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Attitudinal Changes in Experiential Learning via Poverty Simulation

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ATTITUDINAL CHANGES IN EXPERIENTIAL LEARNING VIA POVERTY SIMULATION

By

Madison Bandler

A thesis submitted to the faculty of the University of Mississippi in partial fulfillment of the requirements of the Sally McDonnell Barksdale Honors College.

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ABSTRACT

Attitudinal Changes in Experiential Learning via Poverty Simulation
(Under the direction of Deborah Mower)

More than 10% of people living in the United States are impoverished. These human beings are subjected to poor living conditions, experience increased mental and emotional stress, lack basic necessities, and are more susceptible to many health conditions. Lack of poverty awareness and understanding has contributed to the spread of misconceptions, the majority of which are damaging to the impoverished community. These misconceptions affect how impoverished individuals are viewed by health care professionals and influence the quality of medical treatment they receive. The Community Action Poverty Simulation (CAPS) is an experiential learning tool that requires participants role-play a low-income individual and attempt to survive a month (four 15-minute periods) in poverty. CAPS was held on both March 30, 2017 and February 25, 2018 at the University of Mississippi in partnership with Student Housing and the McLean Institute for Community Action. This project served to measure whether beliefs and attitudes about poverty may be influenced by participation in CAPS. Results show that CAPS is a successful pedagogical tool, and based on its ability to increase understanding of poverty, this project suggests that other experiential learning processes be integrated into curricula for health profession students. By requiring health professionals to engage in CAPS, it is expected that they will be better equipped to provide quality and access care to their low-income patients.
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CHAPTER 1

INTRODUCTION

The United States of America was founded as a land of opportunity where every man, woman, and child maintains the ability to succeed on the basis of hard work and skill. This meritocratic ideology has fueled the creation of the American dream, which draws immigrants from around the world with hopes of forging profitable lives. As the country has progressed, however, income inequalities have contributed to greater opportunity for the upper classes and lesser opportunity for the lower classes. Recent data on wealth inequality shows 38.6 percent of all wealth in America belonging to only 1 percent of the population.¹ With so much of the country’s wealth concentrated in such a small portion of the population, the American dream is no longer within reach for everyone, and many must struggle to survive day-to-day. In 2016 the official poverty rate in the U.S. was 12.7 percent, or 40.6 million people.² These 40.6 million individuals living in poverty experience both physical and psychological hardships as a result of their economic standing, which contributes to significant health problems associated with early mortality, low cognitive development, and

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poor emotional well being. As prevalent as poverty is, many Americans are ignorant to the realities of life for the impoverished. Stereotypes and media have fueled the public’s misconceptions about poverty including living conditions, characteristics, and lifestyles of the impoverished. It is necessary to educate the public about the realities of poverty in order to foster an environment in which we are better prepared to fight in the War on Poverty. The key to implementing a policy that meets the needs of the impoverished lies in understanding the daily tribulations one experiences while living in poverty.

Recognizing the lack of comprehension of the conditions and implications of poverty, I intend for this research project to increase consciousness of the afflictions of poverty and to analyze the effectiveness of the Community Action Poverty Simulation (CAPS) as a pedagogical tool. Poverty simulations are designed to offer policy makers, community leaders, professionals, students and organizations the ability to experience some of the hardships that impoverished individuals face on a daily basis. CAPS includes resources (e.g. transportation passes, food stamps, cash, etc.), assigned roles and tasks for each participant (e.g. occupation requirements, paying bills, seeking medical care) and detailed instructions for facilitators. The simulation is split into four 15-minute periods, each of which represents one week living in poverty.

Based on similar studies analyzing the effectiveness of poverty simulations in changing participants’ perceptions of poverty, it is expected that participants will reduce their biases against the impoverished, acquire greater

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knowledge about the frequent challenges for low-income families, and display heightened empathy toward low-income individuals. In order to measure how participants’ perceptions of poverty change after the simulation, participants were asked to respond to a survey both before and after engaging in the simulation. The surveys consisted of 26 Likert Scale questions involving perceptions of poor people, six Likert Scale questions involving desired social distance from impoverished individuals, attribution questionnaire vignettes that propose 4 different scenarios involving a low-income woman and her children, six questions about participants’ familiarity with poverty, a rank order question that requires prioritizing goods and resources, and open-ended questions asking participants to describe certain aspects of the simulation.

Motivation

As a student at the University of Mississippi I have seen firsthand the prevalence of poverty in one of the poorest states in the country. In areas like the Mississippi Delta, individuals have little to no access to public transportation. This is problematic when one considers the severe lack of health care facilities or even supermarkets in the region. Residents of the Delta and other rural areas in Mississippi must travel long distances to acquire affordable produce or to receive medical treatment. These tasks are daunting without easily accessible

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transportation. I am pursuing a career in medicine, and it is my goal to require
greater experiential learning opportunities for pre-health students so that they
become better informed about the causes and conditions of poverty when providing
quality and accessible care to their patients. The Hippocratic Oath taken by
physicians contains many ‘special obligations,’ which include reducing health care
disparities.\(^5\) In order for physicians to meet this obligation, they must first have an
understanding of the health care disparities that exist. Having shadowed physicians
in several hospitals, I have witnessed many uninsured patients come into the
emergency room with late stage symptoms that could have been easily treated had
they sought medical treatment sooner. Often times low-income individuals
postpone medical treatment because they are unable to pay or do not have access to
regular health screenings. I have been privileged to meet physicians who go above
and beyond for their patients, providing them with community resources and
making sure they feel valued. I have also met physicians who are disrespectful to
low-income patients, or who behave unethically in their practice. Because of my
experiences as a pre-medical student, I was motivated to bring the CAPS to my
fellow students at the University of Mississippi in hopes of generating more
professionals from all fields who are considerate and open-minded of others
regardless of their socioeconomic standing.

I was fortunate to be selected as a fellow for the Frate Fellowship in Bioethics
and Medical Humanities at the University of Mississippi Medical Center in Jackson,

\(^5\) Eric Holmboe and Elizabeth Bernabeo. “The ‘special obligations’ of the modern
Mississippi during summer of 2016. During this fellowship I was able to experience CAPS for the first time myself, and was profoundly impacted. Before this experience I was guilty of feeding into many of the stereotypes surrounding low-income individuals. It is easy to assume that every poor person is lazy or deserving of his or her circumstances, but the reality is that many poor people work tirelessly to escape the lifestyle that they were afforded by the lottery of birth. It is my goal to offer the simulation as a metamorphic experience for my peers in hopes of spurring change in the way my generation addresses the fight against poverty.

I am utilizing the simulation as a means to measure attitudinal changes resulting from an experiential learning experience. If the simulation is successful in causing meaningful changes in participants’ perceptions of poverty, then it is my suggestion that the poverty simulation become a part of the curriculum for students entering a medical profession.

**Study Format**

In order to analyze its effectiveness at informing participants about the realities of poverty and reducing bias toward impoverished persons, I intend for this research project to measure the amount of attitudinal change that occurs before and after participating in CAPS. The poverty simulation was held on two different occasions roughly a year apart at the University of Mississippi. Participants were both graduate and undergraduate students from all disciplines. Signs, extra credit opportunities, course requirements, and word of mouth were used to recruit them. Participants were invited to sign up online for the simulation a week in advance, and
they were immediately sent a link to the pre-simulation survey. This survey asked a series of questions about perceptions of poverty, social distance from poverty, attribution questionnaire vignettes, and basic demographic information. These responses are used to create a standard of comparison to which the post-simulation responses may be related. After completing the simulation, a discussion of poverty and community service opportunities was facilitated before participants were asked to fill out the post-simulation survey. The post survey contained the same perception and social distance questions as the pre-experience survey, but additionally contained questions about the participant's familiarity with poverty and several open-ended questions.

**Study Goals**

The purpose of this project is to examine whether beliefs and attitudes about poverty can be influenced through participation in CAPS. Particular focus will be given to the health care system in the United States and its ability to meet the needs of the impoverished, as well as individual health care providers’ ethical obligations to be more informed about the conditions and causes of poverty in providing care to their patients. I hypothesize that participants will experience significant changes in attitude toward low-income individuals indicative of a better understanding of the implications of poverty after participating in CAPS. The null hypothesis suggests that there will be no significant attitudinal change that occurs after participating in CAPS. To begin I will provide a brief history of poverty, including the common conditions. I will address the popular perceptions of poverty and the ramifications.
Then I will disclose the advantages of using poverty simulations as teaching tools to improve understanding and empathy. Next, I will provide a detailed study design, research format, and the results from the study. I will additionally be presenting a normative argument for the necessity of health care professionals to engage in more experiential learning processes, such as CAPS, to increase their awareness of poverty and improve their ability to treat impoverished patients.
CHAPTER 2
LITERATURE REVIEW

Introduction

To better frame the necessity of poverty simulations, it is helpful to have a strong literary foundation of knowledge on the history of poverty, living conditions associated with poverty, perceptions of the impoverished, and the consequences that result. This section will provide a review of the literature associated with these topics, as well as information on the effectiveness of role-playing simulations such as the Community Action Poverty Simulation used in this study.

Poverty in Modern American History

As long as humans have existed we have been plagued by poverty. Is poverty an enduring element to society, or is there a perfect solution out there just waiting to be uncovered? Judging by the last sixty years, there has been no shortage of attempts to end poverty, but each attempt has had short lived or minimal effects. When President Lyndon Johnson announced his War on Poverty in 1964 there was great promise of restoring economic equality in the United States, with the poverty rate decreasing by eight percent in nine short years.\(^6\) The Official Poverty Measure

(OPM) calculated poverty to be at 14.2 percent in 1967 and 15 percent in 2012. This is evidence showing greater need of a more permanent solution that can withstand time and economic recessions. President Ronald Reagan said it best himself: "We fought a war on poverty and poverty won." This is not to say that the government has made no progress in alleviating poverty, and there have been a handful of social programs that at least function to prevent even more Americans from slipping below the poverty line. Programs such as Social Security, Temporary Assistance for Needy Families, the Earned Income Tax Credit, and many others are working to keep an additional 40 million people from falling into poverty. The fight against poverty is an entirely uphill battle, and for every two steps forward we later fall just as many steps back.

Why have we not maintained the momentum started by Lyndon Johnson? There is a prevalence of low-wage jobs, and according to the Wage Statistics for 2016 released by the Social Security Administration, half of wage earners in America had net compensation less than or equal to $30,533.31 for the entire year of 2016. Job creation has been stressed as a priority of policy makers, but the creation of more low-wage jobs does not help those who are already working full time and still cannot afford even the necessities. Considering the rise of single-parent households and the decrease in cash assistance for low-income mothers and children, it is

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9 Ibid.
increasingly difficult to get people out of poverty. The needs of the American people have become more complicated since the War on Poverty began in the 1960s, and we desperately need new policies that reflect the needs of today’s people. The family structure has shifted to see more single mothers in the work force, but access to quality, affordable childcare is still poor, and the gender pay gap puts single mothers at an even larger disadvantage.

Adequate housing, quality education, safe and healthy communities, medical treatment, and affordable food are all identified as basic and universal needs by the Basic Needs Approach. These needs have always and will always exist, but there are a growing number of needs that are not being met by current government policy. As Peter Edelman said, “So much of our national discussion about poverty turns immediately into a discussion about welfare [...] Yet, tackling poverty is composed of a far larger and more complex set of actions and policies.” The policies that worked in the past are not guaranteed to work in the present, which is why there is such need for updated policies that take into consideration the current climate.

