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Moral Relativists Resist Health Mandates during the COVID-19

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Running head: Compliance with Health Mandates

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Abstract

In a study of US residents' during the COVID-19 pandemic of 2020, their moral judgments of noncompliance with health mandates predicted their failure to comply with these health-promoting guidelines ($r = +0.87$, $n = 303$). Moreover, and consistent with ethics position theory (Forsyth, 2020), moral relativism predicted both moral judgments of noncompliance and noncompliance itself, and these relationships remained significant when controlling for other factors, such as political orientation and race. Moral beliefs that emphasized minimizing harm to others (idealism), in contrast, were not associated with compliance. These findings are both empirically noteworthy and practically significant: (a) they affirm the close connections among moral personality, moral judgment, and individuals' actions in morally turbulent situations and (b) suggest moral framings will strengthen the effectiveness of health promotion campaigns.

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Moral Relativists Resist Health Mandates during the COVID-19 Pandemic

During the COVID-19 pandemic of 2020 health authorities urged people to reduce the spread of the disease through nonpharmaceutical interventions, including disinfecting surfaces, quarantining, and social distancing. Many people complied, but a substantial number refused. Some apparently thought the disease would not cause them harm (e.g., Harper, Satchell, Fido, & Latzman, 2020). Others were more influenced by the opinions of their friends and associates rather than medical professionals (Dryhurst et al., 2020). Some aligned their actions with those of their political leaders (e.g., Pedersen & Favero, 2020).

But some people considered compliance to be a moral issue. As Roy Cooper (2020), governor of North Carolina, tweeted, “A face covering signifies strength and compassion for others. Wearing one shows you actually care about other people's health.” Others, in contrast, considered these restrictions to be a moral affront; an unwarranted restriction of the basic right of self-determination. As one respondent to Governor Cooper’s tweet expressed it, “This is about the #Constitution and our Civil Liberties, the Right to assemble to Worship or Protest. The Right to feed my family or to bury a loved one” (occupycorruptDC, 2020).

The current research examined the relationship between people’s compliance with medical mandates and their moral judgments. Previous research suggests that, in some situations, individuals who judge a behavior to be morally good are more likely to enact that behavior. Adolescents who consider helping others to be morally good were more likely to act in helpful ways (Patrick, Bodine, Gibbs, & Basinger, 2018). Those who morally champion civil disobedience were also the ones who took part in a sit-in protesting the curtailment of free speech (Candee & Kohlberg, 1987). Athletes who disagreed with such statements as “It is OK to cheat if nobody knows” were less likely to cheat in actual match play (Lucidi et al., 2017). These

findings suggest that individuals who believe that compliance with health mandates is morally good should themselves be more likely to comply with those mandates.

But what factors determine individuals' moral appraisals of health mandates? The current investigation draws on ethics position theory (Forsyth, 1980, 2020) to answer this question. This theory traces differences in moral judgments to differences in people's concern for others' well-being (idealism) and compliance with moral standards (relativism). Those who are more idealistic are attentive to the welfare of others, whereas those who are more relativistic are skeptical about universal moral standards. These two dimensions parallel the philosophical distinctions between moral theories based on the consequences of actions (consequentialism) and those based on principles and duty (deontology).

Applied to noncompliance with health mandates, ethics position theory suggests that idealism will limit noncompliance, but that relativism will elevate it. Idealism is associated with concern for others and more negative evaluations of actions that may cause harm. When, for example, individuals respond to moral dilemmas, idealism predicts more positive evaluations of prosocial choices (e.g., McNair, Okan, Hadjichristidis, & de Bruin, 2019). Relativism, however, is associated with a skepticism of, and often noncompliance with, standards that define the difference between right and wrong. Relativism predicts leniency in judgments of moral indiscretions as well as an increased tendency to act in ways that are inconsistent with conventional moral standards (e.g., Tooke & Ickes, 1988). Ethics position theory therefore suggests the following predictions:

Hypothesis 1: Noncompliance with health mandates for limiting the spread of COVID-19 will be associated with individual differences in moral positions, such that (a) idealism will be associated with compliance, (b) relativism will be associated with noncompliance, and (c) low

idealism paired with elevated relativism will be associated with the highest level of noncompliance.

Hypothesis 2: Moral judgments will mediate the relationship between ethics positions and noncompliance, such that those who consider noncompliance to be morally reprehensible will be more compliant, whereas those who consider noncompliance to be morally allowable will be less compliant.

