Feeling less than human: Exploring the causes and consequences of dehumanisation from the target's perspective.

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A thesis submitted in partial fulfilment of the requirements for the for the degree of Doctor of Philosophy

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November 2014

Declaration

The research reported in this thesis is original work. It has not been submitted for a higher degree in any other university or institution.

Signed

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November, 2014

Acknowledgements

First of all, thank you to my supervisor Trevor Case. Without your unwavering support, enthusiasm, wise words and patience this thesis would not have been completed. To my associate supervisor Dick Stevenson, thank you for your helpful feedback and guidance throughout my PhD candidature. Julie Fitness, I am truly grateful for your insightful feedback, guidance and support, particularly in the final months before submission. Thank you Mem Mahmut you have been a great mentor and friend. Special thanks to Alan Taylor for showing me new ways of understanding and presenting data, your love of statistics is infectious and I must say I have been converted.

To everyone in the lab, thank you for affording me some many great opportunities over the last four years, I have learnt so much and had a wonderful time doing it all. Working with such a supportive and inspiring group of people has taught me so much, not only about conducting myself in a professional environment but also the value of mentoring newcomers and fostering their interests and enthusiasm.

Katelin, it has been an adventure, I am sure the next chapter will be just as exciting and rewarding. Thank you Melissa Anderson for helping code my qualitative data and always being ready for a chat. To my family and friends, I appreciate your patience and support. To my husband Emre, thank you for always believing in me and reminding me never to give up. This last year has been a wild ride, but I have loved every minute of it and am grateful to have you by my side. To my Auntie Shirl, thank you for always encouraging me and supporting me physically and emotionally over the course of both my degrees. Ashleigh, I could not have wished for a better sister. Lastly, thank you to my parents, firstly for fostering my sense of curiosity and wonder in the world around me and for always encouraging me to follow my passion. Also, thank you for welcoming me back in to your house this last year when you finally had a chance to live child free.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

ABSTRACT

Research on dehumanisation has typically examined the factors that lead individuals to dehumanise others. This dissertation is significant in that it is among the first attempts to empirically investigate dehumanisation from the perspective of the dehumanised individual. Chapter 1 reviewed the literature and discussed the importance of investigating dehumanisation from the perspective of the victim. Chapter 2 explored the range of experiences people view as dehumanising. A qualitative study using recalled dehumanising episodes investigated who respondents identified as the perpetrator and their emotional reactions to dehumanisation. The results of Study 1 showed that dehumanisation occurs on a continuum ranging from extreme cases of ongoing abuse to single instances of light ridicule. Further, dehumanisation was more likely to occur within the context of the victim's social network rather than with outgroup members or socially distant others. Emotional reactions to dehumanisation commonly involved intense feelings of shame, anger and sadness.

Social exclusion was found to be a dehumanising experience in Chapter 2. Using a quasi-experimental design, the study in Chapter 3 investigated whether experiences of animalistic and mechanistic dehumanisation negatively impact the fundamental needs including belonging, control, self-esteem and meaningful existence. The findings revealed that experiences of animalistic dehumanisation are just as likely as exclusion to threaten the fundamental needs. Whereas, experiences of mechanistic dehumanisation are less likely to threaten one's sense of self-esteem and belonging compared to being excluded.

The results from the first two studies indicated that dehumanisation often occurs within close relationships. Following this, the study in Chapter Four investigated the characteristics of relational dehumanisation. Participants described an autobiographical event in which they had been made to feel less than human in a close relationship. The results

suggest that dehumanising events tend to fuel a cycle of shame and contempt between the victim and perpetrator particularly when it was perceived as intentional.

The study in Chapter 5 investigated the effects of dehumanisation in a common relationship that involves trust and disclosure of personal information—the doctor patient relationship. After reading a vignette depicting the treatment philosophy emphasising either the metaphor of the body as a machine (dehumanising condition) or emphasising individual uniqueness (humanising condition), participants imagined attending a consultation with the doctor regarding a psychological or physical illness. As expected, medical dehumanisation had undesirable consequences for most patients. However, the findings also suggest the intriguing possibility that some patients, particularly men would prefer a dispassionate, dehumanising doctor so they might better control their emotions. This finding has implications for medical professionals suggesting that adopting a dehumanising approach might improve treatment for some patients. The final chapter (Chapter 6) provides a brief review of the findings and discusses the merits of investigating the target's perspective for improving understanding of the causes and consequences of dehumanisation.

Chapter 1

Introduction to dehumanisation

"Man should not address other human beings in the same way as animals, but should regard them as having an equal share in the gifts of nature." Kant 1786/1991.

Historically, it has been common practise for members of hunter-gather societies to refer to themselves as humans and all other (human) groups as subhuman or animal (Read, 2011). For centuries philosophers, poets, and historians have wrestled with defining and explaining what it is to be human, yet the converse of humanness –dehumanisation– has only drawn limited empirical interest from psychologists until very recently (Goff, Eberhardt, Williams & Jackson, 2008; Haslam, Loughnan & Holland, 2013). Dehumanisation was first described in the social psychology literature by Allport (1954/1979) as involving one group of individuals making another group the object of their hate and aggression, enabling them to label the outgroup as less than human. By way of example, he referred to U.S demagogues in the 1950s who called non-Christians "*low animals: insects, germs, subhuman"* (pg. 414). Similarly, Kelman (1973) defined dehumanisation as denying another their identity and community, enabling the perpetrator to see their victim as less than human.

The empirical research on dehumanisation has focused on why people dehumanise others and the moderating and motivating factors involved in the process of viewing a person as less than human, like an object or animal (Haslam, 2006). Until very recently, the perpetrator has almost exclusively been the focus of the research (Bastian & Haslam, 2010, 2011). Certainly, a better understanding of the perpetrator's perspective enables researchers to isolate the conditions that tend to elicit dehumanisation, with the hope that one day there may be social and political change. However, understanding the victim's perspective is also an important aspect to dehumanisation that has been largely overlooked. This matters because

the better we understand the effects of dehumanisation, the better equipped we may be to help victims recover from their experiences. Accordingly, the overall aim of this thesis was to investigate dehumanisation from the perspective of the victim: specifically, to investigate the types of experiences that people find dehumanising and to explore how these experiences affect their emotions, thoughts, behaviours and relationships.

This introductory chapter begins with an examination of dehumanisation and the history of its investigation in the social psychological literature in relation to moral exclusion and disengagement. The factors that motivate perpetrators to dehumanise others will then be discussed, in line with the bulk of literature that addresses this perspective. The related concepts of infrahumanisation and anthropomorphism will also be discussed in terms of how they inform our understanding of dehumanisation. Following this, recent theoretical and empirical literature on dehumanisation as a two dimensional phenomenon, specifically Haslam's (2006) two pronged theory of humanness will be examined. Next, the victim's perspective will be explored; first more broadly, and then in reference to Haslam's (2006) two pronged theory of dehumanisation. The final section of this introduction comprises a brief overview of the studies that make up this thesis.

Dehumanisation Research in Social Psychology

Within social psychology, dehumanisation has mainly been examined as an important component within the contexts of moral exclusion and moral disengagement. Here, it has been defined in terms of denying others their humanity and dignity, and ignoring both their ability to feel and their entitlement to compassion (Opotow, 1990). Moral exclusion occurs when individuals or groups are perceived as existing outside the boundary in which moral values, rules, and considerations of fairness apply. Individuals who are morally excluded are perceived as nonentities or expendable; and as a consequence, harming them is acceptable (Opotow, 1990). According to moral exclusion theories, dehumanisation can occur on a daily basis; however its presence is believed to signal that interpersonal or intergroup conflict is

taking a particularly destructive course (Opotow, 1990). Relatedly, being in a destructive conflict with others, along with harsh social circumstances, may enable moral exclusion to occur (Deutsch, 1990). In relation to moral disengagement, dehumanisation is understood to be the mechanism allowing the perpetration of atrocities (e.g. as in Nazi concentration camps), but also in everyday situations where people routinely act in ways that benefit themselves while causing harm to others (Bandura, 1990).

The majority of this previous research has treated dehumanisation in a brief and/or descriptive way. It has only been in the last decade or so that researchers have highlighted the need to theoretically clarify and explore this important but generally overlooked concept (Haslam, Bastian, & Bisset, 2004; Haslam, 2006; Leyens et al., 2001). Further, dehumanisation has frequently been treated in the research literature as an extreme behaviour, with researchers using extreme examples that highlight the violence and aggression that may be associated with the phenomenon, including genocide (Levi, 1987), racial division (Lott, 1999), torture (Gibson & Haritos-Fatouros, 1986), and the mistreatment of immigrants (O'Brien, 2003). Social psychologists acknowledged that these were, indeed, the most extreme forms of dehumanisation, but some also argued that dehumanisation may be a more everyday way of viewing others (Haslam, 2006; Leyens et al., 2001). For the first time, this led to the empirical investigation of dehumanisation within ordinary social and interpersonal contexts, albeit primarily from perpetrators' perspective. The following section of this Introduction draws on this research to describe what we know about the causes of everyday dehumanisation, and explains how researchers have empirically examined this phenomenon.

Why are People Dehumanised by Others?

Dehumanisation appears to be a universal phenomenon (Read, 2011). In general terms people may dehumanise others when intergroup conflict arises. However, not everyone perceives others as less than human in such circumstances. This section of the introduction

explores the motivational factors that may influence individuals to dehumanise others. Firstly, situational factors will be examined, such as disparities of power and the avoidance of empathic exhaustion. Second, individual differences in people's motivations to perceive others as less than human will be described, and various ideological orientations will be explored.

Motivating factors.

Individuals may seek to dehumanise others when they have power over them, particularly if they aim to harm the less powerful others (Epley, Waytz & Cacioppo, 2007; Haque & Waytz, 2012; Lammers & Stapel, 2011; Waytz, Epley, & Cacioppo, 2010b). The dehumanising of another allows an individual to reduce their feelings of guilt, enabling them to avoid empathic exhaustion (Harris & Fiske, 2009). Anecdotally, when forced adoptions for single women occurred in Australia between 1950-70s nurses were often forbidden from talking to the mothers in case they felt empathy and allowed the mothers to catch a glimpse of their newborns before they were whisked away to a new family (Cole, 2010). This need to minimise feelings of guilt has also been exhibited by executioners who have been found to dehumanise prisoners on death row (Osofsky, Bandura, & Zimbardo, 2005). Furthermore, individuals have been found to attribute fewer mental state verbs (e.g. likes and dislikes) to Black Americans (dehumanised targets) compared to White targets, highlighting a failure to acknowledge the dehumanised target's mind. However, when they are forced to spontaneously mentalise the dehumanised target by inferring the target's (vegetable) preferences, the area of the brain necessary for social cognition, the medial prefrontal cortex (mPFC) is reactivated. These findings suggest that dehumanisation may be a spontaneous regulation strategy, perhaps aimed at avoiding empathy exhaustion (Harris & Fiske, 2009).

People may also be motivated to dehumanise socially distant others when they have strong social connections to their ingroup (Epley et al, 2007; Waytz & Epley, 2012). For instance, the dehumanisation of African Americans by the White American majority is so

deeply ingrained in the American psyche that across a number of Implicit Association Tasks (IAT) participants were found to implicitly associate only African Americans, but not White or Asian Americans, with apes (Goff et al., 2008). Moreover this implicit linking of African Americans with apes led to a greater endorsement of violence against Black suspects rather than White suspects. Outside of the laboratory, this subtle association of black defendants with derogatory animal terms, including *savage* and *predator*, was associated with jury decisions to execute Black defendants (Goff et al., 2008). Furthermore, research investigating the dehumanisation of Bosnian Muslims by Dutch participants has found that individuals, not personally involved in the harsh treatment of members of an outgroup, are willing to dehumanise them. This may allow witnesses of the dehumanisation to cut off empathic distress for outgroup members and justify the perpetrator's actions (Zebel, Zimmerman, Viki & Doosje, 2008).

Individual differences in dehumanising others.

Several factors affect how likely individuals are to dehumanise others, including three related ideological orientations: social dominance orientation (SDO), right-wing authoritarianism (RWA) and universal orientation (UO). SDO refers to one's degree of preference for inequality among social groups (Pratto, Sidanius, Stallworth & Malle, 1994), while UO refers to individuals' tendencies to focus on similarities rather than differences between the self and others (Phillips & Ziller, 1997). Right wing authoritarians are willing to submit to established and conventional authorities; they are also hostile and aggressive towards individuals or groups who do not follow these societal norms or appear to threaten them (Altemeyer, 1981). SDO has been associated with aggression towards immigrants who assimilate into the dominant culture as this blurs existing status boundaries between groups (Thomsen, Green & Sidanius, 2008). Alternatively, high UO has been associated with immigrant humanisation and the heightened perception of animal-human similarities (Costello & Hodson, 2010). Interestingly, when individuals are primed to consider the

similarities between animals and humans in a non-threatening way, even those high in SDO or low in UO are more likely to humanise immigrants (Costello & Hodson, 2010).

RWA is similar to SDO in that people high on either ideological orientation are theorised to be relatively prejudiced, racist, conservative and indifferent towards lower status individuals. Some groups, such as immigrants, may be targets of individuals high in SDO and RWA (Pratto et al, 1994), however the motivating factors behind the prejudice are not the same (Duckitt, 2006; Duckitt, Wagner, Du Plessis & Birum, 2002). Right wing authoritarians are most likely to derogate individuals such as terrorists, drug dealers and generally dangerous individuals who are perceived as threatening to the ingroup and to societal stability. Individuals high on SDO dislike groups that arouse their competitiveness by directly challenging their perceived ingroup dominance, power and superiority, such as protestors and feminists. Further, individuals high on SDO also abhor subordinate groups that activate their competitive desires to maintain dominance and power over lower status groups including housewives, mentally handicapped individuals and the unemployed (Asbrock, Sibley & Duckitt, 2010; Duckitt & Sibley, 2007).

It would appear that these ideological orientations depend on contextual factors such as national identity and the heightened awareness of similarities between ingroups and perceived outgroups (Costello & Hodson, 2010; Esses, Wagner, Wolf, Preiser, & Wilbur, 2006). National identity has been shown to influence immigrant prejudice in individuals high in SDO. Canadians, in general, have positive views towards immigrants whilst Germans have generally been shown to endorse negative views towards immigrants. A study by Esses and colleagues (2006) investigated whether promoting an inclusive national identity including immigrants and non-immigrants would improve the attitudes towards immigrants among Canadian and German participants, with a particular focus on individuals high on Social Dominance Orientation (SDO). When immigrants were included in the common national identity by highlighting their similarities to the ingroup Canadians high in SDO lowered their

prejudice towards immigrants, yet prejudice levels in Germans high in SDO were heightened (Esses et al., 2006). These differences may be explained by the fact that Canada prides itself on being a nation built by immigrants, whereas Germany has typically resisted welcoming immigrants. Thus immigrants threaten the national identity of Germans but not Canadians. Overall, these findings indicate that focusing on inclusive perceptions of national identity can have positive effects on immigrant attitudes, at least in countries where citizens acknowledge their immigrant heritage. However, individual differences in prejudice, specifically the acceptance of social inequalities and hierarchies, may hinder this process; especially in individuals from nations that take pride in distinguishing themselves from outgroups. This ingroup favouritism and outgroup derogation has been thoroughly investigated under the umbrella of infrahumanisation and the findings appear to be robust under a variety of circumstances.

Infrahumanisation

The dehumanisation of an outgroup member implies they are not human. The related concept of infrahumanisation is considered a less severe form of dehumanisation and involves the perception of outgroup members as somewhat less human and more animal-like than ingroup members. (It does not involve likening humans to machines.) Infrahumanisation is intergroup-related, whereas dehumanisation can be interpersonal (Castano & Giner-Sorolla, 2006, Leyens, Demoulin, Vaes, Gaunt & Paladino, 2007). Research into infrahumanisation has revealed that people are more likely to attribute uniquely human characteristics, compared to non-uniquely human characteristics, to the ingroup, regardless of the valence of the characteristic (Leyens et al., 2001). Infrahumanisation also occurs when people are asked to explicitly compare outgroup members to animals or humans (Viki et al., 2006). For instance, British people have been found to attribute more animal-related words (critter) to German names and pair more human-like words (criminal) to British names regardless of word valence (Viki et al., 2006). Utilising a combination of implicit and explicit methods of

association, these results suggest that infrahumanisation involves more than ingroup favouritism.

Importantly, research suggests that infrahumanisation is not omnipresent; the outgroup must be relevant in some way for infrahumanisation to occur. This may include instances of military or political conflict with the outgroup, perceived economic competition (e.g. applying for the same jobs) or proximity (Castano & Giner-Sorolla, 2006). To illustrate, French-speaking Belgians were found to infrahumanise Flemish-speaking Belgians but not Parisians or residents of Prague (Cortes, Demoulin, Rodriguez, & Leyens, 2005, Study 3). Furthermore, British students were more likely to infra-humanise Australian Aborigines when reminded of their near extermination caused by the British colonisation of Australia over 200 years ago, compared to when they were told that the colonisation had little effect on the size of the aboriginal population Castano & Giner-Soralla, 2006). In addition, French-speaking Belgians were shown to infrahumanise Polish people when the latter were presented as potential competitors in the labour market (Cortes, 2005, in Leyens et al. 2007).

Infrahumanisation research has been important to recent theories of humanness and dehumanisation in three main ways. Firstly, it explicitly defined humanness and operationalised human-like attributes. Second, infrahumanisation has been identified in various intergroup contexts, demonstrating its robustness. Finally, this research has found that animalistic dehumanisation has relatively subtle forms that can be studied in everyday social interactions, rather than just the most extreme cases such as genocide (Haslam et al., 2013). Nonetheless, recent research has shown that a single dimension of humanness does not adequately account for the many varieties of dehumanisation. In addition to comparing others to animals (as in infrahumanisation) people can be denied their human nature and compared to machines (Haslam, 2006; Haslam, Bain, Douge, Lee & Bastian, 2005). In the next section of this Introduction, I will discuss a theoretical model that elaborates on this distinction between animalistic and mechanistic dehumanisation.

Haslam's Integrated Model of Dehumanisation: How Individuals are Dehumanised as Animals or Machines

Haslam (2006) argued that the social psychology literature had not adequately defined the concept of dehumanisation or provided a clear indication of what was being denied to others when they were dehumanised. Previous theoretical perspectives on dehumanisation, with the exception of infrahumanisation, discussed dehumanisation from within the context of aggression, arguing that it accompanied extremely negative evaluations of others, and that it was a motivated phenomenon serving individual, interpersonal or intergroup functions (Haslam, 2006). While acknowledging that dehumanisation involves the denial of full humanness to others, unlike other definitions, Haslam argued that it can occur outside the domains of violence and conflict. He further proposed that dehumanisation may occur in interpersonal as well as intergroup contexts and that it has social-cognitive dimensions in addition to the motivational determinants that are usually emphasised.

Two senses of humanness: Uniquely human and human nature.

Haslam (2006) proposed that dehumanisation involves the denial of two forms of humanness: uniquely human (HU) characteristics that distinguish humans from the related category of animals, and human nature (HN) characteristics that are viewed as features that are typical or central to humans. HU characteristics include imagination, intelligence, refinement, culture, socialisation and moral sensibility. These characteristics are seen as being acquired rather than innate and culturally specific (Bain, Vaes, Kashima, Haslam & Guan, 2012; Park, Haslam & Kashima, 2012). HN characteristics on the other hand, are viewed as being essential to humanness and are viewed as the core properties that people share. These characteristics include attributes such as interpersonal warmth, depth, emotional responsiveness, individuality and cognitive openness. Several studies have found that participants can distinguish between HU and HN characteristics, suggesting that these are two distinct senses of humanness (Haslam, Bastian & Bissett, 2004, Haslam et al., 2005).

Two forms of dehumanisation: Animal-like and machine-like.

Haslam (2006) further proposes that the denial of HU and HN characteristics leads to different forms of dehumanisation. Specifically, when HU characteristics are denied to others, they are perceived as lacking refinement, maturity, rationality, moral sensibility and civility. This is known as animalistic dehumanisation. When individuals are dehumanised in this way they are perceived as child-like and acting on instinct rather than intelligence. Their behaviour is seen as being motivated by instinctual appetites. For the remainder of this Introduction individuals who are denied HU characteristics and dehumanised in an animalistic way will be referred to as animal-like. When HN characteristics are denied to others, they are seen as lacking emotion, warmth, cognitive openness and individuality: this is known as mechanistic dehumanisation. Individuals dehumanised this way are perceived as cold, rigid, inert and lacking agency. For the remainder of this introduction individuals who are denied HN characteristics and dehumanised in a mechanistic way will be referred to as machine-like. These dimensions of humanness are not mutually exclusive. Individuals can be denied HN and HU simultaneously. For instance, drug addicts and homeless people can be denied both senses of humanness to the point that they are not even perceived as animals or machines, but rather, as non-entities (Bain, Park, Kwok & Haslam, 2009; Harris & Fiske, 2006; Vaes, Leyens, Paladino & Miranda, 2012).

Dehumanisation may manifest itself in various ways. The denial of humanness can be explicit or subtle. For example, Native Americans may be explicitly labelled as wild creatures or they may be perceived as lacking uniquely human emotions thus being implicitly likened to animals (Castano & Giner-Sorolla, 2006). Furthermore, dehumanisation can also occur in relation to other groups or individuals for example, comparing an ingroup to various outgroups; or it can be absolute, such as calling someone a filthy pig (Haslam et al., 2013). Empirically, these two senses of humanness have also been linked to their corresponding dehumanising metaphors. For example, when a fictional group was explicitly labelled as

animal-like, participants were found to associate them with words low on human uniqueness such as emotional, aggressive, intolerant and curious (Loughnan, Haslam, & Kashima, 2009). In addition, when a vignette described the fictional group as emotional, aggressive and intolerant participants identified the group members as more animal-like compared to machine-like. In sum, individuals appear to recognise the relationship between the metaphorical dehumanisation of others (*Xs are animals*) and the more subtle attribution of certain characteristics (*Xs are aggressive and emotional*) to make others look less than human.

Social categorisation and dehumanisation.

Most theoretical accounts of dehumanisation hold that it is a motivated phenomenon enabling the release of aggression or removing the burden of moral qualms such as guilt or distress. Many theorists also emphasise the role of societal factors such as social movements and political or religious ideologies for motivating individuals to dehumanise others (Haslam, 2006). The socio-cognitive underpinnings of dehumanisation have been given little attention. However, Haslam proposed that dehumanisation could reflect ordinary social cognitive processes, such as social categorisation. Social cognition refers to the encoding, processing, storage and retrieval of information in the brain enabling us to perceive other humans in relation to ourselves (Adolphs, 1999; Moskowitz, 2005). It allows us to make attributions about the causes of other people's behaviours and to understand the motivation behind their behaviours (Fiske & Taylor, 1991). One way of understanding other people efficiently is to categorise them into groups because they share certain features such as ethnicity, and this process is known as social categorisation. Understanding our environment in terms of categories enables us to function effectively in society by focusing on relevant information and ignoring apparently useless information (Bruner, 1957; Taylor, 1981). However, social categorisation can lead to the exaggeration of differences between groups and the overemphasis of ingroup similarities. Ignoring the individuality and uniqueness of group

members may lead to increased occurrences of stigmatisation, stereotyping and prejudice (Krueger & Rothbart, 1990; Wilder, 1981). Consistent with this, Loughnan and Haslam (2007) found that participants associated artists and children with animal-like traits and business people and criminals with machine-like traits, using the Go/No-go Association Task (GNAT), a speeded judgement task intended to measure implicit attitudes. This study suggests that denying human attributes to other people and likening them to nonhumans is a subtle, every day event occurring in the absence of conflict, motivation and negative evaluation (Loughnan & Haslam, 2007). By implication, social groups that are not normally objects of prejudice may be subtly dehumanised in two distinct ways, implicitly likened to animals or machines (Haslam, 2006).

Cross cultural patterns of dehumanisation: animals, machines and supernatural beings. Across all cultures, there is a basic shared understanding of what it means to be human; however the aspects viewed as essential and important may vary depending on cultural expectations. For example, individuals from collectivistic cultures may emphasise the importance of conformity whilst individuals from individualistic cultures may be more likely to emphasise the expectation of emotionality (Haslam, Kashima, Loughnan, Shi & Suitner, 2008; Park et al., 2012). Recent research has shown that when people are likened to animals or machines they are not just denied certain traits or emotions but also distinct types of mental capacities (Haslam et al., 2008). In one study of three cultures (Australia, China, and Italy), there was cross-cultural agreement in that animals were seen as lacking refined emotion and cognitive power but having superior perceptual capacities. In addition, robots were viewed as lacking emotion and desire and supernatural beings were seen as having superior cognitive and perceptual capacities.

Interestingly there were some meaningful cross-cultural differences. Italians perceived the biggest differences between humans and robots and the smallest differences between humans and animals, whereas Chinese participants showed the opposite pattern. These

differences may mirror self-stereotypes of Italian warmth and emotionality and Chinese refinement and intelligence. Italians also had a tendency to attribute higher levels of mental capacity to supernatural beings, probably reflecting the country's strong Roman Catholic tradition (Haslam et al., 2008).

Further, when Anglo-Australians and ethnic Chinese participants were asked to rate themselves and each other on the two dimensions of humanness, the members of each national group appeared to acknowledge their strengths and weaknesses in relation to the other nation (Bain et al., 2009). Australians rated themselves highly on human nature traits and values whilst denying these same traits and values to the Chinese outgroup. However, the Australians attributed greater levels of human uniqueness traits and values to the Chinese outgroup compared to themselves. In a similar way Chinese participants attributed more human nature values to Australians than to themselves, whilst rating themselves higher on uniquely human values and traits compared to Australians. People tend to see ingroup flaws as more relevant to human nature compared to outgroup flaws; this may function to protect the group from blame as they perceive themselves as 'only human' (Koval, Laham, Haslam, Bastian, & Whelan, 2012). Previously research has found that attributing greater human uniqueness to the ingroup is an almost universal phenomenon (Leyens et al., 2001). However, these findings suggest that the way a group defines itself affects what traits and values they will attribute to themselves compared to an outgroup and there is no one group of traits or values that characterise what it is to be human (Bain et al., 2009).

The human/supernatural contrast findings in the study conducted by Haslam and colleagues (2008) raise an interesting implication regarding the process of dehumanisation. Supernatural beings were ascribed superior cognitive and perceptual capacities, suggesting they are looked upon with wonder and admiration. Consequently, viewing individuals such as doctors, celebrities and athletes as superhuman may be considered a form of dehumanisation

if it involves the failure to recognise the person's fallibility, feelings and desires (Haslam et al., 2008).

In a similar way, people often attribute human-like qualities to non-human agents (e.g., saying a computer is 'having a dummy spit'), a phenomenon known as anthropomorphism. Understanding the processes motivating and enabling individuals to view non-human agents as human-like may inform our understanding of the dehumanisation as it has been described as an act of humanisation, the inverse process of dehumanisation (Epley et al., 2007).

Anthropomorphism and its Links to Dehumanisation

Anthropomorphism occurs when nonhuman agents and objects are attributed humanlike properties, characteristics or mental states. A common example of anthropomorphism is a pet owner's belief that her dog 'loves' her. This belief goes beyond observable actions and represents the dog's mental capacities using a human-like descriptor (Epley et al., 2007). Three primary factors appear to be involved in the anthropomorphism of objects and nonhuman agents. Firstly, humans do not have access to the phenomenological experience of nonhuman agents, so we have a tendency use our own mental states and characteristics as a guide when dealing with nonhuman agents (Epley et al., 2007). Secondly, the motivation to explain and understand the behaviour of nonhuman agents drives anthropomorphism. For example, people are more likely to anthropomorphise an unpredictable dog compared to a predictable dog, as this allows them to feel have more control over the situation (Epley et al., 2008). Thirdly, the desire for social connection (loneliness) may drive an individual to anthropomorphise a nonhuman agent such as an animal or object (Epley et al., 2007). The considerable market for human-like robots that create a sense of social connection that has emerged in the last few years, with some of them even having the ability to hug, serving as anecdotal evidence of this function (Waytz et al., 2010b).

Research has demonstrated that individual differences in anthropomorphism predict the amount of moral concern afforded to nonhuman agents, such as increased concerns for the environment when anthropomorphising nature (Waytz, Cacioppo & Epley, 2010a). Additionally, perceiving an object or nonhuman agent to have a mind means it is capable of intention and can therefore be held accountable for its actions (Grey, Grey & Wegner, 2007). To illustrate, representing corporations as single personified agents may increase their chances of being held legally responsible for moral violations compared to corporations that are represented as a group of separate individuals (French, 1986). Finally, perceiving nonhuman agents as being capable of judging and observing humans may function to increase socially desirable behaviours (Waytz et al., 2010a). For example, omnipresent anthropomorphised perceptions of God may have evolved to control large groups of people, particularly when law enforcement was difficult. According to this view, people are less likely to break the law or act anti-socially when they think someone is watching them and they will be punished (Johnson & Kruger, 2004). Understanding individual differences in anthropomorphism is important as it allows researchers to identify who is most likely to treat nonhuman agents as human-like, but it may also help identify those individuals likely to treat other humans as animals or objects (Waytz et al., 2010a). If anthropomorphism increases moral concern, trust and connectedness with non-human agents, then dehumanisation should decrease moral concern, trust, and social connection with other humans (Waytz et al, 2010a).

Effects of Dehumanisation on the Individual

The views and behaviours of individuals involved in dehumanising others have been the exclusive focus of the research on dehumanisation. However the thoughts, feelings and behaviours of those who have been dehumanised have received little attention in social psychology. In order to fully understand the phenomenon of dehumanisation and its effects on the individual and society, it is important to investigate what the dehumanised individual is feeling and thinking about themselves and others. This section of the Introduction will start

broadly by examining our fundamental need to belong, since dehumanisation involves being excluded from humanity (Opotow, 1990). Following this, and in line with Haslam's (2006) two dimensional conceptualisation of dehumanisation, the literature exploring how people feel when they are reminded of their animal nature will be discussed. Relatedly, the occurrence and effects of self-objectification will be explored. Next, reactions to social rejection will be explored, since being ignored and treated with indifference is central to the experience of dehumanisation (Bastian & Haslam, 2010). The discussion will then move to exploring the possibility of displaced aggression following a dehumanising experience. Finally, the empirical research applying Haslam's human uniqueness and human nature attributes to the victim's perspective will be described, thus leading to the overview of the thesis.

The need to belong.

Human behaviours, emotions and thoughts are heavily influenced by a fundamental interpersonal drive to obtain acceptance and to avoid rejection by other people, known as the need to belong (Baumeister & Leary, 1995). This need to belong is thought to have evolutionary origins, developing as membership within social groups gave individuals survival and reproductive benefits (Baumeister & Leary, 1995). According to Baumeister and Leary's (1995) theory, belonging is necessary for psychological and physical health. If people do not feel that they belong due to rejection or limited opportunities to form attachments, their thoughts, behaviour and emotions will be negatively affected. Over a prolonged period of time their health, happiness, ability to adjust and emotional well-being will deteriorate. For example, victims of discrimination, stigmatisation and prejudice experience increased levels of psychological and physical stress responses such as fear, anger, and a compromised immune system, inflating health risks (Clarke, Anderson, Clark & William, 1999; Fischer & Bolton Holz, 2007; Moradi & Risco, 2004; Pascoe & Smart Richman, 2009). However, being the target of discrimination has also been found to increase pro-social behaviours (e.g. social

activism, education) and may buffer against psychological symptomology (DeBlaere et al, 2014; Moradi, 2013; Pascoe & Smart Richman, 2009). Depending on how an individual perceives a dehumanising event, and the protective measures they have in place, they may experience a variety of emotions, physical states and consequences. The next section explores the feelings individuals may experience after a dehumanising episode. Firstly, the feelings resulting from animalistic dehumanisation will be discussed and secondly, those feelings created by self-objectification will be examined.

