

# Stigma and Discrimination in Health-Care Provision to Drug Users: The Role of Values, Affect, and Deservingness Judgments

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This study examined the role of values, affect, and deservingness judgments in health professionals' views of patients with stigmatized conditions (e.g., drug dependence). Participants were 277 nurses who responded to a survey containing 2 scenarios of a nurse providing high- or low-quality care to a patient with a condition related to prolonged use of alcohol or heroin. Affective responses to the patient were more positive for nurses with higher self-transcendence values, and more negative for nurses with higher conservation values. Deservingness judgments were predicted by positive and negative affect toward the patient, but not by attributions of responsibility for drug use. Deservingness judgments emerged as strong predictors of nurses' satisfaction with the provision of high- or low-quality care. The findings imply that the deservingness judgments made by nurses reflected strong entitlement norms concerning the provision of proper care for patients that were independent of patients' perceived responsibility for their condition.

There is evidence that some health professionals have negative views of individuals with stigmatized conditions (e.g., drug dependence, Hepatitis C, HIV/AIDS) and are reluctant to provide high-quality care to these patients (Abed & Neira-Munoz, 1990; Abouyanni et al., 2000; Farmer &

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Greenwood, 2001; Karam-Hage, Nerenberg, & Brower, 2001; Melby, Bore, & Murray, 1992; National Centre in HIV Social Research, 2001; Roche & Richard, 1991). The present study focuses on health professionals' responses to the stigma of problematic alcohol use and drug dependence.

Surveys of health professionals indicate that a significant proportion hold negative or stereotypical views of individuals with drug dependence that are likely to compromise the provision of high-quality care. For example, Abed and Neira-Munoz (1990) found that a small but significant proportion (10%) of general practitioners agreed with the statement "Drug addicts deserve whatever misfortune befalls them." A number of studies with nurses have found that negative and punitive attitudes toward drug users are relatively common (Aalto, Pekuri, & Seppa, 2001; Melby et al., 1992; Norman, 2001). Not only are these attitudes contrary to our expectations concerning professional ethics in the health sector, but the perception that some health professionals are judgmental, unsympathetic, or hostile may discourage individuals with drug-related problems from accessing health-care services (McLaughlin, McKenna, & Leslie, 2000; Telfer & Clulow, 1990). Therefore, a research priority is to identify the antecedents of some health professionals' negative and discriminatory views of patients with stigmatized conditions, such as problematic alcohol use and drug dependence.

Providing high-quality medical care is, in essence, a helping behavior. The large research literature on the antecedents of helping behaviors suggests that attributions of responsibility for a stigmatized condition play a central role in people's willingness to provide assistance and support (Menec & Perry, 1998; Schmidt & Weiner, 1988; Schwarzer & Weiner, 1991; Weiner, 1988, 1995; Weiner, Perry, & Magnusson, 1988). However, health professionals routinely provide high-quality care and treatment to individuals who hold a significant degree of personal responsibility for their health conditions (e.g., heart disease, obesity). Therefore, responsibility attributions alone may not be sufficient to account for some health professionals' reluctance to provide high-quality care to individuals with stigmatized conditions. Indeed, in the context of a hospital, they may play a relatively minor role (if any), given that the normative context prescribes that patients are entitled to proper care.

An alternative perspective is to focus on the social-justice implications of providing care to individuals with stigmatized conditions (e.g., drug dependence). Provision of medical care to individuals with drug-related problems represents a dilemma of social justice (equitable access to high-quality care) and distributive justice (high-quality care is a scarce resource). Therefore, the extent to which a poor standard of care is perceived to be just and deserved is likely to be a key cognition influencing health professionals' acceptance of this outcome. The current study investigates the role of

deservingness judgments in health professionals' satisfaction with both high and low standards of care for patients with drug dependence.

### Deservingness Judgments

Judgments of deservingness relate to the justice or fairness of an outcome: A just and deserved outcome is likely to be viewed with satisfaction and approval, whereas an unjust and undeserved outcome will be met with disapproval and displeasure (Feather, 1999b). There is now a large body of research showing that deservingness judgments influence affective reactions (e.g., resentment, sympathy, *schadenfreude*) to a range of outcomes, such as the arrest and prosecution of environmental protestors (Feather, 2002a), the resolution of industrial conflicts (Feather, 2002b), the imposition of mandatory sentences by a court (Feather & Souter, 2002), and high or low achievement in university exams (Feather & Nairn, 2005; Feather & Sherman, 2002).