Method

We examined the relationship between moral beliefs (idealism and relativism), moral judgment of noncompliance with medical directives, and individuals' own level of noncompliance in a survey of 303 US residents recruited through Amazon's Mechanical Turk (MTurk). All materials and procedures were preregistered on the Open Science Framework (OSF) at <https://osf.io/mwah9/> and are detailed in the Supplemental Materials. The final sample ranged in age from 18 to 76 years ($M = 39.67$, $SD = 13.01$), with 38.9% ($n = 118$) identifying as women, 24.8% were African American, 2.8 were Asian American, 76.3% were white, 5.7% were Latino/Hispanic, 0.6% were Native Americans, and 1.3% were biracial.

Respondents first completed a behavioral measure of their actions during the week of May 13 to 19 which asked them how frequently they engaged in ten medically proscribed behaviors, such as gathering in groups, social distancing, and wearing face coverings. They then completed items from the Ethics Position Questionnaire (EPQ), which assesses individual differences in idealism and relativism (Forsyth, 1980). Respondents also judged the morality of individuals who performed various behaviors that were not in compliance with the health initiatives, such as “does not follow the public health guidelines (they do not maintain social distance, they socialize regularly, they do not wear a face covering).” The items all used a similar format, asking “How

would you judge the morality of a person who” followed by 5-point scale ranging from 1 (very negatively) to 5 (very positively). Their responses were averaged to yield an index of moral approval of noncompliance ($\alpha = .94$). Respondents also indicated their gender, race, age, political orientation, and education level and items pertaining to health and risk. (See the Supplemental Materials for a listing of all items and a table of correlation coefficients.)

Results

Preliminary analyses detected no multicollinearity concerns (Tolerance $M = .641$ and ranged from .402 to .904; VIF $M = 1.395$ and ranged from 1.106 to 2.487). The data also met the assumption of independent errors (Durbin-Watson value = 1.85). We examined the relationship between respondents’ gender, age, education, political orientation, idealism, relativism, and compliance with health mandates in a hierarchical regression analysis with bootstrapping, followed by mean comparisons in the case of categorical variables (e.g., gender, race). In Model 1 shown in Table 1, age, educational level, gender, and race were all associated, to a degree, with compliance. Younger individuals and those who had advanced further in their education reported acting in ways that increased their risk of contracting the coronavirus. Men reported more noncompliance than women ($M_s = 1.95$ & 1.73 , respectively) and a higher percentage of African-Americans (74.4%) were noncompliant compared to whites (37.4%) and people of color (23.7%); $N = 303$, $\chi^2 = 46.03$, $df = 4$, $p < .001$. Politics were significantly associated with noncompliance ($r = -0.26$); more conservatives were noncompliant (60.8%) compared to liberals (36.9%).

Table 1. Regression models predicting noncompliance from political orientation, gender, age, educational level, race, and ethical beliefs (idealism and relativism).

Model 1	Model 2
$R^2 = 0.29$	$R^2 = 0.48$

Variables	<i>b</i> (<i>SE</i>)	<i>p</i>	CI	<i>b</i> (<i>SE</i>)	<i>p</i>	CI
Politics	-0.18 (0.024)	< 0.001	[-0.16, -0.06]	-0.09 (0.021)	< 0.001	[-0.13, -0.05]
Gender	-0.23 (0.010)	< 0.028	[-0.42, -0.03]	-0.10 (0.089)	= 0.247	[-0.28, 0.07]
Age	-0.10 (0.005)	< 0.043	[-0.02, -0.00]	-0.00 (0.004)	= 0.466	[-0.01, 0.01]
Education	0.09 (0.043)	< 0.033	[0.01, 0.18]	0.46 (0.038)	= 0.236	[-0.03, 0.12]
Race1	-0.81 (0.119)	< 0.001	[-1.05, -0.58]	-0.59 (0.105)	< 0.001	[-0.78, -0.38]
Race2	-1.14 (0.169)	< 0.001	[-1.47, -0.81]	-0.93 (0.147)	< 0.001	[-1.22, -0.64]
Idealism	-	-	-	-0.17 (0.078)	= 0.137	[-0.27, 0.04]
Relativism	-	-	-	0.48 (0.047)	< 0.001	[0.39, 0.57]

Note: *b* = unstandardized regression coefficient; SE = standard error; CI = 95% confidence interval

Idealism, Relativism, and Noncompliance

Model 2 in Table 1 included idealism and relativism and controlled for all other predictors. This analysis yielded support for only Hypothesis 1b, for the level of relativism in a person's moral beliefs accounted for approximately one third of the variance in their compliance with health directives ($r = + 0.57, p < .001$), a relatively large effect (Gignac & Szodorai, 2016). Contrary to Hypothesis 1a, idealism was not significantly associated with noncompliance ($r = -0.09, p = .12$ two-tailed, $p = .06$ one-tailed). Also, to test Hypothesis 1c, after centering all variables, we conducted a moderated multiple regression analyses of compliance, with idealism, relativism, and their interaction as predictors. These analyses yielded no significant effects.