Are reminders of one's animal nature always upsetting?

Humans must eat, excrete and breed just like animals; our bodies are soft and fragile like theirs, pouring out blood and soft viscera when violated (Rozin, Haidt & McCauley, 2000). Being reminded of our animal nature reminds us of how easily our soft bodies could be violated, and just how close we are to death at every moment. The emotion of disgust allows us to 'humanise' our animal bodies (Rozin et al. 2000); it dignifies humanity by allowing humans to place themselves above animals which are considered inferior (Rozin, Haidt, McCauley, Dunlop & Ashmore, 1999). For example, Balinese tradition dictates that once children reach puberty they are to have their canine teeth filed back to diminish the similarities between humans and animals (Forge, 1980). Relatedly religious practices worldwide emphasise the importance of bodily cleanliness before one approaches God, and it is only when we can conceal our animality that we are accepted (Haidt, Rozin, McCauley & Imada, 1997).

When individuals are dehumanised in an animal-like way, they become an object of disgust and contempt for the perpetrator. Images of dehumanised others often represent them as filthy, wild beasts (Haslam, 2006). Utilising the emotion of disgust, torturers are told that prisoners are 'worms' that need to be 'crushed, enabling them to dehumanise others and perform their duties (Gibson & Haritos-Fatouros, 1986). Relatedly, sex appears to be problematic for humans as it reminds us of our animal nature. At first glance pornography

may appear to be animalistic, contradicting the terror management perspective which posits that sex makes people uncomfortable because it reminds us of our creaturely mortal nature; and being reminded of our morality should give rise to feelings of terror and anxiety. However on closer inspection, the women are often objectified – bodies' shaven, airbrushed, and augmented – enabling the viewer to distance themselves from the animalistic nature of the acts (Goldenberg, Cox, Pyszczynski, Greenberg & Solomon, 2002).

Self objectification.

As previously mentioned, in contemporary western society women are highly sexualised often leading to self-objectification (Fredrickson & Roberts, 1997; Goldenberg et al., 2002). Men have been found to dehumanise sexually objectified women when they are attracted to them, whereas women are most likely to dehumanise objectified women when they distance themselves from these sexual representation of females (Vaes, Paladino, & Puvia, 2011). Individuals can be objectified regardless of gender; there is evidence suggesting that women as well as men are viewed as emotional but lacking self control and moral responsibility when bodily focus is induced (Gray, Knobe, Sheskin, Bloom & Barrett, 2011). However, in everyday life, women are more likely to be spontaneously objectified than men (Moradi & Huang, 2008). Self-objectification occurs when women internalise observers' perspectives of their physical selves, treating themselves as an object to be looked at, where physical appearance rather than personhood is used to gauge a sense of self, effectively dehumanising themselves (Fredrickson & Roberts, 1997; Heflick & Goldenberg, 2009; Tiggemann & Slater, 2001). The psychological consequences for women appear to be far reaching and have been hypothesised to include anxiety, poor self-image, eating disorders, and feelings of shame, sexual dysfunction, and depression (Fredrickson & Roberts, 1997; Tiggemann & Slater, 2001). It has also been found that women objectify each other, and when asked to focus on the physical appearance of another female versus her personality, the other woman is viewed as less than human (i.e. more robotic and less competent; Heflick &

Goldenberg, 2009). These findings suggest that women feel the need to distance themselves from the creatureliness of being able to carry a child and lactate. Perceiving other women as objects may enable women (and men for that matter) to deny our animal nature and avoid thoughts of morality. This section has discussed the detrimental effect that dehumanisation–animalistic or mechanistic–can have on an individual's feelings. The next section will explore what people might do when they have been dehumanised, based on the social rejection literature.

Reactions to social rejection.

Most people when rejected, be it through discrimination, stigmatisation or ostracism, immediately experience increased levels of negative affect and lowered self-esteem (Smart-Richman & Leary, 2009). However, after this initial reaction subsequent behaviours can be diverse. Some people report emotional numbness, others become extremely angry (Chow, Tiedens & Govan, 2008), while other people try to repair the damage (Smart-Richman & Leary, 2009). Depending on how an individual views their rejection they may be motivated to act pro-socially, aggressively, or to withdraw. According to the multimotive model proposed by Smart-Richman and Leary these three motives occur simultaneously after rejection, which may promote competing behaviours. The first motive involves a heightened desire for social connections, often with the person who rejected them, but also with others. The second motive involves angry, antisocial urges to defend oneself against the rejecter, possibly aiming to hurt others. The third motive involves avoiding further rejection by socially withdrawing.

Which one of these motives predominates depends on how the individual interprets the rejection experience. It is proposed by Smart-Richman and Leary (2009) that individuals view the experience using one or more of the six possible construals involving the fairness of the rejection, expectations of relationship repair, pervasiveness or chronicity of the rejection, value of the damaged relationship, perceived costs of rejection, and the possibility of relational alternatives. For example, if the rejection is viewed as unfair and chronic the

individual is likely to act antisocially or aggressively; however, an individual who has high expectations for relationship repair and sees no relational alternatives is likely to act pro-socially to restore their sense of belonging. Individuals who see other relational alternatives are more likely to socially withdraw from the rejecter, especially if the rejection is chronic (Smart-Richman & Leary, 2009). In sum, the victims or targets of dehumanisation are likely to be negatively impacted by the experience; also they may react in a variety of ways dependent on their relationship to the perpetrator and the chronicity of the dehumanisation. As noted previously, when people are exploited or abused they are treated with contempt, and viewed as less than human, by the perpetrator. Being exploited induces feelings of anger, guilt and shame, resulting in individuals either lashing out at their perpetrator, or choosing to hide (Vohs, Baumeister, & Chin, 2007). The most extreme example of exploitation involves the emotional, physical and sexual abuse of individuals within interpersonal relationships, particularly amongst family members and partners, as these are the people who should be protecting victims. Consequently, there is a strong association between experiences of abuse and increased vulnerability to mental health issues, chronic illness and social problems in adult life (Mullen, Martin, Anderson, Romans & Herbison, 1996).

Abused individuals report higher levels of mental illness, specifically anxiety, depression, substance abuse and post-traumatic stress disorder compared to the general population (Coker et al., 2002; Pico-Alfonso et al., 2006). They are also more likely than the average person to report physical conditions such as gastrointestinal disorders, hypertension and chronic pain, possibly due to high levels of stress or physical injury from abuse (Campbell, 2002). Victims of sexual abuse also report more shame-proneness and interpersonal conflict compared to those without a history of abuse; shame has been associated with submissiveness as well as outward aggression towards partners (Kim, Talbot, & Cicchetti, 2009). Shame-prone individuals may withdraw socially when they feel criticised or rejected, to avoid further loss of face. Alternatively, they may react defensively to protect

their shame-prone self, creating an anger-shame cycle (Lewis, 1971). Further, shame has been found to motivate the need to regain a positive self-image and when this is impossible people withdraw to avoid further shame (de Hooge, Zeelenberg, & Breugelmans, 2010). Relatedly, when people are treated with contempt their self-esteem is lowered, motivating them to reciprocate feelings of contempt and treat the perpetrator aggressively (Melwani & Barsade, 2011). Overall, experiences of abuse and exploitation have been associated with negative physical and psychological outcomes for victims extensively within the literature. Additionally, such experience activates self-conscious emotions such as shame, contempt and anger, proliferating interpersonal conflict or social withdrawal.

Displaced aggression.

The aggression shown towards dehumanised individuals has been extensively examined in social psychology (Bandura, Underwood & Fromson, 1975; Zimbardo & White, 1972), but the aggressive tendencies of those being dehumanised have been largely ignored. In the Stanford prison experiment, dehumanised individuals acted aggressively towards the very people who could allow them to feel human again. Prisoners tormented those who were not coping with being incarcerated by labelling them 'bad prisoners' (Zimbardo & White, 1972). Moreover, Holocaust survivors recall how they were brutalised and tormented by fellow prisoners, the very people they looked to for comfort (Levi, 1987).

This unexpected phenomenon might be explained, in part, by displaced aggression: directing aggressive behaviour towards an innocent, usually less powerful other, when directing it at the initial provocateur is impossible (Dollard, Doob, Miller, Mowrer & Sears, 1939; Miller, Pedersen, Earleywine, & Pollock, 2003). This frustration may be caused by several constraining factors: a) the provoking agent in unavailable (walked away) b) the source of the frustration is elusive (situation), and c) punishment is feared from the provoking agent (e.g. guard) (Marcus-Newhall, Pedersen, Carlson & Miller, 2000; Miller, 1941). In the

case of dehumanised individuals any one of these factors could cause displaced aggression to be directed at innocent others.

A meta-analysis (Marcus-Newhall et al., 2000) of the displaced aggression literature confirmed it is a robust effect. Specifically, a greater magnitude of displaced aggression was directed towards a target if the interaction occurred in a negative situation. Also, the more similar the target was to the provocateur, the more displaced aggression was directed towards them. Evidence for the displacement of aggression and its constraining factors include young boys attributing less positive attributes to foreigners after being put in a frustrating situation (Miller & Bugelski, 1948). Participants rating absent, uninvolved friends lower on personality scales after being frustrated and bullied by a confederate in a competition about cooperation (Miler & Bugelski in Dollard et al. 1939). Finally, on a larger scale historically, public lynchings were more likely to occur in the U.S during times of economic hardship (Hovland & Sears, 1940). Displaced aggression, then, appears to be another possible response to being dehumanised.

Empirical Investigation of Dehumanisation from Target's Perspective

The vast majority of research investigating dehumanisation has examined the perspective of the perpetrator, with a particular focus on intergroup relations (Bain et al., 2009; Castano & Giner-Sorolla, 2006; Leyens et al., 2001). Most studies have explored the external factors leading to the dehumanisation of outgroups including military conflict or economic competition (Castano & Giner-Sorolla, 2006; Cortes et al., 2005; Zebel et al., 2008). In addition, internal motivating factors such as ideologies (Universal Orientation, Social Dominance Orientation) and personality types (dark triad) have also been investigated (Costello & Hodson, 2010; Hodson, Hogg & MacInnis, 2009). Recently there has been a shift towards focussing on interpersonal relationships as a context for dehumanisation, with particular focus on the perpetrator's perspective (Greitemeyer & McLatchie, 2011; Bastian, Jetten & Radke, 2012). Dehumanisation from the victim's perspective had been largely

overlooked until Bastian and Haslam (2010) measured levels of dehumanisation in rejected individuals. Over two studies they found that participants not only viewed themselves as less than human, but they also viewed their perpetrators in the same way. In Study 1, participants wrote about a time they had been excluded or included and then rated themselves and the perpetrator on human nature and human uniqueness attributes. Study 2 involved a computer-simulated ball toss game (Cyberball) where the participant was either included or excluded by the other players. Across both studies, excluded participants rated themselves and the perpetrator as being low on human nature, (machine-like). Moreover, these excluded participants felt that attributes such as curious, friendly, fun-loving, impulsive and jealous did not apply to them or the perpetrators. Human uniqueness did not appear to play a central role in the exclusion of participants. This kind of dehumanisation, viewing the self as emotionally devoid and object-like, may allow victims to avoid feeling the pain of being excluded from humanity. Overall, the studies supported the assumption that when we are excluded our sense of shared humanity is disrupted and so we feel dehumanised.

Following from that study, Bastian and Haslam (2011) investigated subtle forms of dehumanisation from the victim's perspective, such as being treated with condescension, or being neglected. The study focused on the psychological effects of being dehumanised, specifically focusing on cognitive states and emotional reactions. Study 1 employed vignettes describing a range of everyday, subtle interpersonal maltreatments including being treated instrumentally. For example, "*You discover that this person is interested in getting to know you only in order to be closer to your uncle*". The vignettes were linked with either the denial of human uniqueness or human nature; that is, being made to feel animal-like or machine-like, respectively. The denial of human uniqueness, or animalistic dehumanisation, was associated with increased feelings of shame and guilt. In addition, the denial of human nature, or mechanistic dehumanisation, was associated with cognitive deconstructive states such as

numbing and a lack of clarity of thought. Mechanistic dehumanisation was also associated with feelings of anger and sadness.

To investigate actual experiences of maltreatment rather than hypothetical responses a second study in the series asked participants to recall a time they had been mistreated. These experiences were either involved the denial of human uniqueness ("*think about a situation where you were treated as if you were incompetent, unintelligent, unsophisticated and uncivilised*"), or the denial of human nature ("*a situation where you were treated as if you were a means to an end, as if you were an object, and as if you had no feelings*"). The findings were consistent with Study 1; the denial of human nature was associated with cognitive numbing and anger, whereas the denial of human uniqueness was marginally linked to increased feelings of shame and guilt. This study highlighted how acutely aware people are of being denied their humanity, even when the ill-treatment is quite subtle. Furthermore, both studies demonstrated that dehumanisation can affect individuals both cognitively and emotionally, dependent on what aspect of their humanity has been denied.

The findings of these two papers by Bastian and Haslam (2010, 2011) are both interesting and informative. However asking participants to answer the questions only in reference to Haslam's (2006) two-pronged theory of humanness may have skewed the types of experiences participants recalled as they were being asked to respond in a certain way. To combat this possible bias in responses, the overall aim of this thesis was to explore a more diverse range of experiences that people find dehumanising, and to examine the impact of these events on participants' thoughts, feelings, and behaviours.

OVERVIEW OF THESIS

Research on dehumanisation has typically investigated those factors that lead individuals to dehumanise others. This dissertation is significant in that it is among the first that attempts to empirically investigate dehumanisation from the perspective of the

dehumanised individual. The current chapter reviews the literature on dehumanisation, and underlines the need to focus on dehumanisation from the target's perspective. Chapter 2 reports a qualitative study of recalled episodes in which respondents felt dehumanised. The results showed that dehumanisation occurs on a continuum ranging from single instances of light ridicule to extreme cases of ongoing abuse. Further, the tendency to dehumanise was not confined to interactions with outgroup members or to those with whom people shared superficial connections; many of the recalled instances involved family members and close others. Emotional reactions to dehumanisation commonly involved intense feelings of shame, anger and sadness.

Many of the recalled episodes of dehumanisation obtained in the qualitative study also involved instances of social exclusion. Using a quasi-experimental design, the study reported in Chapter 3 investigated whether experiences of animalistic and mechanistic types of dehumanisation threaten fundamental needs including belonging, control, self-esteem and meaningful existence. The findings confirmed that experiences of mechanistic dehumanisation are less likely to threaten one's sense of self-esteem and belonging compared to being excluded. Whereas, experiences of animalistic dehumanisation and exclusion equally threaten fundamental needs.

The results of the first two studies also revealed that the perpetrators of the recalled dehumanising episodes were often family members, friends, partners or colleagues. To further examine the relational aspects of dehumanisation, the study described in Chapter 4 used an autobiographical recall task to investigate the characteristics of dehumanisation and target feelings and reactions in close relationships. The results suggest that episodes of dehumanisation tend to fuel a cycle of shame and contempt between the victim and perpetrator, particularly when it was perceived by the target as intentional.

The study reported in Chapter 5 investigated the effects of dehumanisation in a relationship that involves trust and personal disclosure—the doctor patient relationship. After

reading a vignette depicting a doctor's treatment philosophy emphasising either the metaphor of the body as a machine (dehumanising condition) or emphasising individual humanness (humanising condition), participants imagined attending a consultation with the doctor regarding a psychological or physical illness. Medical dehumanisation generally had undesirable consequences. However, the findings also suggest the intriguing possibility that men who scored high on a measure of emotional expressiveness prefer a doctor who sees the body as a machine in need of repair, when it is a psychological issue. It is possible that having a medical professional explain that the illness has nothing to do with their feelings, but rather reflects a malfunction in their brain, might actually alleviate their worries about the illness by decreasing feelings of personal responsibility. The final chapter (Chapter 6) provides a brief review of the findings and discusses the merits of investigating the target's perspective for improving our understanding of the causes and consequences of dehumanisation.

Chapter 2

Study 1: Qualitative experiences of dehumanisation

Investigating dehumanisation from the perpetrators' perspective has enabled a better understand the various processes motivating intergroup and interpersonal dehumanisation including strong intragroup connections (Waytz & Epley, 2012), guilt avoidance (Osofsky et al., 2005), aggression (Bandura, Underwood & Fromson, 1975), and power (Lammers & Stapel, 2011). To illustrate, when individuals have strong social connections the need to see humanlike traits in socially distant others is diminished (Epley, Waytz & Cacioppo, 2007; Waytz & Epley, 2012). Furthermore when individuals have power over others, particularly with the aim of harming the victim they are likely to dehumanise the other person (Haque & Waytz, 2012; Lammers & Stapel, 2011), enabling them to reduce their feelings of guilt and avoid empathic exhaustion (Harris & Fiske, 2009; Osofsky et al., 2005). The vast majority of research has focused on why people are dehumanised and how they might be viewed by others. There has been very little focus on what it feels like to be dehumanised, and what consequences these events have for victims' views of the self and their world views.

The aim of the first study of this research program was to more fully investigate the range of experiences, both severe and less severe, that people view as dehumanising. Due to the exploratory nature of the study, all questions were of a qualitative nature and answers were free response. It was expected that being excluded (Bastian & Haslam, 2010), discriminated against (Moradi, 2013), likened to animals or machines (Haslam, 2006) and suffering interpersonal maltreatments (Bastian & Haslam, 2011) would elicit feelings of dehumanisation. However, this study sought to investigate the typicality of these events and to identify previously overlooked experiences. This study also investigated who the perpetrators of dehumanisation were in relation to the victim. Drawing on the dehumanisation

literature, it was generally expected that participants would recall being dehumanised by socially distant others, or people in a position of power. Additionally, and in line with previous research, it was expected that participants would recall feeling ashamed, angry and sad following the dehumanising experience (Bastian & Haslam, 2011; Kim et al, 2009). However, this study also explored how those who have been dehumanised felt about someone else faced with the same dehumanising situation as their own. Given the literature showing that victims of dehumanisation may direct aggression at innocent and less powerful others, when the provocateur is unattainable (Miller, Pedersen, Earleywine & Pollock, 2003; Zimbardo & White, 1972), it was speculated that dehumanised individuals would treat someone in the same position as themselves with contempt. It was also hypothesised that some individuals would report a more compassionate response, though it was not possible to speculate about the conditions under which this might emerge.

Method

One hundred and ninety-five participants participated in this study (30 men and 165 women). The mean age of the sample was 21 years (SD = 5.74 years). The first 14 participants were recruited using the university online research portal. The remaining 181 were first year psychology students participating for credit.

The study was completed anonymously online. After providing demographics, participants were asked to answer four, free response questions starting with; "*Please describe in as much detail as you can a time in your life when you have been made to feel less than human. This could have been a positive or negative experience*". Following this participants were asked "*How did this make you feel about yourself?*" then, " *How did you feel towards those who made you feel less than human?"* and finally *" If you saw someone else treated like this, how would you feel towards them*?"

Coding of Open Ended Questions

In general, participants wrote richly detailed accounts recalling episodes

of dehumanisation. The mean response length was 146 words (*SD* = 202.6). The mean response length for self-directed feelings following the incident was 34 words (*SD* = 35.3). The mean response for feelings directed at others following the incident was 30 (*SD* = 35.3). The mean response for reactions to seeing another treated the same way was 24 words (*SD* = 23.9). The primary coder analysed each free-response using a bottom-up approach (Braun & Clarke, 2006). The aim was to create a concise, informative coding scheme that would provide a useful number of discriminatory categories, without being either over or under inclusive. Coding transcripts according to this structured coding scheme required minimal rater training. To analyse interrater reliability, Cohen's kappa was calculated for each question category; the interrater reliabilities were all adequate, with a mean kappa of .75. The two coders agreed 92.2% of the time. All disagreements were later resolved in discussion.

Results

Participants recounted an extensive variety of dehumanising episodes. Nine distinct categories comprised the majority of events recalled: abuse, mechanisation, degradation, discrimination, rejection, bullying, animalisation, dehumanisation of others, and other (see Table 1 for descriptions).

Examples of Dehumanisation by Category

The examples below have been taken directly from participant responses to the question: *"Please describe in as much detail as you can a time in your life when you have been made to feel less than human. This could have been a positive or negative experience".* Two examples from each of the nine categories have been included.

Abuse.

"I was being abused by my ex-partner. I was physically abused by being thrown around, choked, spat on, kicked and punched. I was not allowed to speak and was threatened with death like I was nothing, this was extremely distressing and degrading, and I felt that was treated worse than an animal at that time." **(Female, Aged 38)**

Table 1

Types of Dehumanisation

Type	%	n	Descriptions
Abuse	22.6	44	Sexual, physical, verbal, emotional, intimidation, robbed, horrific situations
Mechanisation	15.9	31	Feeling like a machine, treated like an object, robot, servant, treated like a number, feeling deindividuated, insignificant, work environment, Final high school exam process, being expected to work constantly without flexibility
Degradation	13.8	27	Treated like a child, condescension, treated like you need assistance, humiliated, embarrassed, ashamed, belittled
Discrimination	13.3	26	Being judged on race, religion, sexuality, being different to everyone else,
Exclusion	9.2	18	Being isolated, rejected, ignored, dismissed
Bullying	8.7	17	No specific reasoning behind other people picking on you
Animalisation	7.2	7	Feeling like an animal, being compared to an animal, feeling like a creature/body of cells
Dehumanisation of others	4.1	8	Treating others terribly, seeing others being dehumanised, hearing about others being dehumanised e.g. grandparents in Holocaust
Other	5.1	9	Illness, being good at sport, frightened, scared

Note: N = 195

"The birth of my second child at a private hospital in Sydney. An emergency procedure was required with short notice. A general aesthetic had to be administered which the anaesthetist did incorrectly three times before getting it right. I remember being carried by two men and literally thrown on the operating table with no regard for my 'human' feelings. I

woke to a great deal of pain and a nurse swearing at me in the hospital whilst prodding me like a cushion, again with no empathy to the fact I'd just had a procedure, had no one there at my bedside and had no idea where my child was! I still have chronic back pain 3 years later which I'm sure was from being thrown on the table and it took me a long time to get over the nightmares and anxiety of the whole experience." **(Female, Aged 36)**

Mechanisation.

"For a race our coach gave us a "pep talk" whereby he continuously referred to us as nothing more than part of the boat. A machine that was so finely tuned that in order for it to work every part (boy in the boat) had to work in sync." **(Male Aged 25)**

"Regularly, my employer makes me feel less than human. I work for a casino. Despite the good parts of the job, there is a vibe of harshness, strictness, and callousness permeating the casino. My health is not cared about. If I am sick, I will literally be phoned and bullied to come back to work, even if they can hear that I am suffering from a chest infection. They are inflexible and uncaring. They expect a lot." **(Female, Aged 29)**

Degradation.

"I worked as a waitress at a local restaurant. One night a large family of wealthy, well educated, immaculately dressed people came in. They said "The help wants to know if we're ready to order." when I approached the table. It made me feel belittled and as if I was only there to serve them." **(Female, Aged 18)**

"I used to work as a secretary at a law firm a few years ago. The accounts clerk was away one day and I needed an urgent cheque. I asked one of the partners who was in charge of accounts who will be drawing the cheques as I needed one urgently. He proceeded to get very angry with me and I heard him telling another partner that he 'will not be spoken to by someone who is just an admin' and that 'if I needed anything from him in future that I needed to go through a partner, or someone who is in a higher position than me'." **(Female, Aged 23)**

Discrimination.

*"*I have faced anti-Semitism as a Jewish girl. I have had food thrown at me while walking down the street with friends. It makes me feel dehumanised as people feel that it is acceptable to discriminate against me because of a religion I was born in to*."* **(Female, Aged 18)**

"I was teased and bullied and ignored in primary school for being Asian. During the time when I was in primary school, there were not many other Asian children around. Teachers would often show favouritism towards other students and made no effort to discourage any form of teasing or bullying that occurred. I remember once in the playground, two boys confronted me and one of them decided to pour his small carton of milk over me (luckily I was wearing a hat). When I went to tell the teacher with my broken English, the response I got was 'oh don't worry, it was only a joke'." **(Female, Aged 23)**

Exclusion.

"An important person in my life rang me suddenly and ended our relationship. They gave me no reasoning of why, yet told me they were changing their number and blocking me on Facebook so I had no way of contacting them. This made me feel belittled and unworthy of a human." **(Female Aged 18)**

"A time in my life when I have felt less than human was in my first years of high school when I began to lose all my friends. They alienated me and left to be with the 'popular' groups. They acted as though I didn't exist and if they ever talked to me, they talked down to me." **(Female, Aged 18)**

Bullying.

*"*I was made to feel less than human when I was bullied in primary school. Constantly being put down by another made me feel significantly invaluable and less deserving. I felt less than human*."* **(Female, Aged 18)**

“Getting bullied at work because I wouldn't do someone else's work quickly enough, even though I wasn't meant to be doing the work in the first place.” **(Female, Aged 24)**

Animalisation.

*“*At a BBQ a family friend, saw me getting a piece of cake and jokingly said 'haven’t you had enough to eat, you've eaten as much as a cow'. I felt extremely sad and upset and I felt less than human. The rest of the night I felt ashamed, all I could hear in my head were that woman's words.” **(Female, Aged 18)**

“In everyday life we're being treated as cattle herded somewhere. With herded I mean that we're all waiting for the same train to take us from the city to our lives back in the suburbs. That makes me feel like less of a human and more like an animal in the sense that animals are more often likely to need guidance in where they are going, such as fences and gates marking the path they should take. That is very much how I feel when I'm out travelling in a new city. If you don't know the subway-map for instance then it is very helpful with these mazes down in the ground that helps you find your way. Sure it makes you feel like an animal being shoved in the direction the tunnel is going but at the same time you will be arriving at where you're supposed to go.” **(Female, Aged 21)**

Dehumanisation of others.

“I betrayed my best childhood friend by going behind her back and sleeping with her boyfriend several times and lying to her face about it when she asked me. She still trusts and treats me as her best friend not knowing what I have done. What makes it worse is I know how she feelings about cheating and betrayal.” **(Female, Aged 19)**

“When I was around the age of 13, I was involved in a group of people who were very hateful towards others. The emotional turmoil that I stood by and let happen to these children at that point, did make me feel like I was less than human, not animalistic, just not acknowledging basic humanistic ideals. The trauma this form of bullying would have caused these others by the social group was long lasting, and did not represent my ideologies to any

degree. The fear I had of exclusion was the only reason I didn't stand up for the liberties of these other children. If I had my time again, with the maturity and insight I have now I would certainly have acted in a very different manner." **(Male, Aged 18)**

Other.

"I have chronic pain, headaches and neck pain 24/7. I have been to all types of doctors and have received various types of treatment yet nothing has worked on me. The pain I have experienced since the age of 12 has led me to feel isolated from most people my age who don't understand what I am going through. I sometimes feel like what I'm experiencing is in-humane and unfair" **(Female, 18)**

"About 2 years ago I achieved a very elite level in dancing competition aerobics and felt as if I was less than human due to the level of fitness, flexibility and strength I achieved at this point in my life. I felt like a 'freak', but in a good way." **(Female, Aged 18)**

Context

The majority of people who reported being abused experienced this at home. Bullying, along with discrimination, rejection, and degradation, occurred most often at school. Interestingly, one third of participants recalled experiences of mechanisation during the final year of high school, when they felt like a number rather than a whole person.

Perpetrators

The majority of participants recalled an experience from within their social network; family members, partner, friends, boss or colleagues, peers at school, and teachers, coaches or instructors. The majority of people who recalled being abused and rejected when they felt less than human reported family members, partners or friends being involved in the experience (see Table 2). This was also the case when witnessing the dehumanisation of another person, or treating someone terribly (i.e., betraying a friend made someone feel less than human). Classmates were most likely to have bullied participants, while strangers were most likely to have discriminated against them. Situational factors, rather than other people, were more

likely to have made participants feel machine-like. For example, taking part in the exam process during high school or university was reported by some to reduce individuals to grades and to ignore their feelings, enthusiasm and unique qualities.

Feelings Following the Event

The vast majority of participants recalled feeling ashamed or guilty after the dehumanising event; particularly those who reported being abused, degraded, bullied and discriminated against (see Table 3). All participants who recalled being made to feel like an animal expressed feelings of self-directed anger following the experience; however, only a third of participants recalled feeling angry with themselves following the dehumanising experience. Interestingly a small number of participants recalled feeling empowered by their experience. To illustrate, some people recalled feeling extremely athletic, almost super human, while others recalled seeing another person treated inhumanely and being motivated to fix the situation. Additionally participants also recalled feeling sad and scared after the experience, and some described their feelings as being animal-like or machine-like.

Feelings Towards Others Following the Event

When participants were explicitly asked how they felt towards those who made them feel less than human most recalled feeling anger, resentment and dislike (see Table 4). Participants felt scared and sad when thinking about the perpetrators. A minority of participants felt grateful; again this was because some participants recalled positive events such as competing in a sporting event. Others were grateful, explaining that the experience made them feel like a stronger person and that they benefitted from having their eyes opened.

Table 2

Perpetrators by Type of Dehumanisation in Percentages

Type	Perpetrators %									
	Family	Partner	Friends	Colleagues	Customers	Medical staff	Classmates	Teacher	Stranger	Situation
Abuse	41	5	12	7	9	5	5	2	16	-
Mechanisation	-	3	3	7	3	13	7	7	13	52
Degradation	11	4	7	15	4	11	-	26	11	11
Discrimination	4	-	15	4	-	-	31	-	39	8
Exclusion	22	6	22	6	-	-	6	6	17	11
Bullying	-	6	18	12	-	-	65	-	-	-
Animalisation	14	-	7	-	-	-	14	-	21	43
Dehumanisation of others	25	-	38	-	-	-	-	-	13	25
Other	-	-	-	-	-	-	-	-	-	100

Table 3

Percentage of Participants Reporting Feelings Depending on Type of Dehumanisation

Type	Feelings %						
	Anger	Sadness	Shame	Fear	Empowered	Animal	Machine
Abuse	27	27	96	17	6	-	-
Mechanisation	23	13	74	19	16	3	36
Degradation	11	15	93	11	4	-	-
Discrimination	19	31	92	7	12	4	4
Exclusion	11	33	78	17	6	-	-
Bullying	24	41	94	24	-	-	-
Animalisation	100	43	64	14	36	29	7
Dehumanisation of others	25	25	86	-	50	-	-
Other	10	30	60	-	30	-	-

Feelings and Actions if Witnessing Another Treated the Same Way

An overwhelming majority of participants reported that they would feel empathy for the victim; particularly those who had been discriminated against, bullied, degraded, abused, rejected and made to feel like a machine (see Table 5). Participants who had been bullied and abused were the most likely to help the victim by listening to them, standing up for them and reminding them of their self-worth. A small number of participants said they would blame the victim or feel apathetic about the situation. A small number of participants also mentioned approaching the perpetrators and blaming them.

Table 4

Percentage of Participants Reporting Feelings Towards Others Depending on Type of Dehumanisation

Type	Feelings towards others %				
	Anger	Sadness	Fear	Grateful	None
Abuse	93	36	18	-	5
Mechanisation	81	16	13	10	10
Degradation	78	4	26	-	15
Discrimination	85	16	35	8	4
Exclusion	78	22	44	6	6
Bullying	88	59	53	-	6
Animalisation	50	21	21	14	36
Dehumanisation of others	63	-	-	13	25
Other	40	-	10	10	50

In summary, the results of this study suggest that there are a variety of situations that can make people feel less than human. Almost without exception, the dehumanising experiences were negative: abuse, rejection, degradation, discrimination and being made to feel like a machine or animal. A majority of recalled experiences occurred at home or school; however, other places such as at work, in a medical context, during sporting activities, and in public places, were also included. The majority of perpetrators were family members, partners, friends and colleagues. Though participants were not always dehumanised by other people, in many cases situational factors such as the process of completing exams, being very sick, or being at the airport on the travelator left people feeling less than human. The

experience of dehumanisation left many people feeling ashamed and sad with anger directed at the perpetrators. Further, most participants felt empathy towards others in the same situation. Yet there were a few who felt that it was the victim's fault.