There is also evidence that deservingness judgments are likely to influence health professionals' reactions to clients with a stigmatized health condition (e.g., psychiatric illness). Feather and Johnstone (2001) presented nurses with a hypothetical scenario in which a psychiatric patient with schizophrenic or a personality-disorder patient became aggressive and attacked hospital property. The patient was either assisted in a positive way (i.e., patient's hand was bandaged and patient was listened to by the nurses) or responded to in a negative way (i.e., patient was rebuked and sent away). Feather and Johnstone found that stronger perceptions of the patient's responsibility for the aggressive incident were associated with more anger and less sympathy toward the patient. These affective reactions, in turn, predicted deservingness judgments: Perceived deservingness of the negative treatment increased with higher anger and lower sympathy, whereas perceived deservingness of help and assistance increased with higher sympathy and lower anger. Stronger perceptions that help or punishment was deserved were associated with higher positive affect in response to each outcome. It is important to note, however, that consistent with health-care entitlement norms, the help provided by the nurse was perceived as more deserved and resulted in higher positive affect when compared to the situation in which the patient was rebuked.

### The Present Study

Building on Feather and Johnstone's (2001) study, the current study investigates nurses' responses to two hypothetical scenarios in which either high or low quality of care was provided to individuals who either used

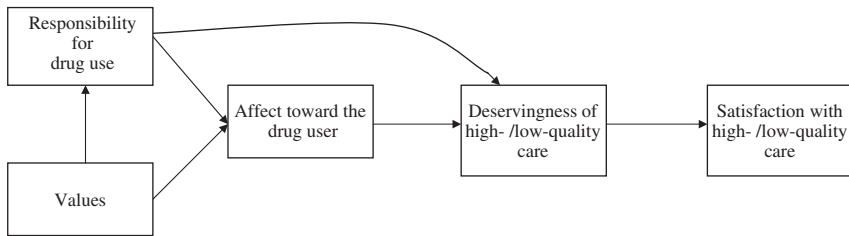


Figure 1. Proposed theoretical model.

heroin or consumed alcohol to excess. Heroin and alcohol were chosen for this study because both drugs are known to be associated with significant personal and social harms, and significant stigma is attached to heroin addiction and heavy alcohol consumption. Therefore, we expect that issues regarding access to and deservingness of medical care will be particularly salient in this context.

The proposed theoretical model is presented in Figure 1 and will be discussed in further detail. As Figure 1 indicates, we expect that the patient's perceived deservingness of high- or low-quality care will be the most proximal predictor of nurses' satisfaction with each outcome. There are three possible antecedents of deservingness judgments that are considered: affective reactions to the drug user, attributions of responsibility for drug use, and values.

#### *Affective Responses to the Drug User*

Findings from previous research are consistent with the assumption from deservingness theory that deservingness judgments about another person's positive or negative outcome are moderated by how much that person is positively or negatively evaluated (e.g., liked or disliked) by the person making the judgments (e.g., Feather, 1999a, 1999b; Feather & Nairn, 2005; Feather & Sherman, 2002). Consistent with these findings, we expect that deservingness of high-quality care (a positive outcome) will increase with stronger positive affect and weaker negative affect toward the drug user. The opposite pattern is expected for deservingness of low-quality care (a negative outcome).

#### *Responsibility Attributions*

In Feather and Johnstone's (2001) study, deservingness judgments relating to the nurse's positive or negative response to the patients' aggressive episode were related to how much the patient was deemed to be responsible

for the aggressive episode. Note that this study involved patients who were expected to differ in their perceived responsibility for the aggressive incident, and, indeed, the results showed that the patient with schizophrenia was deemed to be less responsible when compared with the patient with personality disorder. In contrast to Feather and Johnstone's study, the current study involves patients who are similar in the sense that they are drug users (alcohol, heroin), and responsibility judgments were targeted to their drug use, rather than to a specific behavioral incident within the hospital.

It might be argued that the more these patients were perceived to be responsible for their drug use, the more they would be perceived to deserve low- rather than high-quality care, and the more angry and less sympathetic the nurses would feel toward them. Consistent with this argument, Skitka and Tetlock (1992, 1993) demonstrated that attributions of responsibility for health care (e.g., AIDS patients, organ-donor recipients) resulted in less generous allocation of (hypothetical) public resources. Research has also shown that feelings of anger and lowered sympathy toward another person are more evident when that person is perceived to be more responsible for a negative event or outcome than when perceived responsibility is lower or absent (e.g., Menec & Perry, 1998; Weiner, 1995; Weiner et al., 1988).

Complicating this argument as it relates to deservingness, however, is the fact that people's deservingness judgments are sometimes likely to reflect beliefs about entitlement, especially in contexts in which entitlement norms are salient. People sometimes confuse deservingness with entitlement in their everyday language. Feather (1999b, 2002a, 2003) distinguished between deservingness and entitlement on conceptual grounds. He proposed that *deservingness* refers to judgments about positive or negative outcomes that are contingent on a person's positive or negative behavior (e.g., a student deserving a high grade on an exam because he or she studied hard). In contrast, *entitlement* refers more to the external normative context of rules, laws, or other quasilegal prescriptions (e.g., an employee becomes entitled to a promotion on the basis of an affirmative-action policy). Keeping these fairness principles apart has important implications. For example, in some situations, deservingness and entitlement may be compatible; while in other situations they may come into conflict (Feather, 2002a, 2003; Feather & Johnstone, 2001; Feinberg, 1970).