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14 Ibid.
Conditions of Poverty

In 2017, the federal poverty threshold for a family of four people was $25,283. Unsurprisingly, living options are very limited for individuals who have only $17 to spend per person per day. The implications of living in either rural communities or inner-city low-income neighborhoods are severe, adversely affecting economic well-being, physical and mental health, personal safety and security, as well as behavioral and educational outcomes. Additionally, the federal poverty threshold does not account for inflated living expenses in areas like New York City and California. In low-income neighborhoods where unemployment is high and supplies are limited, neighbors are often forced to compete for scarce resources like job opportunities, childcare facilities, support centers, etc. Michael Holosko and Marvin Feit strongly agree that “the litany of social, psychological, emotional, behavioral, health and financial repercussions related to place [are] overwhelming.”

Low-income neighborhoods consist of a disproportionately high number of ethnic minorities, which is explained by John Kain’s spatial mismatch theory, stating that “the suburbanization of jobs and serious limitations on black residential choice have acted together to create a surplus of workers in relationship to the number of

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17 Ibid. 3.
18 Ibid. 11.
available jobs in inner-city neighborhoods where blacks are often concentrated.”

These instances of residential segregation by race have contributed to the current racial and class segregation in education, transportation systems, access to public services and political representation. Transportation is a massive hurdle for many low-income and minority individuals, who are unable to travel more than short distances to do anything from job hunting to grocery shopping or going to the doctor. Studies have shown that low-income, minority, and transportation constrained communities are more at risk for being impacted by the environmental and systematic burdens of transportation development. For homes with disabled persons, seniors, or no vehicles, there is a great demand for transportation justice, which is the expansion of mobility, access, and modal opportunity by carefully planning, designing and constructing transportation systems.

Limited transportation is more than just an inconvenience for low-income persons. Access to quality food is among the most basic of human necessities, but even that is exceedingly difficult to acquire in many low-income neighborhoods situated in food deserts. The U.S. Department of Agriculture defines food deserts as “parts of the country vapid of fresh fruit, vegetables and other healthful whole foods,

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20 Chow, Johnson, and Austin. 6.
usually found in impoverished areas." A study in the *American Journal of Public Health* found that there is an association between food desert status and obesity status even after controlling for home food environment factors. This has huge implications for public health, because there is a correlation between obesity and many chronic diseases ranging from diabetes to heart disease.

One of the biggest concerns surrounding poverty and a primary focus of this research involves the predisposition of low-income persons to health conditions and the demand for wider reaching health insurance coverage. Children living in poverty are more likely to encounter infant or childhood mortality, learning disabilities, adolescent pregnancy, delinquency, and mental health problems. Those with low socioeconomic status experience greater likelihood of requiring medical care than their higher income counterparts, and yet they have less health insurance coverage. A study published in the *Annals of Human Biology* found that social disadvantage during childhood contributes to adult cardiometabolic disease by predisposing children to adopt unhealthy behaviors such as unhealthy eating, smoking, and excessive alcohol consumption. Because people with lower household income have lower overall health insurance coverage rates than people

with higher income, treatment of these chronic diseases is difficult to manage. In 2016, Americans living below the poverty line had the lowest insurance coverage rate at 83.7 percent, which is inadequate compared to the 95.6 percent of people living at or above 400 percent of poverty with coverage. It follows that those with lower household income also had less private insurance coverage in 2016 than people with higher income.

A major goal of the Affordable Care Act was to expand Medicaid eligibility in hopes of making health insurance accessible to more low-income adults. Having access to health insurance is crucial, but unfortunately it is only the first of many hurdles that low-income persons must overcome in the acquisition of decent health care. The stigma that is associated with public health insurance coverage has effects in both the nature and the content of health care, resulting in additional disparities between the medical treatment of low and high-income individuals. Studies exhibit evidence that health care stigma contributes to underutilized care, infrequent routine check-ups, delaying care, foregoing needed tests, illness progression, and lower quality of life for patients. As a result of this stigma,

29 Ibid, 12.
30 Ibid, 11.
32 Ibid. 162.
patients with public insurance reveal feeling ignored, disrespected, rushed, have problems scheduling future appointments, and are subjected to long wait times.\textsuperscript{34} Feelings of mistreatment are likely to make these patients less likely to seek medical services, even when essential. Medical providers may unknowingly cave in to their implicit biases, allowing misperceptions about the impoverished influence their treatment of such patients. Because health care workers operate under strict time limits, the complex social issues that arise in low-income patients may be deemed as disruptive to the provider’s schedule, leading them to view the patient as troublesome or non-compliant.\textsuperscript{35} Even for those with health insurance there are a slew of factors preventing them from receiving quality medical care, but for those without any insurance coverage at all the difficulties are exponentially greater.

For the many low-income Americans plagued with chronic health conditions, affording regular prescription medications is immensely difficult. Patients with conditions such as high blood pressure, diabetes and high cholesterol lacking either health insurance or prescription medication coverage are less likely to adhere to a medication regimen, and are more likely to visit emergency departments, resulting in non-emergency admission to the hospital, greatly increasing cost.\textsuperscript{36} In 2001 roughly half of all U.S. bankruptcies were caused by medical bills.\textsuperscript{37}

\begin{footnotes}
\footnote{Anna Martinez Hume et al, 163.}
\footnote{Ibid, 164.}
\footnote{Michael J. Holosko and Marvin D. Feit,129.}
\end{footnotes}
access to prescription medications contributes to pain, worsening of the condition as well as higher risk of additional health problems.  

Perceptions of Poverty

When asked to envision what poverty looks like, the focus often immediately goes to something negative. Poor people are frequently reduced to stereotypes, which paint them as lazy and unemployed. Data from the U.S. Bureau of Labor Statistics shows that 9.5 million Americans with incomes below the poverty level worked 27 weeks or more in 2014. Research like this refutes many of the popular assumptions about poverty, but misconceptions and stereotypes still persist.

During the War on Poverty there was a great deal of enthusiasm and hope that the government could make a difference decreasing rates of poverty, but as poverty rates stopped decreasing in the ‘70s the media began portraying the impoverished in a negative light and that enthusiasm for change dwindled. In 1984 sociologist Charles Murray made an argument that contended, “generous government payments and liberal permissiveness in the ‘60s and ‘70s allowed people to choose to be poor enough to live off the state or indulge in a life of crime rather than hard work.” This line of thought is still very prevalent today, and many people believe that the reason poverty rates do not decline is because lower class

individuals oppose work and family stability.\textsuperscript{42} In 1977 \textit{Time Magazine} published a cover story on “The American Underclass,” and referred to them as “more socially alien and more hostile than anyone imagined.”\textsuperscript{43} It goes on to say that, “the underclass minority produces a highly disproportionate number of the nations’ juvenile delinquents, school dropouts and welfare mothers, and much of the adult crime, family disruption, urban decay, and demand for social expenditures.”\textsuperscript{44} This media portrayal of the impoverished drew massive public attention and created polarization between social classes.

During the Johnson administration poor people were viewed as innocent victims excluded from the economic system, and the government was eager to aid in the War on Poverty.\textsuperscript{45} The response to poverty changed dramatically with the Reagan administration, which fed into the media portrayals of poor people cheating the system. President Reagan felt strongly that low income Americans were taking advantage of the food stamp program, telling a story of a “strapping young buck” using food stamps to buy a T-bone steak.\textsuperscript{46} Reagan also spoke during his 1976 campaign of a 47 year old “welfare queen” who had “80 names, 30 addresses, 12 social security cards and [was] collecting veterans benefits on four nonexisting (sic) deceased husbands.”\textsuperscript{47} Reagan’s strong opinions helped to catalyze the transition of the public’s opinion about poor people. In a little over a decade poor people went

\textsuperscript{42} Ibid.
\textsuperscript{44} Ibid.
\textsuperscript{45} Rose and Baumgartner. 2013. 22.
\textsuperscript{46} Ibid.
from being pitied by the public to being blamed for their situation and looked down on. Government policy shifted focus, and the generosity of spending on programs for the poor waned.

During his 1992 campaign for presidency, Bill Clinton stressed the importance of ending current welfare programs, stating in his televised advertisement that it should be “a second chance, not a way of life”\(^\text{48}\) Statements like this perpetuate the idea that there is a culture of poverty in which people are totally dependent on government assistance and do not value work. It was during this time period that public support for welfare programs temporarily declined off, and opinions of welfare spending became more negative.\(^\text{49}\) This is a classic example of victim blaming, where poor people are attributed with being in their current financial situation due to an unwillingness to improve their situation.

Television has continued to be a key factor in influencing public perceptions of the poor. When comedian Norm McDonald was interviewed on *The Tonight Show With Jay Leno* in 1999, he made jokes about buying a homeless man dinner instead of giving him money to spend on crack cocaine. He went on to point out the man’s body odor and mental illness, and was met with laughter from the audience.\(^\text{50}\) Even on television news, poor people are framed as deviants or ignored altogether. The poor are represented most frequently in daytime talk shows or reality based crime shows, both of which display poor and working class individuals in a crooked and

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\(^{50}\) *The Tonight Show With Jay Leno*. (Dec. 20 1999).
unfavorable way. Television news broadcasts infrequently make direct references to poverty, and this lack of contextualization of social issues has a damaging effect on belief systems.

When poor people are presented by television news media, they are often framed in a particular way. Richard Entman defines framing as “selecting and highlighting some elements of reality and suppressing others, in a way that constructs a story about a social problem, its causes, its moral nature and possible remedies.” The two categories Entman identified that news television use to describe poverty are stories that depicted poverty as behaviors that threaten community well-being and stories that focused on the suffering of the poor. The framing of poor people either as deviants or as suffering causes the public to view poor people as nothing but a problem. Even when the news shows stories of poor people suffering, viewers often grow resentful if suggested solutions involve raising taxes or public spending to aid in the fight on poverty.

Many of the misperceptions that exist today are due to the media portrayal of poor people, social influences, and personal experiences or familiarity with poverty. Common research involving public opinions of poverty covers two main areas. The first is perceived causes of poverty and the personal and environmental characteristics of those who are poor, and the second involves the personal

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52 Ibid. 233.
54 Ibid.
55 Heather R. Bullock et. al, 233.
characteristics of interviewees.\textsuperscript{56} According to the National Public Radio (NPR), Kaiser Family Foundation (KFF), and Harvard University Kennedy School of Government (HUKSG) “Poverty in America, 2001” poll, two-thirds of Americans view the poor as having moral values equivalent to their non-poor counterparts.\textsuperscript{57} This data shows that we are headed in the right direction as far as the public’s perceptions of the impoverished are concerned, but still 48% of Americans believe that the “major cause” of poverty is people not doing enough and 70% cited drug abuse as a specific cause of poverty.\textsuperscript{58} When asked to prioritize the United States’ obligations, only 6% indicate “poverty/more help for the poor/homeless” as one of the primary two concerns of the country.\textsuperscript{59} Government funding reflects these popular opinions, which is why it is so important to educate the public about poverty.

\textbf{Poverty Simulations}

Poverty simulations are useful as pedagogical tools that enable participants to craft their own personal narrative centered around direct experiences with poverty. Simulating poverty is an accessible way to educate the public and help develop skills for civic participation.\textsuperscript{60} The overall goal of poverty simulations is to

\textsuperscript{57} National Public Radio, Kaiser Family Foundation, and Harvard University Kennedy School of Government (2001).
\textsuperscript{58} Ibid.
\textsuperscript{59} Ibid.
increase participants’ understanding of poverty and to foster social empathy.\textsuperscript{61} By informing the public about the realities of poverty, America is better equipped to create policies that effectively address social inequalities.