Table 5

Percentage of Participants Reporting Reaction to Seeing Another Dehumanised by Type of Dehumanisation

Type	Reaction %				
	Empathy	Help victim	Anger towards perpetrator	Apathy	Blame victim
Abuse	93	48	9	5	5
Mechanisation	87	32	13	10	7
Degradation	89	30	4	7	-
Discrimination	92	23	12	4	4
Exclusion	94	39	6	6	-
Bullying	88	59	12	-	-
Animalisation	36	29	7	36	7
Dehumanisation of others	50	25	38	13	13
Other	70	30	-	10	-

Discussion

The primary aim of this study was to investigate the array of experiences that people view as dehumanising. In line with Haslam's (2006) integrated theory of dehumanisation and

as predicted, the experiences recalled appear to occur on a continuum, ranging from horrific examples of abuse and discrimination to more subtle cases such as being excluded by friends or having one's feelings dismissed. Dehumanisation is an overwhelmingly negative experience for people; however some participants reported that being reduced to the status of an animal or being compared to a machine was helpful and empowering in certain circumstances. For instance, one female participant aged 20 described stargazing as a positive and humbling experience as it made her think of herself as being very small, 'nothing but a compilation of cells'. So feeling like a creature may remind individuals of their mortality and encourage them to live in the present. In a similar way, a male participant aged 25 described a pep talk by his rowing coach who told the team to consider themselves as part of a well-oiled machine when racing; this inspired him try his very hardest and not let the rest of the team down. Thus, imagining oneself as part of a machine when playing sport may enable individuals to focus on the task, overcome insecurities and strengthen team cohesion.

Consistent with previous research, participants recalled rejection and mistreatment by others as being dehumanising (Bastian & Haslam, 2010; 2011). Participants recalled severe cases of degradation and abuse by a family member or partner. Previously, these extreme examples have not been explored empirically within the dehumanisation literature. Research indicates that abused individuals are prone to feelings of shame and anger (Kim et al, 2009; Lewis, 1971), theoretically aligning these experiences with the denial of human uniqueness, specifically animalistic dehumanisation. Relatedly, experiences of discrimination and prejudice by socially distant others were also described as dehumanising by participants. These findings support Moradi's (2013) position that the well-established discrimination literature may inform our understanding of dehumanisation from the victim's perspective. There is a wealth of research investigating the physical, psychological and social effects of abuse and discrimination (Campbell, 2002; Coker et al, 2002; Moradi & Risco, 2004; Pascoe

& Smart Rickman, 2009). Examining these findings can only better inform methods of research and the interpretation of dehumanisation experiences from the target's perspective.

This study aimed to investigate the experience of dehumanisation without the framework of any particular theory being imposed upon the data. However, the categories that emerged from the data could be separated into Haslam's (2006) two dimensional approach to dehumanisation. Specifically the denial of Human Nature attributes -- mechanistic dehumanisation--relates to experiences of rejection, bullying and dehumanising others. Alternatively, experiences of abuse, discrimination, and degradation parallel animalistic dehumanisation, characterised by the denial of Human Uniqueness attributes. Some participants spontaneously recalled being dehumanised explicitly as an animal or machine as Haslam predicted (2006; 2013). Instances of dehumanisation are also held to vary in their overtness, ranging from blatant and explicit to subtle and implicit (Haslam et al., 2013). Experiences recalled in this study were mainly characterised as implicit; for example, being described as "less sophisticated" than the perpetrator rather than being explicitly called an animal.

Surprisingly, the results indicate that dehumanisation occurs just as frequently, if not more often, in close relationships than isolated exchanges. Previous research focusing on intergroup conflict has cited close social connections and the need to avoid empathic exhaustion as the main reasons motivating the dehumanisation of others (Epley, Waytz & Cacioppo, 2007; Harris & Fiske, 2009; Haque & Waytz, 2012; Waytz & Epley, 2012). Participants recalling experiences of discrimination and bullying were dehumanised by socially distant others, mainly classmates and strangers. However participants recalling episodes of rejection and abuse were frequently dehumanised by family and friends.

Explaining dehumanisation when it occurs in interpersonal relationships is difficult, as it is not motivated by the same processes driving intergroup conflict. It could be partially explained by the power dynamic within some close relationships. For example in parent-child,

boss-employee and doctor-patient dyads one person obviously has power over the other and might need to make some difficult decisions involving the less powerful other. By denying the child, employee or patient some aspect of their humanity and distancing themselves from the less powerful others suffering, the powerful partner is able to lessen their sense of responsibility and do what is best for themselves, the family or the company, whilst avoiding empathic exhaustion (Haque & Waytz, 2012; Lammers & Stapel, 2011). For example, a doctor may refer to a dying patient as their illness rather than their name in an effort to reduce empathic exhaustion and burn out. Additionally, there are more opportunities to devalue and dehumanise those closest to us, compared to unfamiliar others (Leary, Springer, Negel, Ansell & Evans, 1998). Perpetrators may direct dehumanising behaviour towards those closest to them, because they are safe targets and the consequences are perceived as minimal. For example, people might be more inclined to lash out at family members after having a bad day at work than to tell their boss what they really think of them. Conversely, from the victim's perspective, being devalued or rejected by a close other is more painful and salient compared to similar behaviour by a stranger (Leary et al, 1998). The closer we are to someone, the higher our expectations are in regards to their behaviour towards us. As such it is more painful when a close friend or family member treats us poorly or makes light of a personally sensitive topic compared to a stranger. The processes motivating dehumanisation appear to change dependent on the relationship between the victim and the perpetrator. The study described in Chapter 4 will focus on dehumanisation in close relationships to further investigate this novel area of research.

A final, unexpected result of this study is that very little contempt or displaced aggression was reported towards a hypothetical victim by participants. Previously, victims of dehumanisation have been found to direct aggression at innocent, and less powerful others, when the provocateur is unattainable (Miller et al., 2003; Zimbardo & White, 1972). The majority of participants indicated that they would view the victim empathically and offer

them support, and even remind them of their humanity. Only a small proportion of respondents blamed the victim, indicating that they were weak and had brought the situation on themselves. This might have been a limitation of the autobiographical recall method used in this study. If the participants were in the midst of a dehumanising experience they might not be so considerate and supporting of others. However, these results suggest that dehumanising experiences enable individuals to empathise with others in a similar position.

Strengths and Limitations

Previous studies that have focused on dehumanisation solely from the perpetrator's perspective have provided a somewhat limited view of the types of experiences and motivational processes that are important for fully understanding the phenomenon. The findings of this study, focusing on the victim's perspective revealed some previously unidentified instances of dehumanisation. For example, the process of using examinations to assess academic ability left many participants feeling as though their individuality was denied and their passion and enthusiasm negated. They had been reduced to a number and then labelled with a grade. It left them feeling unmotivated and jaded about the learning process. Thus, dehumanisation is not limited to interactions with other humans; situations, processes, and institutions may also deny aspects of an individual's humanity. Further, although participants reported, predictably, feelings of shame, sadness, and anger in response to dehumanisation, several participants felt empowered following the experience and grateful to the perpetrators for making them a stronger person. This would appear to relate to the victim's attempts to gain some control and give meaning to their experience.

It should be noted, however, that the majority of the sample was made up of first year, undergraduate university students; as a result the reported examples of dehumanisation heavily featured incidents within the parental home or school context. Future research would benefit from the use of a more diverse demographic to investigate a wider range of incidences, particularly workplace or partner dehumanisation within older cohorts. However,

even with such a young sample, a wide variety of dehumanising experiences was recalled, supporting the supposition that dehumanisation exists on a continuum, ranging from everyday interactions to extreme violations.

Conclusions

Overall, these findings suggest that a wide range of experiences are deemed to be dehumanising by individuals. The majority of participants recalled a negative experience where they were dehumanised by someone within their social network. Following the dehumanising experience participants indicated feeling overwhelming shame, anger and sadness. There are links here with the research on discrimination, rejection and abuse, and all concepts have many commonalities. This study found that many experiences of dehumanisation involve some type of exclusion, be it from a social group or on a larger scale, humanity itself. The following chapter will aim to quantitatively investigate how experiences of dehumanisation impact or threaten individuals' sense of belonging, control, self-esteem and meaning, otherwise known as the four fundamental needs.

Chapter 3

Study 2: The effects of dehumanisation on fundamental needs

There are many experiences that leave people feeling less than human. Study 1 explored the range of experiences that people view as dehumanising and found that many of them included some type of social rejection such as abuse, degradation, bullying and exclusion. This aim of this second study was to examine the relationships between experiences of animalistic dehumanisation, mechanistic dehumanisation and a variety of fundamental needs that have been shown to be frustrated by experiences of social exclusion: specifically, needs for belonging, control, self-esteem and meaningful existence.

Fundamental needs

Four fundamental needs have been studied in the context of social ostracism and exclusion: specifically, the need to *belong*, the need for *self-esteem*, the need for *control*, and the need for *meaningful existence* (Williams, 2001). There is a wealth of evidence supporting the importance of each of these needs for human motivation. In regards to *belonging*, human behaviour and emotion are powerfully influenced by a fundamental drive to obtain acceptance and to avoid rejection. This need to belong is functional in that there are survival and reproductive benefits gained from group membership (Baumeister & Leary, 1995). In a review of the literature, Baumeister and Leary (1995) found evidence to suggest that a lack of social connections produced a large range of negative consequences for individuals, including physical and mental illness and stress.

S*elf-esteem* is necessary for the maintenance of self-efficacy and mental health (Bandura, 1997; Leary, Tambor, Terdal, & Downs, 1995). Further, self-esteem has been argued to serve as a gauge (or sociometer) of the individual's social acceptance (Leary, 1999).

Moreover, rejection is thought to lower self-esteem, which motivates behaviour to restore social connections or avoid further social devaluation.

When individuals feel that they have *control* over situations they will often persist in the face of failure, believing they can still succeed (Bandura, 1997); without feelings of control individuals may exhibit learned helplessness and become depressed (Seligman, 1975). When people are socially ostracised or excluded they experience a loss of control because they are not given a chance to retaliate or explain themselves, leading to a loss of self-efficacy (Williams, 2001).

Finally, humans need to maintain a sense of *meaningful existence* to better deal with (or avoid) thoughts of death (Solomon, Greenberg, & Pyszczynski, 1991). It has also been argued that social ostracism symbolises death, as it offers a frightening glimpse of what things would be like if one were dead (Case & Williams, 2004). In sum, being excluded or ignored threatens our whole existence; thus, maintaining a sense of belonging, self-esteem, control and meaning is fundamental to social and physical survival.

Empirically, experiences of social ostracism and exclusion have been found to frustrate the fundamental needs for belonging, self-esteem, control, and meaning (Leary, Tambor, Terdal & Downs, 1995; Smart-Richman & Leary, 2009; Williams, 2001). Social ostracism has been induced using brief episodes of social rejection from strangers and computers (e.g., Leary, Tambor, Terdal, Downs, 1995, Williams, Cheung & Choi, 2000; Zadro, Williams & Richardson, 2004), recalled rejection experiences (e.g., Bastian & Haslam, 2010; Nezlek, Kowalski, Leary, Blevins & Holgate, 1997), and false feedback about personality (Twenge, Baumeister, Tice & Stucke, 2001) . Surprisingly, rejection from despised others such as the Klu Klux Klan has also been found to negatively impact the fundamental needs of individuals (Gonsalkorale & Williams, 2007).

Social Exclusion and Dehumanisation

To feel dehumanised is to feel ‘less than human’ (Kelman, 1973), like an object or an

animal. More specifically, the process of dehumanisation involves the denial of mental capacities to people, the very capacities that people associate with being human (Waytz & Epley, 2012). At some level then, the dehumanised individual feels *excluded* from membership of humanity due to some perceived deficit in their stock of human characteristics. The centrality of exclusion to dehumanisation has been referred to both directly and indirectly in the literature. Opotow (1990) described dehumanisation as an exclusion-specific process, manifested by rejecting another's humanity. Additionally, being ignored and treated with indifference has been described as central to both dehumanisation and social ostracism (Bastian & Haslam, 2010).

Bastian and Haslam (2010) investigated dehumanisation in participants who were socially excluded. Using an autobiographical recall task (Study 1) Bastian and Haslam (2010) found that excluded individuals, compared to those who were included, showed frustrated fundamental needs, but also viewed themselves (and those who rejected them) as less human. Bastian and Haslam also replicated this finding using a computerised ostracism task (Study 2; Zadro, Williams & Richardson, 2004). Thus, Bastian and Haslam provided the first evidence that social exclusion produces feelings of dehumanisation. Further, their findings suggested that the dimension of dehumanisation that is most affected by social exclusion is the mechanistic form of dehumanisation—denial of Human Nature.

Bastian and Haslam's (2010) research was novel in that it investigated dehumanisation from the victims' perspective and in showing that feeling dehumanised is one of the consequences of social exclusion. Two implications of their findings are that dehumanisation research could be informed by the extensive empirical literature on social exclusion, and that researchers might fruitfully use common social exclusion inductions as a way to induce feelings of dehumanisation.

Social exclusion has been found to induce feelings of dehumanisation, along with other powerfully aversive feelings (Bastian & Haslam, 2010). Such everyday instances of

exclusion as a child being teased in the school yard, receiving the silent treatment from a partner, or being turned down by a potential love interest are marked by consequences for perceived humanness. However, there are also experiences that threaten our humanness that do not obviously involve exclusion. A factory worker who must endure unrelenting physical repetition might understandably feel machine-like. Similarly, an elite athlete valued only for her physical capabilities might paradoxically feel dehumanised by admiring fans. The principal concern for individuals in such situations is not how rejected they feel, but whether they have lost their sense of humanness. The aim of this study, then, was to investigate whether frustrated fundamental needs—a hallmark of social exclusion—are also an essential component of feeling less human.

Overview of the Present Study

This study investigated the extent to which being dehumanised as an animal or machine has similar or different features and consequences to being socially excluded, with a particular focus on threats to fundamental needs including a sense of belonging, control, self-esteem and meaning. Participants were asked to recall one of three autobiographical events: two of these were dehumanising events (being treated like an animal or being treated like a machine), and one concerned an episode of social exclusion. Participants then rated themselves on measures of fundamental needs, affect, and dehumanisation. In terms of the similarities between exclusion and dehumanisation, and in line with Bastian and Haslam (2010), it was expected that excluded participants would tend to feel less than human. However, the current experimental design also explored whether mechanistic and animalistic dehumanisation can be differentiated from exclusion in terms of impact on fundamental needs.

Method

Participants

Participants were 259 undergraduate students (192 women, 59 men, 8 did not report their gender) who took part in the study as part of a class exercise. Their ages ranged from 18 to 56 years (M = 22.12, SD = 6.16). Informed consent to use their data for research was obtained from each participant and the study was approved by the university ethics committee.

Materials and Procedure

Participants took 20-30 min to complete a booklet containing all the study materials. They completed the questionnaires privately in testing sessions of up to 20 participants. Participants started by completing Rosenberg's (1965) 10-item trait self-esteem scale, which was included to explore possible moderating effects due to the role of self-esteem in social exclusion (see Leary, Tambor, Terdal & Downs, 1995). After this they were asked to recall and write about an exclusion or dehumanisation event that they had experienced. Participants were randomly assigned to one of the three autobiographical event conditions. For each condition [animal, machine, excluded], the following instructions were given.

> Please recall as vividly as you can an [<u>event where others made you feel less than human, like an animal/ event where others made you feel less than human, like a machine/ event where you experienced rejection or social exclusion by others</u>]. Think about your experience in terms of the feelings and the emotions involved. Let yourself feel the event as if you were right there, reliving it and re-experiencing it. Please take about 10 minutes to describe the event below.

After completing the autobiographical memory task, participants rated themselves on the 12-item Dehumanisation scale (Bastian and Haslam, 2010) to assess attributions of Human Nature (HN) and Human Uniqueness (HU). The dehumanisation scale includes such items as "I felt like I was mechanical and cold, like a robot" and "I felt like I was less than human, like an animal," which are each rated on 7-point scale (1 = *not at all*; 7 = *very much so*). These items explicitly ask participants to rate themselves on feelings of animalistic and

mechanistic dehumanisation and were included as a manipulation check. The subscales were reliable: Human Nature, α = .72, Human Uniqueness, α = .75.

Eleven items that Bastian and Haslam (2010) adapted from Zadro et al. (2004) were used to measure the four fundamental needs of belonging, control, self-esteem, and meaningful existence. The scale comprises such items as "I felt like an outsider during the situation", and "I felt non-existent during the situation". Responses were made on a 6-point scale (1= *not at all*; 6 = *very much so*). The subscales were adequately reliable: Belonging, α = .74, Control, α = .55, Self-esteem, α = .64, Meaningful existence, α = .81. These items were correlated between r = .33 - .61, ps <.001.

Finally, state positive and negative affect following the experience was measured on a 5-point scale (1 = *very slightly or not at all*; 5 = *extremely*) using the 20-item PANAS (Watson, Clark & Tellegen, 1988). This was included to determine whether any obtained effects between conditions were simply the result of differences in negative affect. Participants were presented with the list of affective words and asked to "indicate to what extent you felt this way after the experience you wrote about." The subscales were reliable: Positive affect, α = .87, Negative affect, α = .88.The order of the dehumanisation scale and the fundamental needs scale was counterbalanced to avoid order effects.

Coding of open-ended responses.

To compare whether participants in the experimental conditions (i.e. machine, animal and exclusion) answered in qualitatively different ways, their responses were coded utilising an inductive approach (Braun & Clarke, 2006). In the same vein as the qualitative analysis in Study 1 the aim was to create discriminatory categories without being either over or under inclusive. Participants could only be allocated into one category. A second-rater double coded 25% of the transcripts according to a structured coding scheme, which required minimal rater training. To analyse interrater reliability, Cohen's kappa was calculated and adequate at .96. The two coders agreed 97% of the time. All disagreements were later resolved in a discussion.

Results

Qualitative analysis

Participants recounted a variety of experiences in response to the experimental instructions. Four distinct categories encompassed the range of events recalled; exclusion, degradation, mechanisation and abuse (see Table 6 for descriptions).

Examples of the autobiographical recall task by category.

The examples below have been taken directly from participant responses to the question: *"Please recall as vividly as you can an event where others made you feel less than human, like an animal/ event where others made you feel less than human, like a machine/ event where you experienced rejection or social exclusion by others".* Two examples from each of the four categories have been included.

Exclusion.

"I was rejected by my whole family because I chose to live the life I wanted to live. I have not spoken to them since." **Female, Aged 26**

"A group of friends from work had planned a trip away skiing in New Zealand. I was unable to go because of my university commitments. After they had been on the trip they would have regular get togethers. I was always excluded from their get togethers as I had not taken the trip with them." **Female, Aged 29**

Degradation.

"Going to the doctor, I felt like I was spoken about, rather than to, although I was in the same room. It was like I needed to be addressed in a childish manner." Female, Aged 20

"Being on a train and getting pushed around, I felt like an animal because we were all pushed in there like sardines. I felt very uncomfortable, like I wasn't getting any respect." **Female Aged 20**

Mechanisation.

"I was in a sporting team, the coaches made me feel like a machine on a regular basis.

Regardless of how tired, sick or upset I was, I would be yelled at if I gave a less than perfect performance." **Female Aged 19**

"When I used to do ballroom dancing at first I loved it but then everything became extremely repetitive. Mistakes had to be fixed and it was no longer human to human but rather human to 'machine'. There was no sympathy, if a move wasn't right it became a chore to perfect the movement. At practice it wasn't about the social side anymore. I guess it did help perfect the moves but I felt very removed from reality. Repeating the moves over and over did get boring, although it definitely helped at competitions." **Female, Aged 20**

Abuse.

"My friends decided to gang up on me and did things like strike my head, pull my hair and make sarcastic comments." **Male, Aged 19**

"When I was younger about 4, when my sister and babysitter would look after me, they would send me to the dog kennel if I was misbehaving. As a child this was a little bit scary as I was locked outside in the dark." **Female, Aged 19**

The majority of participants answered in accordance with their assigned condition. For example, almost all of the participants in the excluded condition described a time when they were excluded (see Table 7) and only a small number of participants recalled feeling degraded, abused or machine-like. The pattern was similar for those assigned to the mechanistic condition. The vast majority recalled an experience where they felt as though their feelings did not matter. However some participants recalled an experience categorised as exclusion, degradation or abuse. Participants allocated to the animalistic dehumanisation condition tended to recall a degrading experience. A small amount of participants recalled explicitly being made to feel like an animal, in a similar way to the exploratory findings of Study 1 (see Table 6). The researcher decided to subsume these experiences in the degradation category due to the similar nature of the situations such as being belittled and humiliate

Table 6

Descriptions of Qualitative Categories

Category	Description
Exclusion	being ignored; not invited out with friends; feeling different to others; feeling uncomfortable around others; isolated; being dumped; partner shutting you out emotionally; ostracised; not being selected in sporting teams
Degradation	belittled; not feeling good enough e.g. physically, intellectually, socially or sexually; treated like a child; made to feel useless; humiliated; not treated with respect; made to feel powerless; disgusted in self e.g. own behaviour, shameful actions; picked on; bullied; discriminated against for race, religion, sex, social economic status, feeling like prey – scared, powerless, in danger; feeling like a predator – powerful; people trying to make you angry because they know you have a short fuse; like a baboon pitted against another in a fight; packed in like sardines whilst on the train; feel like cattle being herded; feeling like a piece of meat
Mechanisation	emotions ignored; reduced to what you know and can do; feeling invisible; feeling used; being overwhelmed at school or work or home, as expectations are so high without consideration of the person inside; used as an instrument; told you are emotionally cold being told to put feelings aside e.g. being gay is a choice, just move past it; pushing body to extremes in sport; not enough time to process emotions or anything else due to other pressures e.g. work, uni, relationships, expectations
Abuse	verbal, physical; being threatened/intimidated – I will kill you; emotional abuse and neglect such as being made to sleep in the dog kennel; being betrayed

Participants in the animalistic condition were also the most likely to recall an abusive experience. A small number of participants in the animalistic condition recalled an experience coded rejection or mechanistic dehumanisation.

These findings suggest that the experiences of being excluded, being made to feel like a machine, or like an animal, produced the expected differences in categories of events recalled. Although there was some overlap among the conditions the overwhelming majority of participants reported events consistent with the instructions. This was to be expected as these categories are not always mutually exclusive. Additionally, the narrow set of experiences recalled for exclusion may reflect that this autobiographical memory task was just more clear-cut than for animal or machine (i.e. the animal and machine tasks were more ambiguous and so produced a wider range of experiences).

Table 7

Percentage Frequencies of Responses to Exclusion, Mechanisation and Animalisation

		Qualitative Categories %			
		Exclusion	Degradation	Mechanistic	Abuse
Condition	(n)				
Exclusion	87	91	5	2	2
Mechanisation	87	6	10	77	7
Animalisation	85	7	73	5	15

Quantitative Analyses

For the first set of analyses examining differences among the recall conditions, there were no main effects for age, gender, or trait self-esteem, so they were not included in the remaining analyses. Post-hoc comparisons among the three conditions were controlled at α = .05 using Tukey HSD. The Type 1 error rate was controlled decision-wise not family-wise as these dependent measures are considered independent constructs (Bastian & Haslam, 2010).

Manipulation check: Self-ratings of dehumanisation.

Human nature (mechanistic dehumanisation) self-ratings. A one-way ANOVA revealed a significant difference between conditions on Human Nature self-ratings, F (2, 256) = 6.18, p = .002, η^2 = .046 (See Fig. 1). Post-hoc comparisons revealed that participants in the exclusion condition felt significantly less machine-like compared to those in the animal and machine conditions. There was no significant difference between participants in the animal and machine conditions (p = .78). Thus, participants in the machine condition reported feeling more machine-like than did participants in the exclusion condition. However, those in the animal and machine conditions reported feeling equally machine-like.

Human uniqueness (animalistic dehumanisation) ratings. A significant difference was found for ratings on the Human Uniqueness subscale, F (2, 256) = 14.73, p < .0005, η^2 = .10 (See Fig. 1). Post-hoc tests revealed that participants in the animal condition rated themselves as feeling significantly more animal-like, compared to those in the machine and exclusion conditions. There was no significant difference between the machine and exclusion conditions (p = 0.50).

Fundamental needs.

There were no significant differences among the three conditions for levels of perceived control, F (2, 255) = .97, p = .38, η^2 =.008, or meaningful existence, F (2, 255) = 1.26, p = 287, η^2 =.010. However, a one-way ANOVA revealed a significant difference among the three conditions on sense of belonging, F (2, 255) = 7.07, p = .001, η^2 =.052. Tukey HSD post hoc tests confirmed that being excluded had a more negative impact on participants' sense of belonging than being dehumanised as a machine. A one-way ANOVA also revealed a significant difference among the three conditions on self-esteem, F (2, 255) = 6.39, p = .002, η^2 =.047. Being excluded or dehumanised as an animal had a significantly more negative impact on self-esteem compared to being dehumanised as a machine (see Table 8). These findings suggest that being excluded or dehumanised has an equally negative impact

on individuals' perceived control and sense of meaningful existence; however, self-esteem and sense of belonging are more likely to be threatened in instances of social exclusion than mechanistic dehumanisation. Experiences of animalistic dehumanisation had the same negative impacts on fundamental needs as social exclusion.

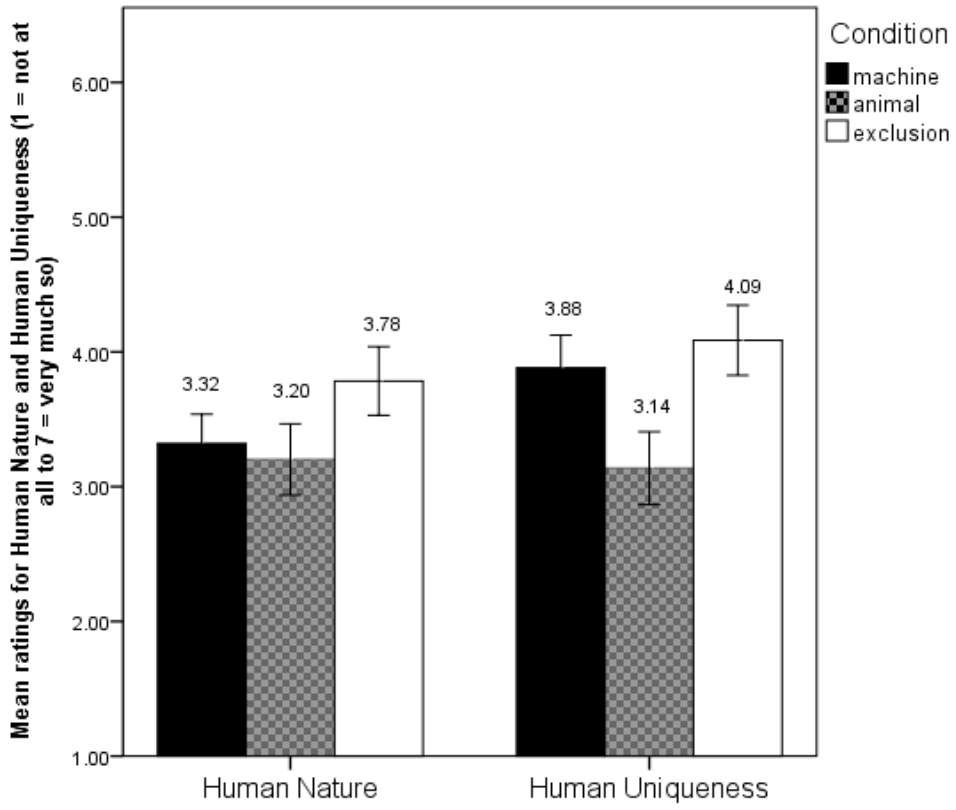

Figure 1. Mean ratings for Human Nature and Human Uniqueness items across conditions. Error bars are 95% confidence intervals.

Positive and negative affect.

An examination of participants' responses on the PANAS using a one-way ANOVA, found no differences among the conditions on levels of positive affect, F (2, 256) = 1.55, p = 213, η^2 = .012. However, a one-way ANOVA found that the conditions differed in the amount of negative affect they produced, F (2, 256) = 4.39, p = .013, η^2 = .033. Tukey HSD post-hoc tests confirmed that being dehumanised as an animal resulted in higher levels of negative affect than being dehumanised as a machine (see Table 9). Being excluded elicited similar levels of negative affect as being dehumanised as a machine or an animal. Overall,

experiences of dehumanisation (either animal or machine) and exclusion appear to reduce positive affect equally, whereas animalistic dehumanisation induces significantly more negative affect than mechanistic dehumanisation but not exclusion.

Table 8

Means and Standard Deviation for Fundamental Needs Across Conditions

Fundamental needs	**Condition**		
	Mechanisation (*n* = 86)	Animalisation (*n* = 85)	Exclusion (*n* = 87)
Belonging	2.52 (1.45) [a]	2.13 (1.32) [a,b]	1.79 (1.03[b]
Control	2.03 (1.11) [a]	1.83 (.92) [a]	1.98 (.80) [a]
Self-esteem	2.53 (1.24) [a]	2.03 (1.01) [b]	1.97 (1.01) [b,c]
Meaningful existence	3.33 (1.65) [a]	3.50 (1.63) [a]	3.14 (1.43) [a]

Note. [a,b,c] values in a row with dissimilar superscripts are significantly different at $p = .05$

Table 9

Means and Standard Deviation for PANAS Subscales

PANAS	Condition		
	Mechanisation (*n* = 87)	Animalisation (*n* = 85)	Exclusion (*n* = 87)
Positive affect	18.92 (7.85) [a]	20.08 (8.30) [a]	18.07 (6.88) [a]
Negative affect	24.91 (9.31) [a]	29.40 (10.88) [b]	27.33 (8.76) [a,b]

Note. [a, b,c] Values in a row with dissimilar superscripts are significantly different at $p = .05$

Discussion

The aim of this study was to examine the impact of animalistic and mechanistic dehumanisation and social exclusion on participants' experiences of belonging, control, self-

esteem and meaning. The findings revealed that being dehumanised as an animal frustrated all four fundamental needs to the same extent as being socially excluded. Additionally, mechanistic dehumanisation and exclusion were equally likely to frustrate the needs for control and for meaningful existence. Thus, it appears that being dehumanised as either a machine or animal is as much of a symbolic death for individuals as experiences of exclusion. It could also be postulated that chronic dehumanisation might lead to learned helplessness as people lose their sense of control. However, being dehumanised as a machine is less likely to threaten one's sense of belonging and self-esteem compared to being excluded. In addition, experiences of animalistic dehumanisation are more likely to threaten self-esteem than mechanistic dehumanisation. This is an interesting finding because mechanistic dehumanisation threatens one's sense of place in the world (i.e. meaningful existence and sense of control); however a sense of self-respect and belonging is maintained. These findings might be explained by the fundamental differences between these experiences. Specifically, at the core of animalistic dehumanisation and social exclusion the target is being stripped of their dignity and self-respect; they are being told that they have nothing to offer the world. However, targets of mechanistic dehumanisation still maintain some sense of self and purpose because they are still treated as useful and necessary. In sum, experiences of dehumanisation and exclusion negatively impact the fundamental needs. However, experiences of mechanistic dehumanisation are less likely to threaten the need for belonging and self-esteem compared to being dehumanised as an animal or excluded.