We can add further to this analysis. While judgments of deservingness for a contingent outcome presuppose personal causation for the action that produced the outcome and some degree of perceived responsibility, there is no reason to expect that a person's perceived entitlement to an outcome should depend in part on that person's perceived responsibility. A judgment that a patient who uses drugs is personally responsible for his or her condition should not mean that he or she is not entitled to proper care, given

the norms under which the hospital and its employees operate and the caring roles that these employees are expected to perform. Note that norms of entitlement had an important influence on nurses' responses in Feather and Johnstone's (2001) study, and we expect them to do so in the current study as well.

The implication of the preceding argument is that if the nurses responded to questions about deservingness as if these questions concerned entitlement, then their responses may be unrelated to the patient's perceived responsibility for drug abuse. Deservingness, then, would be equated with entitlement, and all patients would be perceived to be entitled to good, quality care, regardless of their perceived responsibility for their drug-related ailments. Beliefs about entitlement would dictate the responses to be made, especially when the context is one in which there are strong entitlement norms about proper treatment directed toward the welfare of patients and where, in contrast to Feather and Johnstone's (2001) study, there is an absence of a specific behavior (e.g., an aggressive episode) that would engage deservingness judgments. Entitlement norms would dictate that nurses should express sympathy (or positive affect), rather than anger (or negative affect), toward patients who are under their care, regardless of patients' perceived responsibility. Hence, the paths in Figure 1 between responsibility and deservingness, and between responsibility and affect are presented with considerable qualification, and, indeed, they may be absent.

### *Values*

The focus so far has been on relations between responsibility, affect, and deservingness. In the current study, we also are interested in the role of values as possible antecedents of responsibility attributions and affective responses to the drug user. Values reflect general beliefs that people hold about desirable or undesirable ways of behaving (e.g., being honest, being loving) and about general goals or end states of existence (e.g., equality, freedom; Feather, 1999b).

Values are assumed to be central components of the self-concept and to be important influences on a person's attitudes and behaviors. They are used as criteria to guide the way people construe situations in terms of what objects and events, behaviors and goals, or actions and outcomes are perceived as desirable or undesirable, or as possessing positive or negative valence (Feather, 1975, 1994, 1995; Rokeach, 1973), influencing the way actions and their outcomes are evaluated (Feather, 1995). For example, people with strong right-wing authoritarian values are more likely to view crimes as serious (depending also on the context and the perpetrator of the

offense; Altemeyer, 1988; Christie, 1993; Feather, 1996, 1998). In the current study, we explore the role of the higher order conservation and self-transcendence value dimensions described by Schwartz (1992, 1994). These values were chosen because they were most likely to relate to the issues of drug use and provision of medical care that are examined in the current study.

Conservation values encompass values that emphasize the importance of conformity, tradition, and security values for self, as opposed to values that emphasize the importance of openness to change (e.g., stimulation, self-direction values). We expect that an emphasis on conservation values will be associated with more punitive judgments, and will be reflected in perceptions that drug users are largely responsible for their drug use and also in lower positive affect and stronger negative affect toward the drug user. Evidence from studies of right-wing authoritarians is consistent with this assumption. Right-wing authoritarians tend to have stronger conservation values, to be more punitive in their judgments, and to be more negative in their social attitudes in situations in which these values are threatened (Feather, 1996, 1998, 1999b).

Self-transcendence values encompass universalism values that emphasize the importance of general social goals (e.g., equality, social justice for self), and benevolence values that emphasize the importance of prosocial values that are more interpersonal in nature (e.g., being forgiving, being helpful). They are opposed to values that emphasize self-enhancement (e.g., power, achievement values). We expect that an emphasis on self-transcendence values will be associated with more compassionate and prosocial judgments, and will be reflected in perceptions that drug users are less responsible for their drug use and also in higher positive affect and lower negative affect toward the drug user. Evidence from values research is consistent with this prediction. For example, people with stronger universalism values tend to perceive a crime committed by a member of the public as less serious, depending on the context and nature of the crime (Feather, 1996, 1998).

### *Summary*

This is the first study to examine the role of deservingness judgments in health professionals' provision of care to drug users. The study also builds on previous research by investigating the effects of nurses' values on their reactions to drug users. Finally, the study provides an opportunity for determining how far Feather and Johnstone's (2001) findings with psychiatric patients can be generalized to a new area (i.e., drug users).