The simulation used in this study, The Missouri Community Action Poverty Simulation (CAPS), may be purchased online and includes a director’s manual, resource packets, and family packets that are all reusable. CAPS is “an interactive immersion experience,” that “sensitizes community participants to the realities of poverty.”\textsuperscript{62} The simulation demands 4-6 hours of time in total, including volunteer training, setup, registration, orientation, the simulation itself, facilitated conversation, and clean up. In order to host the simulation, one needs a large, open room, 15-20 volunteers, and up to 80 participants.\textsuperscript{63} The goals for participants are to keep their family and home secure, feed their family, keep their utilities on, make all necessary loan payments, pay for miscellaneous expenses, and meet unexpected situations. The volunteers provide necessary community resources, consisting of a grocery store, employment office, school, childcare facility, health care office, Social Security office, interfaith services, police, pawnshop, and others. The simulation itself lasts about an hour and a half, and is divided into four 15-minute periods that each represent one week of the month. There are also 5-minute periods between each week to represent the weekend.\textsuperscript{64} Before the simulation begins, a facilitator


\textsuperscript{63} Ibid.

\textsuperscript{64} Ibid.
gives a brief orientation to provide participants with the basic instructions and aims of CAPS. After the simulation is complete, a debriefing is held in order to engage students and promote community engagement.

The poverty simulation provides a unique opportunity for a learner-centered approach to learning as opposed to a teacher-centered approach to learning.65 Learning by way of experience rather than classroom lecture has been found to be beneficial for long-term student success. Experiential education has been defined as follows: it promotes learning through direct experience, often outside the classroom, at times not directly related to academic courses, frequently not graded, and sometimes not mediated through language or academic discourse and practice.66 The concept of experiential education dates back to Confucius in 450 BC: “Tell me and I will forget. Show me, and I may remember. Involve me, and I will understand.”67 Experiential education emphasizes the development of “real world skills” by way of hands-on and applied learning, which prepares students for the challenges they will encounter in the professional world.68 According to David Kolb, “experience leads to reflection, then to conceptualizing, and then to action.”69

CAPS is a form of role-playing simulation that displays aspects of the real world in a precise and straightforward manner. Role-play simulations such as CAPS

69 McKenzie Malcolm, 27.
are effective at increasing awareness of human and environmental issues, and their main advantage is that they focus on the cognitive, behavioral and emotional domains and have the capacity to challenge attitudes and presuppositions. There are several possible disadvantages of simulations including the length of time, poor role assignments, or the over-dramatization of the experience by participants. If students get bored, don’t feel a connection with the role they are playing, or don’t take the experience seriously, then it is possible they will form a negative perception of role playing and lose the point of the experience. Other barriers to learning would be small room size, which contributes to noise and discomfort and detracts from the learning experience.

Previous studies using poverty simulations indicate that the vast majority of students participating in the experience were motivated to think deeper about poverty and its effects, while only a slight majority indicated that they were planning to participate in social action. The goal of this experience is to introduce critical thinking about poverty in an attempt to dismantle many of the prevailing misconceptions about poor people. Transformational learning, according to Merriam and Caffarella, begins when a disorienting dilemma occurs that causes a

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72 Ibid, 154.
A person to confront their assumptions about the way things are. Participants often become frustrated or exasperated by the tasks they must complete in the simulation, and this emotional response opens the door for further thinking on the subject. Poverty is an incredibly complex issue, but by introducing the concept to students through hands on experience, it is intended that they will begin to reevaluate their ideas about poverty.

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CHAPTER 3
RESEARCH DESIGN

Rationale

In order to examine whether beliefs and attitudes can be influenced through participation in the Community Action Poverty Simulation (CAPS), surveys were used to measure students’ responses to a series of questions related to poverty both before and after engaging in CAPS. The mixed methods approach was used to quantitatively measure participants’ perceptions of poverty and also to enable them to openly discuss their personal experiences in the simulation. The overarching goal of this research project was to determine whether CAPS is a useful pedagogical tool for increasing awareness of the causes and conditions of poverty. CAPS was purchased by the McLean Institute for Public Service and Community Engagement to be used by organizations at the University of Mississippi. This project fulfilled its goal of analyzing CAPS as a teaching mechanism and also explored students’ familiarity with poverty and desired social distance from poverty. Many of the questions addressed specific issues of health care for poor people including the distribution of medical resources on the basis of income, stigmatization of poor patients by medical providers, and quality of care depending on insurance level.
**Expected Outcomes**

Based on similar studies analyzing poverty simulations, it is anticipated that the results from this study will lend additional evidence of the effectiveness of CAPS at raising awareness of poverty and encouraging community service. By taking on the role of an impoverished individual, participants are likely to develop a greater understanding of the complex circumstances that influence daily living for impoverished people. It is expected that there will be significant change between the means of the responses for the majority of the questions between the pre and post-surveys, indicating increased social empathy. Whether the mean increased or decreased from pre- to post- experience survey depended on the nature of question. Questions which frame poor people as being equal to everyone else or deserving of medical treatment are expected to have an increase in means from pre- to post-surveys, corresponding to a negative change in means. This applies to all questions in the category Personal Qualities of the Impoverished (Q 8, 9, 10, 11, 12, 15, 16, 17, 18) and also 13, 19, and 22. It is expected that an increase in means from pre- to post-surveys indicate a greater understanding of the impoverished due to the nature of the questions. For all other questions a decrease in mean is expected to show that participants achieved a higher level of understanding in regard to causes and conditions of poverty. For the social distance questions it is anticipated that a negative difference in means will be achieved if students gain a greater understanding of poverty.
The attribution questionnaire vignettes are designed to measure students’ perceptions of poor people who have varying levels of control over their situation and varying levels of severity of harm. In all four scenarios, the subject, Karen, is presented as a single mother living in poverty dealing with depression. In situation one she is unemployed, but still satisfies the needs of her children and lives a fairly productive life. In scenario 2 Karen’s depression impairs her ability to take care of her children. In scenarios 3 and 4 Karen abuses the welfare system and neglects her children, but in scenario 3 her depression was caused by the death of her husband and job loss during a recession whereas in scenario 4 her depression was caused by the loss of her job as a result of drinking too much. When comparing the mean responses for each question across the four scenarios it is expected that questions in the categories of personal responsibility, anger, fear, and coercion-segregation will follow an increasing trend from scenario 1 to 4. For the remaining categories of pity and helping a decreasing trend is expected from scenario 1 to 4.

Because many of the participants will likely be residents of the state of Mississippi, which has infamously poor public transit systems, I anticipate that most participants will classify the public transportation in the hometown to be poor in the open-ended questions. I also expect that the majority of participants will not have gone to a medical care provider during the simulation, and for those that did, lack of insurance and financial burden will likely impact their experience. I base these expectations on my own personal experiences participating in and planning CAPS.
Survey Participants

CAPS was hosted on two separate occasions roughly a year apart. On March 30, 2017, the simulation was held in the basement of Residential Housing building 2. I facilitated the event along with the director of housing for Residential Housing buildings 1 and 2 and the number of participants was 24. CAPS was hosted again on February 25, 2018 at the Jackson Avenue Center Ballroom. I facilitated the event in partnership again with the director of housing for Residential Housing buildings 1 and 2 and the total number of participants was 31. While there was representation from many races and schools, the majority of participants were white, college aged students belonging to the Liberal Arts College. Results were combined from both events and the total number of responses was 55.

Survey Design

This study employed the mixed methods approach to analyze performance of the Community Action Poverty Simulation at the University of Mississippi as a pedagogical tool for educating participants about the existence of poverty in the United States of America. As mentioned previously, the simulation was held on two occasions, March 30, 2017 and February 25, 2018. Participants signed up for the simulation via a Google document, and were emailed a link to the pre-experience survey. A physical copy of the post experience survey was handed out to participants after completion of CAPS. Both the pre- and post-simulation surveys contained a section of 26 questions created to evaluate participants’ opinions on the conditions of poverty, qualities of the impoverished, and the health care experience
for impoverished. The questions used on the survey were categorized according to
groups: Perceptions of Poverty and the Impoverished, Personal Qualities of the
Impoverished, and Medical Treatment of the Impoverished. Table 3.1 provides a
breakdown of the questions in their respective categories as well as descriptions of
the categories.

As a means of measuring CAPS’ ability to affect participant’s ideas of poverty,
these 26 questions were included in both the pre- and post- experience survey.
Participants read the questions and were asked to select their level of agreement,
ranging from strongly disagree to strongly agree on a 5 point Likert Scale. A list of
these statements may be found in Table 3.1.

The pre- and post-experience surveys were similar in their presentation of
these 26 Likert Scale questions involving general attitudes toward poverty, and the
6 Likert scale questions involving desired social distance from the impoverished but
after that they varied greatly. For the social distance questions participants read a
series of questions and were asked to indicate their willingness to engage in certain
situations with impoverished individuals with 1 being very unwilling and 4 being
definitely willing. A list of these questions is available in the Appendix as part of the
pre-experience survey. The pre-experience survey also included a series of
attribution questionnaire vignettes proposing four different scenarios in which a
low-income woman loses her job. The four scenarios each present this woman in
varying levels of severity in her condition. Participants were randomly assigned a
vignette and answered questions involving the level of personal responsibility the
woman has for her situation, the level of pity, anger, or fear they feel toward her,
likelihood of helping her, and desire to segregate her from society. A list of these different scenarios and the categorization of questions is available in Table 3.2. Lastly, the pre-experience survey contained several demographic questions asking for age, classification in school, race/ethnicity, college/school affiliation, and whether or not they are a first generation college student.

The post-experience survey differed from the pre-experience survey in several ways. The post-experience survey also included questions about desired social distance from the impoverished but did not include the attribution questionnaire vignettes. Instead, there was a section on familiarity with poverty in which participants read a series of statements about closeness to impoverished persons and indicated “yes,” “no,” or “I do not know.” Next, the post-experience survey asked participants to rank items and services ranging from food and water to receiving medical treatment from most important to least important. There were two open-ended questions in which participants described an experience that took place during the simulation, the quality of public transportation in their hometown, and whether or not they had a car. A code book was used to categorize responses to these questions, and can be found in Table 3.3. Lastly, participants were asked to mark which (if any) government assistance they had received and to indicate their family’s economic status. These questions may be found in the Appendix as part of the post-experience survey.
### Table 3.1. Categorization of Likert Scale

**Perceptions of Poverty and the Impoverished:** These questions measure the participant’s attitudes of the impoverished as well as their understanding of infrastructure in the United States.

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Most poor people are satisfied with their standard of living</td>
</tr>
<tr>
<td>2. Poor people are content with receiving welfare</td>
</tr>
<tr>
<td>3. There is a correlation between race and poverty</td>
</tr>
<tr>
<td>4. Poor people live as well as I do</td>
</tr>
<tr>
<td>5. Poor people are getting more than they need from the government</td>
</tr>
<tr>
<td>6. Everyone in the United States has access to water and electricity</td>
</tr>
<tr>
<td>7. Public transportation in the United States is sufficient</td>
</tr>
<tr>
<td>13. Poor people experience the same amount of misfortune in their lives as everyone else</td>
</tr>
<tr>
<td>14. Poor people misspend their money on non-essential items (for example: cigarettes, junk food, etc.)</td>
</tr>
</tbody>
</table>

**Personal Qualities of the Impoverished:** These questions evaluate the participant’s opinions about the characteristics of impoverished individuals.

