relativism and stigmatization of mental illness or as a basis for the hypotheses regarding those relationships.

The concepts of moral relativism and stigmatization of mental illness cannot be observed and measured on their own so they were represented in the study as latent variables made up of a set of observable variables. The index measures of moral relativism and of stigmatization of mental illness were created according to the guidelines of structural equation modeling which states that a concept be specified and based on theory and research. The theoretical basis behind Quintelier and Fessler’s (2012) three-index variable for moral relativism was a fairly new, but well supported schematic definition of the concept that has been used previously by other researchers. The variables that made up the index were chosen specifically because they fit this theory of moral relativism. The failure of this latent variable to stand up to a test of internal validity had implications for this study, but more importantly, it implies that the 3-part schematic definition of moral relativism does not hold up to thorough testing and should be re-evaluated and re-tested.
Corrigan and Watson’s (2002) theory of stigma as consisting of ignorance/stereotype prejudice and discrimination was the basis for the construction of the measurement index of the latent variable stigmatization of mental illness. The index was reliable enough according to Cronbach’s alpha scores to measure the concept of stigmatization. Structural equation modeling performed with maximum likelihood estimates resulted in fit indices scores that indicated the model was not a good fit with the data. Further analysis of residual values revealed the problematic elements of the components of this index measurement. The correlations between the variables socialization, coworker, neighbor and dangerous all had residual values of over 2.0. It is recommended that those elements of the model with the highest residual values be targeted for modification during model revision (Anderson & Gerbing, 1988; Chau, 1997: Schermelleh-Engel et al., 2003). Because the residuals are almost all negative values, the model likely overestimated the covariance between the variables. Researchers recommend modifying the model by eliminating the paths and freeing the variables (Anderson & Gerbing, 1988; Chau, 1997). However, modifications should not be made to a model for the purpose of improving its overall fit scores, without adequate theoretical rationale (Schermelleh-Engel et al., 2003). Such theoretical rationale to modify the model by removing the paths is not supported in this dissertation.

Each of this dissertation’s original hypotheses reflected a path in the model and can now be compared to the statistical correlations to assess if the model supported these hypotheses. Hypotheses 1a, 2a, 3a, and 4a were represented in the model as paths from the sociodemographic variables to moral relativism. They were hypothesized based on social dominance theory that states that members of dominant
groups will support the idea of a standard set of society-enhancing morals, rules and expectations and will want this set of rules to apply to every member of society. Hypotheses 1b, 2b, 3b, and 4b were represented in the model as paths from the sociodemographic variables to stigmatization of mental illness. They were hypothesized based on social dominance theory that states that dominant group members will oppress members of subordinate groups that are seen as a threat to the societal structure. The core of social dominance theory is that it is instinctive in human beings to want to fight to preserve their dominant position in society. This instinct to fight for more of society’s resources is the primary drive behind the social dominance orientation that favors any element of society that preserves their group’s dominance and opposes any element of society that threatens it.

*Hypothesis 1a: Respondents who are White will be less likely to be moral relativists than respondents who are non-White.* This hypothesis was not supported by the data. The effect of race on moral relativism was a positive correlation which would indicate an inverse relationship between being White and being a moral relativist, but it was not statistically significant. The data indicated that White respondents were less likely to be moral relativists, but this result was not significant (.01).

*Hypothesis 1b: Respondents who are White will be more likely to stigmatize mental illness than respondents who are non-White.* This hypothesis was not supported by the data. The effect of race on stigmatization of mental illness was a negative relationship. This indicates that White respondents were less likely to stigmatize mental illness. The
data indicated that White respondents were less likely to stigmatize mental illness and the result was significant (-.10).

Hypothesis 2a: Male respondents will be less likely to be moral relativists than female respondents. This hypothesis was supported by the data. The effect of gender on moral relativism was a positive correlation that was statistically significant. The data indicated that males were less likely to be moral relativists; this result was significant (.06).

Hypothesis 2b: Male respondents will be more likely to stigmatize mental illness than female respondents. This hypothesis was not supported by the data. The effect of gender on stigmatization of mental illness was a positive correlation but it was not statistically significant. The data indicated that males were more likely to stigmatize mental illness, but this result was not significant (.01).

Hypothesis 3a: The more years of education a respondent has, the less likely he or she is to be a moral relativist. This hypothesis was not supported by the data. The effect of education on moral relativism was a positive correlation, and it was statistically significant. The data indicated that respondents with more education were more likely to be moral relativists, and the result was significant (.06).