## Method

### *Participants*

In a single mailing, questionnaires were sent to a random sample of 800 nurses registered with the Nurses Registration Board in New South Wales, Australia in December 2002. Participants were mailed a hard copy or completed an online version of the questionnaire posted on the university Web site. A total of 277 surveys were returned (34.6% response rate). Of these surveys, 141 concerned alcohol use and 136 concerned heroin use. For the total sample ( $N = 277$ ), participants' ages ranged from 22 to 75 years ( $M = 48.1$ ,  $SD = 9.3$ ), and number of years working as a nurse ranged from 1 to 53 years ( $M = 24.5$ ,  $SD = 10.7$ ).

### *Procedure*

A 2 (Quality of Care: high vs. low)  $\times$  2 (Drug Type: alcohol vs. heroin) mixed within-between subjects design was used. The study was introduced as an exploration of how nurses view individuals who use licit or illicit drugs. The questionnaires were completed under anonymous conditions.

Participants were provided with a hypothetical scenario of a drug user presenting to an Emergency Department (ED) nurse with a serious medical condition associated with one type of drug use. Participants were randomly assigned to a scenario addressing problematic alcohol use or injection of heroin. The scenarios contained identical wording, except for the specific type of drug and associated medical condition (heroin and a skin abscess; alcohol and a stomach ulcer). The medical conditions were chosen carefully to ensure that they represented common and realistic conditions associated with each drug type, and were of equivalent seriousness with regard to treatment priorities in an ED setting. The heroin scenario was as follows:

On a relatively quiet Sunday night, MJ presents at an Emergency Department with a large and painful abscess on their arm. On close questioning, MJ reveals to the triage nurse that the abscess has developed from regular injection of heroin over the past 5 years.

The alcohol scenario was as follows:

On a relatively quiet Sunday night, MJ presents at an Emergency Department with a strong stomach pain. On close questioning, MJ reveals to the triage nurse that they have previously been diagnosed with a large stomach ulcer that has developed from regular excessive drinking sessions over the past 5 years.



Participants then responded to items addressing perceptions of the patient's responsibility for the drug use, and positive and negative affect toward the patient.

Participants then were presented with two scenarios describing the nurse as providing high- or low-quality care. Quality of care was operationalized in terms of the degree to which the nurse provided help and assistance to the patient, and the timeliness of treatment for the medical condition. The high-quality care scenario described the nurse providing information on treatment and support services and arranging for treatment of the drug user's medical condition as soon as possible. The low-quality care scenario described the nurse providing a reprimand and placing the drug user as "non-urgent" on the priority list for treatment. Each scenario was followed by scales addressing perceived deservingness of the quality of care provided, and positive and negative affective responses to each outcome. The scenarios were presented in counterbalanced order. Order of scenario presentation did not significantly affect responses on these scales.

#### *Measures Concerning Perceptions of the Drug User*

After reading the first part of each scenario, participants were presented with five questions concerning (a) perceived responsibility for drug use, measured by the extent to which the patient was responsible for the drug use (1 = *not at all responsible* to 5 = *very responsible*); and (b) positive (sympathy, concern) and negative (anger, disappointment) affective responses to the patient (e.g., 1 = *not at all angry* to 5 = *very angry*).

The affect items were chosen on the basis of previous research on affective responses to stigmatized others (Feather & Johnstone, 2001; Menec & Perry, 1998; Schmidt & Weiner, 1988). A principal-components factor analysis with varimax rotation was conducted on the four scales. There were two factors that emerged with eigenvalues greater than 1. Anger and disappointment items loaded on a single factor with factor loadings of .82 and .87, respectively. Scores on the two items were averaged to produce a measure of negative affect toward the drug user. Sympathy and concern items loaded on a second factor with factor loadings of .83 and .85, respectively. Scores on these two items were averaged to produce a measure of positive affect toward the drug user.

#### *Measures Concerning the Quality of Care Provided to the Drug User*

Following each scenario describing high- or low-quality care, participants were presented four questions concerning (a) the extent to which the

patient deserved the high- or low-quality care (1 = *not at all deserving* to 5 = *very deserving*); and (b) satisfaction with the quality of care provided (*pleased, satisfied, disappointed, annoyed*; e.g., 1 = *not at all pleased* to 5 = *very pleased*).

The selection of affect items was based on previous research on affective responses to outcomes experienced by others (Feather, 1996; Feather & Deverson, 2000; Feather & Johnstone, 2001). Separate principal-components factor analyses with varimax rotation were conducted on the four scales for the high- and low-quality care scenarios. For each scenario, one factor emerged with an eigenvalue greater than 1. Factor loadings for the disappointment, annoyance, pleased, and satisfied items were -.78, -.79, .78, and .83, respectively, for the high-quality care scenario; and -.80, -.77, .82, and .88 for the low-quality care scenario. Scores on the disappointment and annoyance items were reverse-coded, and scores on the four affect items then were averaged to obtain an overall measure of satisfaction with the quality of care provided.