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Poor people are as hygienic as everyone else</td>
</tr>
<tr>
<td>9. Poor people work about as hard as everyone else</td>
</tr>
<tr>
<td>10. Poor people are as intelligent as everyone else</td>
</tr>
<tr>
<td>11. Poor people are about as trustworthy as everyone else</td>
</tr>
<tr>
<td>12. Poor people are about as lazy as everyone else</td>
</tr>
<tr>
<td>15. Poor people have the same moral values as everyone else</td>
</tr>
<tr>
<td>16. Poor people have the same work ethic as everyone else</td>
</tr>
<tr>
<td>17. Poor people are just as likely to become sick as everyone else</td>
</tr>
<tr>
<td>18. Poor people make mostly healthy eating choices</td>
</tr>
</tbody>
</table>

**Medical Treatment of the Impoverished:** These questions specifically evaluate the participant’s beliefs and attitudes about the accessibility and quality of medical care for impoverished individuals.

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>19. Physicians have a responsibility to treat all patients even if they cannot pay</td>
</tr>
<tr>
<td>20. Physicians treat all patients equally without regarding their socioeconomic status</td>
</tr>
<tr>
<td>21. Everyone in America has access to affordable health insurance</td>
</tr>
<tr>
<td>22. Just as many non-poor people are on disability as poor people</td>
</tr>
<tr>
<td>23. The quality of hospitals in low-income areas is the same as hospitals in middle and upper income areas</td>
</tr>
<tr>
<td>24. Individuals with public health insurance receive the same level of medical care as individuals with private health insurance</td>
</tr>
</tbody>
</table>
25. Poor people take care of themselves about as well as non-poor people do

26. Medical services and resources are distributed without influence from socioeconomic status

**Table 3.2 Categorization of Attribution Questionnaire Vignettes**

<table>
<thead>
<tr>
<th>Condition #1 No Danger</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Karen is a 28 year old single mother of three young children who is living in poverty. Since losing her job two years ago, Karen has been relying on welfare to support her family. Karen battles with depression, which has prevented her from securing steady employment. Despite her inability to work, Karen still manages to care for her three children and provide suitable living conditions.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition #2 Danger</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Karen is a 28 year old single mother of three young children who is living in poverty. Since losing her job two years ago, Karen has been relying on welfare to support her family. Karen suffers from depression, which often causes her to experience exhaustion, insomnia, sadness, or trouble concentrating. Karen’s depression frequently impairs her ability to care for herself and her children.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition #3 Danger Without Controllability of Cause</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Karen is a 28 year old single mother of three young children who is living in poverty. Karen has been known to abuse the welfare system for years, even before she lost her job two years ago. Karen suffers from depression, which often prevents her from caring for her children. After leaving her children unfed for two days, a neighbor contacted social services. Upon investigating Karen, a social service agent learns that she has been filing exaggerated welfare claims. Karen’s depression was originally caused by the death of her husband and loss of her job during a recession.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition #4 Danger With Controllability of Cause</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Karen is a 28 year old single mother of three young children who is living in poverty. Karen has been known to abuse the welfare system for years, even before she lost her job two years ago. Karen suffers from depression, which often prevents her from caring for her children. After leaving her children unfed for two days, a neighbor contacted social services. Upon investigating Karen, a social service agent learns that she has been filing exaggerated welfare claims. Karen’s depression began when she lost her job as a consequence of drinking too much alcohol and frequently showing up to work intoxicated.</td>
<td></td>
</tr>
</tbody>
</table>

**Personal Responsibility**

1. How much of the blame for her family’s present situation should be placed on Karen? (1 = none at all; 5 = very much)
2. How responsible, do you think, is Karen for her present situation? (1 = not at all; 2 = very much responsibility)
3. What level of control, do you think, Karen has over the way her life has transpired? (1 = no control at all; 5 = complete control)

**Pity**

4. I would feel sympathetic toward Karen. (1 = not at all; 5 = very much)
5. Would you feel that Karen has experienced a great deal of misfortune? (1 = not at all; 5 = very much)

**Anger**

6. Would you feel anger toward Karen? (1 = not at all; 5 = very much)

**Fear**

7. How much of a danger do you feel that Karen is to herself, her children, and to society? (1 = none at all; 5 = very much a danger)
8. I would feel nervous to spend time around Karen. (1 = not at all; 5 = very much)

**Helping**

9. If I were an employer I would consider Karen as a candidate for a job with my company. (1 = not at all likely; 5 = very likely)
10. If I were a landlord, I would feel comfortable renting a room to Karen. (1= not at all likely; 5= very likely)

11. Do you believe that you could help Karen improve her present situation? (1= not at all; 5= very much)

12. I would offer Karen a ride to work. (1= not at all likely; 5= very likely)

<table>
<thead>
<tr>
<th>Coercion-Segregation</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. I believe that it is for the best interest of her children if Karen loses custody (1= not at all; 5= very likely)</td>
</tr>
<tr>
<td>14. I think that Karen is a burden for the community and she would be better off living in another town (1= not at all; 5= very much)</td>
</tr>
<tr>
<td>15. Do you feel that Karen should be locked up in a jail? (1= not at all; 5= very much)</td>
</tr>
</tbody>
</table>

Survey Development

All the surveys used in this project were developed on Qualtrics, the university licensed survey software. Qualtrics is an easy to use survey software online and is helpful for collecting survey responses and also has some merit for simple data analysis. The survey was sent out via an anonymous link, so in order to compare the pre- and post-experience surveys students were assigned to a number that they recorded on both surveys. The average time it took to fill out the surveys was 5-10 minutes.

Analysis

Post-experience survey responses were entered manually into Qualtrics after the simulation. Because the simulation was held on two different occasions, all the pre-experience results were imported into one survey and all of the post-experience results were imported into another survey. Qualtrics data analysis enabled the calculation of mean, range, standard deviation and variance for the 26 general Likert Scale questions as well as the 6 social distance Likert Scale questions. Results were exported from Qualtrics as Excel sheets that could then be downloaded into IBM
SPSS for further data analysis. By comparing means from the pre- and post-experience surveys, it may be determined if there was a significant change in students’ perceptions. To measure if the change in mean was significant or merely due to random chance, a paired samples T-test was performed. If the value for p was less than or equal to 0.05, the response was labeled as statistically significant and the null hypothesis, which stated that there would be no significant difference between the mean value for pre- and post-experience responses, was disproven.

**Institutional Review Board Approval**

In order to conduct research involving human subjects, the Institutional Review Board (IRB) at the University of Mississippi must grant approval. The purpose of the IRB is to “review all proposed research involving human subjects to ensure that subjects are treated ethically and their rights and welfare are adequately protected.”

The materials submitted to IRB as part of the Screening/Abbreviated IRB Application are all included in the Appendix and include recruitment tools, survey questions, consent procedures, project summary and purpose, facilitator script and research design. IRB approval was granted and this research project was found to be exempt.

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### Table 3.3 Qualitative Response Code Book

**Medical Treatment:** Where the participants describe any encounters with the medical care specialist throughout the simulation.

- Did not see medical care specialist: the participant deliberately chose not to seek medical help during the “month” they lived in poverty.
- Insurance: the participant visited a health care specialist but was unable to pay for treatment due to lack of insurance.
- Medical bills: the participant visited a health care specialist and paid out of pocket for treatment or prescriptions.
- Quality of care: the participant visited a health care specialist and felt disrespected or belittled by the medical provider.

**Hometown Public Transportation:** Where the participants describe the quality, availability, and cost of public transportation in their hometown.

- High quality but expensive: the participants feel as though there is reliable transportation but it comes with significant costs.
- Fair/satisfactory: the participant is pleased with the transportation and believes it is fairly priced and accessible to everyone.
- Scarce or nonexistent: the participant describes their hometown as either having no public transit system at all or for being uncommon.
- Inconvenient: the participant has a public transit system, but describes it as having poor run times, long routes, etc.
CHAPTER 4

DESIGN IMPLEMENTATION

Students were able to sign up for the Community Action Poverty Simulation starting one week in advance, so on March 23, 2017, the first pre-experience survey links were sent out via email. In the email students were asked to follow the URL and fill out the survey before engaging in the simulation on March 30, 2017. Students signed up voluntarily to participate in CAPS on a Google document requiring the subject’s email address. After signing up, participants were sent an email containing instructions about completing the survey, time and location of CAPS, and their assigned number so that their pre-experience surveys could later be compared to their post-experience surveys anonymously. The number of pre-experience responses totaled 41, but only 24 of these could be matched to a post-experience survey because many students who signed up did not end up participating. This process was repeated again on February 18, 2018, where students signed up to participate in CAPS on February 25, 2018 using a Google document and were sent the same pre-experience survey. The total number of pre-experience responses from both events was 55.
After completing the simulation and engaging in discussion, participants were asked to fill out the post-experience survey on paper. These results were then manually entered into Qualtrics. The means and frequencies were calculated for all 26 Likert scale questions that appeared on both surveys and paired T-test analysis was used to determine if the difference in means was greater than or equal to 0.05, meaning it is significant. For the questions involving desired social distance and familiarity with poverty frequencies were used to measure the proportion of students who selected each option. This provided background information on students’ general knowledge and associations with poverty and impoverished persons. The attribution questionnaire vignettes were analyzed according to which scenario the participant received and the response frequencies across different categories of questions. For the rank order question frequencies were compared across the different options to determine the general trends in prioritization of goods and resources.

For the open-response questions, qualitative coding methods were employed in order to identify prevailing themes or ideas for the questions and to organize the responses based on similarity.
CHAPTER 5
RESULTS

Demographics

Participation in the Community Action Poverty Simulation was open to all students at the University of Mississippi. Out of the 55 participants, 37 (67.27%) were white, 11 (20%) were African American, 5 (9.09%) were Asian, 1 (1.82%) was Hispanic or Latino, and 1 (1.82%) described him or herself as “other.” Students enrolled in the College of Liberal Arts who participated totaled 27 (49.09%), followed by 6 (10.91%) students from the School of Business Administration, 5 (9.09%) students from the School of Accountancy, 4 (7.27%) students from the School of Education, 4 (7.27%) students from the School of Journalism and New Media, 2 (3.63%) of students from General Studies, 2 (3.63%) students from the School of Engineering, 2 (3.63%) students from the School of Law, 2 (3.63%) students from Graduate School, and 1 (1.82%) students from the School of Applied Sciences. When asked if they were a first-generation college student, 7 (22.58%) responded yes, and 24 (77.42%) responded no. According to classification in school, 20 (37.74%) participants were first year undergraduate students, 5 (9.43%) participants were second year students, 15 (28.30%) were third year
students, and 13 (24.53%) were fourth year students. The remaining 2 students (3.64%) were in graduate school.

**General Responses**

**Pre-Experience Survey**

For the 26 Likert scale questions about general perceptions of poverty, responses could range from strongly disagree (1) to strongly agree (5). Mean responses ranged from 1.55 for question 23, to 3.78 for question 3. The standard deviation ranged from 0.71 (Q23; mean 1.55) to 1.41 (Q20; mean 2.64). These descriptive statistics may be found in the Table 8.1 of the Appendix. For the questions involving desired social distance from poverty, a 5-point Likert Scale was also used. Lower scores indicate a strong desire to avoid impoverished persons, and high scores indicate a strong desire to interact with impoverished persons. Mean responses ranged from 2.71 for questions 3 and 5 to 4.07 for question 6. The standard deviation ranged from 1.07 (Q2; mean 3.75) to 1.29 (Q4; mean 2.85).