The types of events recalled when participants were made to feel excluded, animal-like or machine-like also differed with respect to participants' qualitative responses. Animalistic dehumanisation produced the widest range of experiences, including the most abusive and degrading events. Conversely, being excluded produced the smallest range of experiences. It could be that these differences are linked to the language we use to describe these experiences and the frequency of their occurrences. When we are excluded by friends

we may be comfortable admitting that we feel rejected. However, we are much less likely to say '*I felt like an animal*' when being humiliated or physically abused, even if it is the case, perhaps due to the particularly painful and shameful nature of these animalistic experiences. As such it is not surprising that only a small amount of participants recalled explicitly feeling like animals and these experiences were belittling and humiliating in nature. This may also explain why being dehumanised as an animal appeared to have similar emotional consequences to being excluded, when it might be expected that abuse would produce much more negative affect. Shame is such a painful emotion that people often have trouble identifying it, and they can only describe it once the pain has started to subside (Lewis, 1971).

In the present study, being dehumanised as a machine did not appear to consistently induce the same intensity of negative emotion as animalistic dehumanisation. The common use of phrases such as '*working like a machine*' to describe a dedicated employee or athlete may shed some light on these differences in negative affect. People who are experiencing mechanistic dehumanisation may feel low positive emotion, but they may not feel the same intensities of shame, anger or sadness as those denied their equal status as a functioning member of society, as when one is dehumanised as an animal.

Strengths and limitations

This study has several implications for research and theory on dehumanisation. It is clear that social exclusion leads to feelings of dehumanisation in relation to the self. However, as a method of inducing dehumanisation, exclusion may not be as clean as asking participants to focus on the specific dehumanising elements of an episode. Specifically, feelings of dehumanisation resulting from exclusion are linked to other aversive effects associated with exclusion. As such, there is the potential for subtle aspects of the experience of humanness to be overlooked. In addition, the present findings have provided further support for the relevance of Haslam's (2006) two dimensions of humanness. To date, empirical support for the two dimensions of humanness has been demonstrated using trait measures. This was the

first time a task has been used to specifically examine the effects of each dimension and compared the task to an established method of producing dehumanising feelings (exclusion). Not only do the findings support the existence of the dimensions of Human Nature and Human Uniqueness, they show that they can each be distinguished from the effects of social exclusion.

The design of the study may have been improved with the addition of a negative control group such as '*Remember a time you were made to feel terrible about yourself*'. This would have made it possible to investigate whether people spontaneously recall instances of dehumanisation (e.g. abuse, discrimination) that are not necessarily associated with the explicit animal or machine labels. Conversely, some participants may have still recalled being made to feel like an animal or machine even though this instruction was not given, as was found in Study 1. Future research could take this approach to answer these questions.

Conclusion

The types of dehumanising experiences recalled by participants in this study, as well as Study 1, involved many close relationships. Friends, family members and partners were often involved in making people feel less human. Instances of social exclusion often involve those closest to us as they are the people we expect or hope will include us. Additionally, these are the people we spend most of our time with, so they have more opportunities to cause emotional pain. Dehumanisation has not typically been linked with close relationships in the literature as much of the research has focused on intergroup conflict. The next study, reported in Chapter 4, sought to further explore this novel and important aspect of dehumanisation.

Chapter 4

Dehumanisation in close relationships

As discussed in previous chapters of this thesis, dehumanisation occurs when we deny full humanness to others, potentially allowing us to subject them to cruelty and suffering (Haslam, 2006). Research on dehumanisation has previously focused on its role in moral disengagement (Bandura, 1990; Osofsky, Bandura & Zimbardo, 2005) and moral exclusion (Deutsch, 1990; Opotow, 1990). Following this line of enquiry, the majority of research has continued to focus on the role of dehumanisation in intergroup relations, specifically from the perpetrators' perspective (Bain, Park, Kwok, & Haslam, 2009; Boccato, Capozza, Favlo & Durante, 2008; Costello and Hodson, 2010). Adopting a different approach, Studies 1 and 2 investigated dehumanisation from the victim's perspective and demonstrated that dehumanisation occurs just as frequently, if not more frequently, in close relationships than in isolated and/or intergroup exchanges. Further, victims recalled feeling an overwhelming sense of shame, anger and sadness following their dehumanising experiences. Building on these findings, the first aim of Study 3 was to more explicitly investigate the occurrence of dehumanisation in close relationships and to explore how these experiences affect the individual and their relationship with the perpetrator. The second aim was to explore in more detail the roles of two emotions that appear to be particularly relevant to the experience of dehumanisation -- shame and contempt.

People are dehumanised differently dependent on their relationship with the perpetrator. Study 1 found that participants recalled instances of discrimination (which involves being treated prejudicially based on perceived differences compared to the perpetrator's ingroup), by socially distant others, rather than individuals within their social network. Conversely, individuals were more likely to recall being rejected, abused and

degraded by people connected to their social network. These findings suggest that there are more opportunities to dehumanise or relationally devalue those we are closest to, compared to strangers (Leary, Springer, Negel, Ansell, & Evans, 1998). Victims may also be more likely to feel and recall the sting of being dehumanised by a loved one than by a stranger. Further, perpetrators may be more likely to dehumanise the people they are closest to because the consequences are perceived to be comparatively negligible (Leary et al., 1998). Accordingly, people may be most likely to recall experiences of dehumanisation that involve instances of rejection, abuse and degradation within their close relationships, rather than instances of discrimination or bullying that may have occurred with more distant others. What we still know little about, however, are the kinds of emotions and emotional responses that are most closely related to such experiences. Two emotions, in particular, are theorised here to be integral to the experience of dehumanisation: shame and contempt. Exploring these potential emotional reactions was a major focus of the current study.

Shame and contempt appear to play central roles in the process of dehumanisation (Bastian & Haslam, 2011; Haslam, 2006). Feelings of shame involve a negative evaluation and scrutiny of the entire self (Tangney, 1995). Shame is so painful that people often find it hard to identify; when someone can admit to feeling ashamed the affect is likely to be diminishing (Lewis, 1971). When people experience shame they also feel exposed, unworthy, powerless and small, emotions often linked with dehumanisation (Tangney, 1995). Contempt from others can elicit feelings of shame, as the victim is made to feel inadequate and wanting by the perpetrator (Izard, 1991). A shamed individual may want to disappear and hide or lash out at others involved in the shameful situation (Tangney, 1995). Contempt, on the other hand, communicates that the target is perceived as inferior and the shame that the target feels in response to being dehumanised leaves them feeling inadequate and powerless. As such, experiences of dehumanisation are expected to be associated with increased levels of shame

and relational contempt. Additionally, higher levels of shame are expected to be associated with more intense emotional reactions to dehumanisation such as tears and anger.

The frequent use of contempt as a conflict tactic in close relationships has been consistently linked to relationship dissatisfaction and marriage breakdown (Gottman, 1994; Gottman & Notarius, 2002). Contempt is associated with devaluing and depersonalisation, and it lies at the heart of prejudice (Izard, 1991) and possibly dehumanisation. It can involve treating others with condescension or sarcasm escalating to hateful and violent behaviours (Izard, 1991). Contempt breeds contempt, particularly in dyads with an uneven distribution of power, such as the work place (Melwani, Sigal & Barsade, 2011). Here it has been found that the target of contempt in the workplace may in turn experience contempt for his or her supervisor, thus continuing the contemptuous cycle in an attempt to regain a sense of control and justice. In a close relationship, victims of dehumanisation might reciprocate the perpetrator's contempt, particularly if they feel the dehumanising behaviour is intentional and unjust. Additionally, increased contempt towards the perpetrator and feelings of shame following the experience are likely to be associated with relationship breakdown and negative effects on psychological well-being.

Experiencing dehumanisation as unjust and intentional may also contribute to relationship breakdown, regardless of perceived contempt. Research on hurtful events in relationships, for example, has found that they generally weaken the relationship temporarily (and sometimes permanently) as the person who feels hurt loses their trust in the other, experiencing anxiety and worry they will be let down again (Feeney, 2004). When individuals are hurt in the context of highly satisfying close relationships, and the hurtful events have been judged as unintentional, the relationship is more likely to continue. However, when people feel that the other person has a tendency to hurt them (i.e., the behaviour is typical and intentional), they are more likely to engage in relational distancing (Vangelisti & Young, 2000). Clearly, then, relationship breakdown and a loss of

psychological well-being following dehumanisation within a close relationships is likely to be positively associated with increased levels of perceived perpetrator intentionality and typicality. Similarly, research on causal attributions associated with relationship distress have found that personality-based attributions (i.e., attributing the cause of negative behaviours to typical, global, and stable features of the perpetrator's personality) are characteristic of relationship dysfunction, whereas attributing the same behaviours to external, unstable and atypical causes are characteristic of relationship enhancement (Fitness, Fletcher, & Overall, 2003).

Overview of the Present Study

Study 2 found that instances of dehumanisation were more likely to occur in the context of the victim's social networks rather than as an isolated incident, particularly in the case of abuse and rejection. Building on these findings, the overall aim of the current study was to investigate the occurrence of dehumanisation in close relationships, focusing particularly on the roles of shame and contempt, and exploring how the whole experience affects the victim and the sustainability of the relationship. First, it was expected that participants would recall instances of abuse and rejection, rather than discrimination as examples of dehumanisation in their close relationships. Second, high levels of dehumanisation were expected to be associated with increased levels of shame and relational contempt. Third, it was hypothesised that as levels of perceived intention to dehumanise and how typical it is for the perpetrator to dehumanise increased, so too would reported levels of dehumanisation and relational contempt, but not necessarily shame. Fourth, it was expected that levels of dehumanisation and relational contempt would be positively associated with causal attributions involving the perpetrator's personality rather than situational pressures. Fifth, higher levels of dehumanisation, shame and relational contempt were expected to be positively associated with relationship breakdown and a loss of psychological well-being. Finally, it was hypothesised that increased levels of perceived intention to dehumanise and

how typical it is for the perpetrator to dehumanise would be associated with relationship breakdown and a loss of psychological well-being for the victim.

Method

Participants

Two hundred and twenty eight third year university students who volunteered as part of a class exercise took part in the study (61 men, 167 women). Their ages ranged from 18 to 51 years (M = 23.32 years, SD = 5.75 years). However 77 participants (34%) did not complete the study as they could not recall being made to feel less than human in a close relationship. This parallels the findings from Chapter 2, where 45% of participants recalled being dehumanised by someone external to their social network. A further nine participants stopped answering questions after recalling the dehumanising experience. Accordingly, 142 participants were included in the subsequent analyses.

Procedure and Materials

The study was completed online and was completely anonymous. After providing demographics, participants completed a 6-item individual differences measure of Hurt Proneness (Leary & Springer, 2001). This scale measures the frequency with which people's feelings are hurt but not the intensity of specific hurtful episodes. It was included to test whether instances of relational dehumanisation could be explained by the victim's hurt proneness, rather than the perpetrators' actions. This scale was internally consistent (α = .80).

Participants were then asked to "*Think of a specific situation when someone close to you (i.e. friend, relative, or partner) said or did something that made you feel dehumanised – less than human (treated as if you did not count as a real person).*" As in Leary et al. (1998), participants were asked to record who had been involved in the incident, the gender and age of the other person and their relationship to the victim. This was an attempt to ensure that participants were recalling an actual event. Participants were asked to describe (a) the events that led up to the situation, (b) what the other person did or said that made them feel

dehumanised (less than human) (c) how it made them feel, and (d) what happened after the incident. Participants then answered questions about the event as described below.

Self perceptions and emotions.

Dehumanisation. An adapted version of the 10-item Dehumanisation scale (Bastian & Haslam, 2011) was used to implicitly assess attributions of human nature and human uniqueness. The scale includes such items as "*I felt like I was being treated as a child*" and "*I felt like I was treated as if I had no feelings*", rated on 7-point Likert scales (1 = *not at all*; 7 = *very much so*). A higher score indicates a greater denial of humanness. The scale comprises two sections designed to assess the denial of Human Nature (in the current study, α = .61) and the denial of Human Uniqueness (α = .77). The two subscales were weakly correlated r = .26, p < .01. Participants were also explicitly asked how dehumanised they felt overall, and if they felt they were being treated like a machine or treated like an animal. These three items were rated on the same 7-point Likert scales as the implicit dehumanisation scale.

Sense of belonging. Participants indicated how accepted or rejected they felt (1 = *completely accepted*; 7 = *completely rejected*), how much they thought the person who made them feel less than human liked or disliked them (1 = disliked me greatly; 7 = liked me greatly) and how much they thought the other person hated or loved them when they made them feel less than human (1 = hated me a lot; 7 = loved me a lot). They also rated how much they agreed with the statement "*This event was one of the most negative things that could happen in my relationship with this person*" on a 7-point scale (1 = *strongly disagree*; 7 = *strongly agree*).

Positive and negative self perceptions. Participants rated on 5-point Likert scales how the other person made them feel about themselves on six positive (α = .89) and six negative (α = .82) self-relevant adjectives (see Leary et al.,1998). These items were: stupid, undesirable, unlikeable, unattractive, intelligent, wise, likeable, incompetent, attractive, competent, and desirable (1 = *not at all*; 5 = *extremely*).

Shame. Victims' shame levels following the dehumanising event were measured using 14 items, adapted from Izard (1991). Participants were asked to rate on 5-point Likert scales (1 = *not at all*, 5 = *extremely*) the extent to which they felt hurt, belittled, embarrassed, angry, sad, disgusted, shy, inadequate, disappointed in self, like a failure, discouraged, unclean, morally unfit, and isolated. The scale was internally consistent ($\alpha = .82$). Together these words encompass the variety of ways people describe shameful experiences (Izard, 1991). The term "shame" was not included because it is considered to be so painful that people often have a hard time identifying it or admitting to feeling this way (Lewis, 1991). However, "ashamed" appeared later as part of the negative affect measure (PANAS) described below.

Relational contempt. Participants were also asked to rate four items on a 5-point scale (1 = *never*; 5 = *very often*) indicating how much contemptuous behaviour generally occurred within their relationship with the perpetrator. They were asked to rate their contempt towards the perpetrator and how much they felt the perpetrator generally treated them with contempt using a scale from Holman and Jarvis (2003), which in turn was adapted from Gottman (1994). The items in relation to the victim's contempt towards the perpetrator were: "*How often have you had a lack of respect for this person when discussing an issue*?" and "*How frequently have you seen glaring faults in this person's personality*?" The two items in relation to the contempt from the perpetrator felt by the victim were: "*How frequently have you felt unfairly attacked when you were in an argument with this person?" "How frequently have you felt you had to ward off attacks from this person?"* The internal consistency for this scale was adequate ($\alpha = .82$).

PANAS. State positive and negative affect following the dehumanising experience was measured on a 5-point Likert scale (1 = *very slightly or not at all*; 5 = *extremely*) using the 20-item PANAS (Watson, Clark & Tellegen, 1988). Participants were presented with the list of affective words and asked to "indicate to what extent you felt this way after the

experience you wrote about." The subscales were reliable: Positive affect, α = .81, Negative affect, α = .87.

Attributions.

***Typicality*.** Participants then answered several questions relating to their perceptions of the perpetrators' thoughts and actions, and what they believed had caused the event to occur. Participants were asked to rate how typical it was of the perpetrator to dehumanise the victim and others, using four items adopted from Vangelisti and Young (2000). Items included "*It is typical of them to dehumanise me*." and "*They often say or do things that dehumanise other people*", which were rated on 7-point Likert scales (1 = *strongly disagree*; 7 = *strongly agree*). The items were internally consistent (α = .88).

Intentionality. Participants then indicated (a) whether the perpetrator intended to dehumanise them, (b) whether or not they believed they deserved to be dehumanised, (c) whether they believed the perpetrator knew they had made the victim feel less than human, and finally, (d) whether the perpetrator had showed contempt when they made the participant feel less than human. These four items were rated on 5-point Likert scales (1 = *definitely not*; 5 = *definitely yes*) (see Leary et al., 1998).

Situational vs. personality. Participants were also asked to rate whether "*This behaviour or event was completely due to the situation*" and whether "*This behaviour or event was completely due to their personality*" using a 7-point scale (1 = *strongly disagree*; 7 = *strongly agree*).

Explanations of perpetrator behaviour. Participants rated how plausible six items were, in explaining the perpetrator's dehumanising behaviour. The scale comprises such items as "*The perpetrator was insensitive"* and *"I had done something that hurt the perpetrator*" rated on 5-point scales (1 = *not at all true*; 5 = *absolutely true*) (Leary et al., 1998).

Reactions.

Victim's response. Participants also responded to six items describing how they reacted to the dehumanising event, e.g. "*I expressed my feelings about what he or she did*" and "*I cried after I was by myself*". Items were rated on 5 point Likert scales (1 = *not at all*; 5 = *absolutely true*).

Perpetrator's response. Participants also chose the behaviour that best described the perpetrator's reaction to the event from a list that included: a) did nothing, b) acted like he or she didn't care, c) blamed the victim, d) apologised, or e) asked for forgiveness (Leary et al. 1998).

Consequences.

Victim. Consequences for the well-being of the victim following the dehumanising event were also measured (adopted from Leary et al. 1998). Participants rated four items measuring how the dehumanising event had affected them personally (e.g., "*lowered self-esteem*" and "*made you worry about being dehumanised again*"), on 5-point Likert scales (1 = *not at all true*; 5 = *absolutely true*).

Relationship. Finally, participants rated six items measuring the consequences for the relationship following the event (e.g. "*weakened the relationship with the other person permanently*" and "*made you hate the other person*") on a 5-point scale (1 = *not at all true*; 5 = *absolutely true*) (Leary et al. 1998).

Coding of free response protocols.

In general, participants wrote highly detailed accounts of recalled episodes of dehumanisation. Each free-response was initially analysed by the primary coder using a bottom-up approach (Braun & Clarke, 2006). The aim was to create a concise, informative coding scheme that would provide a useful number of discriminatory categories, without being either over or under inclusive. Coding transcripts according to this structured coding scheme required minimal rater training. To analyse interrater reliability, Cohen's kappa was

calculated for each question category. The interrater reliabilities were all adequate (mean kappa = .84). All disagreements were later resolved in discussion.

Results

The various measures in this study were viewed as independent constructs due to the exploratory nature of the study. This was to ensure that interesting relationships between the various measures were not missed. As such the analyses were controlled decision-wise. Correlations between the various measures ranged from r = .02 to .76, indicating a wide range of convergent and divergent validity, as was expected due to the inter-related nature of the questions.

Features of Dehumanising Experiences in Relationships

Participants recounted an extensive variety of dehumanising episodes. The first hypothesis was that participants would recall instances of abuse and rejection rather than discrimination as examples of dehumanisation in their close relationships. In line with expectations six distinct categories comprised the events recalled: rejection (26%), degradation – including being made to feel like an animal (19%), betrayal (16%), mechanisation (14%), abuse (13%), and criticism (12%) (see Table 10). Participants also recalled a variety of emotions following the dehumanising experience: shame (55%), sadness (50%), anger (45%), fear (13%) and shock (9%).

The majority of dehumanising events recalled by participants involved friends (42%) or romantic or dating partners (35%). Participants also reported being dehumanised by family members (14%) and teachers or employers (9%). The majority of offenders were male (55%), with a mean age of 27.5 years (SD = 11.12) ranging from 6 years of age through to 62. The majority of relationships (60%) continued to some extent following the incident, whilst the remaining 36% of relationships ended permanently, and 4% did not respond.

ANOVAs conducted on the magnitude of participants' self-reported dehumanisation, perceived rejection, and feelings following the dehumanising experience as a function of their

relationship to the perpetrator revealed no significant differences (*ps* > .05). Analyses of the gender of the victim and perpetrator showed no significant difference in the proportion of male and female victims who reported that the perpetrator was male versus female, X^2 (1, *N* = 142) = 2.11, *p* > .15.

Self-Perceptions and Emotions

Dehumanisation.

On average participants reported feeling moderately dehumanised (*M* = 5.00, *SD* = 1.27); 85% of the episodes were rated as at least somewhat dehumanising (i.e. at least 4 on a 7-point scale). This scale appeared to be the most intuitive for participants to identify with; by comparison, 78% of participants reported feeling that their Human Nature (*M* = 4.39, *SD* = 1.21) attributes had been at least moderately denied and 62% reported feeling that their Human Uniqueness (*M* = 4.03, *SD* = 1.48) had been at least moderately denied. The majority of participants did not explicitly feel like animals (*M* = 3.20, SD = *2*.07) or machines (*M* = 1.92, *SD* = 1.92). Examination of participants' responses on the various dehumanisation measures using one way ANOVAs found that self-reported dehumanisation was not significantly different across the two implicit or three explicit measures dependent on type of event recalled (see Tables 11 & 12 for F values, means and correlations).

Sense of belonging.

Victims' perceptions of belonging following the incident are shown in Table 13 for each category of the dehumanising event, including their ratings of how rejected they felt at the time, how much they thought the perpetrator hated or liked them and how negative they felt the event was for this relationship. An overwhelming majority (70%) of participants felt that this event was one of the worst things that could have happened in that particular relationship. One way ANOVAs conducted on the four measures revealed a significant main effect of type of event for perceived rejection, perceived hate and how negative this event was for the relationship (F values and means are shown in Table 13).

Post hoc tests (Tukey HSD) revealed that being abused elicited the highest ratings of perceived hate from the other person. This was significantly higher compared to those made to feel like a machine only (p = .006). Inspections of the means for perceived rejection revealed that obvious incidence of rejection by the perpetrator made participants feel significantly more rejected compared to those who were made to feel like a machine or degraded. Being abused was the most negative thing that could happen in a relationship and was significantly worse than being treated like a machine (p = .015).

Relationship between participants' self perception, emotions.

Several aspects of the victims' subjective experiences were examined including emotions, general affect states and self perceptions. One way ANOVAs comparing participants' emotions and perceptions, dependent on the type of dehumanising event recalled, found no significant differences (ps > .05). Correlations were examined between victims' ratings of dehumanisation and emotions, general affective state and self perceptions.

As can be seen in Table 14, overall dehumanisation was moderately positively associated with feeling rejected (r =.32). Although the negative affect measure and shame scale are strongly correlated r =.60, p = .01, they appear to be measuring different constructs as the shame measurement rather than negative affect was more strongly associated with higher levels of rejection and dehumanisation (see Table 14 for details). The denial of human nature was only weakly associated with increased levels of perceived rejection whilst the denial of human uniqueness and perceived rejection were not significantly associated (r = .11, p = .195).

The second hypothesis was that as levels of dehumanisation increased so too would levels of shame and contempt. As predicted, dehumanisation was moderately positively correlated with feelings of victim shame (r = .45) and relational contempt (r = .38). The denial of human nature was also moderately correlated with shame (r = .29) and relational contempt (r = .31), as was the denial of human uniqueness (rs ≥ .32). The three measures of

dehumanisation were weakly negatively correlated with positive self perceptions and moderately positively correlated with negative affect and negative self perceptions. In line with expectations as levels of dehumanisation increased, participants felt more ashamed and contemptuous; they also viewed themself in a more negative light (e.g. as unintelligent and unattractive) and reported increased levels of negative affect. Participants also felt more rejected as levels of overall dehumanisation increased; however the relationship between feelings of rejection and the denial of human nature and uniqueness was not as closely associated.

Shame and relational contempt were weakly correlated with one another (r = .26). Shame was strongly correlated with negative affect (r = .60) and a negative self-perception (r = .72); similarly, relational contempt was positively correlated with negative self perception (r = .30) and negative affect (r = .18) but to a lesser degree. Feelings of rejection were moderately positively associated with increased levels of shame (r = .41) whilst only weakly associated with increased relational contempt (r = .19). In sum, although feelings of shame and relational contempt both appeared to have negative repercussion for participants, shame appeared to be more intense and internally directed.

Hurt proneness was only weakly associated with increased levels of shame (r = .17, p = .043). It was not associated with increased levels of dehumanisation, relational contempt, negative self-perception or affect (p > .05). As such, it appears that being dehumanised in a personal relationship has more to do with the perpetrator inducing those feelings in the victim rather than the victim being susceptible to feeling less than human, due to individual differences such as sensitivity to hurt.

Table 10

Types of Dehumanisation Recalled in Percentages with Descriptions

Type of event	%	Description
Rejection	26	isolated, ignored, excluded from plans, kick out of home, said they never loved you, cut out of their life
Degradation	19	treated like a child, condescension, humiliated, treated like a joke, embarrassed, shamed, belittled, told you are overreacting, being called an animal
Betrayal	16	lying, cheating, stealing, manipulated, broken promises, being let down, gossiping, being inconsiderate
Mechanisation	14	denied emotions, called rubbish, treated like an object, don't count, mean nothing, feelings ignored
Abuse	13	physical, verbal, emotional, did or said very offensive things, told you are unlovable
Criticism	12	insulted, blamed for something

Note. N = 141

Table 11

Dehumanisation Measures Dependent on Event Recalled

					Denial	
		Overall	Like an	Like a	human	human
		Dehumanisation	animal	machine	nature	uniqueness
Type of event	%			M (SD)		
Rejection	26	4.89[a] (1.29)	3.11[a] (2.16)	2.16[a] (1.50)	4.21[a] (1.17)	3.66[a] (1.43)
Degradation	19	5.00[a] (1.27)	3.37[a] (1.78)	2.89[a] (1.74)	4.06[a] (1.28)	4.50[a] (1.23)
Betrayal	16	5.04[a] (1.19)	2.96[a] (1.87)	2.87[a] (1.87)	4.40[a] (1.13)	3.77[a] (1.68)
Mechanisation	14	4.65[a] (1.46)	2.95[a] (2.24)	3.65[a] (2.35)	4.58[a] (1.12)	3.86[a] (1.37)
Abuse	13	5.50[a] (1.10)	3.72[a] (2.32)	3.28[a] (2.22)	5.09[a] (1.17)	4.29[a] (1.72)
Criticism	12	5.18[a] (1.24)	3.24[a] (2.25)	3.29[a] (1.93)	4.32[a] (1.30)	4.35[a] (1.46)
F (5,136)		0.99	0.40	2.06	1.95	1.48

Table 12

Correlations of Implicit and Explicit Dehumanisation Measures

	Measure of dehumanisation	1.	2.	3.	4.	5.
1.	Overall dehumanisation	-				
2.	Felt like a machine	.44**	-			
3.	Felt like an animal	.40**	.45**	-		
4.	Denial human nature	.48**	.52**	.37**	-	
5.	Denial human uniqueness	.37**	.27**	.24**	.26**	-

Note. $df = 141$. ** $p < .01$.

Table 13

Perceptions of Belonging by Type of Dehumanisation

		Perceived			Most negative thing
		liking	hate	rejection	that could happen
Type of event	%	M (SD)			
Rejection	26	3.46[a] (1.60)	3.73[a,b,c] (1.22)	6.00[a] (1.25)	4.65[a,b] (2.12)
Degradation	19	3.52[a] (2.01)	4.04[a,b,c] (1.63)	5.00[b,c] (1.39)	4.67[a,b] (1.75)
Betrayal	16	3.78[a] (1.91)	3.78[a,b,c] (1.91)	5.70[a,b,c] (1.11)	4.91[a,b] (2.07)
Mechanisation	14	4.45[a] (1.61)	4.90[a,b] (1.25)	4.75[b,c] (1.59)	4.05[a] (1.88)
Abuse	13	2.83[a] (2.23)	3.00[a,c] (2.09)	5.39[a,b,c] (1.72)	6.06[b] (1.55)
Criticism	12	3.41[a] (2.06)	3.82[a,b,c] (1.85)	5.76[a,b,c] (1.20)	5.53[a,b] (1.36)
F(5,136)		1.55	2.76*	3.16**	2.81*

Note. Means in a column with dissimilar superscripts differ significantly by Tukey's honestly Significant different procedure at the .05 level. *$p < .05$, **$p < .01$.

Attributions

Typicality.

Almost half of the participants (42%) agreed at least moderately that the dehumanising behaviour was typical of the perpetrator (M = 3.33 on a 7-point scale, SD = 1.70).

Intentionality.

Participants were also asked to indicate how much insight the perpetrator had in regards to dehumanising them. Half of the participants agreed at least moderately that the perpetrator intended to make them feel less than human (M = 2.67 on a 5-point scale, SD = 1.38). The majority (63%) also felt that the other person knew that they had dehumanised the victim (M = 3.05, SD = 1.26). Half of the participants also felt that the other person was

treating them with contempt (*M* = 2.81, *SD* = 1.41) and the overwhelming majority (91%) believed that they did not deserve to be treated as less than human (*M* = 1.32, *SD* = .68)

Situational vs. personality.

Participants were also more likely to believe that the dehumanising behaviour was due to the other person's personality (*M* = 4.70, *SD* = 1.94) compared to the situation (*M* = 3.57, *SD* = 1.96); 60% of participants at least moderately agreed that the dehumanising event occurred due to the perpetrator's personality, whilst only 32% at least moderately agreed it was caused by situational factors.

Explanations of perpetrator behaviour.

Participants rated six reasons that the other person said or did whatever it was that made them feel less than human. By far the most frequently endorsed reason was that the other person was insensitive or inconsiderate (*M* = 3.98 on a 5-point scale). The means for the other reasons were as follows: the perpetrator was trying to make me feel dehumanised (*M* = 2.58), it was an accident (*M* = 2.39), the person was trying to get me back for something I did (*M* = 2.22), the person thought they were being helpful (*M* = 2.12) and I had done something to hurt the perpetrator (*M* = 1.98). In general, participants felt that the dehumanisation was more often than not due to the perpetrator's personality rather than situational factors; however they did not necessarily think it was intentional.

Relationship between participants' self-perception, emotions and attributions.

The third hypothesis was that as perceived typicality and intentionality increased so too would levels of dehumanisation and relational contempt, but not necessarily shame. As predicted, correlations investigating the relationships between participants' emotions and attributions revealed that typicality of dehumanisation was strongly correlated with relational contempt (*r* =. 76, *p* = .002) and only weakly correlated with shame (*r* = .20, *p* = .017). Typicality was also moderately correlated with increased feelings of dehumanisation (*r* = .42, *p* = .0005). Similarly, there was a strong association between perpetrator intent and relational

contempt (r = .57, p = .0005) and a weak association with shame (r = .26, p = .002). Intentionality was also associated with increased levels of dehumanisation (r = .33, p = .0005). Perceiving the perpetrator as inconsiderate was moderately correlated with shame (r = .36, p = .0005) and relational contempt (r = .44, p = .0005). In line with expectations, perceiving the perpetrator as trying to dehumanise the victim was weakly correlated with shame (r = .27, p = .001) and strongly correlated with relational contempt (r = .53, p = .0005). When victims felt that the perpetrator was trying to get them back for something they did, it was weakly correlated with shame (r = .21, p = .016) and relational contempt (r = .20, p = .019). However when the victims felt that the perpetrators were only trying to help or they had hurt the perpetrator themselves there was no relationship with shame or indication of relational contempt (ps > .05). Finally, as expected, perceived contempt from the perpetrator during the dehumanising experience was positively correlated with the more general relational contempt (r = .29, p = .0005); additionally, there was no relationship with shame (p = .120).

The fourth hypothesis was that increased dehumanisation and relational contempt would be positively associated with causal attributions involving the perpetrator's personality rather than situational pressures. As predicted attributing the dehumanising behaviour to the perpetrator's personality was strongly correlated with relational contempt (r = .62, p = .0005) whilst the relationship with shame was not significant (r = .16, p = .054). Conversely, when the dehumanising event was attributed to situational factors rather than the perpetrator's personality it was negatively correlated with relational contempt (r = -.39, p = .0005) but not with shame (r = -.08, p = .367). As predicted, the relationship between overall dehumanisation and situational factors (r = -.18, p = .032) was only weak, whereas overall dehumanisation correlated moderately with personality (r = .41, p = .0005).

In sum, these results suggest that participants felt more dehumanised when they attributed the dehumanising behaviour to the perpetrator's personality compared to the

situation. Attributions relating to personality factors including intentionality and typicality appeared to be strongly associated with increased levels of relational contempt including contemptuous thoughts towards perpetrators, and less victim shame (i.e., the dehumanisation was more a function of the dehumaniser's than the victim's 'badness').

Reactions

Victim's response.