### *Internal Reliabilities*

Internal reliabilities, as measured by Cronbach's alpha, were acceptable for items related to negative ( $\alpha = .60$ ) and positive ( $\alpha = .60$ ) affective responses to the drug user. They were good for satisfaction with high-quality care ( $\alpha = .77$ ) and with low-quality care ( $\alpha = .82$ ).

### *Values Measure*

Values were measured using the Schwartz Value Survey (SVS; Schwartz, 1992). Participants indicated the extent to which 57 values are a "guiding principle in your life" using the standard SVS 9-point response scale ranging from -1 (*opposed to my values*) to 0 (*not important*) to 7 (*of supreme importance*). The scale taps 10 different value types that reflect four higher order value dimensions. The higher order value dimensions of conservation and self-transcendence were considered in the current model.<sup>2</sup>

Self-transcendence value types were tapped by two scales: universalism (i.e., understanding, appreciation, tolerance, protection for the welfare of all people and for nature;  $\alpha = .83$ ) and benevolence (i.e., preservation and enhancement of the welfare of people with whom one is in frequent personal contact;  $\alpha = .77$ ; Schwartz, 1994). Conservation value types were tapped by

<sup>2</sup>Examination of correlation matrices indicates that the values that were excluded from the current analyses did not demonstrate large or consistent relationships with the dependent variables.

three scales: tradition (i.e., respect, commitment, acceptance of the customs and ideas that traditional culture or religion provide;  $\alpha = .60$ ), conformity (i.e., restraint of actions, inclination, and impulses likely to upset or harm others and violate social expectations and norms;  $\alpha = .69$ ), and security (i.e., safety, harmony, and stability of society, of relationships, and of self;  $\alpha = .60$ ; Schwartz, 1994).

Schwartz (1992) recommended controlling for differences in participants' use of the SVS by computing each participant's mean importance rating for the 57 values and controlling for its effect using partial correlation. To control for individual differences in scale use while maintaining an acceptable degree of model parsimony (i.e., to avoid including a large number of additional variables in the model), we centered each participant's importance rating for each value by subtracting the mean importance rating for the 57 values for each participant. Participants' final score on each of the 10 value types was the average of the set of centered items making up each value type. Scores on the higher order value dimensions were calculated by averaging the final score on the set of values that made up each higher order value dimension.

## Results

### *Mean Scores for Scenarios*

Table 1 presents mean scores on items related to perceptions of the patient in the alcohol and heroin scenarios. Overall, participants perceived drug users to hold high levels of responsibility for their alcohol or drug use, and reported low levels of negative affect (anger, disappointment) and relatively high levels of positive affect toward these individuals (sympathy, concern). Scores on these measures did not differ significantly between the heroin and alcohol scenarios.

As Table 2 shows, overall participants perceived high-quality care to be highly deserved and low-quality care to be undeserved. They reported high satisfaction in response to high-quality care and low satisfaction in response to low-quality care. A 2 (Quality of Care: high vs. low)  $\times$  2 (Drug Type: heroin vs. alcohol) mixed within-between subjects MANOVA indicates that for both drug types, participants perceived high-quality care to be more deserved, and they reported greater satisfaction with high- compared to low-quality care; differences that, in accordance with our previous discussion, reflect the influence of entitlement norms for patients within a hospital setting. Participants' scores on the centered higher order value dimensions indicate that self-transcendence value types ( $M = 0.82$ ,  $SD = 0.45$ ) were

Table 1

*Means for Items Related to Perceptions of the Patient According to Drug Type*

Variable	Alcohol ( $n = 141$ )		Heroin ( $n = 136$ )		$t$
	$M$	$SD$	$M$	$SD$	
Responsibility	4.08	0.94	4.03	0.98	0.41
Positive affect	3.88	0.82	3.84	0.78	0.47
Negative affect	2.43	1.04	2.57	1.08	-1.08

*Note.*  $df = 275$ ; None of the  $t$  tests were significant ( $p > .05$ ).

rated as slightly more important, as compared to conservation value types ( $M = -0.02$ ,  $SD = 0.51$ ).

#### *Correlations Between Variables*

Correlations between variables are presented in Table 3. With respect to the predictions of the theoretical model (Figure 1), the central features of the correlation matrix are as follows:

1. Perceived responsibility for heroin use increased with higher importance assigned to conservation values.
2. Positive affect toward the patient (sympathy, concern) increased with higher importance assigned to self-transcendence values.
3. Negative affect (anger, disappointment) toward the patient increased with higher importance assigned to conservation values and decreased with higher importance assigned to self-transcendence values.
4. Perceived deservingness of high-quality care increased with stronger positive affect (sympathy, concern) and decreased with stronger negative affect (anger, disappointment) toward the patient.
5. Perceived deservingness of low-quality care increased with stronger negative affect (anger, disappointment) and decreased with stronger positive affect (sympathy, concern) toward the patient.
6. Satisfaction with high/low quality of care increased with the perceived deservingness of each outcome.