**Post-Experience Survey**

For the 26 Likert scale questions on the post-experience survey, mean responses ranged from 1.24 for question 4 to 3.85 for question 19. Standard deviation ranged from 0.54 (question 4; mean 1.24) to 1.44 (question 19; mean 3.85). These descriptive statistics may be found in the Appendix. For the questions involving desired social distance from poverty mean responses ranged from 3.09 (Q4) to 4.49 (Q6). Standard deviation ranged from 0.87 (Q6) to 1.34 (Q4). For the
questions involving participants’ familiarity with poverty question 1 had the highest percent responding “yes” (83.64%) and question 6 had the highest percent responding “no” (81.82%). When ranking goods and services, shelter was most often indicated as the number one priority (43.64%) followed by groceries (27.27%), practicing religion (12.73%), transportation (7.27%), electricity and water (3.64%), prescription medications (3.64%) and medical treatment (1.82%). The majority of participants indicated that they own a car (83.64%) and the remaining 16.36% did not. The number of participants indicating that they had received government support was as follows: Medicaid (13; 23.64%), Food Stamps (12; 21.8%), Supplemental Security Income (3; 5.45%), Heating Assistance (2; 3.64%), and Temporary Assistance for Needy Families (1; 1.82%). When classifying their family’s socioeconomic status results were: wealthy (4; 7.27%), upper class (12; 21.82%), middle class (28; 50.91%), lower class (10; 18.18%), and poor (1; 1.82%). The post-survey also contained two free-response questions addressing the participants’ experience with health care during the simulation and the quality of public transportation in their hometown.

Pre- and Post-Experience General Perceptions of Poverty Data Compared

By calculating the descriptive statistics for both the pre- and post-experience surveys, it was possible to measure whether participants experienced significant changes in their attitudes toward poverty. Significant changes in means occurred for 20 of the 26 questions. For questions 3, 8, 10, 11, 13, and 19 the significance was greater than 0.05, making the change likely due to random chance rather than
attitudinal change. A decrease in mean for questions in the categories Perceptions of Poverty and Medical Treatment of the Impoverished and an increase in mean for questions in the category Personal Qualities of the Impoverished is expected.

Achieving statistically significant change in means between the pre- and post-experience surveys is indicative of the simulation’s success at correcting misconceptions, informing participants, and inspiring future learning and community action. The expected trends were followed with the exception of questions 12 and 22. Question 12 had the opposite trend from what was expected, with means decreasing from the pre- to post-experience survey rather than increasing. Question 22 should have increased from pre- to post- surveys leading to a negative change in means (pre-post) but there was a positive change in means that was small enough it was considered not to be significant. In question 13 there was no difference between the means on the pre- and post-experience surveys.

Differences between the means of pre- to post- survey responses ranged from -0.7636 (Q17) to 0.8546 (Q14). To compare the mean responses from pre- to post-experience survey a paired samples t-test was utilized for each of the 26 Likert Scale questions. The purpose of this parametric test is to determine whether or not changes between the means are significant or merely caused by random chance. For questions 3, 8, 10, 11, 13, and 19 where the change in means was due to random chance, the null hypothesis is unable to be disproven. Despite these results CAPS may still be considered successful. It is likely that the wording of these questions was ambiguous. For all 26 questions combined, the mean of the pre-experience
survey was 2.56 and the mean of the post-experience survey was 2.42. These statistics may all be found in Table 8.7 in the Appendix.

**Pre- and Post-Experience Social Distance Data Compared**

The six social distance questions were analyzed in a manner identical to the general perceptions of poverty questions. These six questions were based on a 5-point Likert scale and the means were calculated for each question on both the pre- and post-experience surveys. These means were then compared using a paired samples t-test to see if the changes were significant. Significant change occurred for 4 of the 6 questions. For questions 2 and 4 the significance was greater than 0.05 and therefore the null hypothesis cannot be disproved in these cases. The difference in means ranged from -0.509 for question 1 to -0.145 for question 2. The difference in means was expected to be negative for all responses in this section because the post-experience answers would be higher than the pre-experience answer if participants developed better understanding through interactions with CAPS. Data related to these questions may be found in the Appendix in Tables 8.2, 8.4 and 8.8.

**Pre-Experience Attribution Questionnaire Vignette Responses**

In this section of the survey four different scenarios were randomized in Qualtrics so that each scenario was distributed a roughly equal number of times. All scenarios involved an unemployed, single mother battling with depression. Scenarios ranged from 1 (no danger), 2 (danger), 3 (danger without controllability of cause), and 4 (danger with controllability of cause). For the personal
responsibility questions, a definite trend was followed as responses increased across each of the four scenarios. For questions 1, 2, and 3, which fall into the category of personal responsibility, responses increased from scenario 1 (2.2143, 2.3571, 2.1429) to scenario 2 (2.3429, 2.4143, 2.2714) to scenario 3 (3.4167, 2.75, 2.4167) to scenario 4 (3.6667, 4, 3.0667) indicating that participants place more personal responsibility on the subject as their level of control increases and the danger of the situation increases.

The single question involving anger also showed a clear trend of increasing across the scenarios. In question six responses increased from scenario 1 (1.2857) to scenario 2 (1.4286), to scenario 3 (2.25), to scenario 4 (2.3333). This trend indicates that participants’ anger toward the subject increased as the subject’s level of control and danger increase.

For the fear questions, the same general trend was followed. Questions 7 and 8, which fall into the category of anger increased in mean from scenario 1 (1.6429, 1.5) to scenario 2 (2, 2.0714) to scenario 3 (3.25, 1.9167*) to scenario 4 (2.3333, 3.6, 2.6). It may be noted that there was one exception to this trend in question 8 of scenario 3, where the mean responses slightly decreased from scenario 2. As the danger increased and the subject had more control over the situation, participants became more afraid.

The final group of questions, coercion-segregation, followed a less direct path of increase across the scenarios, but in all three questions 13, 14, 15, there was a definite increase from scenario 1 to scenario 4. Responses increased from scenario 1 (2, 1.3571, 1.1429), to scenario 2 (2*, 1.2857*, 1.2143), to scenario 3 (3.4, 1.6667, 2.6).
2), to scenario 4 (3.5833, 1.6667*, 2.0667). Numbers indicated with an asterisk indicate no increase from the response of the previous scenario. Overall, the participants displayed increased desire for the subject to be punished or excluded as her level of control and the level of danger increased.

For the questions categorized as pity, responses were mixed. For question 4 there was a decrease across the scenarios from scenario 1 (3.7857), to scenario 2 (3.6429), to scenario 3 (3.25), to scenario 4 (2.8). For question 5 there was an increase from scenario 1 (3.0714), to scenario 2 (3.5714) to scenario 3 (3.6667) and then a decrease to scenario 4 (3.5333). Generally, it may be deduced that participants experience less pity as the subject’s level of control over the situation increased and the danger increased.

For the questions categorized as helping, the prevailing trend showed a decrease across scenarios. Responses to questions 9, 10, 11, and 12 decreased from scenario 1 (3.2857, 2.8571, 3.3333, 3.5), to scenario 2 (2.8571, 2.7143, 3.5*, 3.757*), to scenario 3 (2.5, 2.6667, 3.3333*, 4.0833*), to scenario 4 (2.2, 2.1333, 3.2, 3.3333). Despite several variations from this trend, it appears that overall participants reported a decreased likelihood to help the subject when her level of control over the situation increased. All of this data may be found in Table 8.9 of the Appendix.

**Post-Experience Familiarity With Poverty Responses**

This section asked participants six questions involving their own familiarity and personal experiences with impoverished persons. The six statements were listed and participants could either select “yes,” “no,” or “I do not know.” For
question 1, 83.64% of participants said “yes,” 3.64% said “no” and 12.37% responded, “I do not know.” For question 2, 53.73% of participants responded “yes,” 38.18% responded “no,” and 9.09% responded “I do not know.” For question 3, 29.09% of participants responded “yes,” 43.65% responded “no,” and 27.27% responded I do not know. For question 4, 50.91% responded “yes,” 32.73% responded “no,” and 16.36% responded, “I do not know.” For question 5, 45.45% responded “yes,” 43.64% responded “no,” and 10.91% responded, “I do not know.” For question 6, 9.09% responded “yes,” 81.82% responded “no,” and 9.09% responded, “I do not know.” Question 1 is general, asking if the respondent has ever encountered an impoverished individual in passing, and the questions get more intimate as number 6 asks if the participant lives with someone who is impoverished. It was expected that the vast majority had seen an impoverished person in passing, but the number of participants with impoverished relatives (45.45%) was unexpectedly high. Descriptive data for this section may be found in Table 8.5 of the Appendix.

**Post-Experience Rank Order Responses**

Students were given a list of seven goods and resources and asked to rank them 1-7 ranging from highest priority to lowest priority. Means were calculated for each option to see the average order in which they were listed. Shelter appeared to have the highest priority with a mean of 2.04, followed by groceries (mean = 2.64), electricity and water (mean = 3.16), transportation (mean = 4.35), medical treatment (mean = 4.44), prescription medications (mean = 5.38), and practicing
religion (mean = 5.95). Standard deviation ranged from 1.04 (electricity and water) to 2.08 (practicing religion). Although practicing religion was ranked as number 7 according to overall means, 7 of the 55 participants (12.73%) ranked it as number one. Contrary to expectations, receiving medical treatment was not a big priority for most participants and it actually fell on the bottom half of the list. This data may be found in Table 8.6 of the Appendix.

Post-Experience Qualitative Responses

The two open-ended questions enabled participants to openly respond to issues of medical treatment for the impoverished as well as ease of transportation. The vast majority of participants were unable to seek medical treatment or buy prescription medication due to lack of money or insurance. For those who did seek medical treatment, several reported feeling disrespected or rushed by the medical care provider and characterized their experience as negative. Participants overwhelmingly described the public transportation in their hometown as being poor or nonexistent, although 83.64% of participants cited having their own car.

Medical Treatment

Participants were asked whether or not they saw a medical care specialist during their experience with the poverty simulation. If they answered yes, they were also asked to explain their experience and include any information about billing, prescriptions, and diagnoses. The majority of participants did not seek medical help, citing reasons such as lack of time and money:
“No I wanted to but I could not afford it.”
“No, I had medical bills but I couldn’t pay them so I avoided it.”
“I did not have time because I was too busy with work and trying to keep my house.”
“No, which is why I believe that health care should be the most important issue”
“I did not because I did not have enough money.”

For those participants who did visit their medical care provider, high costs or inability to pay caused additional stress:

“Yes my child broke his arm but I did not have insurance to pay so it was a waste of my time.”
“Yes, my girlfriend’s baby (1 year old) broke its arm at daycare. It cost me $80 at first, an additional $20, then $80 more for the follow up which was ridiculous”
“I took my child and I did have health insurance but it only covered me so I still had to pay full price.”
“Yes my child broke his arm and with no insurance it was $80.”
“Yes, I was 8 months pregnant and had to get a check up it was $80 and I got medicine.”
“I didn’t have insurance so it was so hard to get some prescriptions.”
“Yes, to see if I could get my prescription cheaper but I couldn’t because I didn’t have insurance.”
“Yes, but I had no money to pay so I left.”