Hypothesis 3b: The more years of education a respondent has, the more likely he or she is to stigmatize mental illness. This hypothesis was not supported by the data. The effect of education on stigmatization of mental illness was a negative correlation, but it
was not statistically significant. The data indicated that respondents with more education were less likely to stigmatize mental illness, but this result was not significant (\(-.02\)).

*Hypothesis 4a: Region of respondent will have no correlation to moral relativism.*

This hypothesis was not supported by the data. The effect of region on moral relativism was positive and it was statistically significant. This result indicated that respondents from non-Southern regions were more likely to be moral relativists. (\(.11\))

*Hypothesis 4b: Region of respondent will have no correlation to stigmatization of the mental illness.* This hypothesis was supported by the data. The effect of region on stigmatization of mental illness was a negative correlation, but it was not statistically significant. This result indicated that respondents from the Southern region of the United States were more likely to stigmatize mental illness, but the result was not significant (\(-.02\))

*Hypothesis 5: Moral relativism will have a negative correlation with stigmatization of mental illness.* This hypothesis was not supported by the data. There was no correlation between moral relativism and stigmatization of mental illness. The three-dimensional latent measurement for moral relativism that was originally intended for this study was not used to test this hypothesis due to an unacceptable score of internal validity. Each of the three index measures was used as a single measure of moral relativism and alternate model assessment and
For the purpose of this study these hypotheses were created solely on the basic tenet of social dominance theory which states that those in dominant groups will fight to retain their dominant status by oppressing subordinate groups that threaten the distribution of resources, and supporting the acceptance of hierarchy enhancing legitimizing myths that serve to maintain the hierarchical structure of society. According to the theory, group status should correlate with stigmatization and moral relativism. Members of dominant groups should be more likely to stigmatize out-groups and to adopt the perspective of absolute standards regarding behavior and morals, and members of subordinate groups should be less likely to stigmatize out-groups and less likely to support the perspective of absolute standards regarding behavioral and morals.

The results from this study do not support the results from the previous study of Bizer et al. (2012) in which social dominance orientation was shown to have a positive correlation with stigmatization of mental illness. Instead of the psychological concept of SDO, this study examined the sociological elements of group status as represented by sociodemographics. The theory that dominant group members will want to protect the status quo of the societal hierarchy describes the characteristics that indicate a high SDO. From the results of this study, it is not accurate to use SDO and dominant group status interchangeably. The results of this study indicate that dominant group status does not necessarily indicate the same oppressive tendencies as SDO.

Social dominance theory was created as a multi-level approach to understanding oppression and encompasses other principles, such as behavioral asymmetry, that could explain the outcomes of this study that seem to contradict the basics of the theory. Behavioral asymmetry describes the phenomena in which members of
subordinate groups behave in ways that maintain the status quo of societal structure and their subordinate, and even oppressed, status. This occurs when the hierarchy-enhancing legitimizing myths are so widely accepted within society that the subordinate groups adopt them as justification for the hierarchical system and the result is behavioral asymmetry such as out-group bias and ideological asymmetry. Out-group bias refers to the bias of subordinate group members to favor the dominant group (Pratto et al., 2006). Ideological asymmetry refers to instances in which members of a subordinate group support ideologies that maintain the hierarchical structure and their own subordination, and members of the dominant group support ideologies such as moral relativism, that would threaten the hierarchical structure of society,

Implications

It was hoped that there would be practical implications for this study. The model created was intended to represent a comprehensive scope of the problem of stigmatization of mental illness by illustrating the effect of group status on moral relativism and stigmatization of mental illness and the effect of the combination of group status and moral relativism on stigmatization of mental illness. This model could be modified to apply to other types of stigmatization and incorporate other demographic groups.

An absolute set of rules will act to regulate behavior in society and maintain the status quo. The statistically significant effect of education on moral relativism does not adhere to the theory that dominant group members will want to support a hierarchy
enhancing ideology, but the effect may still be explained within social dominance theory. There are many aspects of social dominance theory such as support of hierarchy enhancing legitimizing myths, out-group bias, behavioral asymmetry, etc. that can explain behavioral phenomena such as this. The theory supposes that structural characteristics of society and individual personal characteristics interact and reinforce each other to create and maintain hierarchy enhancing desires and behaviors (Pratto et al, 1994).

Limitations

The first limitation of this study is the lack of an index measure for the latent variable, moral relativism. Moral relativism is a very complicated concept that seems difficult to define by just one variable, and also difficult to define by several variables.