Table 2  
*Means for Deservingness of High Versus Low Quality of Care and Satisfaction With Outcome According to Drug Type*

Variable	Alcohol			Heroin			Univariate <i>F</i> s						
	<i>M</i>	<i>SD</i>		<i>M</i>	<i>SD</i>		Drug Quality of care (A)	Drug Quality of care (B)	Interaction (A × B)				
Deservingness of high- low-quality care	4.63	0.68		1.31	0.67		4.70	0.58	1.29	0.57	0.50	2547.40***	0.68
Satisfaction with high- low-quality care	4.69	0.54		1.61	0.84		4.69	0.51	1.67	0.71	0.81	2153.20***	0.14

\*\*\*  $p < .001$ .

Table 3  
Correlations Between Variables

Variable	1	2	3	4	5	6	7	8	9
1. Self-transcendence	—	-.19*	-.16	.27**	-.18*	.20*	-.32***	.10	-.28**
2. Conservation	-.13	—	.11	-.03	.23**	-.16	.12	.01	.07
3. Responsibility for drug use	-.01	.23*	—	.01	.14	-.07	.06	.02	.04
4. Sympathy/concern	.24**	-.02	-.04	—	-.11	.37***	-.38***	.31***	-.42***
5. Anger/disappointment	-.21*	.32***	.08	-.12	—	-.28**	.37***	-.16	.28***
6. Deservingness of high-quality care	.22**	-.02	.01	.31***	-.23**	—	-.64***	.62***	-.50***
7. Deservingness of low-quality care	-.28**	.07	-.13	-.28**	.32***	-.43***	—	-.40***	.62***
8. Satisfaction with high-quality care	.21*	.12	.15	.35**	-.05	.55***	-.37***	—	-.49***
9. Satisfaction with low-quality care	-.20*	.01	-.02	-.47***	.06	-.37***	.59***	-.38***	—

Note. Alcohol correlations are presented above the diagonal, while heroin correlations are presented below the diagonal.  
\* $p < .05$ . \*\* $p < .01$ . \*\*\* $p < .001$ .

*Regression Analyses*

The proposed model was tested using path analysis. The analysis used multiple regression with pairwise deletion of missing cases to generate standardized regression coefficients. Path coefficients were obtained by regressing each variable on those that directly impinged on it. Figure 2 summarizes the results of the regression analysis in a path diagram (non-significant paths for both drugs are not shown, but will be discussed in further detail).

*Affective Responses to the Drug User and Perceived Deservingness of High- and Low-Quality Care*

As Figure 2 indicates, the current findings were generally supportive of the proposed model. The conservation value dimension (security, tradition, conformity) was associated with stronger feelings of anger and disappointment toward the patient. The self-transcendence value dimension (benevolence, universalism) was associated with higher levels of sympathy and concern for the drug user. Contrary to expectations, the conservation value dimension was not associated with reduced positive affect toward the drug

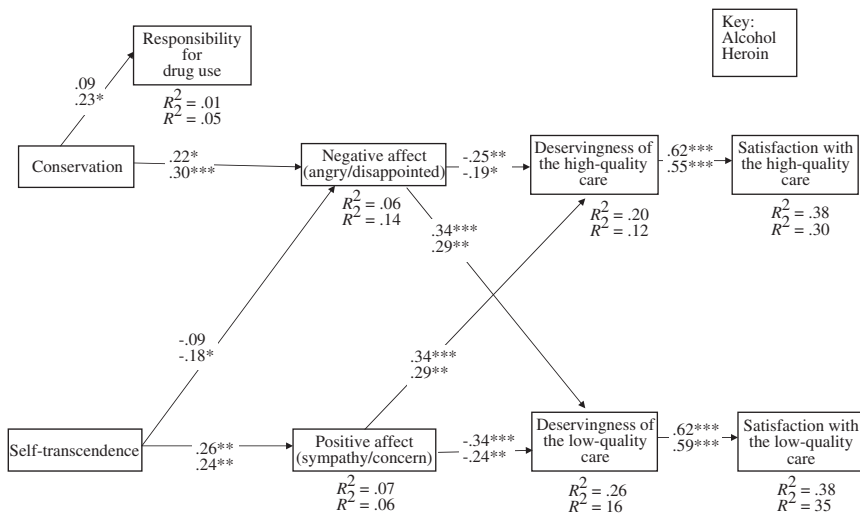


Figure 2. Theoretical model of affective responses to the drug user and deservingness and satisfaction (standardized coefficients). Path coefficients for negative affect on deservingness of low-quality care and for positive affect on deservingness of high-quality care were identical when rounded to two decimal places. \**p* < .05. \*\**p* < .01. \*\*\**p* < .001.

user, nor was the self-transcendence value dimension associated with reduced negative affect (with the exception of a weak effect in the heroin scenario). In addition, conservation and self-transcendence value dimensions did not predict perceived responsibility for drug use in the alcohol scenario, and only the conservation value dimension predicted perceived responsibility in the heroin scenario.