Several participants reported feeling mistreated by the medical provider:

“I felt like she didn’t care about me or my problems.”
“I can’t believe I was refused treatment just cause I didn’t have insurance.”
“They rushed me and didn’t answer my questions.”
“The doctor was unsympathetic to my situation and when I said I couldn’t afford it all they responded was they were sorry but they couldn’t help me.”

Transportation

When asked to describe the public transportation in their hometown, most participants were unsatisfied:

“It leaves a lot to be desired.”
“Nonexistent”
“Not enough.”
“Slim”
“We don’t have any.”
“Poor, Uber and that’s it.”
“My town is small enough to walk places so there is none.”
“My hometown in TN doesn’t have any public transit other than taxis and Uber.”
“Nonexistent. I live in a very quaint and small town, New Albany MS.”
“Inadequate.”
“It is not sufficient, does not meet the need.”
“Not obvious, possibly minimal.”
“People have to drive themselves, there are no busses.”
“Our public transportation is awful. I don’t even think there are public busses and there are no taxis.”

Several concerns about hometown public transportation included high costs, little advertising, and inaccessibility:

“It’s a little inconvenient because I can’t use that late at night or on weekends.”
“I live in San Diego, CA. Transportation is somewhat expensive but there’s assistance for that.”
“Expensive and hard to find.”
“Not very accessible, runs to very few places.”
“Good for students but otherwise just ok.”
“It’s not available all the time and it’s not that widely advertised.”
“Insufficient and highly expensive.”
“Not good, too expensive.”

Several respondents cited having positive experiences with public transportation in their hometowns:
“Good but only because I am from a large city.”
“Usually reliable. It takes less than 40 min to get to my intended destination.”
“My hometown is super good, there are 400+ routes of buses and 3 routes for tubes.”
“Ok. Uber is rare but I think there is a bus system.”
“Good, steadily improving.”

Generally, participants acknowledged the difficulties and expenses associated with receiving medical care and using public transportation.
Discussion

Based on the results, CAPS is successful at increasing participant understanding of the impoverished and the situational challenges that they face and therefore supports the hypothesis. Significant attitudinal changes occurred in the majority of questions related to General Perceptions of the Impoverished and Social Distance from the Impoverished. This indicates a better understanding of the conditions of poverty as well as qualities of impoverished persons after completing CAPS. It also indicates that there is a greater likelihood for participants to interact and engage with impoverished persons after completing CAPS. Overall, CAPS is an effective pedagogical tool for changing participants’ perceptions of poverty.

Based on limited sample size and diversity, the results found in this study may not be universal. Additional limitations involve the Attribution Questionnaire Vignettes and their inclusion on only the pre-experience survey and not the post-experience survey as well. The randomizer function on Qualtrics assigns the different scenarios randomly, and because the participants’ responses are anonymous it was not possible to assign the same scenario to each participant on the both the pre- and post-experience surveys. In order to have a more accurate measure of attitudinal change, the rank order questions could be included on both the pre- and post-experience surveys. The reason why they were only included on the post-experience survey is because there was concern that students would be primed to think about resources in terms of degrees of importance if they ranked...
these items before participating in the simulation. It was intended that their simulation experience be reflective of the reasoning they use in daily life, uninfluenced by prior and forced rankings. Given the background of this project and the intention to include CAPS in the curricula for health professions students, it would be helpful to run the simulation with only pre-health students. Because the simulation requires a big time commitment it was difficult to recruit enough participants and it was not possible to limit sign ups only to students of a certain field of study. For future studies it is recommended that CAPS be conducted exclusively for students in pre-health programs.

Overall, however, the mixed methods approach was successful and the majority of expected trends were followed. Significant differences in attitude occurred for 24 of the 32 questions that were used on both the pre- and post-experience survey. The average percent change in means between pre- and post-experience surveys was 17.77%, for the general perceptions of poverty questions, which shows significant attitudinal change. This value is calculated by taking the absolute value of the percent change in means for each question, adding them together, and dividing by 26. The percent change in mean ranged from -30.42% (Q17) to 32.27% (Q5). Q 13, 19, and 25 did follow the expected trend, and showed a slight negative difference in means. Based on these results participants were better informed and had a more accurate understanding of poverty after being involved with CAPS. Results from the social distance questions also provide evidence that participants were more likely to engage with or have relationships with low-income persons after participating in CAPS. Average percent change in mean for the six
social distance questions combined was 12.64%. The percent change in mean ranged from -3.87% (Q2) to -17.70% (Q1). A more negative percent change indicates a greater likelihood of the participant to interact with an impoverished person. From comparing the two surveys, it may be concluded that the majority of participants displayed heightened empathy and were better informed about the causes and conditions of poverty after completing the simulation.
CHAPTER 6
PHILOSOPHICAL IMPLICATIONS

General findings from the research show that the Community Action Poverty Simulation is successful at increasing participant understanding of the impoverished and the situational challenges that they face. The philosophical implications of this are large in that they point to service learning as an effective way to increase an individual’s moral sensitivity as well as moral motivation and action. Alan Preti stresses that not only should students achieve the ability to understand and think critically about moral issues, but they should also gain a sense of responsibility to take action, “which may include having moral emotions such as empathy and concern for others.” The poverty simulation focused on accomplishing this by engaging participants emotionally. Feelings of indignation, anger, or compassion achieved by participating in the simulation may spur individuals to take action to make changes in the community and help alleviate some of the effects of poverty. Taking on the role of another individual allows one to “relate to the other in terms of common humanity.” By focusing on commonalities

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77 Ibid, 136.
rather than differences, the general public is less likely to unfairly judge low-income individuals. Policy is influenced heavily by public opinion, so improving perceptions of poverty has the potential to steer future government policies addressing the poor.

The Hastings Center’s Summary Recommendations describes “The general purpose of the teaching of ethics ought to be that of stimulating the moral imagination, developing skills in the recognition and analysis of moral issues, eliciting a sense of moral obligation and personal responsibility, and learning both to tolerate and to resist moral disagreement and ambiguity.”78 When engaging in the poverty simulation, participants have the opportunity to work together to identify moral issues, actively discuss the issues from different perspectives, and collaborate to determine the best course of action moving forward. After identifying the moral issues plaguing many low-income individuals, it is my goal that participants will feel compelled to take action in their own communities to campaign for the rights of the poor. The development of moral sensitivity may be catalyzed by feelings of shock and disgust. As a participant, experiencing mistreatment from the perspective of an impoverished individual allows better understanding for the complexity of moral dilemmas that many poor people encounter.

CHAPTER 7

NORMATIVE ARGUMENT

This section will explore what ought to be done in light of the findings from this research project. Philosopher David Hume understood the importance of human sentiment in the formation of moral judgments about people and their traits.\textsuperscript{79} No human being is perfectly reasonable, so morality must spring from emotion rather than reason. It is with this in mind that I suggest experiential learning, which strongly engages emotional response, as an effective teaching style for developing one's moral thinking and actions.

In chapter 2, specific examples were given relating to the treatment of poor people by medical care providers. Some of this substandard treatment may be attributed to a lack of ethical training throughout the medical education process. A study conducted at the University of New Mexico School of Medicine found that medical trainees in all levels of training and disciplines recognized a need for more training in practical ethics and professional dilemmas.\textsuperscript{80} Learning about ethics in an academic setting has merit, but experiential learning of ethics enables students to apply ethical theory to real life, practical situations. A proposed solution to the lack

\textsuperscript{79} Rachel Cohon, “Hume’s Moral Philosophy,” The Stanford Encyclopedia of Philosophy (Fall 2010).
of ethical education in medical school and the mistreatment of low-income patients is to incorporate more role playing activities, particularly the Community Action Poverty Simulation, into the curriculum of all health professions schools.

As future professionals, participants in CAPS are encouraged to incorporate changes in their field of practice that will more effectively cater to the needs of the impoverished. The median family income for matriculating medical students was $100,000 in 2006 and shows an increasing trend. This lends evidence that the majority of medical students do not have direct experience with poverty. Lack of familiarity with poverty contributes to the inability of physicians to effectively meet the needs, whether physical, mental, or emotional, of low-income patients. Physicians also tend to serve populations of patients with backgrounds similar to their own, which explains the lack of doctors who choose to practice in areas of low-income. By requiring medical students to participate in CAPS, the awareness and greater understanding of poverty has the potential to sensitize them to the effects of poverty when treating patients.

Previous studies show that simulation-based teaching in the medical school is highly effective. Findings exhibit that student’s knowledge, attitudes, and skills are all affected in this learning style. Researchers analyzed test scores after the geriatric care simulation had been offered, and, using quantitative methods, found

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that those who participated in the simulation received higher scores.\textsuperscript{83} Additionally, those students who participated had a more positive regard toward the training and said that participating in the simulation was very impactful in their studies of geriatric care.\textsuperscript{84} Another test was given a month after the simulation was offered, and those who participated in the simulation showed greater retention of information over time and higher test scores.\textsuperscript{85} This provides confirmation that the effectiveness of experiential learning is long-term and may easily be incorporated into the medical school curriculum.

All practitioners of public health could greatly benefit from participating in poverty simulations. Sheryl Strasser et al. claims that, “creating a deeper level of understanding and awareness among this group is important for better informing policies and practices that affect underserved populations.”\textsuperscript{86} She goes on to acknowledge that, “a core principle of health is social justice,” which is why students’ perceptions of poverty should be addressed during training.\textsuperscript{87} Poverty simulations in particular, and experiential learning practices in general have the potential to enhance moral sensitivity and have long-term impacts on participants. Given the current need for pre-health professions students to experience more ethical training and experience with poverty, simulations such as CAPS can be used as meaningful pedagogical tools to expose participants to complex moral thinking practices that carry over into all aspects of life.

\textsuperscript{83} Ibid.
\textsuperscript{84} Ibid.
\textsuperscript{85} Ibid.
\textsuperscript{87} Ibid.
APPENDIX

1. Pre-Experience Survey

**Information Sheet**

**Title:** Attitudinal Changes in Experiential Learning via Poverty Simulation

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**Description**
The purpose of this research project is to examine whether individuals' beliefs and attitudes about poverty can be influenced through participation in the Community Action Poverty Simulation. Particular focus will be given to the health care system in the United States and its ability to meet the needs of the impoverished. You will be asked to complete an anonymous online pre-experience survey before the poverty simulation, and a post-experience survey after the poverty simulation.

**Cost and Payments**
The pre-experience online survey will take 15-20 minutes and the post-experience survey will take about 15-20 minutes. The simulation is expected to last roughly an hour and a half.

**Risks and Benefits**
No risks are anticipated from participation in this study. You should not expect direct benefits from participating in the study, although the experience may provide you with an increased knowledge about daily life of the impoverished. You will also be given the opportunity to expand your knowledge about poverty and efforts that you can make to mitigate its effect in your community.

**Confidentiality**
All information in the study will be collected anonymously. No one, including researchers, will be able to associate you with your survey responses.

**Right to Withdraw**
You are not required to volunteer for this study, and there are no repercussions if you choose not to. If you begin the study and no longer wish to continue, you may simply close the webpage containing the survey. Whether or not you participate or withdraw will not affect your current
or future relationship with the University, and it will not cause you to lose any benefits to which you are entitled.

**Statement of Consent**
I have read and understand the above information. By completing the survey I consent to participate in this study.