Participants indicated the degree to which they had reacted in each of six ways after the dehumanising event. As can be seen in Table 15 the most common reactions were telling the other person what they did (82%), expressing anger (76%) and arguing with the perpetrator (73%). Participants were least likely to cry in front of the other person (40%). Crying alone or in front of the perpetrator was positively associated with increased levels of victim shame and negative self-perceptions (e.g. unlikeable, unattractive).

A 2 (gender of victim) x 2 (gender of perpetrator) ANOVA investigating victims' reactions revealed a significant main effect for victim gender when reporting crying in front of the other person, F (1,132) = 5.78, p = .02, η^2_p = .04 and crying alone later, F (1, 132) = 18.97, p = .0005, η^2_p = .13. Men were significantly less likely to cry in either circumstance compared to women. Men and women were equally likely to say something nasty or critical to the perpetrator, irrespective of the perpetrator's gender, F = (1,132) = .52, p = .471, η^2_p = .004. A significant victim gender x perpetrator gender interaction was found for the final three items: defending oneself, F (1, 132) = 6.23, p = .014, η^2_p = .05; expressing anger, F (1,132) = 4.34, p = .039, η^2_p = .03; and telling the other person what they had done, F (1, 132) = 5.48, p = .021, η^2_p = .04. Tests of simple effects revealed that men were significantly less likely to express anger (p = .032) or tell the other person what they had done (p = .051) when the perpetrator was a man, whereas women were likely to express anger and tell the other person how they had been dehumanised regardless of the perpetrator's gender (ps > .05).

Interestingly, dehumanised men were more likely to argue with female perpetrators compared to women who had been dehumanised (p =. 009). Men and women argued with male perpetrators to the same extent (p > .05). However, men were less likely to express their emotions compared to women, particularly when the perpetrator was also male. No other gender differences were found in the study.

Perpetrator's response.

Participants were asked to describe how the perpetrator reacted after dehumanising them. In 28% of cases perpetrators did nothing and a further 27% acted as if they did not care; 20% blamed the victim whilst 18% apologised and 7% asked for forgiveness. A one way ANOVA investigating the typicality of dehumanisation as a function of the perpetrator's reaction found significant differences, F (4, 131) = 6.47, p < .0005, η^2 = .16. Post-hoc comparisons using Tukey HSD revealed that dehumanisation was reported as being more typical when perpetrators acted as if they didn't care, compared to apologising (p = .001). No other comparisons were significantly different. Not surprisingly, when the dehumanising behaviour was out of character for the perpetrator they were more likely to have apologised.

Consequences

Victim.

The dehumanising experiences described by participants had serious consequences for their well-being and relationship with the perpetrator. The fifth hypothesis was that higher levels of dehumanisation, shame and relational contempt would be associated with a greater loss of psychological well-being. Eighty-five percent of participants indicated that the event lowered their self-esteem, and 82% reported being worried about the way other people judged them, as well as being worried that they would be dehumanised again. Further, 81% of participants reported a loss of self confidence as a result of the dehumanising experience. As predicted, these intrapersonal consequences were moderately positively associated with feelings of shame (all r = .36 to .57, ps < .01) (see Table 16) and relational contempt (all r =

.18 to .28, ps < .05) (see Table 16). Feeling rejected was also moderately positively associated with a loss of confidence, self–esteem and worrying about being dehumanised again (all *r* = .27 to .44, *p*s < .01) (see Table 16). Unexpectedly, increased dehumanisation was only weakly associated with lowered self-esteem (*r* = .18, *p* < .05) and worrying about being dehumanised again (*r* = .3, *p* < .05). Furthermore, the denial of human nature and human uniqueness (*p*s > .05) was not associated with the psychological well-being of victims following the dehumanising episode. In sum, the predictions were partially supported; shame, relational contempt and rejection appear to be closely associated with negative intrapersonal effects following a dehumanising experience in a personal relationship. However feelings of dehumanisation alone did not have such an influential effect on psychological well-being.

Relationship.

Participants reported that the episode had long-term consequences for their relationship with the perpetrator. As previously mentioned, hypothesis six was that increased levels of dehumanisation, shame and relational contempt would be associated with relationship breakdown. Ninety-five percent of participants indicated that the event had temporarily weakened their relationship with the perpetrator and 83% felt that the relationship was permanently weakened to some extent. Their feelings towards the perpetrator were also damaged as a result of their dehumanising behaviour. Ninety percent of participants were left with a dislike and distrust (89%) of the perpetrator; further, 75% reported hating the perpetrator as a result of the incident. As expected, relationship breakdown and a lower opinion of the perpetrator were both associated with increased levels of dehumanisation (all *r* =. 26 to .43, *p*s < .01), rejection (all *r* = . 28 to .39, *p*s < .01), shame (all *r* = .29 to .37, *p*s < .01) and relational contempt (*r* = .25 to .62, *p*s < .01) (see Table 16).

Multiple one-way ANOVAs found no significant differences for the various consequences as a function of relationship type (e.g. family member versus dating partner, *p*s > .05). The final hypothesis was that intentionality and typicality of dehumanisation by the

perpetrator would be associated with relationship breakdown and a loss of psychological well-being for the victim. As predicted, when victims indicated that the dehumanising behaviour was typical of the perpetrator's personality rather than situational factors it was strongly associated with negative long-term consequences for the relationship ($r = .48$, $p < .01$) and their feelings towards the perpetrator (all $r = .50$ to $.54$, ps $< .01$) (see Table 16). Interestingly, intentionality was more strongly associated with a loss of self-esteem ($r = .22$, $p < .01$) and social anxiety ($r =. 20$, $p < .01$) compared to typicality or personality (ps $> .05$) (see Table 16). It may be the case that some perpetrators are likely to dehumanise others, but victims do not necessarily think it is intentional; they may just be very inconsiderate. Thus intentionality —which may constitute a one-off event— rather than pervasiveness on the perpetrators part was more likely to lead to a loss of self-esteem and social confidence for the victim. In line with expectations, the breakdown of the relationship was more likely to be explained by the perpetrator's personality or intentionality rather than the type of relationship they had with the victim.

Table 14

Correlations Between Dehumanisation and Measures of Belonging and Affect

	Measure of affect	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
1.	Overall dehumanisation	-									
2.	Denial human nature	.48**	-								
3.	Denial human uniqueness	.37**	.26**	-							
4.	Perceived rejection	.32**	.22**	.11	-						
5.	Shame	.45**	.29**	.32**	.41*	-					
6.	Relational contempt	.38**	.31**	.35**	.19*	.26**	-				
7.	Positive affect	.02	-.06	.04	-30**	-.23**	.04	-			
8.	Negative affect	.36**	.25**	.34**	.29**	.60**	.18*	-.11	-		
9.	Positive self perception	-.26**	-.22**	-.29**	-.31**	-.24**	-.27**	.27**	-.27**	-	
10.	Negative self perception	.39**	.33**	.43**	.43**	.72**	.30**	-.20*	.47**	-.41**	-

Note. $df = 141$.** $p < .01$, * $p < .05$.

Table 15

Victim's Reaction Correlated With Dehumanisation and Emotion

			Correlations with dehumanisation and emotions						
								Affect	
Victim's reaction	M	%	Dehumanisation	HN	HU	Shame	Relational contempt	Positive	Negative
Told the other person	3.37	82	.16	.17	.13	.02	-.06	.30**	.12
Expressed Anger	3.19	76	.17	.14	.18*	.14	.06	.12	.19*
Argued and defended	2.71	73	.10	.16	.08	-.08	.04	.27**	.02
Cried later when alone	3.15	65	.14	.24**	.12	.40**	.10	-.09	.41**
Said something critical or nasty	2.46	61	.11	-.08	.10	.02	-.02	.16	.13
Cried in front of other person	2.29	40	.10	.06	.16	.23**	.04	-.19*	.38**

Note. df = 141.** $p < .01$, * $p < .05$.

Table 16.

Correlations of Consequences, Emotions and Attributions

			Correlations with emotions and attributions										
									Attributions				
Consequences	M	%	Dehumanisation	HN	HU	Rejection	Shame	Contempt	Trying	Intent	Typicality	Personality	Situation
Intrapersonal effects													
Lower self-esteem	3.31	85	.18*	.13	.15	.44**	.57**	.22*	.28**	.22**	.15	.17	-.00
Loss of self-confidence	3.26	81	.14	.11	.09	.39**	.43**	.18*	.20**	.19**	.15	.22*	-.06
Worried about evaluations	3.15	82	.10	.00	.10	.16	.36**	.08	.21**	.20**	.12	.13	-.08
Worried about dehumanisation	3.01	82	.30**	.13	.10	.27**	.47**	.28**	.31**	.32**	.28**	.34**	-.33
Relationship effects													
Permanent damage	3.36	83	.30**	.32**	.07	.32**	.29**	.42**	.43**	.38**	.40**	.48**	-.32**
Temporary damage	4.12	95	.26**	.43**	.18*	.36**	.37**	.25**	.11	.08	.18*	.29**	-.13
Distrust	3.73	89	.33**	.36**	.07	.34**	.37**	.43**	.39**	.30**	.41**	.51**	-.30**
Dislike	3.55	90	.43**	.35**	.17*	.39**	.32**	.62**	.50**	.50**	.59**	.54**	-.31**
Love	1.50	29	-.30**	.28**	-.08	-.37**	-.11	-.30**	-.12	-.14	-.35**	-.38**	.29**
Hate	2.86	75	.39**	.38**	.23**	.28**	.36**	.56**	.48**	.50**	.50**	.50**	-.24**

Note. $df = 141$. $^{**}p < .01$, $^{*}p < .05$

Discussion

The principal aim of this study was to investigate the psychological and social effects of dehumanisation in personal relationships. The findings revealed that victims reported more relational contempt when they perceived the dehumanising behaviour to be intentional or typical of the perpetrator, and indicative of their personality. Increased levels of victim shame were also linked to perceived intentionality and typicality, but to a lesser extent. Relatedly, victims tended to reciprocate the perpetrator's perceived contempt. Overall, it was found that being dehumanised within a close relationship is associated with feelings of shame and contempt, relationship break down, and reduced levels of psychological well-being.

Participants recalled a variety of experiences in which they were made to feel less than human, including being rejected, degraded – including being made to feel like an animal, betrayed, treated like a machine, abused or criticised. Unlike Study 1, where participants were not directed to recall an episode of dehumanisation experienced in a close relationship, there were no recalled experiences of discrimination or bullying. In sum, the types of experiences associated with dehumanisation in personal relationships appear to systematically differ from those experiences involving intergroup relations.

Dehumanisation was associated with increased levels of shame for victims and contempt towards perpetrators. These findings are in line with previous research by Bastian and Haslam (2011) where victim shame was associated with the denial of human uniqueness. However in this sample, shame and contempt were equally associated with both denial of human uniqueness and human nature. It is possible that dehumanisation in close relationships induces feelings of shame and contempt, regardless of the type of experience recalled. This might be due to the ongoing embarrassment or pain it may cause, particularly when victims feel it is intentional and pervasive. The self-conscious emotions of shame, guilt and particularly contempt were more strongly associated with feelings of dehumanisation than they were with rejection. Furthermore, the denial of human uniqueness was not associated

with feelings of rejection. These results support the experimental findings of Study 2 where dehumanisation was found to be distinguishable from rejection. In sum, it appears that being made to feel less than human in a close relationship involves more than just rejection.

Participants were more likely to perceive the perpetrator's behaviour as being due to personality rather than situational pressures. Furthermore, relationships were more likely to breakdown when victims felt the behaviour was typical and due to the perpetrator's personality rather than based on their relationship with them (e.g. family member versus friend). As such, it appears that the personality of the perpetrator rather than the type of relationship they have with the victim, may strongly affect how likely the relationship is to continue. It could be the case that people who typically dehumanise others in their close relationships may do so as a function of their values or ideologies (e.g., holding authoritarian attitudes). Personality traits and ideologies have been associated with increased levels of prejudice (Adorno, Frenkel-Brunswick, Levinson & Stanford, 1950; Altemeyer 1981; Duckitt, 1992; Duckitt, Wagner, Du Plessis & Birum, 2002; Hodson, Hogg & MacInnis, 2009), and as such, these factors may also influence dehumanisation in close relationships. It may also be the case that the experience of chronic dehumanisation from close relatives may contribute to familial estrangement, including divorce (Fitness, 2006).

However, this pattern of attributing the perpetrator's behaviour to their personality rather than the situation could also be partly a function of the tendency of observers to overestimate personality or disposition when inferring the causes of the actor's behaviour, whilst underestimating the influence of situational factors (Kelley, 1967; Jones & Nisbett, 1971). Future research investigating both victim and perpetrator experiences would allow researchers to determine the impact of situational and personality factors in episodes of dehumanisation. This might be achieved, for example, by evaluating the perpetrator's own attributions along with measuring their personality (e.g. narcissistic or psychopathic tendencies) and ideologies including authoritarianism, and social dominance orientation.

Despite these ambiguities, dehumanised individuals in the current study felt that the perpetrator had a tendency to dehumanise others, and more often than not the experience was due to the perpetrator's personality rather than situational factors.

Dehumanisation was associated with feelings of hate and distrust towards the perpetrator, and with permanent relationship breakdown. Previous research has found that people who had been deeply hurt by their partner were more likely to describe the relationship as being very satisfying and more likely to continue, compared to those who were not as hurt (Vangelisti & Young, 2000). This, however, does not appear to be the case when we are dehumanised in a close relationship; perhaps because being made to feel less than human is not something we expect from those who are closest to us. Interestingly, the denial of human nature traits was associated with relationship breakdown to a greater extent than the denial of human uniqueness traits. The nature of close relationships may explain this difference. We expect our partners, family members and friends to consider our feelings and accept us unconditionally. When those who are close to us ignore our emotions or objectify us, the pain is much worse than being labelled as overly dramatic (or being treated like a child), as may be the case when our uniquely human attributes are denied. In sum, when someone makes us feel less than human rather than just hurt, the relationship is more likely to collapse because, although we might expect a loved one to occasionally hurt our feelings, we never expect to be treated as less than human by those closest to us.

In a related vein, increased levels of relational contempt and shame were linked to relationship breakdown and a loss of self-esteem and social confidence for victims. Shame was most strongly associated with lowered self-esteem and worrying about being dehumanised again; whereas relational contempt was most strongly associated with feelings of hate and more permanent damage to the relationship. Shame and relational contempt were also positively associated with each other. Contempt was strongly associated with typicality and intentionality of the dehumanisation by the perpetrator. As such contempt appears to be a

defensive reaction against self-blame, as shame was not as strongly correlated with these attributes. Moreover, when participants felt that the perpetrator was treating them with contempt, they were more likely to reciprocate this emotion. Combined, these findings describe a cycle of shame and contempt following a dehumanising experience in a close relationship. First the perpetrator contemptuously makes the target feel less than human, thus inducing feelings shame and guilt in the victim. The victim then reciprocates the contempt and is more likely to relationally distance themselves from the perpetrator. These results support previous findings where the cycle of contempt and shame has been associated with relationship breakdown in marriages (Gottman, 1994; Gottman & Notarius, 2002; Scheff & Retzinger, 1991) and in the workplace (Melwani et al., 2011).

Strengths and Limitations

Research by Bastian and Haslam (2011) has examined the role of guilt and shame in the victim's experience of dehumanisation, finding weak associations between these self-conscious emotions and being made to feel less than human. This study further explored the role of shame in experiences of dehumanisation, along with relational contempt and how the interaction of these two emotions may affect the individual and the dyad. Future research would benefit from investigating both perspectives, particularly of the same recalled event. However, if the relationship has ended due to constant dehumanisation it would be unlikely that both members would agree to participate. Alternatively, the perpetrators' perspective could be investigated and participants asked to recall a time they treated a close other (e.g. partner, friend, or family member) as less than human. Following this, investigators may be able to ascertain whether some individuals are more likely than the average person to dehumanise loved ones due to personality traits or ideological beliefs. Equally important, hurt proneness was not related to increased levels of dehumanisation in this sample. However exploring shame-proneness and other individual differences in victims may also shed light on this topic. Importantly, investigating individual differences will enable investigators to

determine whether particular relational dyads are more susceptible to this reciprocal cycle of dehumanisation, contempt and shame.

Conclusions

This study investigated dehumanisation in close relationships and the consequences these events have on the dehumanised individuals and their relationship with the perpetrator, focusing in particular on the roles of shame and contempt within the dyad. The results demonstrated that the attributions that people make about being dehumanised affect how likely the relationship is to continue and their own feelings of self-worth. When participants felt the perpetrator was to blame they were more likely to end the relationship, but also more likely to lose self confidence. If some individuals are in fact more susceptible to feeling dehumanised, or alternatively some individuals are more likely to treat others in such a way, it would helpful for individuals and therapists to identify such circumstances. For example, therapists would be able to use this knowledge to work with clients to prevent these events from occurring by arming potential victims with the psychological tools to cope with the behaviour. If one person in the relationship can identify and stop the cycle of contempt the relationship is more likely to continue and the victim will retain their self-esteem and social confidence. Alternatively if they identify the perpetrator's behaviour as pervasive and intentional they can distance themself before permanent personal damage is done.

Chapter 5
Mechanistic Dehumanisation in Medicine

As noted in previous chapters, dehumanisation refers to the denial of a person's humanness. Specifically, a person can be denied their uniquely human (UH) attributes such as rationality, refinement and civility when they are viewed as child-like or animalistic. Alternatively, a person can be denied their human nature attributes, including emotional responsiveness, agency and interpersonal warmth when they are viewed as an object or machine (Haslam, 2006). Study 3 examined the relational aspects of dehumanisation and found that it is quite common amongst family members, friends and even colleagues. Overall it was found that being dehumanised in a close relationship is associated with feelings of shame and contempt, relationship breakdown, and reduced levels of psychological well-being.

Another important relationship context that involves considerable intimacy and vulnerability and potential for dehumanisation is between doctors and their patients. Indeed, the common tendency in medicine of referring to patients by case or disease label (Schulman-Green, 2003) may reflect the presence of entrenched dehumanisation. The emphasis on the somatic aspect of illness might bias doctors toward perceiving the patient as part of the disease, rather than the disease as part of the patient (Miles, 2012). For patients, however, their relationship with their doctor is unique and highly valued, often requiring disclosure of their most intimate details. Theorists such as Miles (2012) argue that patients need to be cared *for* as well as cared *about*. The aim of the current study was to investigate how individuals react to a doctor who holds a dehumanising view towards patients compared to a doctor who holds a person-focussed or humanising perspective. In addition, the study explores individual characteristics that might make patients more or less vulnerable to such effects.

Dehumanisation in the Medical Context

Of the two forms of humanness described by Haslam (2006), denial of human nature

characteristics (mechanistic dehumanisation) is likely to be most relevant within the medical context. Mechanisation is inherent in the predominant medical diagnostic and treatment approach, which is characterised by interpreting illness dispassionately and objectively; viewing patients as mechanical systems with interacting parts (Haque & Waytz, 2012; Kriel, 1988). This tends to result in a downplaying of the mental and emotional capacities of patients as whole functioning humans, viewing them, instead, as objects (Borbasi, Galvin, Adams, Todres, & Farrelly, 2012). This dehumanising approach to patients may help to reduce the high levels of stress (and occupational burnout) that doctors and medical professionals routinely face in the course of their day-today work (Haque & Waytz, 2012). In support of this, Lammers and Stapel (2012, Study 3) found that participants who were assigned the role of surgeon, opted to perform a more painful but effective procedure on patients, which in turn led to a more dehumanised view of the patient. That is, the 'surgeons' dehumanised their patients in order to effectively perform an ordinarily stressful, but life-saving operation. While this suggests that there is some value in medical dehumanisation from the perspective of the physician, the experience of dehumanisation from the patient's perspective tends to be overwhelmingly negative.

The general approach of modern medicine as described by Kriel (1988) is to regard the body as a machine that can be analysed in terms of its parts, with disease explained as a malfunctioning of this machine. Critics of this Cartesian ethos argue that medicine appears to have lost its appreciation for the patient as a responsible individual who presents at the consultation with their own stories, anxieties and cultural context, and who could play a role as a partner in the process of healing (Kriel, 1988; Miles, 2012). Accordingly, the person-centred model of practice aims to humanise medicine by embracing technology whilst also involving the patient in the process of recovery (Haslam, 2007; Kriel, 1988; Miles, 2012).

Moreover, people appreciate and respond well to empathic doctors (Haslam, 2007; Kim, Kaplowitz & Johnston, 2004). This preference for a connection with the doctor is

reflected in the following anecdotal account from a patient provided by Sheeler (2013): Although the patient acknowledged that his local doctor might not be as competent as other doctors, the bond that had formed between the local doctor and the patient over many years had become more important than the perceived competence of the doctor, with the patient stating that *"I'd rather have Doc B operate on me drunk than anyone else sober."* (p. 240)

Empathy in the medical context can be broadly defined as the patient feeling understood and accepted by their physician (Kim et al., 2004). A doctor lacking empathy towards patients might avoid eye contact, read off a medical chart rather than asking for the patient's experiences, be rough with physical care, and act as if they are too busy and efficient to engage with patients (Kralik, Koch & Wotton, 1997).

There are many reasons (e.g., fatigue, boredom, stigmatisation, arrogance, or aggression) why a doctor might become empathically disengaged. However, one under-explored reason for the lack of empathy in the medical context is institutionalised mechanistic dehumanisation. Mechanistic dehumanisation often occurs, not because the doctor dislikes the patient (or is bored, etc.), but due to the overarching mechanistic medical philosophy to understanding and treating illness. Thus, it is motivationally distinct from these other forms of empathic disengagement and may therefore have a different impact on patient perceptions. What remains unclear from the research on empathy and medical consultations is how the mechanistic model of medicine affects patients' views of doctors and the effectiveness of treatment. On the one hand, medical dehumanisation could be expected to be associated with a range of adverse effects on patients. However, the objective, reductionist, and impersonal mechanistic approach to encapsulating and treating illness might be preferred by some individuals. The aim of this study, then, was to investigate how individuals respond to this specific type of empathic disengagement by medical professionals.

Factors Impacting Patient Perceptions

Type of illness.

Many of the concerns about dehumanisation that have been discussed for medical conditions might be expected to be amplified for psychological illnesses, as opposed to physical. The fear of receiving an illness label may discourage individuals from seeking treatment; once labelled, people may try to distance themselves by discontinuing treatment (Link & Phelan, 2006). Many people minimise their contact with mental health professionals in order to avoid being labelled mentally ill (Corrigan, 2004). Further, when people with mental illnesses feel stigmatised, they show poorer adherence to treatment compared to those who do not self-stigmatise (Fung, Tsang, & Corrigan, 2008). In fact, the mere labelling of chronic mental illness (versus chronic physical illness) has been found to trigger dehumanising responses by third parties such as ascribing less humanity to targets and perceiving them as dangerous, or crazy (Martinez, Piff, Mendoza-Denton, & Hindshaw, 2011). In the current study, type of illness was manipulated in order to examine whether labelling people with mental illness as opposed to physical illness increases feelings of dehumanisation and decreases satisfaction and intended compliance.

Gender.

Whereas a consultation with a dehumanising doctor is likely to have adverse consequences for the patient, there are several individual characteristics that might affect how patients react to being dehumanised. One such variable is gender. Compared to men, women have been found to empathise more with others and to expect the same in return (Timmers, Fischer, & Manstead, 1998). Further, young, healthy, educated women in particular, prefer being actively involved in their treatment progress rather than seeking help from a paternalistic doctor (Krupat et al., 2000). Women have also been shown to report higher levels of depersonalisation from their doctors than men (Coyle & Williams, 2001). For example, women were more likely to report that they felt as though the doctor did not fully understand their problem, and that they felt like a number rather than a person. Thus it might

be expected that women, compared to men, would favour a person-focussed doctor due to their higher expectations in regards to empathy.

Men and women experience similar emotions when dealing with various situations; however, their willingness to express these emotions varies systematically (Kring & Gordon, 1998). Women are much more willing to express emotions such as fear and disgust or happiness compared to men when watching a film (Kring & Gordon, 1998). In addition, women are more likely than men to display powerless emotions as they are less concerned about being judged as emotional (Timmers et al., 1998). As such, participants with high levels of emotional expressiveness might be more responsive to a person-focussed doctor, compared to those with lower levels of emotional expressiveness. This might be especially relevant for psychological illnesses (vs. physical illness) where patients generally feel more vulnerable (Gaillard, Shattell & Thomas, 2009).

Locus of control.

Individuals with an internal locus of control tend to believe that outcomes result from personal effort, whereas individuals with an external locus of control tend to believe that outcomes occur as a result of forces outside of their control (Marks, 1998). Numerous studies have found a correlation between low levels of perceived (internal) control and high psychological distress (Holder & Levi, 1988; Petrosky & Birkimer, 1991; Tiggemann & Raven, 1998). Additionally, individuals with internal locus of control have been found to spend less time in counselling and to demonstrate higher levels of improvement compared to those with an external locus of control (Nowicki & Duke, 1978). Further, internal control has been linked to positive health behaviours including seeking information, taking medication, keeping appointments, making life-style changes and coping with stressful medical interventions (Miller & Mangan, 1983; Steptoe & Wardle, 2001; Wallston & Wallston, 1978). Accordingly, it might be expected that those with an external locus of control might prefer

handing over responsibility to a dehumanising doctor as opposed to a person-focussed doctor who would require them to be more actively involved in their own recovery and treatment.

Overview of Study

Dehumanisation affords medical professionals a means of protecting themselves from the stress associated with making hard decisions. Nonetheless, a dehumanising approach might also have many adverse consequences for treatment and patient well-being. An examination of outcome measures such as patient reported satisfaction and patient adherence to treatment can provide an approximation of the impact of medical mechanisation on patient care (Haque and Waytz, 2012).To investigate the impact of dehumanisation in a medical consultation, in the present study, participants were presented with vignettes depicting a doctor who holds a dehumanising philosophy towards medical treatment or a doctor who hold a person-focussed philosophy towards medical treatment. For the dehumanising doctor, the body as a machine metaphor was employed as this is a widely held view in modern medicine (Kriel, 1988). The hypothetical vignettes used in this study provided participants with an insight into the doctor's treatment philosophy and enabled the manipulation of variables such as patient illness type that would be impossible under naturalistic conditions. It was predicted that participants would prefer a humanising (person-focussed) doctor compared to a dehumanising doctor. However, type of illness, gender, emotional expressiveness and perception of control were also included in the study to explore whether they would moderate participants' opinions and future behaviours.

The following hypotheses were proposed: First, participants assigned to imagine seeing the dehumanising doctor compared to those assigned to the humanising doctor, were expected to report low levels of compliance and satisfaction, viewing the doctor as incompetent, dehumanising and lacking empathy. Second, participants in the psychological condition compared to those in the physical condition were also expected to report low levels of compliance and satisfaction, viewing the doctor as incompetent, dehumanising and lacking

empathy. Third, participants assigned to imagine the combination of seeing the dehumanising doctor (vs. humanising doctor) for a psychological condition (vs. a physical condition), were expected to be additive. Fourth, compared to men, women were expected to be less satisfied with the doctor and subsequently less compliant. In particular, women were expected to be less accepting than men of the dehumanising doctor's philosophy. Fifth, those high in emotional expressiveness were expected to be less accepting of the dehumanising doctor compared to those low in emotional expressiveness. Finally, participants with an external (vs. internal) locus of control were expected to be more accepting of the dehumanising doctor's paternalistic approach.

Method

Participants

Participants were 387 undergraduate students (280 women, 107 men) who took part in the study as part of a class exercise. Their ages ranged from 18 to 66 years (M = 21.37 years, SD = 5.61 years). The median number of doctor's visits that participants reported making in the past 12 months was six (M = 5.90, SD = 7.58).

Procedure and Materials

Participants were provided with a link to the online experiment as part of a class exercise, and completed it in their own time.

Individual differences.

First, participants completed the 17-item Emotional Expressivity (Kring, Smith & Neale, 1994). The scale comprises such items as "*I think of myself as emotionally expressive*", and "*I display my emotions to other people*". A higher score represents higher emotional expressiveness. Items were rated on 6-point Likert scales (1 = *never true*, 6 = *always true*). This measure was internally consistent (α =. 92). Participants then completed the 28-item Internal Control (Duttweiler, 1984) scales. The scale comprises items such as "*When faced*

with a problem I ____ try to forget it." and "*If I want something I ____ work hard to get it*." Participants filled in the blanks using 5-point Likert scales (1 = *rarely – less than 10% of the tim*e, 5 = *usually – more than 90% of the time*). The measure was internally consistent (α =.82, in this sample).

Vignettes

Following this, participants were randomly assigned to one of four conditions in which they read a vignette about a doctor's treatment philosophy. The vignettes for each condition have been included below. All vignettes finished by instructing the participant to, "*Please answer the following questions, imagining that you were treated by this doctor for a psychological (or physical) condition.*"

Dehumanising Dr, psychological condition.

Please read the doctor's statement carefully as the rest of the survey will concern your impressions of this doctor. Dr A is a medical practitioner and has treated many patients with psychological conditions. Speaking candidly, he says "When I treat a patient with a psychological problem, I don't pay any attention to the patient's thoughts and feelings. I think of the brain as a finely balanced machine and the malfunction must be understood without any consideration given to the patient's feelings and thoughts about their condition. When I determine the particular nature of the brain malfunction, depression or anxiety for example, I prescribe a treatment regime that has the effect of tuning or recalibrating the machine. Overall, my approach to treating psychological conditions is like that of a mechanic fixing an engine - the driver is irrelevant.

Dehumanising Dr, physical condition.

Please read the doctor's statement carefully as the rest of the survey will concern your impressions of this doctor. Dr A is a medical practitioner and has treated many patients with physical conditions. Speaking candidly, he says: "When I treat a patient with a physical problem, I don't pay any attention to the patient's thoughts and feelings. I think of

the body as a finely balanced machine and the malfunction must be understood without any consideration given to the patient's feelings and thoughts about their condition. When I determine the particular nature of the physical malfunction, viral infection or chest pains for example, I prescribe a treatment regime that has the effect of tuning or recalibrating the machine. Overall, my approach to treating physical conditions is like that of a mechanic fixing an engine—the driver is irrelevant.

Humanising Dr, psychological condition.

Please read the doctor's statement carefully as the rest of the survey will concern your impressions of this doctor. Dr A is a medical practitioner and has treated many patients with psychological conditions. Speaking candidly, he says: "When I treat a patient with a psychological problem, I pay close attention to the person's thoughts and feelings. I believe that understanding the individual is integral to understanding their psychological condition. When I'm in a position to understand the nature of the particular psychological problem, depression or anxiety for example, I place the upmost importance on working together with the person to find an individual, personalised solution that best suits their needs. Overall, my approach is person focussed.

Humanising Dr, physical condition.

Please read the doctor's statement carefully as the rest of the survey will concern your impressions of this doctor. Dr A is a medical practitioner and has treated many patients with physical conditions. Speaking candidly, he says: "When I treat a patient with a physical problem, I pay close attention to the person's thoughts and feelings. I believe that understanding the individual is integral to understanding their physical condition. When I'm in a position to understand the nature of the particular physical problem, viral infection or chest pains for example, I place the upmost importance on working together with the person to find an individual, personalised solution that best suits their needs. Overall, my approach is person focussed.

Dependent Variables.

After reading the vignette, participants rated themselves and the doctor on a variety of measures.

Dehumanisation. Firstly, an adapted version of the 12-item Dehumanisation scale (Bastian & Haslam, 2010) was used to assess attributions of human nature and human uniqueness. The Dehumanisation scale includes such items as "*The doctor would leave me feeling like I was mechanical and cold, like a robot"* and *" The doctor would leave me feeling like I was an adult not a child"*, which are rated on 7-point Likert scales (1 = *not at all*; 7 = *very much so*). Two subscales assess Human Nature (α = .95) and Human Uniqueness (α = .85) traits, which were highly correlated (r = .87, p = .005) and so were combined in this study. The overall scale was internally consistent in this sample, α = .95. The dehumanisation scale was always administered immediately after the induction. The order of the subsequent scales was randomised, excluding the manipulation check, which always appeared last. Items within each scale were randomised. A lower score indicates feeling less human compared to a higher score.