As expected, affective responses to the patient predicted the perceived deservingness of high- and low-quality care. Low-quality care was perceived to be more deserved when negative affect was stronger and positive affect toward the patient was weaker. The opposite pattern was evident for perceived deservingness of high-quality care. However, perceived responsibility for drug use did not predict positive or negative affect toward the drug user or deservingness judgments. As expected, perceived deservingness of each outcome (i.e., high- or low-quality care) strongly predicted satisfaction with each respective outcome.

#### *Tests for Nonmediated Effects*

The presence of nonmediated effects that were not predicted by the model were tested by using Baron and Kenny's (1986) regression methodology. Nonmediated effects are present if a variable in the model is associated with a variable appearing later in the model, even after controlling for intervening variables. Specifically, we examined the presence of direct effects of (a) values on deservingness of high- or low-quality care; and (b) positive affect, negative affect, and responsibility on satisfaction with the nurse's response.

Only two nonmediated effects were found. After controlling for perceived deservingness, positive affect toward the patient had a direct impact on satisfaction with low-quality care (alcohol,  $\beta = -.25, p < .01$ ; heroin,  $\beta = -.34, p < .001$ ). For the heroin scenario, positive affect toward the drug user had a direct impact on satisfaction with high-quality care ( $\beta = .21, p < .01$ ). These findings indicate that higher levels of positive affect toward the patient (sympathy, concern) predicted lower satisfaction with low-quality care (alcohol, heroin) and higher satisfaction with high-quality care (heroin). Therefore, these results are not unexpected.

#### *Comparison of Model Across Drug Type*

It is possible that the effects of different variables in the model might differ according to whether the drug involved is alcohol or heroin. The equivalence of path coefficients across drug types was tested using Kline's



(1998) structural equation modeling multiple-group comparison procedure. The fit indexes were low when the path coefficients from the two models were constrained to be invariant,  $\chi^2(62, N = 277) = 185.82, p < .00$  (normed fit index = .658, non-normed fit index = .695), and none of the Lagrange multiplier modification indexes were significant. This indicates that none of the paths in the model were significantly different across drug type.

### Discussion

This study supports the utility of a social-justice perspective in understanding the dynamics of health-care practices regarding stigmatized conditions (e.g., heroin dependence, alcohol-related problems). Specifically, judgments of patients' deservingness of low (or high) quality of care influenced health professionals' satisfaction with these standards of care. The results also support the influence of affective responses to individuals on judgments that high- or low-quality care is deserved.

Positive affect (sympathy, concern) predicted deservingness of high-quality care, while negative affect (anger, disappointment) predicted deservingness of low-quality care. In addition, general value orientations influenced affective reactions toward the drug user. In particular, conservation values predicted negative affect toward both the heroin user and the alcohol user.

#### *Deservingness or Entitlement?*

Our results suggest that the nurses' judgments of deservingness reflected the strong influence of entitlement norms within the hospital setting. We say that for two reasons. First, the ratings of deservingness for high- and low-quality care were at the high and low ends of the rating scale, respectively (Table 1). So were the composite ratings of satisfaction with high- and low-quality care. These large differences in ratings are consistent with an interpretation that assumes that the nurses equated deservingness with entitlement in this context; responding in terms of a belief, inculcated in their training and emphasized within the hospital, that all patients are entitled to high-quality care, regardless of their perceived responsibility for their medical conditions.

Second, the fact that perceived responsibility did not predict patients' deservingness or nurses' affective reactions to either patient is consistent with an interpretation that entitlement norms dominated their judgments. As argued previously, perceived responsibility would be expected to influence judged deservingness when there is a specific and identifiable

behavioral outcome that can be related to personal causation, as occurred with the aggressive episode in Feather and Johnstone's (2001) study. There was no such specific, salient behavioral outcome in the present study. The nurses simply responded to patients who were admitted to hospital with a drug-related complaint, and patients' perceived responsibility for their conditions was not an issue. Instead, patients were perceived as entitled to sympathy and concern, rather than to responses expressing anger and disappointment. Patients were also perceived as entitled to high-quality, rather than low-quality care (see means in Tables 1 and 2).

This interpretation raises interesting issues about the distinction between deservingness and entitlement, and about how respondents interpret questions about deservingness. The present results show that in contexts (e.g., a hospital setting) in which entitlement norms are highly salient, deservingness judgments may primarily reflect beliefs about entitlement. Similarly, a person left a legacy in a will generally would be perceived as more entitled to the legacy if he or she were close kin (i.e., a son or daughter), as compared with a friend who rendered help (Feather, 2003).