(1=strongly disagree; 5=strongly agree)

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Poor people make mostly healthy eating choices

Physicians have a responsibility to treat patients even if they cannot pay

Physicians treat all patients equally, without regarding their socioeconomic status

Everyone in America has access to affordable health insurance

Just as many non-poor people are on disability as poor people

The quality of hospitals in low-income areas is the same as hospitals in middle and upper income areas

Individuals with public health insurance receive the same level of medical care as individuals with private health insurance

Poor people take care of themselves about as well as non-poor people do

Medical services and resources are distributed without influence from patient income

Social Distance
(1=definitely unwilling; 2=probably unwilling; 3=probably willing; 4= definitely willing)

1. Would you consider renting a room in your house to someone living in poverty?
2. Would you feel that you could trust a coworker who is impoverished?
3. How would you feel about an impoverished individual taking care of your home while you were out of town?
4. How would you feel about leaving a family member in the care of someone living in poverty?
5. How would you feel about setting up one of your friends on a date with an impoverished individual?
6. If you were an organ donor, how would you feel about one of your organs going to an impoverished individual rather than a more affluent individual?
Attribution Questionnaire Vignettes

Condition #1 (no danger)—Karen is a 28 year old single mother of three young children who is living in poverty. Since losing her job two years ago, Karen has been relying on welfare to support her family. Karen battles with depression, which has prevented her from securing steady employment. Despite her inability to work, Karen still manages to care for her three children and provide suitable living conditions.

Condition #2 (danger)- Karen is a 28 year old single mother of three young children who is living in poverty. Since losing her job two years ago, Karen has been relying on welfare to support her family. Karen suffers from depression, which often causes her to experience exhaustion, insomnia, sadness, or trouble concentrating. Karen's depression frequently impairs her ability to care for herself and her children.

Condition #3 (danger without controllability of cause) - Karen is a 28 year old single mother of three young children who is living in poverty. Karen has been known to abuse the welfare system for years, even before she lost her job two years ago. Karen suffers from depression, which often prevents her from caring for her children. After leaving her children unfed for two days, a neighbor contacted social services. Upon investigating Karen, a social service agent learns that she has been filing exaggerated welfare claims. Karen's depression was originally caused by the death of her husband and loss of her job during a recession.

Condition #4 (danger with controllability of cause) - Karen is a 28 year old single mother of three young children who is living in poverty. Karen has been known to abuse the welfare system for years, even before she lost her job two years ago. Karen suffers from depression, which often prevents her from caring for her children. After leaving her children unfed for two days, a neighbor contacted social services. Upon investigating Karen, a social service agent learns that she has been filing exaggerated welfare claims. Karen's depression began when she lost her job as a consequence of drinking too much alcohol and frequently showing up to work intoxicated.

Personal Responsibility

1. How much of the blame for her family's present situation should be placed on Karen? (1=none at all; 5= very much)
2. How responsible, do you think, is Karen for her present situation? (1=not at all responsible; 5= very much responsibility)
3. What level of control, do you think, Karen has over the way her life has transpired? (1= no control at all; 5= complete control)
Pity
1. I would feel sympathetic toward Karen. (1= not at all; 5= very much)
2. Would you feel Karen has experienced a great deal of misfortune? (1= not at all; 5= very much)

Anger
1. I would feel anger toward Karen. (1= not at all; 5= very much)
2. How incensed would you feel by Karen? (1= not at all; 5= very much)

Fear
1. How much of a danger do you feel that Karen is to herself, her children, and to society? (1= none at all; 5= very much a danger)
2. I would feel nervous to spend time around Karen. (1= not at all; 5= very much)
3. How scared of Karen would you feel? (1= not at all; 5= very much)

Helping
1. If I were an employer I would consider Karen as a candidate for a job with my company. (1= not at all likely; 5= very likely)
2. If I were a landlord, I would feel comfortable renting a room to Karen. (1= not at all; 5= very much)
3. Do you believe that you could help Karen improve her present situation? (1= not at all; 5= very much)
4. I would offer Karen a ride to work. (1= not at all likely; 5= very likely)

Coercion-Segregation
1. I believe that it is for the best interest of her children if Karen loses custody. (1= not all; 5= very much)
2. I think that Karen is a burden to the community and she would be better off living in another town. (1= not at all; 5= very much)
3. Do you feel that Karen should be locked up in a jail? (1= not at all; 5= very much)

1. What is your age?
2. What is your classification in school?
   a. Freshman
   b. Sophomore
   c. Junior
   d. Senior
3. What is your race/ethnicity?
   a. White
   b. black/African American
   c. American Indian or Alaskan Native
d. Asian
     e. Native Hawaiian or other Pacific Islander
     f. Hispanic/Latino
     g. Other

4. With which college or school are you affiliated? Check all that apply.
   a. College of Liberal Arts
   b. General Studies
   c. School of Accountancy
   d. School of Applied Sciences
   e. School of Business Administration
   f. School of Education
   g. School of Engineering
   h. School of Health Related Professions
   i. School of Journalism and New Media
   j. School of Law
   k. School of Pharmacy
   l. Graduate School

5. Are you a first generation college student?
   a. yes
   b. no

6. Please record the number that was assigned to you in your confirmation email.

Responses to the pre-experience survey collected responses anonymously and is accessible online at the following link:

http://uofmississippi.qualtrics.com/jfe/form/SV_dcXqDJfFh9VcXVr
2. Post-Experience Survey

Information Sheet
Title: Attitudinal Changes in Experiential Learning via Poverty Simulation

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<td>Poor people work about as hard as everyone else</td>
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<td>Poor people are as intelligent as everyone else</td>
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<td>Poor people are about as trustworthy as everyone else</td>
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<td>Poor people are about as lazy as everyone else</td>
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<tr>
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<tr>
<td>Poor people have the same work ethic as everyone else</td>
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<tr>
<td>Poor people are just as likely to become sick as everyone else</td>
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</tbody>
</table>
Poor people make mostly healthy eating choices 1 2 3 4 5

Physicians have a responsibility to treat patients even if they cannot pay 1 2 3 4 5

Physicians treat all patients equally, without regarding their socioeconomic status 1 2 3 4 5

Everyone in America has access to affordable health insurance 1 2 3 4 5

Just as many non-poor people are on disability as poor people 1 2 3 4 5

The quality of hospitals in low-income areas is the same as hospitals in middle and upper income areas 1 2 3 4 5

Individuals with public health insurance receive the same level of medical care as individuals with private health insurance 1 2 3 4 5

Poor people take care of themselves about as well as non-poor people do 1 2 3 4 5

Medical services and resources are distributed without influence from patient income 1 2 3 4 5

Social Distance
(1=definitely unwilling; 2=probably unwilling; 3=probably willing; 4= definitely willing)

1. Would you consider renting a room in your house to someone living in poverty? 1 2 3 4 5

2. Would you feel that you could trust a coworker who is impoverished? 1 2 3 4 5

3. How would you feel about an impoverished individual taking care of your home while you were out of town? 1 2 3 4 5

4. How would you feel about leaving a family member in the care of someone living in poverty? 1 2 3 4 5

5. How would you feel about setting up one of your friends on a date with an impoverished individual? 1 2 3 4 5
6. If you were an organ donor, how would you feel about one of your organs going to an impoverished individual rather than a more affluent individual?

Familiarity with Poverty
(1= yes; 2= no; 3= I do not know)

1. I have observed, in passing, a person I believe may have been impoverished

2. I have observed persons living in poverty on a frequent basis

3. There are persons who live in my neighborhood who are impoverished

4. A friend of the family is impoverished

5. I have a relative who is impoverished

6. I live with someone who is impoverished

Please rank the following in order of importance:

Shelter
Groceries
Practicing religion
Electricity and water
Medical treatment
Transportation
Prescription medications

During your experience with the poverty simulation did you see a medical care specialist? If yes, please explain your experience and include any information about billing, prescriptions, and diagnoses.

How would you describe the public transportation available in your hometown?

Do you have a car?
Have you or your family ever received any of the following supports (remember your responses are considered confidential and cannot in any way be traced back to you)?
Supplemental security income
Food stamps
TANF (Temporary Assistance for Needy Families)
Medicaid
Heating Assistance

In your opinion, which of the following best describes your family's economic status?

a. wealthy
b. upper class
c. middle class
d. working class
e. poor

Please record below the number that was assigned to you in your confirmation email.
3. Recruitment Materials

EMAIL SENT TO FACULTY BY DEBORAH MOWER

Dear Dr. XXXX,

I am the faculty advisor for Madison Bandler, who is a philosophy and pre-med major working on her Honors thesis in bioethics. She is interested in whether beliefs and attitudes about poverty can be influenced through a Poverty Simulation, and her long term project is to argue for the ethical obligation of health care providers to be more informed about the conditions and causes of poverty in providing quality and access of care to their clients. She is working with the McLean Institute for Public Service and Community Engagement, which is conducting the Poverty Simulation.

We are seeking students as volunteer participants in this research project who would be willing to engage in the Poverty Simulation and take a pre and post survey. The surveys should each take less than 20 minutes to complete and the simulation itself is 1 hour long. Given the topic of your course, we wondered if you would either be willing to create an assignment around the Poverty Simulation experience (as a service learning component of the course, the basis for a writing project, or as the impetus to research an aspect related to your coursework), or to offer some extra credit points to students. (If you do offer extra credit points, the University of Mississippi Institutional Review Board suggests alternative possibilities for students to earn points should they opt not to participate in this project so that no student is penalized for failing to participate in a voluntary opportunity).

If you would like more information about this project or would like to discuss ways to integrate your course materials with the Poverty Simulation as an assignment, please do not hesitate to contact me. If you would like to offer this as an extra credit opportunity to students, we have included a flyer/handout you can use for announcements (with details about the purpose of the simulation removed so as not to influence the results of the study).

Sincerely,

Deborah S. Mower
Mr. and Mrs. Alfred Hume Bryant Chair of Ethics
Associate Professor
Philosophy and Religion
Good Afternoon all!

I am currently working with Madison Bandler, who is a Biology pre-med major working on her Honors thesis in bioethics. She is interested in whether beliefs and attitudes about poverty can be influenced through a Poverty Simulation, and her long term project is to argue for the ethical obligation of health care providers to be more informed about the conditions and causes of poverty in providing quality and access of care to their clients.

I am asking for you to volunteer during the event or to participate in the event on March 30th at 6pm.

We will be working with the McLean Institute for Public Service and Community Engagement, which is conducting the Poverty Simulation.

We are seeking students as volunteer participants in this research project who would be willing to engage in the Poverty Simulation and take a pre and post survey. The surveys should each take less than 10 minutes to complete and the simulation itself is about 2 hours long.

Please send me an email with your name and room number if you would be willing to volunteer or participate. Please identify if you would like to volunteer or be a participant in the email as well!

Thank you,

Erin

---

**Erin Parker, M.Ed.**  
Community Coordinator  
The University of Mississippi  
Department of Student Housing  
P.O. Box 1848  
University, MS 38677-1848  
U.S.A.  
eeparker@olemiss.edu | www.olemiss.edu
TODAY: 1 IN 5 MISSISSIPPIANS LIVES IN POVERTY

43% of working families in Mississippi are low-income

Nearly 1 in 3 children under 18 in Mississippi lives in poverty

JOIN US TO RAISE AWARENESS AND TAKE ACTION

February 25th
12:45pm-5pm
Jackson Avenue Center

Sign up by Wed February 21
Email residencehall2@olemiss.edu or https://goo.gl/forms/xvANwzqcc1xFjycg2
4. IRB Approval Email

irb@olemiss.edu

IRB Exempt Approval of 17x-193

To: Madison Bandler, dsmower, Cc: STEVEN C SKULTETY

Ms. Bandler:

This is to inform you that your application to conduct research with human participants, "Attitudinal Changes in Experiential Learning via Poverty Simulation" (Protocol #17x-193), has been approved as Exempt under 45 CFR 46.101(b)(2) and UM Policy RSP.301.015 (Category #7)*.