Doctor's perceived empathy. An adapted version of the CARE measure (Mercer, Maxwell, Heaney, and Watt, 2004) assessed participants' perceptions of the doctor's empathy. The adapted CARE measure includes 5 items such as *"Would you expect this doctor to show care and compassion (i.e. seeming genuinely concerned, connecting with you on a human level; not being indifferent or "detached")?"* and *"Would you expect this doctor to make you feel at ease (i.e. being friendly and warm towards you, treating you with respect; not cold or abrupt)?"* Items were rated on 5-point Likert scales (1 = not at all, 5 = very much so). This measure was internally consistent in this sample, α = .93.

Doctor's perceived competence. A single item measured the doctor's perceived competence: "*Would you expect this doctor to be competent (i.e. having knowledge of the*

area, giving necessary information)?" This item was rated on a 5-point Likert scale (1 = not at all, 5 = very much so).

Patient satisfaction. Four items were created to measure how satisfied participants thought they would feel after a consultation with the doctor. The scale included "*Would you be feeling more or less hopeful about your situation following a consultation with this doctor?*", "*Would you be feeling more or less concerned about your situation following a consultation with this doctor?*", "*How comfortable would you be asking this doctor questions regarding your situation in a consultation?*" and "*How frustrated would you be feeling following this consultation?*" The items were rated on 7-point Likert scales, (1 = *less hopeful/very uncomfortable*, 7 = *more hopeful/ very comfortable*). The scores for the four items were averaged to produce a single scale score. This measure was internally consistent in this sample, α = .88.

Intended compliance. To measure intended compliance, three items adapted from Ross, Steward and Sinacore (1995) were included, with each analysed separately to capture the full scope of the data. A single item measured how much participants would be willing to return for care. *"If you had been treated by this doctor how willing would you be to return for care?"* Each question was rated on a four-point Likert scale (1 = *definitely yes*, 4 = *definitely not*). A second item measured how likely participants would be to refer a friend to the doctor. "*If you had been treated by this doctor how willing would you be to refer a friend to the doctor?*" A third item measured how likely participants would be to follow the doctor's recommendations "*If you had been treated by this doctor how willing would you be to follow the doctor's recommendations?*"

Manipulation check. Following the compliance items, participants answered a manipulation check item, "*Was the content of the doctor's approach to treat patients*: 1 = *dehumanising (i.e. treating patients like an object or machine*)? 2 = *humanising (i.e. person focussed),* was devised to assess the effectiveness of the manipulation. Out of the total 387

individuals who participated 97% answered the question correctly; the 12 answered incorrectly were removed from the data set. Finally, participants completed an item requesting permission for their data to be used for research purposes.

Results

Analysis

The individual difference measures of Emotional Expressivity and Internal Control were analysed as discrete data sets, with focus on the way sex, illness type and the doctor's treatment philosophy affected participants' reactions. The data was analysed using GLM and where there were multiple comparisons, Bonferroni adjustment of alpha was employed.

Analyses for Emotional Expressivity

Dehumanisation.

A four-way between-subject ANCOVA was used to test differences in levels of dehumanisation under the various conditions. Emotional expressiveness served as the continuous predictor variable, with Doctor's treatment philosophy (Dehumanising vs. Humanising), illness type (Psychological vs. Physical), Sex (Male vs. Female) as the fixed factors.

It was hypothesised that participants in the dehumanising doctor condition would report feeling more dehumanised compared to those in the person-focussed doctor condition. It was also hypothesised that those high on emotional expressiveness would be less accepting of the dehumanising doctor compared to those low on emotional expressiveness. As expected the ANCOVA revealed three effects including a significant main effect for doctor's treatment philosophy, F (1, 359) = 633.47, p = .0005, η_p^2= .64, which was qualified by an interaction between Doctor's treatment philosophy and Emotional expressiveness, F (1, 359) = 4.05, p = .045 η_p^2 = .01. As illustrated in Figure 2, participants with high levels of Emotional expressiveness predicted that they would feel less human after consulting a doctor with a dehumanising treatment philosophy compared to those imagining a consultation with a

humanising doctor. The difference between participants low on emotional expressiveness was not as pronounced. It was also hypothesised that participants in the psychological illness condition would report feeling more dehumanised compared to those in the physical illness condition. Consistent with expectations there was also a main effect for illness type, F (1, 359) = 13.27, p = .0005, η_p^2 = .036. Those who imagined seeking help for a psychological condition (M = 3.95, SD = 1.64) felt significantly less human compared to those who imagined seeking help for a physical condition (M = 4.20, SD = 1.51) regardless of sex, doctor's treatment philosophy and emotional expressiveness.

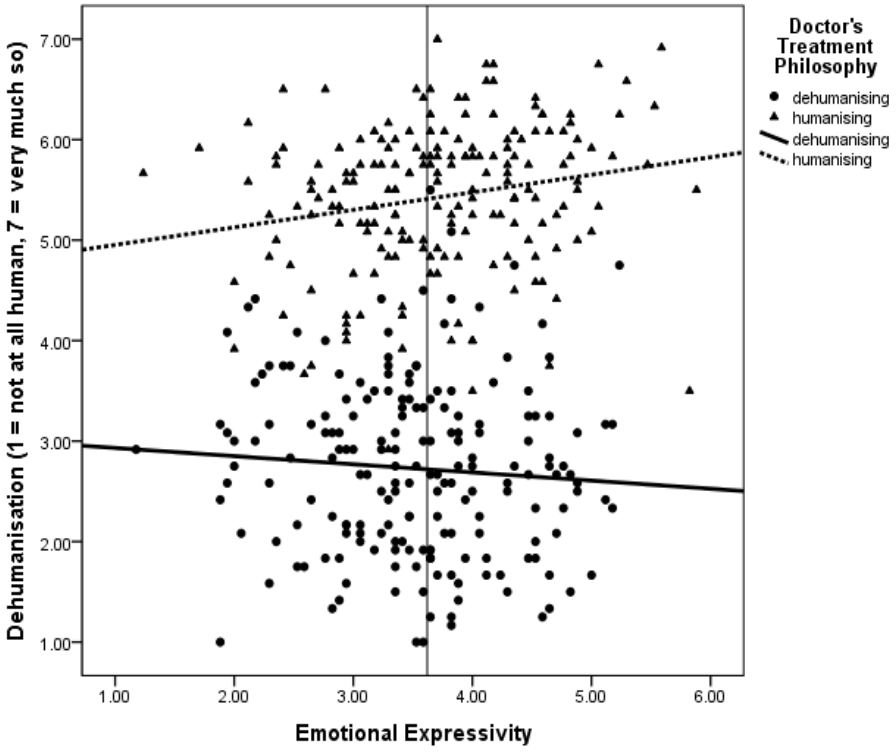

Figure 2. Dehumanisation across doctor's treatment philosophy and emotional expressivity.

Perceptions of the doctor.

Empathy. It was hypothesised that participants in the dehumanising doctor condition would report lower levels of empathy for the doctor compared to those in the person-focussed condition. Consistent with expectations, perceptions of the doctor's empathy revealed a significant main effect for the doctor's treatment philosophy, F (1, 359) = 362.53, p = .0005, η_p^2= .50. Participants in the dehumanising condition (M = 11.18, SD = 4.79) perceived the

doctor as having less empathy towards patients compared to those in the person-focussed condition (M = 22.02, SD = 3.16). It was also predicted that participants in the psychological illness condition would rate the doctor as less empathic compared to those in the physical condition. Furthermore it was hypothesised that participants high in emotional expressiveness would rate the doctor as less empathic compared to those low in emotional expressiveness. Inconsistent with these predictions there were no other significant effects for empathy when controlling for emotional expressiveness.

Doctor's competence. It was hypothesised that participants in the dehumanising condition would report lower levels of competence for the doctor compared to those in the person-focussed condition. Further, those in the psychological illness condition were expected to report lower levels of competence for the doctor compared to those in the physical illness condition. Also women were expected to view the dehumanising doctor as less competent compared to men. Finally, those high in emotional expressivity were expected to view the dehumanising doctor as less competent compared to the person-focussed doctor. In line with these expectations, ratings of perceived doctor's competence revealed three significant effects, including a four-way interaction between sex, doctor's treatment philosophy, illness type and emotional expressiveness, F (1, 359) = 5.191, p = .023, η_p^2 = .01.The other effects were: Doctor's treatment philosophy, and Doctor's treatment philosophy by Sex. As can be seen in Figure 3, women, whether high or low on emotional expressiveness, rated the humanising doctor as more competent, regardless of illness type. However, inconsistent with expectations, men high in emotional expressiveness rated the dehumanising doctor as more competent than the humanising doctor when they imagined seeking help for psychological condition, but not for a physical condition. Men low in emotional expressiveness, when imagining seeking help for a psychological condition from a dehumanising doctor, followed a similar pattern to women, rating the doctor's perceived competence as low, but when the imagined illness was physical they rated the competence much higher than women.

Reaction to doctor's treating philosophy.

Feelings. Ratings of how satisfied participants thought they would feel following a consultation with the doctor revealed three significant main effects. It was hypothesised that participants in the dehumanising condition would feel less satisfied and more frustrated about their situation compared to those in the person-focussed condition. As expected, following the imagined consultation with the dehumanising doctor, participants (M =3.18, SD = 1.21) indicated that they would feel significantly less comfortable, less hopeful, and more frustrated and concerned about their situation, compared to those who imagined seeing the person-focussed doctor (M = 5.30, SD = 1.03), F (1, 359) = 191.95, p = .0005, η_p^2 = .35. It was also hypothesised that participants in the psychological illness condition would feel less satisfied and more frustrated about their situation compared to those in the psychical illness condition. In line with expectations, participants who imagined having a psychological illness (M = 4.04, SD = 1.59) indicated that they would feel significantly less comfortable and less hopeful and more frustrated and concerned about their situation following a consultation compared to those in the physical illness condition (M = 4.44, SD = 1.48), F (1, 359) = 13.48, p = .0005, η_p^2 = .036. It was also hypothesised that women would be less accepting of the dehumanising doctor compared to men. As expected, women (M = 4.14, SD = 1.61) indicated that they would feel significantly less satisfied with the doctor and their situation than did men (M = 4.5, SD = 1.35), F (1, 359) = 5.29, p = .022, η_p^2 = .015. There were no significant interactions.

Intended compliance.

Firstly, it was hypothesised that participants in the dehumanising doctor condition would be less compliant compared to those in the person-focussed condition. Second, it was hypothesised that participants in the psychological illness condition would be less compliant compared to those in the physical illness condition. Finally it was hypothesised that women would be less compliant compared to men.

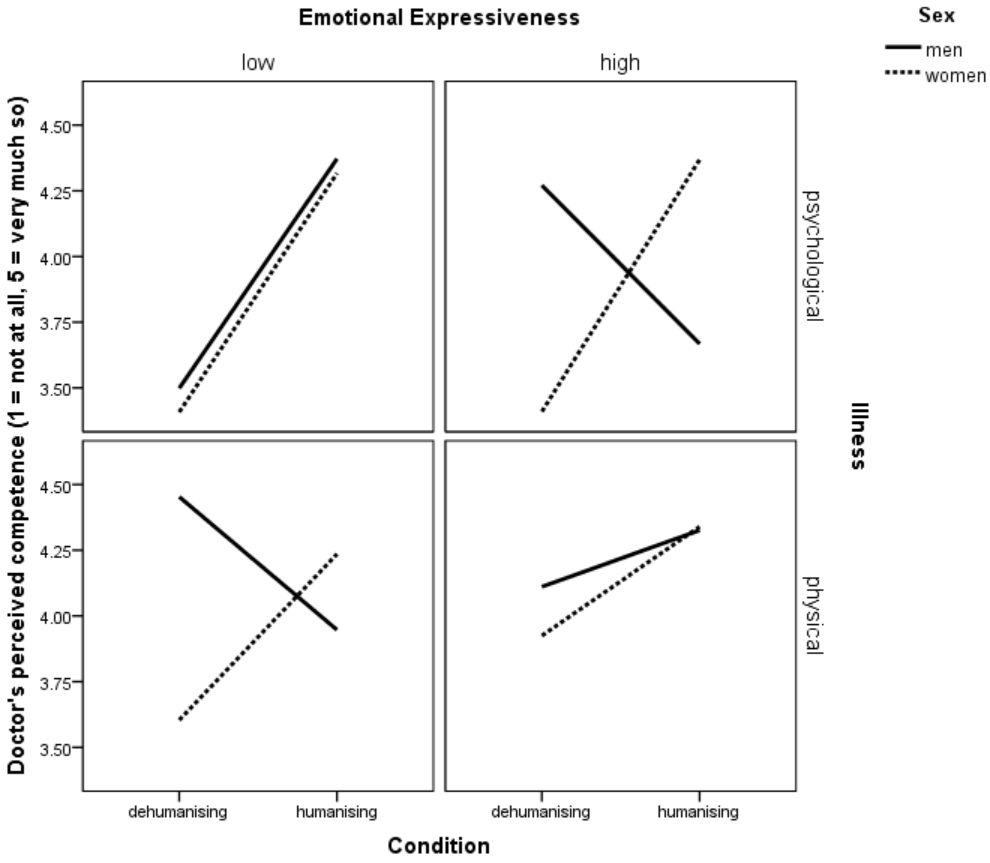

Figure 3. Doctor's perceived competence across sex, illness type, doctor's treatment philosophy, and emotional expressiveness at ± 1 SD.

Willingness to return for care. Participants' estimates of their willingness to return for care to the doctor revealed a main effect for doctor's treatment philosophy, F (1, 359) = 272.27, p = .0005, η_p^2 = .43. In line with expectations, participants indicated that they would be more likely to return for care from the person focussed doctor (M =1.78, SD = .57) than the dehumanising doctor (M = 3.15, SD = .57). Inconsistent with expectations there were no differences based on sex or illness type.

Willingness to refer a friend to the doctor. Three main effects were significant when examining how willing participants would be to refer a friend to the doctor. As predicted, participants in the dehumanising condition (M = 3.43, SD = .62) estimated that would be less likely to refer a friend to the doctor than those in the humanising condition (M = 1.84, SD = .58), F (1, 359) = 277.20, p = .0005, η_p^2 = .44. In line with expectations, those who imagined

seeking help for a psychological condition (M = 2.65, SD = .99) were less likely to refer a friend to the doctor than those in the physical illness condition (M = 2.51, SD = .96), F (1, 359) = 6.73, p = .01, η_p^2 = .018. Finally, as expected men (M = 2.41, SD = .89) were more likely to refer a friend to the doctor than were women (M = 2.64, SD = 1.00), F (1, 359) = 6.25, p = .013, η_p^2 = .017.

Willingness to follow the doctor's recommendations. Estimates of willingness to follow the doctor's recommendations, revealed three significant main effects. As expected, participants in the dehumanising condition (M = 2.44, SD = .71) were less likely to follow the doctor's recommendations than were those in the humanising condition (M = 1.70, SD = .56), F (1, 359) = 68.94, p = .0005, η_p^2= .16. As predicted participants who imagined seeking help for a physical illness (M = 1.88, SD = .67) were more likely to follow the doctor's recommendations then were those in the psychological condition (M = 2.25, SD = .76), F (1, 359) = 19.95, p = .0005 η_p^2 = .053. Finally, and in line with expectations, men (M = 1.93, SD = .67) were more likely to follow the doctor's recommendations compared to women (M = 2.12, SD = .74) F (1, 359) = 5.88, p .016, η_p^2= .016. There were no interaction effects.

Analyses for Internal Control

Dehumanisation.

A four-way between-subject ANCOVA was used to test differences in levels of dehumanisation under the various conditions. Internal control served as the continuous predictor variable, with Doctor's treatment philosophy (Dehumanising vs. Humanising), illness type (Psychological vs. Physical), and Sex (male vs. female) as the fixed factors.

The ANCOVA revealed 5 effects including a significant main effect for internal control, F (1, 359) = 9.37, p = .002, η_p^2 = .025, which was qualified by an interaction between sex and internal control, F (1, 359) = 8.66, p = .003, η_p^2 = .024. It was hypothesised that participants with an external locus of control (low internal control) would feel less dehumanised following a consultation with a dehumanising doctor compared to those with an

internal locus of control. This prediction was partially supported, in line with expectations women with an external locus of control reported feeling less dehumanised compared to those high in internal control following the hypothetical consultation. Surprisingly, men high in internal control reported feeling less dehumanised compared to men with an external locus of control. The other significant effects were: Doctor's treatment philosophy, illness type and Doctor's treatment philosophy by sex. These effects have been described in the previous analyses.

Perceptions of the doctor.

Empathy. It was hypothesised that participants high on internal control would be less accepting of the dehumanising doctor compared to those low on internal control. There were three significant effects for doctor's perceived empathy, including an interaction between doctor's treatment philosophy and internal control, F (1, 359) = 5.83, p = .016, η_p^2 = .016 (the other effects were Doctor's treatment philosophy and Doctor's treatment philosophy by Sex). As predicted, participants high on internal control rated the dehumanising doctor as less empathic than did participants low on internal control (see Figure 4).

Doctor's competence. Ratings of perceived doctor's competence revealed three significant effects including an interaction between doctor's treatment philosophy and illness type, F (1,359) = 7.11, p = .008, η_p^2 = .019 (the other effects were a main effect for Doctor's treatment philosophy; and a two-way interaction for Doctor's treatment philosophy by Sex). An analysis of simple effects showed that participants in the dehumanising condition viewed the doctor as significantly less competent when the imagined illness type was psychological rather than physical. There was no difference in doctor's perceived competence between illness types when the doctor had a person-focussed philosophy. It was hypothesised that participants with an internal locus of control would be less accepting of dehumanising doctor's paternalistic approach compared to those with an external locus of control. This

prediction was not supported, unlike emotional expressivity, internal control does not appear to impact judgements of the doctor's perceived competence.

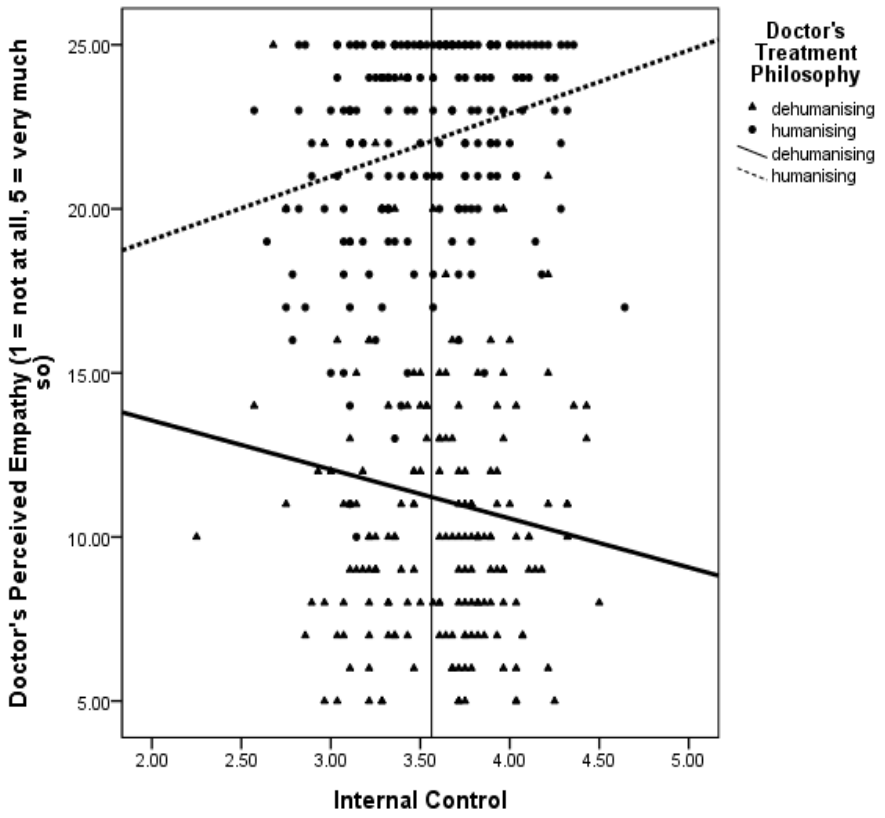

Figure 4. Perceived doctor's empathy across by treatment philosophy and internal control.

Reaction to doctor's treating philosophy.

Feelings. It was hypothesised that participants low on internal control would be more accepting of the dehumanising doctor's approach compared to participants high on internal control. Ratings of how satisfied participants thought they would feel following a consultation with the doctor revealed five significant effects, including a main effect for internal control, F (1, 359) = 11.19, p = .001, η_p^2 = .03. This was qualified by a three-way interaction between doctor's treatment philosophy, sex and internal control, F (1, 359) = 5.05, p = .025, η_p^2 = .014. (The other effects were main effects for Doctor's treatment philosophy and Illness type; and a two-way interaction for Doctor's treatment philosophy by Sex). Unexpectedly, men who were high on internal control estimated that they would feel more satisfied after a

consultation with the dehumanising doctor compared to women high on internal control (Figure 5). Conversely, men and women with an external locus of control reported that they would be feeling much less satisfied after a consultation with the dehumanising doctor compared to men with an internal locus of control.

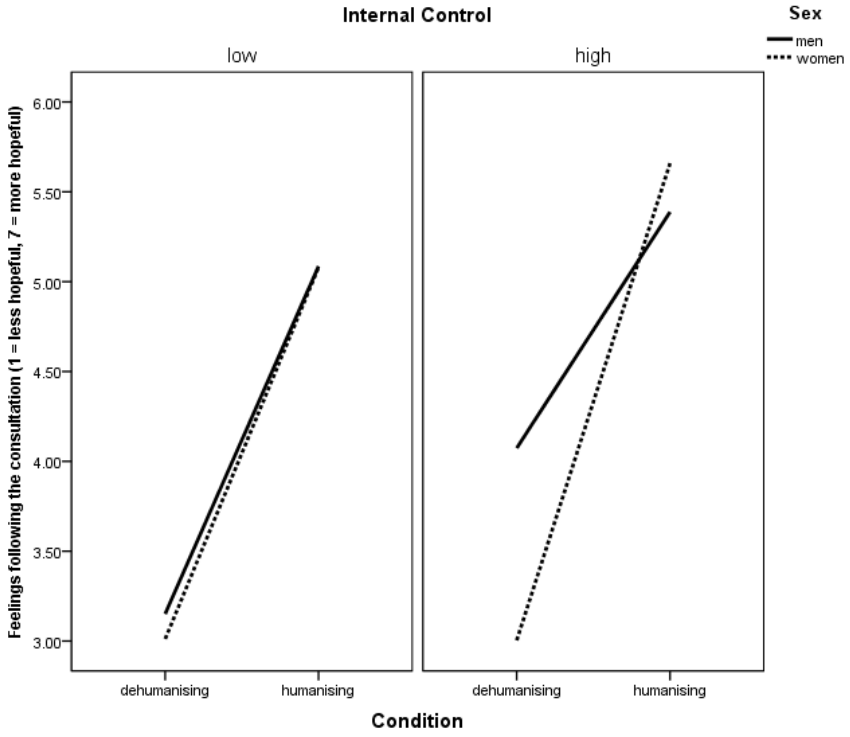

Figure 5. Feelings towards the doctor following consultation by doctor's treatment philosophy, sex and internal control at ± 1 SD.

Intended compliance.

It was hypothesised that participants with an external locus of control would be more accepting of the dehumanising doctor's approach compared to those with an internal locus of control. Restated, it was expected that participants low on internal control would be more likely to return to see the dehumanising doctor, be more likely to recommend the doctor to a friend and also more likely to follow the doctor's recommendations compared to those high on internal control.

Willingness to return for care. Participants' estimates of their willingness to return for care to the doctor, revealed five significant effects including an interaction between sex

and internal control, F (1, 359) = 4.62, p = .032, η_p^2 = .013. This was qualified by a three-way interaction between doctor's treatment philosophy, sex and internal control, F (1, 359) = 5.51, p = .019, η_p^2 = .015. Inconsistent with predictions, Figure 6 shows that men high on internal control indicated that they would be more likely to return to a dehumanising doctor than were women high on internal control. Men and women low on internal control rated themselves as being unlikely to return to the dehumanising doctor to an equal degree. The other effects were: Doctor's treatment philosophy; Illness type; Doctor's philosophy by Sex. These effects have been described in the previous analyses.

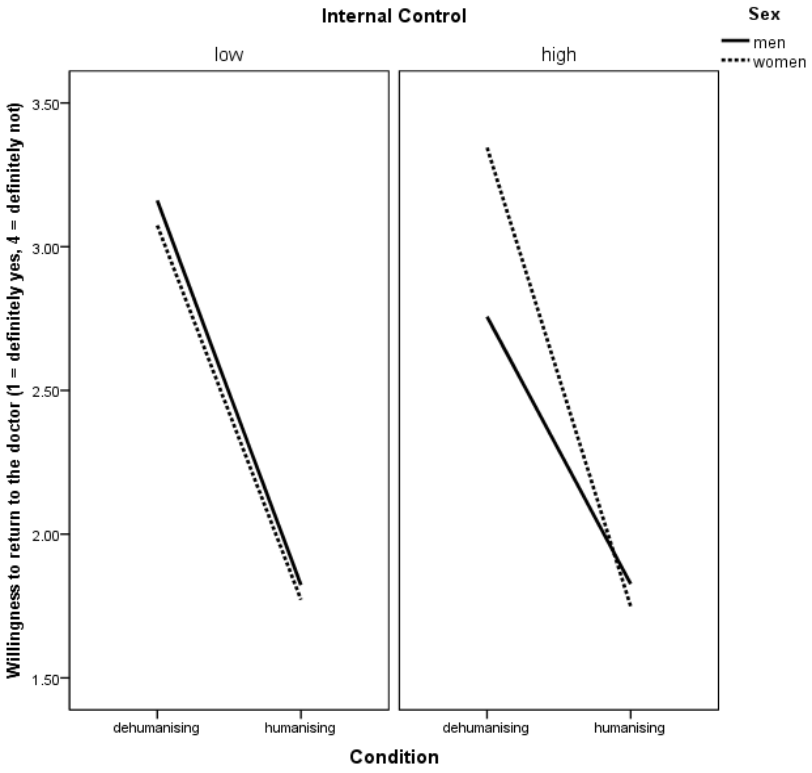

Figure 6. Willingness to return to the doctor following the consultation by doctor's treatment philosophy, sex and internal control at ± 1 SD.

Willingness to refer a friend to the doctor. Five effects were significant when examining willingness to refer a friend to the doctor, and as predicted, a main effect for internal control, F (1,359) = 6.354, p = .012, η_p^2 = .017 (the other effects were: Doctor's treatment philosophy; Illness type; Illness type by Sex, these have already been described in the previous analysis). There was also a three-way interaction between doctor's treatment

philosophy, sex and internal control, F (1,359) = 14.56, p = .0005, η_p^2= .039. Contrary to expectations, men high on internal control were more likely than women high on internal control to say that they would refer a friend to the dehumanising doctor (see Figure 7). There was no difference between men and women low on internal control in terms of their willingness to refer a friend to the dehumanising doctor.

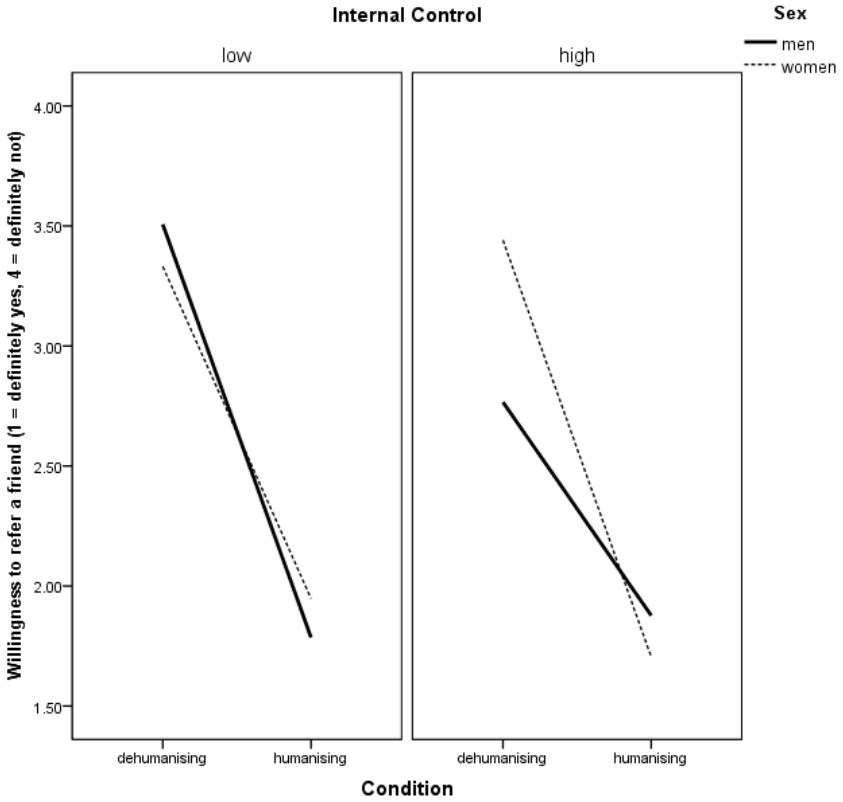

Figure 7. Willingness to a friend to the doctor following the consultation by doctor's treatment philosophy, sex and internal control at ± 1SD.

Willingness to follow the doctor's recommendations. Estimates of willingness to follow the doctor's recommendations, revealed four significant effects including, doctor's treatment philosophy, Illness type, Sex, and Doctor's treatment philosophy by Illness type. These patterns have been described in the previous analyses. Inconsistent with expectations, it was apparent that internal control did not appear to affect how willing participants were to follow the doctor's recommendations.

Discussion

The principal aim of this study was to investigate how individuals might react to doctors who take a mechanistic view towards treatment. Overall it was found that being treated by a doctor with a dehumanising philosophy led to feelings of dehumanisation, lower levels of satisfaction with the doctor, and less compliance with treatment, compared to a humanistic or person-focussed doctor. These findings are in line with research demonstrating that patients value empathic doctors and are subsequently more compliant with treatment (Fung & Mercer, 2009: Krupat et al., 2000; Roter et al., 1998) compared to doctors who adopt a less patient-focussed approach. However, the study also revealed that the beneficial effects of the humanising approach is not without exception, as there was a subset of male participants who preferred the dehumanising doctor. This will be discussed later.

In general, the type of condition that a patient was seeking help for also affected feelings of dehumanisation. Overall, the findings suggest that seeking treatment for a mental illness can be a dehumanising experience, resulting in feelings of frustration, hopelessness, and low levels of compliance. Previous work on the stigmatisation of patients has found that being labelled with a mental illness negatively impacts patient compliance levels (Fung et al., 2008; Link & Phelan, 2006). Empirical evidence also suggests that describing someone as having a mental illness triggers a dehumanising response from others (Martinez et al., 2011). In support of these findings, the present study found that the effect of stigmatisation is so powerful that participants seeking help for a psychological condition (vs. a physical illness) reported feeling more dehumanised compared to those seeking treatment a physical illness, even when they were seeking treatment from a person-focussed doctor. Further, feelings of dehumanisation increased when a psychological illness was described in the vignette in terms of ‘a malfunction in the brain, needing to be retuned’, affirming Kvaale, Haslam and Gottdiener (2013) conclusion that using a biogenic explanation for the illness denies patients their humanity and increases their prognostic pessimism. This suggests that a person focussed

approach to medical treatment is more effective than a mechanistic, dehumanising approach, particularly for patients who are seeking treatment for psychological conditions.