In other contexts, however, the focus may be on personal causation and intentionality, and deservingness judgments may be largely unaffected by issues of entitlement. Deserving promotion within an organization, for example, may be perceived as depending more on an employee's contributions and hard work for the organization, rather than on his or her entitlement to promotion based on formal or informal rules.

In some cases, deservingness judgments may reflect perceived responsibility for an action and its outcome as well as the effects of entitlement norms, as was the case in Feather and Johnstone's (2001) study. In that study, a specific behavioral episode occurred involving a patient with either schizophrenia or personality disorder who differed in the perceived responsibility for the aggressive incident. These possible interactions between deservingness and entitlement have been previously discussed (Feather, 2002a; Feather & Johnstone, 2001) and investigated in recent studies (Boeckmann & Feather, 2005; Feather, 2003). They raise important issues for future research.

It might be argued that the failure of perceived responsibility to predict either affective reactions to each patient or deservingness of high- or low-quality care could be a result of inadequate measurement of perceived responsibility. However, the measure we used has been employed successfully in previous research addressing complex social problems (e.g., Feather, 1996, 1998, 1999a, 1999b, 2002b, 2003; Feather & Deverson, 2000; Feather & Johnstone, 2001; Feather & Nairn, 2005; Feather & Oberdan, 2000; Feather & Sherman, 2002; Feather & Souter, 2002). Therefore, our interpretation that deservingness judgments in the current study strongly reflect

entitlement norms remains as the most likely explanation of the failure of perceived responsibility to predict either affect or deservingness.

### *Affective Reactions to the Drug User*

Consistent with previous research (Feather & Johnstone, 2001), negative affective reactions to the drug user were associated with more negative deservingness judgments (i.e., high-quality care less deserved, low-quality care more deserved); whereas, positive affective reactions were associated with more compassionate deservingness judgments (i.e., high-quality care more deserved, low-quality care less deserved). These affective responses reflect the effects of entitlement norms. They also may partly reflect private feelings that the nurses held: feelings that could affect the nurses' own beliefs about each patient's deservingness or entitlement to care, but only in a minor way, given the fact that these beliefs were affected strongly by entitlement norms within the hospital setting.

### *Values*

The current findings support the influence of values on affective reactions to others in distress. They are consistent with results from other research that has related reported affect to measures of right-wing authoritarianism and value types (e.g., Altemeyer, 1981, 1988; Feather, 1996, 1998). The importance assigned to conservation values (conformity, security, tradition) was associated with higher negative affect toward the drug user; whereas, the importance assigned to self-transcendence values was associated with stronger reported positive affect toward the drug user.

Note, however, that in the path analysis, the conservation value dimension did not predict lower positive affect toward drug users, and the self-transcendence value dimension did not predict lower negative affect. Consideration of the context represented by the hypothetical scenario may provide further insight. Feather (1999b) proposed that values are activated by situational cues, and that the likelihood of activation also depends on the importance placed on a particular value relative to other values within a person's value system.

In the current study, individuals who placed high importance on conservation value types would be expected to be more sensitive to those aspects of the scenario that threatened these core beliefs (e.g., deviance and non-conformity associated with drug addiction). Therefore, in this context, the activation of conservation value types would be related to a perceived threat to important values and with negative affect (anger, disappointment)

associated with this threat. In contrast, individuals who placed a high value on self-transcendence value types would be expected to be more sensitive to aspects of the scenario that related to the provision of care and assistance. Therefore, in this context, the activation of self-transcendence value types would be related to the potential for fulfilling important values and to positive affect (sympathy, concern) associated with this potential fulfillment.

### *Methodological Limitations*

Much of the research on individuals' affective reactions to others in distress has been conducted with university students. The present study makes an important contribution to this research literature by examining the responses of health professionals to a realistic scenario of health-care provision. However, the limitations of hypothetical scenarios are acknowledged (Parkinson & Manstead, 1993). To what extent nurses' responses to a hypothetical scenario reflect the quality of care they are likely to provide is a difficult question to study directly. This question does not lend itself easily to experimental or observational studies because both types of design raise significant ethical issues concerning the participation of vulnerable individuals (i.e., alcohol or drug users). However, the consistent relationship of deservingness judgments to affective responses to high- or low-quality care suggests that these deservingness judgments—which we propose largely reflect entitlement norms—are key variables that are likely to impact the quality of care that health professionals provide to individuals with stigmatized conditions.

Injection of heroin and problematic alcohol use are stigmatized drug-taking behaviors that often evoke strong emotional responses as a result of their association with criminal or antisocial acts (e.g., drunk driving, domestic violence, theft) and their historical link with moral decline (e.g., lack of will power, hedonism). The current study supports the utility of a social-justice perspective for enhancing the understanding of health-care delivery for stigmatized conditions, such as drug dependence. It also indicates the importance of addressing both affective responses to stigmatized groups (e.g., anger, sympathy, concern) and deservingness and entitlement judgments in education and training programs for health professionals.

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