Second, as with any study of discriminatory behavior, it is difficult to get adequate validity through the use of a survey. How a person says they would behave and how they actually behave are not the same thing, but researchers are limited to the data available.

The third limitation is that this study did not take into account an individual’s social dominance orientation. This orientation is a crucial element of social dominance theory, but was omitted from this study for two reasons. The first reason SDO was omitted was because this study was conducted using an existing data set which did not have variables that corresponded to the social dominance orientation scale. The second reason SDO was not included in the study was that it is not always feasible or practical
to assess an individual’s SDO, and more information is needed in the relationship between hierarchy enhancing traits and sociodemographics.

Fourth is the absence of any direct observation of behavior. Behaviors such as discrimination were not observed directly, but a self-reported likelihood of behavior had to be relied upon.

Suggestions for Future Research

Future research is necessary to extend the understanding of stigmatization in society, particularly the stigmatization of mental illness. This study has reveals areas in which knowledge is still needed.

The concept of moral relativism needs further study, particularly its definition and the construction of a reliable index measure to use in social science research. This study addressed the connection between moral relativism and group status, but research should test the connection between moral relativism and social dominance orientation. More information is also needed regarding the relationship of moral relativism and decision makers in institutional structures that provide services to individuals with mental illness. The connection between moral relativism and group status was addressed in this study, but research should test the connection between moral relativism and social dominance orientation. More information is also needed regarding the relationship of moral relativism and decision makers in institutional structures that provide services to individuals with mental illness.
This study used demographic indicators of social dominance instead of social dominance orientation because it is more practical in a real world setting to have information related to a demographic characteristic than to a latent characteristic such as social dominance orientation. More research should use demographics as indicators to make information more useful. Research should also focus on the differences between dominant group status and social dominance orientation. From its origins, most of the work in social dominance theory has been conducted from a psychological social psychology perspective. To further its intent to answer questions of oppression in society, more studies should be conducted from the perspective of sociological social psychology. Future studies could include socio-economic status as a mediating variable to test for the direct and indirect influence of class distinction on social dominance orientation.

Finally, research should take information from this and other studies and look for a relationship between the empirical information and the components of anti-stigma initiatives as well as their successfulness. Research about stigmatization should be conducted with the intent that it will contribute to its eradication.

Summary

The goal of this dissertation was to determine the effect a respondent’s societal group status has on moral relativism and on stigmatization of mental illness, as well as the interactive effect of group status and moral relativism on the stigmatization of mental illness. The problem was studied from a social dominance theory perspective, a theory
created to analyze the interaction of societal and individual characteristics and how they cause and maintain the oppression of subordinate groups in society.

A conceptual model based on social dominance theory was created to test the research problem. The model included five sociodemographic variables (race, gender, education and region) to measure group status; one variable measure of the latent construct of moral relativism; and a five variable index of the latent construct of stigmatization of mental illness. The conceptual model was created and tested according to structural equation modeling, which is intended for testing theoretical models that contain latent variables such as moral relativism and stigmatization of mental illness.

It was hypothesized according to social dominance theory that subordinate group members would be more likely to be moral relativists and dominant group members would be more likely to stigmatize mental illness. It was also hypothesized that a perspective of moral relativism would correlate with a lower likelihood to stigmatize mental illness. The hypotheses were based on the core assumptions of social dominance theory that members of dominant groups will be driven by a desire to maintain their dominant hierarchical status through oppression of subordinate groups and support of absolute morals and norms that defend the hierarchical structure.

Structural equation modeling estimates could not specify the model as a good fit with the data. Therefore, it is not a valid model for predicting stigmatization through group status and moral relativism.

As with any study, this dissertation provides new information to social science by identifying issues that require further attention. The creators of social dominance theory
espouse that before subordination can be corrected, it must be revealed (Sidanius & Pratto, 2011). The realization that social science lacks empirically valid definitions of moral relativism and stigmatization of mental illness signifies that more effort needs to go in to identifying the problem before it can be corrected. For that reason, the hope is that the information from this study can be a stepping stone to creating a model that will successfully identify the problem of stigmatization of mental illness.
APPENDIX

MORAL RELATIVISM INDICES
### Moral Relativism Indices

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***Measure based on conceptual definition and index of Emerson (1996)

**Measure based on conceptual definition of Qunitelier & Fessler (2012)

*Measure based on conceptual definition and index of Rlgney & Kearl (1994).
REFERENCES