As mentioned above, however, the mechanistic, dehumanising approach was not universally reviled. Specifically, men reported being more willing than women to follow the instructions of a dehumanising doctor, and they were even more likely to refer a friend to the doctor. Moreover, men anticipated feeling more satisfied with the dehumanising doctor following a consultation compared to women. These findings are consistent with previous research showing that women report higher levels of depersonalisation compared to men following a consultation (Coyle & Williams, 2001), and also have higher expectations of empathy from medical professionals (Timmers et al., 1998). This might have been particularly relevant in the present sample which comprised predominately young, healthy, educated women, a population found to have exceptionally high expectations of doctors (Krupat et al., 2000). Importantly, this finding suggests that in terms of enhancing compliance with treatment, a dehumanising consultation might be particularly detrimental for women.

Another finding to emerge from the present study was that individuals with high scores on the measure of emotional expressiveness were found to be especially susceptible to feelings of dehumanisation in response to the dehumanising doctor compared to the person focussed doctor; however this difference was not as pronounced for those who scored low on the emotional expressiveness measure. Perceptions of the doctor's competence varied with changes in emotional expressiveness in men, but not women. Women rated the person-focussed doctor as far more competent than the dehumanising doctor. This supports the view that women, compared to men, expect higher levels of empathy from others (Timmers et al., 1998).

Surprisingly, however, the relationship between expected empathy from the doctor appears to be more complicated for men with high scores on the measure of emotional expressiveness. Emotionally expressive men rated the dehumanising doctor as more

competent when having a consultation regarding a psychological compared to physical illness. It is possible that expressive men already feel vulnerable and out of control, and being asked to discuss this further may make them even more uncomfortable (Kring & Gordon, 1998; Timmers et al., 1998). Generally, men are less likely to seek help compared to women, especially for mental health issues such as depression (Addis & Mahalik, 2003; Padesky & Hammen, 1981). If a male characterises his emotional expressiveness as a central part of self, then he may be especially uncomfortable explaining his feelings to a stranger and admitting there is a problem (Addis & Mahalik, 2003). Emotionally, men may prefer having a medical professional explain that their illness has nothing to do with their feelings, but rather reflects a malfunction in their brain, because it might actually alleviate their worries by decreasing feelings of personal responsibility for the illness.

Men with low scores on the emotional expressiveness measure viewed the dehumanising doctor as more competent compared to the person-focussed doctor when imagining a physical illness. However, when the condition was psychological they rated the person focussed doctor as more competent than the dehumanising doctor, the opposite pattern to highly emotional men. This finding might reflect a tendency for men low on emotional expressiveness to perceive humanising doctors as overly intrusive when they have a physical ailment, but when the issue is psychological they welcome the focus on how they feel.

In sum, comparing emotionally expressive men to machines in a medical context may lead to positive outcomes when the illness is of a psychological nature. Otherwise, emotionally expressive individuals prefer person-focussed doctors. Additionally, males low in emotional expressiveness also value a mechanistic, dehumanising doctor, but only when they have a physical ailment, highlighting the fact that being dehumanised by a doctor can have positive outcomes for potential patients dependent on gender, emotional expressivity and illness type.

Individual differences in internal control also affected perceptions of the doctor. Although there was an overall preference for the person focussed doctor, regardless of the differences in internal control, participants who scored high on the internal control measure described the dehumanising doctor as being more detached and less caring compared to those low on internal control. Women high on internal control felt less human in response to the dehumanising doctor compared to women low on internal control. Conversely, men who felt they controlled their own lives predicted feeling more human and more satisfied following a consultation with a dehumanising doctor compared to men who scored low on the internal control measure. Further, men high on internal control were also more likely than their female counterparts to return to, and refer a friend to a doctor with a dehumanising treatment philosophy. Generally these findings support previous research where internal control has been linked to a greater adaptation of life style changes and medical interventions (Miller & Mangan, 1983; Steptoe & Wardle, 2001). The gender differences might reflect different expectations. It is possible that men with high internal control use the doctor to gain information, and then come to their own conclusions. Women, however, might want information, but they also expect more emotional support compared to men (Coyle & Williams, 2001; Krupat et al., 2000; Timmers et al., 1998).

Limitations and Strengths

This study provided the first empirical evidence that a dehumanising medical approach might be desirable to some people. Nonetheless, there were several limitations to the study. First, the study used hypothetical vignettes to manipulate the doctor's philosophy. This gave participants an (unrealistic) insight into the doctor's approach. In a real-life consultation the patient could only infer the doctor's attitude from the doctor's behaviours (e.g., eye contact, metaphors that the doctor uses, etc.). As such, the benefit of this method was that it provided an ethical and unambiguous presentation of a mechanistic dehumanising doctor or a person-focussed doctor. The limitation of this method, however, was that the

findings might not extend to real medical contexts. Now that the first step has been taken to establish that at least for some patients, a mechanistic dehumanising medical approach might be preferred, subsequent studies could investigate this phenomenon in real patient-doctor relationships, monitoring patient outcomes such as recovery and adherence.

A secondly limitation of the study concerns the sample of undergraduate psychology students. These young, mainly female, participants are likely to differ from typical patient populations in many respects, which would have implications for the generalisability of the findings. However, individuals in the general population might be expected to respond more positively to the mechanistic explanation of mental illness than the psychologically aware sample used in the study, as it gives a simple explanation to a largely misunderstood area of health. As such, the findings obtained using the undergraduate student sample in this study, might be expected to the augmented in a patient sample.

Future research might also investigate the influence of factors such as cultural differences, age and gender of the doctor on patients' reactions to dehumanising versus person-focussed medical professionals (Roter, Hall & Aoki, 2002; Roter & Hall, 2006). For example, women may be more comfortable with other women providing care as they generally expect and give more empathy compared to men (Timmers et al., 1998). Future research might also compare the impact of different motivations for the physician's empathic disengagement, such as comparing mechanistic dehumanisation to boredom and stigmatisation and the impact of medical dehumanisation on different illnesses such as curable versus terminal. Patients seeking help for terminal illnesses may find the mechanistic approach more acceptable compared to a doctor's empathic disengagement resulting from boredom or stigmatisation, as they know the doctor is still focused on treating them. Finally, people might be prepared to tolerate a mechanistic, dehumanising doctor if they believe the doctor is highly competent. This could be investigated by modifying the vignettes used in the present study so that doctor competence is manipulated.

Conclusion

Overall, these findings support claims that dehumanisation in the medical context is generally detrimental for individuals seeking help (Haque & Waytz, 2012). However the present findings also suggest that, some actually prefer a doctor who adopts a mechanistic, dehumanising approach to treatment. Specifically, emotionally expressive men seeking help for psychological illnesses such as depression and anxiety may find comfort in the emotional distance that characterising their illness objectively and mechanistically affords. These findings have important practical implications for treatment. While taking a person-focussed approach is generally likely to lead to positive outcomes, one size does not fit all. Medical professionals could improve outcomes by adjusting their treatment style to take into account such patient factors as gender, illness type, locus of control and emotional expressiveness. At least for men, a mechanistic, dehumanising approach can offer the appeal of emotional distance and might in turn improve treatment outcomes.

Chapter 6

General Discussion

This dissertation contributes to the growing research interest in dehumanisation by investigating the phenomenon from the perspective of the dehumanised victim. Until recently, the large body of research examining dehumanisation has focussed on the perspective of the perpetrator (Bandura, Underwood & Fromson, 1975; Costello & Hodson, 2010; Haslam, 2006), with the exception of Bastian and Haslam (2010; 2011). In order to establish how individuals define dehumanising experiences, this thesis began with a collection of autobiographical accounts of dehumanisation from which a series of themes was extracted and which guided the subsequent studies. The overarching aims of this thesis were twofold: (1) to investigate the experiences that people find to be dehumanising and (2) to investigate the effects that these experiences have on individuals in different contexts. This chapter begins with a brief overview of the research conducted in this thesis, followed by a discussion of theoretical perspectives and implications of these findings for the understanding of dehumanisation.

Summary of Findings

Study 1 investigated the range of autobiographical experiences that people find dehumanising. This qualitative study showed that dehumanisation occurs on a continuum ranging from singular instances of ridicule to extreme cases of ongoing abuse. Dehumanisation was found to occur just as frequently, if not more so, in close relationships than in isolated exchanges. Moreover dehumanisation was not limited to interactions with other humans; situations, processes and institutions were also found to deny individuals some aspect of their humanity (e.g., sitting examinations, work environments where feelings and individuality were ignored). Further, the characteristic emotional reactions to dehumanisation

were identified as feelings of shame, anger and sadness. Employing a quasi-experimental paradigm, Study 2 found that, like victims of ostracism, dehumanised individuals report feelings of being deprived of their fundamental needs (i.e. sense of belonging, self-esteem, control, meaningful existence).

To further explore the relational aspects of dehumanisation, Study 3 used an autobiographical recall task to investigate dehumanisation in close relationships, including its effects on victims and their relationships with the perpetrators. Overall, the results suggested that the denial of humanity by close others occurs frequently and the emotions of shame and contempt are central to understanding the victims' reactions.

Study 4 examined dehumanisation within a medical context, with participants asked to make judgements about mechanistic dehumanising versus person-centred doctors. While the person-centred doctor was generally preferred to the dehumanising doctor, and the anticipated consequences of seeing the dehumanising doctor were generally worse, the results also indicated some patients may prefer the dehumanising doctor's approach as it took the focus off their emotional state and personal responsibility. These findings have implications for medical professionals, suggesting that adopting a mechanistic dehumanising approach might improve treatment for some patients in certain circumstances.

Theoretical Implications for the Study of Dehumanisation Victims

The findings of this thesis have important theoretical implications for the investigation of dehumanisation from the victim's perspective. Theoretically it has been suggested that individuals dehumanise others as animals or machines (Haslam, 2006). Empirically this theory has been supported many times over; for example, criminals and outgroup members are often depicted as primitives or animals (Goff, Eberhardt, Williams & Jackson, 2008; Vasquez, Loughnan, Gootjes-Dreesbach & Weger, 2014) or vermin (Allport, 1954/1979; Taylor, 2007) and patients are often described as machines rather than unique individuals with emotions and needs (Kriel, 1988; Miles, 2012). Overall the results of this thesis indicated that

experiences of dehumanisation may not necessarily involve being explicitly treated as an animal or a machine, but rather, that dehumanisation may be implicit when one feels that that one's human uniqueness or human nature characteristics have been denied.

In line with Haslam's (2006) integrated theory of dehumanisation and as predicted, the experiences recalled within this thesis appear to occur on a continuum, ranging from horrific examples of abuse and discrimination to more subtle cases such as being excluded by friends or having one's feelings dismissed. The categories that emerged from the data could be separated into Haslam's (2006) two dimensional approach to dehumanisation. Specifically the denial of Human Nature attributes -- mechanistic dehumanisation--relates to experiences of rejection, bullying and dehumanising others. Alternatively, experiences of abuse, discrimination, and degradation parallel animalistic dehumanisation, characterised by the denial of Human Uniqueness attributes. Some participants spontaneously recalled being dehumanised explicitly as an animal or machine as Haslam predicted (2006; 2013). Instances of dehumanisation are also held to vary in their overtness, ranging from blatant and explicit to subtle and implicit (Haslam et al., 2013). Experiences recalled in this thesis were mainly characterised as implicit; for example, being described as "less sophisticated" than the perpetrator rather than being explicitly called an animal. Only a small amount of participants recalled feeling explicitly like animals e.g. like a fat pig.

Participants in Study 1 were more likely to recall feeling explicitly animal-like compared to those in the other two qualitative studies. The animalistic experiences generally included feeling belittled and humiliated. As such the coding schemes in Study 2 and Study 3 integrated '*feeling like an animal*' into the degradation category. The widest range of experiences were recalled in Study 1 due to the exploratory nature of the questions. Whereas participants in Study 3 were directed to recall an episode of dehumanisation experienced in a close relationship, as such, there were no recalled experiences of discrimination or bullying. In sum, the types of experiences that people recall depend on the context in which they are

questioned, for example dehumanisation in personal relationships appear to systematically differ from those experiences involving intergroup relations.

The use of various methodologies across the qualitative studies might explain why participants were more likely to recall feeling explicitly animal-like in Study 1 compared to those in Study 2 and Study 3. The data in Study 1 was collected online and participants self-selected to participate in the study. Additionally the questionnaire did not specify a type of situation that needed to be recalled, whereas the questions in Study 2 and Study 3 were much more specific e.g. feeling like an animal and in a close relationship, respectively. Additionally the data for Study 2 was collected in class time and tutors could see what students wrote. Similarly students completed Study 3 as part of a class activity and then discussed the topic and methodology. In the case of Study 2 and 3 it is possible that students felt uncomfortable answering such questions in class and were more restrained in their answers. As such it is possible that overall participants only recalled mild instances of dehumanising events and the spectrum is actually much more extreme. Thus it is possible that the effects of everyday dehumanisation are actually worse than described in this thesis. However, this does not detract from the results as the experiences recalled still varied from horrendous experiences of abuse to everyday instances of social rejection as expected.

In addition, participants were likely to describe experiences of discrimination, stigmatisation, abuse and rejection as dehumanising. Building this connection empirically between dehumanisation and experiences of abuse, discrimination and rejection allows researchers to further investigate and understand how individuals are affected by such treatment. To demonstrate, individuals often describe themselves as feeling worthless and belittled following abusive experiences (Kim, Talbot, & Cicchetti, 2009). By investigating which particular aspect of their humanity has been affected, researchers and clinicians may be able to work towards increasing the victims' sense of autonomy, worth, or emotional security. Relatedly, the plethora of research investigating the psychological and physical impacts of

these other kinds of aversive interpersonal experiences can also deepen dehumanisation researchers' understanding of the victim's experiences and perspectives (Moradi, 2013; Mullen, Martin, Anderson, Romans, & Herbison, 1996; Smart Richman & Leary 2009). Applying this knowledge to victims of dehumanisation and integrating it into the way research is conducted and interpreted within the field would enrich our understanding of all these areas (Moradi, 2013).

Close relationships and dehumanisation: The importance of context.

Previously, research has focussed on intergroup relations and dehumanisation (Bain, Park, Kwok & Haslam, 2009; Castano & Giner-Sorolla, 2006; Leyens et al., 2001). Recently, there has been a shift towards focussing on experiences of interpersonal dehumanisation from the perspective of the perpetrator (Greitemeyer & McLatchie, 2011; Bastian, Jetten, & Radke, 2012) and targets (Bastian & Haslam, 2010, 2011). For the first time, Studies 1–4 in the current thesis focussed on examining dehumanisation within the context of close, personal relationships. Somewhat surprisingly, dehumanisation was found to occur just as frequently, if not more so, within a close relationship as it did between intergroup members. However, the types of dehumanisation experienced within close relationships appear to be systematically different to those experienced with strangers. In particular, relational dehumanisation is more likely to include rejection, abuse and degradation, whilst intergroup dehumanisation was mainly related to acts of discrimination and bullying.

The differences between the types of dehumanisation experienced within intergroup and relational contexts may be better understood with reference to social identity theory (Tajfel & Turner, 1979) and infrahumanisation (Leyens et al. 2001). According to these approaches, individuals are motivated to derogate outgroup members and prefer ingroup members. Judging outsiders as less than human compared to ingroup members bolsters self-esteem and cements bonds and loyalty between group members (Lemyre & Smith, 1985; Leyens et al. 2001). As such, individuals are motivated to discriminate and bully those they

perceive as being outside their group membership, including members of different religious, ethnicity or gender (Esses, Wagner, Wolf, Presier & Wilbur, 2006; Sinclair & Kunda, 1999). In line with this, participants in Studies 1 and 2 often described themselves as feeling very hurt, ashamed and angered by this type of dehumanisation because perpetrators were making judgements about them without actually knowing them. They were reduced to their race, religion or gender and all other aspects of their humanity were denied.

Alternatively, dehumanisation within personal relationships involved cases of rejection, abuse and degradation. It is more difficult to explain the motivating factors behind relational dehumanisation, since social identity and infrahumanisation theory would posit that individuals should revere fellow ingroup members rather than dehumanise them (Brewer, 1999; Brewer & Brown, 1998; Leyens, Demoulin, Vaes, Gaunt & Paladino, 2007). However, it could be that individuals who treat the people closest to them as a means to an end or as subhuman (like an animal) may do so due to particular kinds of personality traits (Hodson, Hogg & MacInnis, 2009) and ideologies (Duckitt, 1991). Researchers have found, for example, that when individuals are given the silent treatment by their partners, they frequently attribute the cause of this event to the perpetrator's personality (e.g., my partner cannot deal with conflict; Williams, 2001). In a similar way, perpetrators of dehumanisation within close relationships may have narcissistic tendencies and view other people as extensions of themselves and only useful if they enable them to achieve a goal; if the victim has served their purpose or is not acting the way the perpetrator expected they may treat them with contempt and belittle them (Locke, 2009). This, of course, negatively impacts the victim's sense of belonging, and control. Further, individuals with authoritarian beliefs are likely to consider that some people are naturally more important than others (Duckitt, 1991), and so may treat even those closest to them as less than human if it fits with this perspective (e.g., believing that husbands are the head of the family and need to control their wives).

However, when an individual is treated as a means to an end or reduced to the status of an animal by a close relationship partner, it may not always be possible to simply dismiss it as part of the perpetrator's personality. The victim is more likely to feel rejected, and to think that the degradation reflects on their own flaws; it goes to the core of their identity. To illustrate, in Study 3, even when participants felt that dehumanisation in their relationships had more to do with the perpetrator's personality rather than themselves or situational factors, they still experienced a lowered sense of well-being and were worried about being dehumanised again. Thus, dehumanisation in close relationships strips people of their identity and self-worth, creating an overwhelming sense of shame and loss of self.

The results of this thesis also suggest that the prolonged and intimate nature of close relationships in themselves may help to explain why people more likely to be dehumanised by loved ones. In short, there are many more opportunities to dehumanise those closest to us. Further, perpetrators may be more likely to 'take it out' on family members and partners, rather than bosses or strangers, as the consequences of conflict with the latter may be more significant (e.g. losing their jobs or even incurring criminal charges; Leary, Springer, Negel, Ansell, & Evans, 1998). However, it should be noted that only 70% of participants reported being dehumanised in a close relationship (Study 3) – clearly, although the phenomenon appears to be common, not everybody resorts to belittling and devaluing their loved ones. Together, these findings suggest that the study of dehumanisation would benefit from focusing on different types of relationships, rather than just intergroup relations, as the motivational and behavioural features associated with different social contexts may be quite different.

Dehumanisation and fundamental needs.

There is a wealth of evidence supporting the importance to human psychological well-being of four fundamental needs: specifically, the need to belong, the need for self-esteem, the need for control, and the need for a meaningful existence (Bandura, 1997; Baumeister &

Leary, 1995; Williams, 2001; Solomon, Greenberg, & Pyszczynski, 1991). Experiences of social ostracism and exclusion have reliably been found to frustrate these fundamental needs (Bastian & Haslam, 2010; Leary, Tambor, Terdal & Downs, 1995; Twenge, Baumeister, Tice, & Stucke, 2001; Zadro, Williams, & Richardson, 2004). When these fundamental needs are frustrated people have been found to feel a sense of helplessness, lose their self confidence, and report increased instances of mental and physical illness (Bandura, 1997; Baumeister & Leary, 1995; Seligman, 1975).

Extending this large body of work, this thesis found that being dehumanised also frustrates the fundamental needs. Specifically, the findings in Study 2 revealed that being dehumanised as an animal or machine is as likely as social ostracism to threaten an individual's sense of control and meaningful existence. However, mechanistic dehumanisation was less likely to threaten self-esteem and a sense of belonging than were animalistic dehumanisation or social ostracism. These findings might be explained by the fundamental differences between these experiences. For example, at the core of animalistic dehumanisation and social exclusion the target is being stripped of their dignity and self-respect; they are being told that they have nothing to offer the world. However, targets of mechanistic dehumanisation still maintain some sense of self and purpose because they are still treated as useful and necessary. In sum, animalistic dehumanisation frustrates the fundamental needs in a similar way to social ostracism and exclusion. It takes away one's sense of meaning, control, belonging and self-esteem, possibly inducing feelings of helplessness and disconnection in victims. Mechanistic dehumanisation, however, may not always be perceived negatively; indeed, people may even pride themselves on their machine-like skills in certain contexts requiring persistence, speed, and accuracy, for example. This remains an interesting avenue for further research.

The emotions of dehumanisation: Shame and contempt.

It has been suggested that no other affect is more central to one's sense of identity than shame, making it the most disturbing and deconstructive emotion to experience (Kaufman, 1996). Victims of abuse often report high levels of shame (Feiring & Taska, 2005; Kim, Talbot, & Cicchetti, 2009), and shame was found to be strongly associated with experiences of dehumanisation in this thesis. In line with previous findings, many instances of dehumanisation recalled by participants involved experiences of degradation, verbal, physical and sexual abuse. It would appear that, as Kaufman theorised, to feel ashamed is to feel judged by others as less than equal, and ultimately less than human.

Shame can be a functional emotion, particularly in family systems when parents are trying to develop a child's conscience, enabling them to conform to societal expectations (Scheff & Retzinger, 1991). For example, a parent may shame their small child for stealing from a shop. The child will learn that they cannot have whatever they want without paying; the intense feeling of shame will remind them not to make the mistake again. However, if an individual is continuously shamed without any functional purpose the outcomes can be detrimental for them and their relationship with the perpetrator, particularly if the shaming does not discriminate between the person and the behaviour (Braithwaite, 1989; Scheff & Retzinger, 1991).

When people are overwhelmed by shame they may react in one of two ways. They may turn their anger outwards and act with aggression and hostility towards the perpetrators, but also towards innocent others that they may deem as possible threats to their safety or sense of self. Alternatively, they may withdraw from social interactions with others to avoid further conflict and shame (Lewis, 1971). Some researchers have found that shamed women are more likely to withdraw and experience depression, whereas shamed men are more likely to act out aggressively towards others (Harper & Arias, 2004). These differences may be explained by socialisation (e.g. expectations that women should not be physically aggressive,

or that men do not cry), and as gender roles continue to evolve these gender difference may not be as obvious (Garbarino, 2006).

Within intimate relationships men are often the perpetrators of the most severe assaults (Feld & Straus, 1989). Theorists suggest that violent offenders are motivated by unacknowledged shame and feelings of powerlessness, and that being physically and verbally aggressive towards others enables them to take back control of a situation and stops them from feeling re-victimised and ashamed (Brown, 2004; Gilligan, 1996; Ray, Smith & Wastell, 2004). However, instead of fixing their problems they are creating a perpetual cycle of shame and contempt within their relationships. For example, a husband may verbally and physically lash out at his wife if she scolds him for being irresponsible with money. By contemptuously dehumanising his wife and pushing her around, he replaces his shame with anger to humiliate and dominate her. She may then feel at once ashamed for letting him treat her so terribly and also harbour contempt towards him for being out of control and irresponsible.

Unlike shame, contempt does not appear to have any functional role in close relationships. In fact, treating a partner as less than equal is the single most likely factor to predict relationship breakdown (Gottman, 1994). Surprisingly, in the work place contempt may not always be detrimental to individuals. It has been associated with better performance outcomes for lower-status workers when they are treated with contempt by a superior (Melwani & Barsade, 2011). This may be because it drives the lower-status individual to show that they are as good or better than their contemptuous overseer. However, the outcomes are not all positive, as victims of workplace contempt were found to direct more aggression towards the perpetrator following the transgression. Whereas, contempt may sometimes improve productivity in the workplace, there is likely a cost to employee wellbeing. The findings of this thesis revealed that in personal relationships (i.e. friends, family and partners) the use of contempt is more likely to drive people apart and destroy the victim's self-esteem and psychological well-being.

In sum, dehumanisation in close relationships impacts us so profoundly because being treated with contempt in a close relationship and being made to feel ashamed by the people who connect us to humanity is a kind of social death. Without the support of our loved ones we cease to exist socially, which can quickly extend to a practical manifestation. If we are deprived of shelter, protection from danger or emotional support we die.

Dehumanisation in a medical context.

The connection between patient and doctor is a unique relationship in that the consultation often involves the exchange of personal and highly sensitive information. However, the doctor is required to maintain a professional distance. This professional and emotional distance is often achieved by seeing the patient as a combination of symptoms (dehumanising), rather than as a unique individual (Haque & Waytz, 2012). For the first time, Study 4 empirically investigated how dehumanisation in a medical context may influence patient adherence and satisfaction compared to the person-centred approach. Previously, none of the research on medical empathy explicitly focussed on the effects of a doctor's mechanistic philosophy. It was suspected that the impact of mechanistic dehumanisation might not be as negative as other possible motivations for empathic disengagement because patients might attribute it to the doctor's attempt to be objective and it might thus contribute to better recovery. However, the results revealed that this was not the case; generally the dehumanisation of patients by medical staff would appear to have little benefit in terms of promoting the seeking out and continuation of treatment.

Surprisingly, though, there was a subset of participants with a preference for the dehumanising doctor. Males high on emotional expressiveness who imagined being treated for a psychological illness such as depression or anxiety actually preferred it when the doctor described them as a machine with a malfunction. It is likely that these emotional males responded positively to the dehumanising doctor because the mechanistic explanation of their

illness takes some of the responsibility away from the patient and gives them hope that 'repair' is possible.

In fact, medical researchers and practitioners have used this kind of mechanistic explanation in an effort to reduce the stigmatising effects of mental illness. Public campaigns have emphasised the biomedical origins of psychological illnesses, explaining that they are "...related to chemical, structural and functional abnormalities in the brain" (SANE Australia, 2013). When physicians use biogenic explanations for psychological problems patients typically blame themselves less. However, prognostic pessimism increases as patients feel they have little control over their illness (Kvaale, Haslam, & Gottdiener, 2013). Moreover, those suffering from psychological conditions tend to see themselves as complex beings and resent being seen as a problem with a simple solution (Gaillard, Shattell, & Thomas, 2009). These explanations may explain why the majority of the participants in Study 4 rejected the dehumanising doctor's philosophy. Participants wanted the chance to express themselves and take some control of the situation. Although the intent of using the biomedical model is to alleviate stigmatisation of mental illness, it may inadvertently leave many suffers feeling as if they have been reduced to an illness label.

In sum, the findings of Study 4 emphasise the need for mental health care providers to empathise with patients and express this understanding to patients; but to also identify which patients (particularly male) would benefit from the mechanistic versus person-focused explanations of mental illness.

Future Directions and Implications

This thesis employed a range of methodologies including the use of hypothetical vignettes and autobiographical recall tasks, open ended and forced choice questions, to investigate dehumanisation from the perspective of the target. The categories of dehumanisation extrapolated from the free response data in Study 1 enabled investigators to appreciate the types of experiences deemed as dehumanising by individuals without imposing

an a priori theoretical framework on participants. Further, these categories of dehumanisation and associated emotions could be employed to investigate the perspective of both the perpetrator and the victim. For example, participants could be asked to recall a time they discriminated, abused or rejected another individual and the motivations for these actions could be investigated. Furthermore researchers could record the type of relationship the perpetrator claimed to have with the victim and how this affected their understanding of the victim's feelings following the incident. It would be interesting to measure the perpetrator's theory of mind in regards to the victim, particularly if they connected, rather than strangers. It might be that perpetrators would downplay the effect that their behaviour had on the victim's thoughts, feelings and reactions, regardless of their social connection, to avoid empathic exhaustion. Alternatively, when perpetrators are socially connected to their victims, they may not be able to avoid acknowledging the possible pain and stress they created, thus causing the perpetrator to reprimand themselves or regret their actions. This would be consistent with Bastian et al.'s (2013) observation that when people recall a time they rejected someone else, they rate themselves as feeling less than human.

The studies in this thesis, for the most part, utilised university students as participants. Due to their higher level of education than might be found in sample from the general population, university students they might view themselves as being more civil and moral, or universally higher on human uniqueness compared to the general population (Bain et al., 2009) . Furthermore, the majority of participants were Australian residents, a population that has been found to attribute more human nature characteristics (i.e. individuality and openness) to themselves compared to other nationalities including Japanese, Italians and Chinese (Bain et al., 2009; Bain, Vaes, Kashima, Haslam, & Guan, 2012). As such, Australians may be more likely than individuals of other nationalities to recall instances of dehumanisation involving the denial of their human nature. Specifically recalling an instance when they felt their emotional warmth or individuality was denied and they felt like they were treated like a

machine. Australians generally value these characteristics due to cultural norms and national identity and might therefore be more sensitive than some other cultural group to having this violated. Thus, future research would be enriched by investigating cross-cultural difference in experiences of dehumanisation.

The implications of the study exploring dehumanisation in the medical context are very interesting. Overall, Study 4 found that people do not appreciate being reduced to a machine in a medical consultation. However a small number of participants, specifically males who rated either low or high on emotional expressiveness, preferred the dehumanising doctor when their imagined condition was physical or psychological, respectively. Now that this link has been established it would be interesting to investigate these findings in a clinical sample, or with those who actually have these psychological and physical conditions. Relatedly, a number of participants recalled being made to feel less than human in an academic and work environment. Future research would benefit from investigating how this may affect performance and productivity. Based on the findings using the varying medical philosophies in Study 4, it would also be worthwhile investigating whether there are any individual differences or circumstances associated with a preference for dehumanisation in such contexts.

Concluding Thoughts

To date, researchers have been particularly interested in understanding what motivates someone to dehumanisation another, and what kinds of situations create the drive for one human to see another as no more than an object or lowly animal. These are important questions to ask if we aim to minimise dehumanisation. While understanding the motivations of perpetrator can help to reach this goal, history has shown us that knowledge of extreme instances of dehumanisation does nothing to stop it happening again

The findings of this thesis indicate that dehumanisation is not confined to extreme conflict regarding intergroup relations. Every day, people in a relatively safe society are

regularly dehumanised by institutions, work place environments, strangers, health care providers, and the people they love. These experiences most often leave victims with an overwhelming sense of shame and anger. Some try to cope by empowering themselves and others avoid certain situations and people in an attempt to preserve their sense of humanity.

Listening to the experiences of dehumanised individuals allows us to understand the phenomenon in a more complete sense. Perpetrators are motivated to only see their perspective; this is an important aspect to understand, of course, especially if we want to decrease instances of dehumanisation. However, as researchers and human beings we also need to understand how the process of being made to feel less than human effects individuals; and importantly how they can become whole again. Research needs to listen to the neglected voice of the victims of dehumanisation in order to build a complete picture of this intriguing social phenomenon.