Moral Judgment and Noncompliance

To test Hypothesis 2—that individuals' moral judgments of noncompliance would mediate the relationship between idealism and relativism and noncompliance—we conducted a path analysis, using maximum likelihood estimation, testing the model shown in Figure 1. Before entering moral judgments as a mediator in the model, the paths from relativism and idealism to noncompliance were significant (β s = 0.57 & -0.10, p s < .001 & .05, respectively), indicating that increases in relativism and decreases in idealism were associated with increased noncompliance. Moral judgments, however, fully mediated the relatively weak relationship

between idealism and noncompliance, for the idealism-noncompliance relationship was not significant in the mediational model. Moral judgments also partially mediated the relationship between relativism and noncompliance. The paths from relativism to moral judgments and from moral judgments to noncompliance were significant ($ps < .001$), as was the direct path from relativism to noncompliance ($p < .001$). Gender, age, educational level, race, and political orientation are not shown in Figure 1, but were included as control variables in the model. The direct path coefficient between political orientation and noncompliance was not significant ($\beta = 0.03$), but the political orientation to moral judgment path was ($\beta = 0.30, p < .001$).

Figure 1. Standardized regression estimates of the relationships between idealism and relativism with noncompliance, with and without (in parentheses) mediation by moral judgments. All paths are significant ($p < .05$), except for the idealism-noncompliance and idealism/relativism relationships.

Discussion

First on the list of McGuire's (1997) compendium of hypothesis-generating heuristics is “responding to the provocative oddity of exceptional occurrence” (p. 3). And even though oddity is often in the eye of the beholder, the reaction of a substantial portion of the population to

medical interventions designed to reduce the spread of a disease, if not odd, certainly seems exceptional.

The findings reported here provide a partial explanation for this “provocative oddity”: Individuals’ moral judgments of noncompliance predicted who did and who did not engage in proscribed, health-compromising behavior. Those who morally condemned people who did not comply with health mandates (joining social gatherings, not wearing face coverings, and so on) were themselves more compliant; those who judged the noncompliant more positively were not. They considered noncompliance to be as ethically acceptable as compliance. Moreover, moral relativism predicted both moral leniency and noncompliance, although moral idealism did not. People who express a heightened concern for protecting others from harm did not judge noncompliance favorably, and they were slightly more compliant, but the effect was not a strong one—particularly in comparison to relativism’s effects; the gap between noncompliance and harm may have been too great to set off the idealist’s moral alarms.

These conclusions should be accepted with caution. We controlled for a number of variables that might be associated with both moral beliefs and compliance, but endogeneity threats cannot be eliminated (Hill, Johnson, Greco, O’Boyle, & Walter, 2020). We studied the responses of people who volunteered, for a small remuneration, and by no means was our sample a representative one. We used very different items to measure compliance behaviors, relativism and idealism, and moral judgments, but nonetheless common-method variance may account for some portion of the judgments-relativism-noncompliance relationships.

These limitations aside, the findings confirm a configuration that has often proven elusive: a close connection between moral personality, moral reasoning (judgment), and morally evaluable actions. Two rival explanations can account for the robust relationship between moral

judgments and moral action. Individuals who considered noncompliance to be morally acceptable may have subsequently engaged in risky behaviors, but then again: after engaging in risky behaviors, individuals may have rationalized their actions as morally acceptable. Nonetheless, in identifying a personality characteristic that determines the strength of this judgment-behavior relation (relativism), this research meets a goal set by Blasi (1980) by identifying “the processes that fill the space between a concrete moral judgment and its corresponding action” (p. 42). The results may also prove useful in developing more successful health-promoting interventions. These interventions, such as the Centers for Disease Control (CDC) anti-COVID-19 advisories, provide logical arguments for compliance, underscore civic duty, and explain that precautions protect others from harm. The current findings suggest that such messages could be strengthened by framing prevention in moral terms: taking precautions is not just the healthy choice, but the morally commendable choice. That messaging, however, should be framed in such a way as to appeal to both high and low relativists. Whereas nonrelativists may be motivated by a message that stresses moral duty, those who are relativists will likely be influenced by messages that indicate compliance is not an indicator of the abrogation of the right of each individual to make their own moral choices.

Acknowledgements

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