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Appendix A

Table 1

Means and standard deviations of measures used in Study 3

Measure	*M*	*SD*
Hurt proneness	3.22	.66
Human nature	4.39	1.21
Human uniqueness	4.03	1.48
Overall dehumanisation	5.01	1.27
Treated like an animal	3.20	2.07
Treated like a machine	2.90	1.92
How accepted versus rejected	5.48	1.42
How liked or disliked	3.58	1.89
How loved or hated	3.88	1.68
The most negative thing that could happen in this relationship	4.89	1.93
Positive self-perception	2.06	.83
Negative self-perception	3.27	.98
Shame	3.27	.79
Relational contempt	3.14	.97
Positive affect	1.87	.66
Negative affect	2.84	.88
Typicality of dehumanisation	3.32	1.70
Perpetrator intended to dehumanise the participant	2.67	1.38
Whether participant deserved to be dehumanised	1.32	.68
Whether the perpetrator knew they had dehumanised them	3.05	1.26
Whether the perpetrator showed contempt to the participant	2.81	1.41

Completely due to the situation	3.57	1.96
Completely due to the personality of the perpetrator	4.70	1.94
The perpetrator was trying to get back at the participant	2.22	1.30
The perpetrator thought they were helping the participant	2.12	1.34
The participant had done something to hurt the perpetrator	1.98	1.19
It was an accident, the perpetrator did not mean to do it	2.39	1.30
The perpetrator was insensitive or inconsiderate	3.98	1.14
The perpetrator was trying to make them feel dehumanised	2.58	1.39
I expressed my feelings	3.37	1.48
I expressed my anger to the other person	3.19	1.57
I cried in front of the other person	2.29	1.72
I argued with the person or defended my self	2.71	1.43
I said something critical or nasty	2.46	1.47
The perpetrators response	2.49	1.26
Lowered self-esteem	3.31	1.32
Loss of self-confidence	3.26	1.43
Worried about evaluations	3.15	1.40
Worried about being dehumanised again	3.01	1.34
Permanent damage to the relationship	3.36	1.50
Temporary damage to the relationship	4.12	1.15
Distrust the perpetrator	3.73	1.32
Dislike the perpetrator	3.55	1.36
Love the perpetrator	1.50	.91
Hate the perpetrator	2.86	1.46

Appendix B

Table 1

Means and Standard Deviations for Study 4 Measures

Measure	*M*	*SD*
Emotional expressivity	3.62	.83
Internal control	3.60	.40
Dehumanisation	4.10	1.58
Patient satisfaction	2.32	.74
Willingness to return	2.47	.92
Willingness to follow recommendations	2.07	.74
Willingness to refer to a friend	2.58	.98
Doctor's perceived empathy	16.58	6.77
Doctor's perceived competence	3.98	1.04

Table 2

ANOVAs not included in results section of Study 4

ANOVAs	*Statistics*
Emotional Expressiveness	
Competence	
Doctor's philosophy	F (1, 359) = 7.98, p = .005, η_p^2 = .022
Doctor's philosophy x sex	F (1, 359) = 8.22, p = .004, η_p^2 = .022
Internal Control	
Dehumanisation	
Doctor's philosophy	F (1, 359) = 833.11, p = . 0005, η_p^2 = . 699
Illness type	F (1, 359) = 11.40, p = .001, η_p^2 = .031
Doctor's philosophy x sex	F (1, 359) = 5.73, p = .017, η_p^2 = .016
Empathy	
Doctor's philosophy	F (1, 359) = 489.86, p = .0005, η_p^2 = .577
Doctor's philosophy x sex	F (1, 359) = 4.22, p = .041, η_p^2 = . 012
Doctor's competence	
Doctor's philosophy	F (1, 359) = 15.24, p = .0005, η_p^2 = . 041
Doctor's philosophy x sex	F (1, 359) = 6.81, p = .009, η_p^2 = .019
Feelings	
Doctor's philosophy	F (1, 359) = 252.30, p = .0005, η_p^2 = .413
Illness type	F (1, 359) = 16.09, p = .0005, η_p^2 = .043
Doctor's philosophy x sex	F (1, 359) = 8.64, p = .004, η_p^2 = .023
Willingness to return for care	
Doctor's philosophy	F (1, 359) = 339.54, p = .0005, η_p^2 = .486
Illness type	F (1, 359) = 5.35, p = .021, η_p^2 = .015
Doctor's philosophy x sex	F (1, 359) = 5.06, p = .025, η_p^2 = .014
Willingness to refer a friend	
Doctor's philosophy	F (1, 359) = 389.11, p = .0005, η_p^2 = .52
Illness type	F (1, 359) = 13.18, p = .0005, η_p^2 = .035
Illness type x sex	F (1, 359) = 4.94, p = .027, η_p^2 = . 014
Willingness to follow recommendations	
Doctor's philosophy	F (1, 359) = 94.47, p = .0005, η_p^2 = . 208
Illness type	F (1, 359) = 35.61, p = .0005, η_p^2 = . 09

Sex	F (1, 359) = 5.84, p = .016, η_p^2 = .016
Doctor's philosophy x illness	F (1, 359) = 5.07, p = .025, η_p^2 = .014

Appendix C

Questionnaires used in Study 1 - 4

Study 1

Demographic Questions

Sex: Male Female

Age: _____ years

Nationality: _____

Ethnic background: _____

Language/s spoken at home: _____

Religious views: _____

Highest level of education achieved:

Prior to year 10
Year 10 (School Certificate or equivalent)
Year 12 (HSC or equivalent)
Certificates I, II, III or IV
Diploma/ Advanced Diploma
Bachelor Degree
Graduate Certificate/ Graduate Diploma
Master Degree
Doctoral Degree

Are you a Macquarie University student participating in this study for course credit?

Yes No

1. Please describe in as much detail as you can a time in your life when you have been made to feel less than human. This could have been a positive or negative experience.

2. How did this make you feel about yourself?

3. How did you feel towards those who made you feel less than human?

4. If you saw someone else treated like this, how would you feel towards them?

Study 2

Sex: Male Female (Please circle one)

Age: _____ years

This scale relates to personal attitudes. Read each item and then mark the appropriate answer in the space next to that word. Indicate to what extent you feel this way right now, that is, at the present moment.

1	2	3	4	5
not at all characteristic of me		unsure		extremely characteristic of me

_____On the whole, I am satisfied with myself

_____At times I think I am no good at all

_____I feel that I have a number of good qualities

_____I am able to do things as well as most other people

_____I feel I do not have much to be proud of

_____I certainly feel useless at times

_____I feel that I am a person of worth, at least on an equal plane with others

_____I wish I could have more respect for myself

_____All in all, I am inclined to feel that I am a failure

_____I take a positive attitude towards myself

Please recall as vividly as you can an event where others made you feel <u>less than human, like an animal</u>. Think about your experience in terms of the feelings and the emotions involved. Let yourself feel the event as if you were right there, reliving it and re-experiencing it. Please describe the event below.

Please fill-out the following questionnaire in relation to how you felt during the event that you just recalled and wrote about. Read each item and then mark the appropriate answer in the space next to that word.

1	2	3	4	5	6	7
not at all			unsure			very much so

_____I felt like I had interpersonal warmth

_____I felt like I was open minded, like I could think clearly

_____ I felt that I was emotional, like I was responsive and warm

_____I felt superficial like I had no depth

_____I felt like I was an object, not human

_____I felt like I was mechanical and cold, like a robot

_____I felt like I was refined and cultured

_____ I felt like I was an adult not a child

_____I felt like I had self restraint

_____I felt like I was rational and logical, like I was intelligent

_____I felt like I was less than human like an animal

_____I felt like I was unsophisticated

Please fill-out the following questionnaire in relation to how you viewed the other people during the event that you just recalled and wrote about. Read each item and then mark the appropriate answer in the space next to that word.

1	2	3	4	5	6	7
not at all			unsure			very much so

_____I felt like they had interpersonal warmth

_____I felt like they were open minded, like they could think clearly

_____I felt that they were emotional, like they were responsive and warm

_____I felt that they were superficial like they had no depth

_____I felt like they were an object, not human

_____I felt like they were mechanical and cold, like a robot

_____I felt like they were refined and cultured

_____I felt like they were an adult not a child

_____I felt like they had self restraint

_____I felt like they were rational and logical, like they were intelligent

_____I felt like they were less than human like an animal

_____I felt like they were unsophisticated

Please fill out the following questions in relation to how you felt during the event that you just recalled and wrote about. Read each item and then mark the appropriate answer in the space next to that word.

1 2 3 4 5 6
not at all very much so

_____I felt as though I had made a 'connection' or bonded with the other people in the situation

_____I felt poorly accepted by the other people in the situation

_____I felt like an outsider during the situation

_____I felt that I was in control during the situation

_____I felt somewhat frustrated during the situation

_____I felt that I was able to participate as often as I wanted in the situation

_____I felt good about myself in the situation

_____I felt that the other people in the situation failed to perceive me as a worthy and likeable person

_____I felt somewhat inadequate during the situation

_____I felt as though my existence was meaningless during the situation

_____I felt non-existent during the situation

This scale consists of a number of words that describe different feelings and emotions. Read each item and then mark the appropriate answer in the space next to that word. Indicate to what extent you felt this way after the experience you wrote about.

1 very slightly or not at all	2 a little	3 moderately	4 quite a bit	5 extremely
_____ cheerful	_____ sad	_____ active		_____ angry at se
_____ disgusted	_____ calm	_____ guilty		_____ enthusiasti
_____ attentive	_____ afraid	_____ joyful		_____ downhearte
_____ bashful	_____ tired	_____ nervous		_____ sheepish
_____ sluggish	_____ amazed	_____ lonely		_____ distressed
_____ daring	_____ shaky	_____ sleepy		_____ blamewort
_____ surprised	_____ happy	_____ excited		_____ determined
_____ strong	_____ timid	_____ hostile		_____ frightened
_____ scornful	_____ alone	_____ proud		_____ astonished
_____ relaxed	_____ alert	_____ jittery		_____ interested
_____ irritable	_____ upset	_____ lively		_____ loathing
_____ delighted	_____ angry	_____ ashamed		_____ confident
_____ inspired	_____ bold	_____ at ease		_____ energetic
_____ fearless	_____ blue	_____ scared		_____ concentrati
_____ disgusted with self	_____ shy	_____ drowsy		_____ dissatisfied with self

Place a tick in the box below only if you **DO NOT** give permission for your data to be included for the purposes of research.

Study 3

1. **Demographics**

Sex: Male Female (Please circle one)

Age: _____ years

Nationality: _____

2. **Hurt Proneness Scale (Leary & Springer, 2001)**

Rate the degree to which each statement is true or characteristic of you.

(1 = not at all, 2 = slightly, 3 = moderately, 4 = very, and 5 = extremely characteristic of me)

My feelings are easily hurt

I am a sensitive person

I am "thick-skinned"

I take criticism well

Being teased hurts my feelings

I rarely feel hurt by what other people say or do to me

3. **Recall Exercise:**

Think of a specific situation when someone close to you (i.e. friend, relative, or partner) said or did something that made you feel dehumanized—less than human (not treated like a real person). Please answer the following questions in relation to the remembered incident.

Describe the events that led up to the situation

_____
_____
_____

What did the other person (or people) say or do that made you feel dehumanized (less than human)?

_____
_____
_____

How did this make you feel?

_____
_____
_____

What happened after this incident?

_____
_____
_____

Age of the other person _____

Gender of the other person_____

Relationship to this person at the time of the dehumanizing event_____

4. **Dehumanization Scale (Bastian & Haslam, 2011)**

1	2	3	4	5	6	7
not at all			unsure			very much so

____I felt like I was seen as being immature

____I felt like I was seen as being unintelligent

____I felt like I was seen as being unsophisticated

____I felt as if I was being treated as a child

____I felt like I was not being seen as an individual

____I felt like I was seen as being superficial

____I felt like I was being treated as a means to an end

____I felt like I was being treated as if I were an object

____I felt like I was being treated as if I had no feelings

5. **Victim's feelings following event (adopted from Leary et al., 1998)**

1	2	3	4	5	6	7
not at all			unsure			very much so

____I felt like I was being treated as if I was an animal

____I felt like I was being treated as if I was a machine

____How dehumanized you felt overall

How (hurt, belittled, embarrassed, angry, sad, disgusted, shy, inadequate, disappointed in self, like a failure, discouraged, unclean, morally unfit, isolated) you felt overall (1 = not at all, 5 = extremely)

How accepted versus rejected you felt (1=completely accepted; 7 = completely rejected)

How much do you think the person disliked or liked you when they made you feel less than human (1 = disliked me greatly; 7 = liked me greatly).

How much do you think the other person hated or loved you when they made you feel less than human (1 = hated me a lot; 7 = loved me a lot)

Rate how the other person made you feel about yourself: stupid, undesirable, unlikeable, unattractive, intelligent, wise, likeable, incompetent, attractive, competent, foolish and desirable (1 = not at all; 5 = extremely)

This event was one of the most negative things that could happen in my relationship with this person (1 = strongly disagree; 7 = strongly agree)

6. **PANAS (Watson, Clark & Tellegan, 1988)**

This scale consists of a number of words that describe different feelings and emotions. Read each item and then mark the appropriate answer in the space next to that word. Indicate to what extent you felt this way after the experience you wrote about.

(5 point scale 1= very slightly or not at all, 2= a little, 3 = moderately, 4= quite a bit, 5= extremely)

PA words= interested, excited, strong, enthusiastic, proud, alert, inspired, determined, attentive, active

NA words= irritable, ashamed, nervous, jittery, afraid, distressed, upset, guilty, scared, hostile

7. **Intent and frequency of dehumanization (adopted Vangelisti & Young, 2000)**

Please rate the following questions in relation to the person who made you feel dehumanized (1 = strongly disagree; 7 = strongly agree)

___It is typical of them to dehumanize me

___They often dehumanize me

___A lot of people have been dehumanized by their behaviour

___They often say or do things that dehumanize other people

8. **Contempt questions (Holman & Jarvis, 2003, adopted from Gottman)**

1= never, 2 = rarely, 3 = sometimes, 4 = often, 5 = very often)

1. How often have you had a lack of respect for this person when discussing an issue?
2. How frequently have you seen glaring faults in this person's personality?
3. How frequently have you felt you had to ward off attacks from this person?
4. How frequently have you felt unfairly attacked when you were in an argument with this person?

9. Attributions (adopted from Leary et al., 1998)

Did the other person (people) intend to make you feel less than human? (1 = definitely not; 5 = definitely yes)

Did you deserve to be treated as if you were less than human? (1 = definitely not; 5 = definitely yes)

Did the other person (people) know they made you feel less than human? (1 = definitely not; 5 = definitely yes)

Did the other person show contempt towards you when they made you feel less than human? (1 = definitely not; 5 = definitely yes)

Rate the plausibility of six reasons for why the perpetrator said or did the thing that made you feel less than human (1 = not at all true; 5 = absolutely true).

____It was an accident; the perpetrator didn't mean to

____ The perpetrator was insensitive or inconsiderate

____The perpetrator was trying to make you feel dehumanized

____The perpetrator was trying to get you back for something you did to them,

____The perpetrator thought he or she was helping you by what he/ she said or did,

____You had done something that hurt the perpetrator.

____This behaviour or event was completely due to the situation (1= strongly disagree; 7 = strongly agree)

____This behaviour or event was completely due to their personality (1 = strongly disagree; 7 = strongly agree)

10. Victim's reactions (adopted from Leary et al., 1998)

Please rate the extent to which each of the following is true in relation to how you reacted when you were made to feel less than human (1= not true at all; 5 = absolutely true)

___I expressed my feelings about what he or she did

___I expressed anger toward the other person

___I cried in front of the other person

___ I cried after I was by myself,

___I argued with the person or defended myself in a calm, rational manner

___ I said something critical or nasty

Which of the 5 reactions best described the perpetrator's response after making you feel less than human? Please tick one of the following.

___ Did nothing,

___Acted as if he or she didn't care,

___ Blamed the victim,

___Apologised

___Asked for forgiveness

Rate the extent to which the event (1 = not at all true; 5 = absolutely true):

a) lowered your self-esteem,

b) made you more worried about what other people thought of you,

c) made you worry about being dehumanized again,

d) made you less confident in situations similar to the one in which you were dehumanized

Please indicate the extent to which the event (1 = not at all true; 5 = absolutely true):

a) weakened the relationship with the other person permanently

b) weakened the relationship with the other person temporarily,

c) made you trust the other person less

d) made you dislike the other person

e) made you love the other person

f) made you hate the other person

Please tick the box below if you **DO** give permission for your data to be included for the purpose of research.

Study 4

1. Demographics

Sex: Male Female (Please circle one)

Age: _____ years

Nationality: _____

In the past twelve months how many times have you been to a medical professional to seek treatment or advice? __

Emotional expressivity scale (Kring, Smith, & Neale, 1994)

Please answer Yes or No for the following questions.

1. I think of myself as emotionally expressive.
2. People think of me as an unemotional person.
3. I keep my feelings to myself.
4. I am often considered indifferent by others.
5. People can read my emotions.
6. I display my emotions to other people.
7. I don't like to let other people see how I am feeling.
8. I am able to cry in front of other people.
9. Even if I am feeling very emotional, I don't let others see my feelings.
10. Other people aren't easily able to observe what I'm feeling.
11. I am not very emotionally expressive.
12. Even when I'm experiencing strong feelings, I don't express them outwardly.
13. I can't hide the way I'm feeling.
14. Other people believe me to be very emotional.

15. I don’t express my emotions to other people.

16. The way I feel is different from how others think I feel.

17. I hold my feelings in.

Internal Control Index – 28 items Duttweiler ,1984

Please read each statement. Where there is a blank _____, decide what your normal or usual attitude, feeling, or behaviour would be:

(A)	(B)	(C)	(D)	(E)
RARELY	OCCASIONALLY	SOMETIMES	FREQUENTLY	USUALLY
(Less than 10% of the time)	(About 30% of the time)	(About half the time)	(About 70% of the time)	(More than 90% of the time)

Of course, there are always unusual situations in which this would not be the case, But think of what you would do or feel in the most normal situations.

Pick the answer that describes your usual attitude or behaviour.

1. When faced with a problem I ___ try to forget it.

2. I ___need frequent encouragement from others for me to keep working at a difficult task.

3. I ___like jobs where I can make decisions and be responsible for my own work.

4. I ___ change my opinion when someone I admire disagrees with me.

5. If I want something I ___work hard to get it.

6. I ___ prefer to learn the facts about something from someone else rather than have to dig them out

for myself.

7. I will ___accept jobs that require me to supervise others.

8. I ___have a hard time saying “no” when someone tries to sell me something I don’t want.

9. I ___like to have a say in any decisions made by any group I’m in.

10. I ___ consider the different sides of an issue before making any decisions.

11. What other people think___ has a great influence on my behaviour.

12. Whenever something good happens to me I ___ feel it is because I've earned it.

13. I ___enjoy being in a position of leadership.

14. I ___ need someone else to praise my work before I am satisfied with what I've done.

15. I am ___sure enough of my opinions to try and influence others.

16. When something is going to affect me I ___learn as much about it as I can.

17. I ___decide to do things on the spur of the moment.

18. For me, knowing I've done something well is ___ more important than being praised by someone

else.

19. I ___let other people's demands keep me from doing things I want to do.

20. I ___stick to my opinions when someone disagrees with me.

21. I ___do what I feel like doing not what other people think I ought to do.

22. I___ get discouraged when doing something that takes a long time to achieved results.

23. When part of a group I ___prefer to let other people make all the decisions.

24. When I have a problem I ___follow the advice of friends and relatives.

25. I ___enjoy trying to do difficult tasks more than I enjoy trying to do easy tasks.

26. I ___prefer situations where I can depend on someone else's ability rather than just my own.

27. Having someone important tell me I did a good job is ___more important to me than feeling I've

done a good job.

28. When I'm involved in something I ___try to find out all I can about what is going on even when

someone else is in charge.

Vignettes:

Dehumanizing Dr, psychological condition

Dr A is a medical practitioner and has treated many patients with psychological conditions. Speaking candidly, he says: "When I treat a patient with a psychological problem, I don't pay any attention to the patient's thoughts and feelings. I think of the brain as a finely balanced machine and the malfunction must be understood without any consideration given to the

patient's feelings and thoughts about their condition. When I determine the particular nature of the brain malfunction, depression or anxiety for example, I prescribe a treatment regime that has the effect of tuning or recalibrating the machine. Overall, my approach to treating psychological conditions is like that of a mechanic fixing an engine—the driver is irrelevant.

Dehumanizing Dr, physical condition

Dr A is a medical practitioner and has treated many patients with physical conditions. Speaking candidly, he says: "When I treat a patient with a physical problem, I don't pay any attention to the patient's thoughts and feelings. I think of the body as a finely balanced machine and the malfunction must be understood without any consideration given to the patient's feelings and thoughts about their condition. When I determine the particular nature of the physical malfunction, viral infection or chest pains for example, I prescribe a treatment regime that has the effect of tuning or recalibrating the machine. Overall, my approach to treating physical conditions is like that of a mechanic fixing an engine—the driver is irrelevant.

Humanizing Dr, psychological

Dr A is a medical practitioner and has treated many patients with psychological conditions. Speaking candidly, he says: "When I treat a patient with a psychological problem, I pay close attention to the person's thoughts and feelings. I believe that understanding the individual is integral to understanding their psychological condition. When I'm in a position to understand the nature of the particular psychological problem, depression or anxiety for example, I place the upmost importance on working together with the person to find an individual, personalised solution that best suits their needs. Overall, my approach is person focussed.

Humanizing Dr, physical

Dr A is a medical practitioner and has treated many patients with physical conditions. Speaking candidly, he says: "When I treat a patient with a physical problem, I pay close attention to the person's thoughts and feelings. I believe that understanding the individual is integral to understanding their physical condition. When I'm in a position to understand the nature of the particular physical problem, viral infection or chest pains for example, I place the upmost importance on working together with the person to find an individual, personalised solution that best suits their needs. Overall, my approach is person focussed.

Questions

Dehumanization scale (Bastian & Haslam, 2010) - 12 items

Please answer the following questions imagining that you were to be treated by this doctor for a psychological (physical) condition. The doctor would leave me feeling like:

1 not at all, 7 very much so

1 I had interpersonal warmth

2. I was open minded, like I could think clearly

3. I was emotional, like I was responsive and warm

4. I was superficial like I had no depth

5. I was an object, not human

6. I was mechanical and cold, like a robot

7. I was refined and cultured

8. I was an adult not a child

9. I had self restraint

10. I was rational and logical, like I was intelligent

11. I was less than human like an animal

12. I was unsophisticated

Measure of behavioural intention

Ross, Steward & Sinacore (1995), adopted from PSQ (Ware, Snyder, Wright & Davies, 1983)

Rated on a 4 point scale 1= definitely yes, 2= probably yes, 3= probably not, 4= definitely not

If you had been treated by this doctor, how willing would you be to:

1) to return for care
2) refer the doctor to a friend
3) follow the doctors' recommendations
4) report that the doctor gave a clear explanation

Measures of adherence/ reaction to consultation

1) If the doctor had to charge you for an appointment what is the most that you would be willing to pay? __ (Ross, Steward & Sinacore, 1995)

I made these next 5 questions up after looking at the literature.

2) Would you be feeling more or less concerned about your situation following a consultation with this doctor?
   1= more concerned, 4 = unsure, 7 = less concerned

3) Would you be feeling more or less hopeful about your situation following a consultation with this doctor?
   1 = less hopeful, 4= unsure, 7 = more hopeful

4) How comfortable would you be asking this doctor questions regarding your situation in a consultation?
   1 = very uncomfortable, 4 = unsure, 7 = very comfortable

5) How frustrated would you be feeling following this consultation?
   1 = very frustrated, 4 = unsure, 7 = not at all frustrated

Consultation And Relational Empathy (CARE) measure

Mercer, Heaney & Watt (2004).

1= poor, 2 = fair, 3 = good, 4 = very good, 5 = excellent, 6 = Does not apply

How do you think this doctor would be at.:

1. making you feel at ease (i.e. being friendly and warm towards you, treating you with respect; not cold or abrupt)?
2. being interested in you as a whole person (i.e. asking/knowing relevant details about your life, your situation; not treating you as "just a number")?
3. showing care and compassion (i.e. seemed genuinely concerned, connecting with you on a human level; not being indifferent or "detached")?
4. being positive(i.e. having a positive approach and a positive attitude; being honest but not negative about your problems)?
5. explaining things clearly (i.e. fully answering your questions, explaining clearly, giving you adequate information; not being vague)?
6. being competent (i.e. having a knowledge of the area, giving the necessary information)?

<u>Manipulation Check:</u>

Was the content of the doctor's approach to treating patients?

__Dehumanizing (i.e. treating patients like an object or machine)?

OR

__Humanising (i.e. person focussed)?

Please tick the box below if you **DO** give permission for your data to be included for the purpose of research.

Appendix D

Final ethics approval for Study 1-4

Study 1

Dear Dr Case

Re: "Experiences of Dehumanisation" (Ethics Ref: 5201100114)

Thank you for your recent correspondence. Your response has addressed the issues raised by the Human Research Ethics Committee and you may now commence your research.

The following personnel are authorised to conduct this research:

Dr Trevor Case- Chief Investigator/Supervisor
Miss Samantha Adams- Co-Investigator

NB. STUDENTS: IT IS YOUR RESPONSIBILITY TO KEEP A COPY OF THIS APPROVAL EMAIL TO SUBMIT WITH YOUR THESIS.

Please note the following standard requirements of approval:

1. The approval of this project is conditional upon your continuing compliance with the National Statement on Ethical Conduct in Human Research (2007).

2. Approval will be for a period of five (5) years subject to the provision of annual reports. Your first progress report is due on 08 March 2012.

If you complete the work earlier than you had planned you must submit a Final Report as soon as the work is completed. If the project has been discontinued or not commenced for any reason, you are also required to submit a Final Report for the project.

Progress reports and Final Reports are available at the following website:

http://www.research.mq.edu.au/for/researchers/how_to_obtain_ethics_approval/human_research_ethics/forms

3. If the project has run for more than five (5) years you cannot renew approval for the project. You will need to complete and submit a Final Report and submit a new application for the project. (The five year limit on renewal of approvals allows the Committee to fully re-review research in an environment where legislation, guidelines and requirements are continually changing, for example, new child protection and privacy laws).

4. All amendments to the project must be reviewed and approved by the Committee before implementation. Please complete and submit a Request for Amendment Form available at the following website:

http://www.research.mq.edu.au/for/researchers/how_to_obtain_ethics_approval/

human_research_ethics/forms

5. Please notify the Committee immediately in the event of any adverse effects on participants or of any unforeseen events that affect the continued ethical acceptability of the project.

6. At all times you are responsible for the ethical conduct of your research in accordance with the guidelines established by the University. This information is available at the following websites:

http://www.mq.edu.au/policy/

http://www.research.mq.edu.au/for/researchers/how_to_obtain_ethics_approval/human_research_ethics/policy

If you will be applying for or have applied for internal or external funding for the above project it is your responsibility to provide the Macquarie University's Research Grants Management Assistant with a copy of this email as soon as possible. Internal and External funding agencies will not be informed that you have final approval for your project and funds will not be released until the Research Grants Management Assistant has received a copy of this email.

If you need to provide a hard copy letter of Final Approval to an external organisation as evidence that you have Final Approval, please do not hesitate to contact the Ethics Secretariat at the address below.

Please retain a copy of this email as this is your official notification of final ethics approval.

Yours sincerely
Dr Karolyn White
Director of Research Ethics
Chair, Human Research Ethics Committee

Study 2

Dear Dr Case

Re: "PSY234 2011 Tutorial Exercise" (Ethics Ref: 5201100117)

The above application was reviewed by the Human Research Ethics Committee at its meeting on 25/02/2011 . Final Approval of the above application is granted, effective 04 March 2011, and you may now commence your research.

The following personnel are authorised to conduct this research:

Dr Trevor Case- Chief Investigator/Supervisor
Miss Samantha Adams- Co-Investigator

NB. STUDENTS: IT IS YOUR RESPONSIBILITY TO KEEP A COPY OF THIS APPROVAL

EMAIL TO SUBMIT WITH YOUR THESIS.

Please note the following standard requirements of approval:

1. The approval of this project is conditional upon your continuing compliance with the National Statement on Ethical Conduct in Human Research (2007).

2. Approval will be for a period of five (5) years subject to the provision of annual reports. Your first progress report is due on 04 March 2012.

If you complete the work earlier than you had planned you must submit a Final Report as soon as the work is completed. If the project has been discontinued or not commenced for any reason, you are also required to submit a Final Report for the project.

Progress reports and Final Reports are available at the following website:

http://www.research.mq.edu.au/for/researchers/how_to_obtain_ethics_approval/human_research_ethics/forms

3. If the project has run for more than five (5) years you cannot renew approval for the project. You will need to complete and submit a Final Report and submit a new application for the project. (The five year limit on renewal of approvals allows the Committee to fully re-review research in an environment where legislation, guidelines and requirements are continually changing, for example, new child protection and privacy laws).

4. All amendments to the project must be reviewed and approved by the Committee before implementation. Please complete and submit a Request for Amendment Form available at the following website:

http://www.research.mq.edu.au/for/researchers/how_to_obtain_ethics_approval/human_research_ethics/forms

5. Please notify the Committee immediately in the event of any adverse effects on participants or of any unforeseen events that affect the continued ethical acceptability of the project.

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Yours sincerely
Dr Karolyn White
Director of Research Ethics
Chair, Human Research Ethics Committee

Study 3

Dear Dr Case

Re: "Dehumanization in close relationships" (Ethics Ref: 5201100664)

The above application was reviewed by the Human Research Ethics Committee at its meeting on 26-Aug-11 . Final Approval of the above application is granted, effective 30 August 2011, and you may now commence your research.

The following personnel are authorised to conduct this research:

Dr Trevor Case- Chief Investigator/Supervisor
Miss Samantha Maree Adams- Co-Investigator

NB. STUDENTS: IT IS YOUR RESPONSIBILITY TO KEEP A COPY OF THIS APPROVAL EMAIL TO SUBMIT WITH YOUR THESIS.

Please note the following standard requirements of approval:

1. The approval of this project is conditional upon your continuing compliance with the National Statement on Ethical Conduct in Human Research (2007).

2. Approval will be for a period of five (5) years subject to the provision of annual reports. Your first progress report is due on 30 August 2012.

If you complete the work earlier than you had planned you must submit a Final Report as soon as the work is completed. If the project has been discontinued or not commenced for any reason, you are also required to submit a Final Report for the project.

Progress reports and Final Reports are available at the following website:

http://www.research.mq.edu.au/for/researchers/how_to_obtain_ethics_approval/human_research_ethics/forms

3. If the project has run for more than five (5) years you cannot renew

approval for the project. You will need to complete and submit a Final Report and submit a new application for the project. (The five year limit on renewal of approvals allows the Committee to fully re-review research in an environment where legislation, guidelines and requirements are continually changing, for example, new child protection and privacy laws).

4. All amendments to the project must be reviewed and approved by the Committee before implementation. Please complete and submit a Request for Amendment Form available at the following website:

http://www.research.mq.edu.au/for/researchers/how_to_obtain_ethics_approval/human_research_ethics/forms

5. Please notify the Committee immediately in the event of any adverse effects on participants or of any unforeseen events that affect the continued ethical acceptability of the project.

6. At all times you are responsible for the ethical conduct of your research in accordance with the guidelines established by the University. This information is available at the following websites:

http://www.mq.edu.au/policy/

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Please retain a copy of this email as this is your official notification of final ethics approval.

Yours sincerely
Dr Karolyn White
Director of Research Ethics
Chair, Human Research Ethics Committee

Study 4

Dear Dr Case

Re: "PSY234 Tutorial Exercise 2013" (Ethics Ref: 5201300059)

Thank you for your recent correspondence. Your response has addressed the

issues raised by the Human Research Ethics Committee and you may now commence your research.

This research meets the requirements of the National Statement on Ethical Conduct in Human Research (2007). The National Statement is available at the following web site:

http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/e72.pdf.

The following personnel are authorised to conduct this research:

Dr Trevor Case
Miss Samantha Maree Adams

NB. STUDENTS: IT IS YOUR RESPONSIBILITY TO KEEP A COPY OF THIS APPROVAL EMAIL TO SUBMIT WITH YOUR THESIS.

Please note the following standard requirements of approval:

1. The approval of this project is conditional upon your continuing compliance with the National Statement on Ethical Conduct in Human Research (2007).

2. Approval will be for a period of five (5) years subject to the provision of annual reports.

Progress Report 1 Due: 26 February 2014
Progress Report 2 Due: 26 February 2015
Progress Report 3 Due: 26 February 2016
Progress Report 4 Due: 26 February 2017
Final Report Due: 26 February 2018

NB. If you complete the work earlier than you had planned you must submit a Final Report as soon as the work is completed. If the project has been discontinued or not commenced for any reason, you are also required to submit a Final Report for the project.

Progress reports and Final Reports are available at the following website:

http://www.research.mq.edu.au/for/researchers/how_to_obtain_ethics_approval/human_research_ethics/forms

3. If the project has run for more than five (5) years you cannot renew approval for the project. You will need to complete and submit a Final Report and submit a new application for the project. (The five year limit on renewal of approvals allows the Committee to fully re-review research in an environment where legislation, guidelines and requirements are continually changing, for example, new child protection and privacy laws).

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Yours sincerely
Dr Karolyn White
Director of Research Ethics
Chair, Human Research Ethics Committee