Please remember that all of The University of Mississippi's human participant research activities, regardless of whether the research is subject to federal regulations, must be guided by the ethical principles in The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research.

It is especially important for you to keep these points in mind:

- You must protect the rights and welfare of human research participants.
- Any changes to your approved protocol must be reviewed and approved before initiating those changes.
- You must report promptly to the IRB any injuries or other unanticipated problems involving risks to participants or others.

If you have any questions, please feel free to contact the IRB at irb@olemiss.edu.

*Protocols approved under UM Policy's RSP 301.015 additional exempt categories will receive periodic progress follow-up emails.

Jennifer Caldwell, PhD, CPIA, CIP
Senior Research Compliance Specialist, Research Integrity and Compliance
The University of Mississippi
212 Barr
P.O. Box 1848
University, MS 38677-1848
U.S.A.
+1-662-915-5006
irb@olemiss.edu | www.olemiss.edu

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5. Statistics Tables

*Table 8.1 Pre-Experience Response Data Q1-26*

<table>
<thead>
<tr>
<th>#</th>
<th>Field</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std Deviation</th>
<th>Variance</th>
<th>Count</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Most poor people are satisfied with their standard of living</td>
<td>1.00</td>
<td>4.00</td>
<td>1.85</td>
<td>0.98</td>
<td>0.96</td>
<td>55</td>
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<tr>
<td>2</td>
<td>Poor people are content with receiving welfare</td>
<td>1.00</td>
<td>5.00</td>
<td>2.95</td>
<td>1.10</td>
<td>1.22</td>
<td>55</td>
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<td>3</td>
<td>There is a correlation between race and poverty</td>
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<td>3.78</td>
<td>1.04</td>
<td>1.08</td>
<td>55</td>
</tr>
<tr>
<td>4</td>
<td>Poor people live as well as I do</td>
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<td>Poor people are getting more than they need from the government</td>
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<td>5.00</td>
<td>2.31</td>
<td>1.14</td>
<td>1.30</td>
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<td>6</td>
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<td>1.93</td>
<td>1.16</td>
<td>1.34</td>
<td>55</td>
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<tr>
<td>7</td>
<td>Public transportation in the United States is sufficient</td>
<td>1.00</td>
<td>5.00</td>
<td>2.09</td>
<td>1.15</td>
<td>1.32</td>
<td>55</td>
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<tr>
<td>8</td>
<td>Poor people are as hygienic as everyone else</td>
<td>1.00</td>
<td>5.00</td>
<td>2.07</td>
<td>1.04</td>
<td>1.09</td>
<td>55</td>
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<tr>
<td>9</td>
<td>Poor people work about as hard as everyone else</td>
<td>1.00</td>
<td>5.00</td>
<td>3.18</td>
<td>1.18</td>
<td>1.39</td>
<td>55</td>
</tr>
<tr>
<td>10</td>
<td>Poor people are as intelligent as everyone else</td>
<td>1.00</td>
<td>5.00</td>
<td>3.31</td>
<td>1.20</td>
<td>1.45</td>
<td>55</td>
</tr>
<tr>
<td>11</td>
<td>Poor people are about as trustworthy are everyone else</td>
<td>1.00</td>
<td>5.00</td>
<td>3.33</td>
<td>1.02</td>
<td>1.04</td>
<td>54</td>
</tr>
<tr>
<td>12</td>
<td>Poor people are about as lazy as everyone else</td>
<td>1.00</td>
<td>5.00</td>
<td>3.15</td>
<td>1.03</td>
<td>1.07</td>
<td>55</td>
</tr>
<tr>
<td>13</td>
<td>Poor people experience the same amount of misfortune in their lives as</td>
<td>1.00</td>
<td>5.00</td>
<td>2.42</td>
<td>1.04</td>
<td>1.07</td>
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<td></td>
</tr>
<tr>
<td>14</td>
<td>Poor people misspend their money on non-essential items (for example: cigarettes, junk food, etc.)</td>
<td>1.00</td>
<td>5.00</td>
<td>3.05</td>
<td>1.05</td>
<td>1.11</td>
<td>55</td>
</tr>
<tr>
<td>15</td>
<td>Poor people have the same moral values as everyone else</td>
<td>1.00</td>
<td>5.00</td>
<td>3.24</td>
<td>0.99</td>
<td>0.99</td>
<td>54</td>
</tr>
<tr>
<td>16</td>
<td>Poor people have the same work ethic as everyone else</td>
<td>1.00</td>
<td>5.00</td>
<td>3.20</td>
<td>1.03</td>
<td>1.07</td>
<td>55</td>
</tr>
<tr>
<td>17</td>
<td>Poor people are just as likely to become sick as everyone else</td>
<td>1.00</td>
<td>5.00</td>
<td>2.51</td>
<td>1.37</td>
<td>1.89</td>
<td>55</td>
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<tr>
<td>18</td>
<td>Poor people make mostly healthy eating choices</td>
<td>1.00</td>
<td>4.00</td>
<td>1.73</td>
<td>0.72</td>
<td>0.53</td>
<td>55</td>
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<tr>
<td>19</td>
<td>Physicians have a responsibility to treat patients even if they cannot pay</td>
<td>1.00</td>
<td>5.00</td>
<td>3.73</td>
<td>1.27</td>
<td>1.62</td>
<td>55</td>
</tr>
<tr>
<td>20</td>
<td>Physicians treat all patients equally, without regarding their socioeconomic status</td>
<td>1.00</td>
<td>5.00</td>
<td>2.64</td>
<td>1.41</td>
<td>1.98</td>
<td>55</td>
</tr>
<tr>
<td>21</td>
<td>Everyone in America has access to affordable health insurance</td>
<td>1.00</td>
<td>5.00</td>
<td>1.67</td>
<td>0.97</td>
<td>0.95</td>
<td>55</td>
</tr>
<tr>
<td>22</td>
<td>Just as many non-poor people are on disability as poor people</td>
<td>1.00</td>
<td>5.00</td>
<td>2.75</td>
<td>0.99</td>
<td>0.99</td>
<td>55</td>
</tr>
<tr>
<td>23</td>
<td>The quality of hospitals in low-income areas is the same as hospitals in middle and upper income areas</td>
<td>1.00</td>
<td>4.00</td>
<td>1.55</td>
<td>0.71</td>
<td>0.50</td>
<td>55</td>
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<tr>
<td>24</td>
<td>Individuals with public health insurance receive the same level of medical care as individuals with private health insurance</td>
<td>1.00</td>
<td>4.00</td>
<td>1.87</td>
<td>0.90</td>
<td>0.80</td>
<td>55</td>
</tr>
</tbody>
</table>
Poor people take care of themselves about as well as non-poor people do

Medical services and resources are distributed without influence from patient income

Table 8.2 Pre-Experience Response Data Social Distance

<table>
<thead>
<tr>
<th>#</th>
<th>Field</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std Deviation</th>
<th>Variance</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Would you consider renting a room in your house to someone living in poverty?</td>
<td>1.00</td>
<td>5.00</td>
<td>2.87</td>
<td>1.19</td>
<td>1.42</td>
<td>55</td>
</tr>
<tr>
<td>2</td>
<td>Would you feel that you could trust a coworker who is impoverished?</td>
<td>1.00</td>
<td>5.00</td>
<td>3.75</td>
<td>1.07</td>
<td>1.14</td>
<td>55</td>
</tr>
<tr>
<td>3</td>
<td>How would you feel about an impoverished individual taking care of your home while you were out of town?</td>
<td>1.00</td>
<td>5.00</td>
<td>2.71</td>
<td>1.11</td>
<td>1.22</td>
<td>55</td>
</tr>
<tr>
<td>4</td>
<td>How would you feel about leaving a family member in the care of someone living in poverty?</td>
<td>1.00</td>
<td>5.00</td>
<td>2.85</td>
<td>1.29</td>
<td>1.65</td>
<td>55</td>
</tr>
<tr>
<td>5</td>
<td>How would you feel about setting up one of your friends on a date with an impoverished individual?</td>
<td>1.00</td>
<td>5.00</td>
<td>2.71</td>
<td>1.15</td>
<td>1.33</td>
<td>55</td>
</tr>
<tr>
<td>6</td>
<td>If you were an organ donor, how would you feel about one of your organs going to an impoverished individual rather than a more affluent individual?</td>
<td>1.00</td>
<td>5.00</td>
<td>4.02</td>
<td>1.15</td>
<td>1.33</td>
<td>54</td>
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</tbody>
</table>
### Table 8.3 Post-Experience Response Data Q1-26

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<th>#</th>
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<th>Maximum</th>
<th>Mean</th>
<th>Std Deviation</th>
<th>Variance</th>
<th>Count</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Most poor people are satisfied with their standard of living</td>
<td>1.00</td>
<td>5.00</td>
<td>1.31</td>
<td>0.66</td>
<td>0.43</td>
<td>55</td>
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<tr>
<td>2</td>
<td>Poor people are content with receiving welfare</td>
<td>1.00</td>
<td>5.00</td>
<td>2.11</td>
<td>1.11</td>
<td>1.22</td>
<td>55</td>
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<tr>
<td>3</td>
<td>There is a correlation between race and poverty</td>
<td>1.00</td>
<td>5.00</td>
<td>3.47</td>
<td>1.23</td>
<td>1.52</td>
<td>55</td>
</tr>
<tr>
<td>4</td>
<td>Poor people live as well as I do</td>
<td>1.00</td>
<td>3.00</td>
<td>1.24</td>
<td>0.54</td>
<td>0.29</td>
<td>55</td>
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<tr>
<td>5</td>
<td>Poor people are getting more than they need from the government</td>
<td>1.00</td>
<td>4.00</td>
<td>1.53</td>
<td>0.78</td>
<td>0.61</td>
<td>55</td>
</tr>
<tr>
<td>6</td>
<td>Everyone in the United States has access to water and electricity</td>
<td>1.00</td>
<td>4.00</td>
<td>1.40</td>
<td>0.68</td>
<td>0.46</td>
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<tr>
<td>7</td>
<td>Public transportation in the United States is sufficient</td>
<td>1.00</td>
<td>4.00</td>
<td>1.51</td>
<td>0.76</td>
<td>0.58</td>
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<tr>
<td>8</td>
<td>Poor people are as hygienic as everyone else</td>
<td>1.00</td>
<td>5.00</td>
<td>2.09</td>
<td>1.07</td>
<td>1.14</td>
<td>55</td>
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<tr>
<td>9</td>
<td>Poor people work about as hard as everyone else</td>
<td>1.00</td>
<td>5.00</td>
<td>3.75</td>
<td>1.10</td>
<td>1.21</td>
<td>55</td>
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<tr>
<td>10</td>
<td>Poor people are as intelligent as everyone else</td>
<td>1.00</td>
<td>5.00</td>
<td>3.67</td>
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<td>11</td>
<td>Poor people are about as trustworthy are everyone else</td>
<td>1.00</td>
<td>5.00</td>
<td>3.35</td>
<td>1.21</td>
<td>1.46</td>
<td>55</td>
</tr>
<tr>
<td>12</td>
<td>Poor people are about as lazy as everyone else</td>
<td>1.00</td>
<td>5.00</td>
<td>2.64</td>
<td>1.18</td>
<td>1.40</td>
<td>55</td>
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<tr>
<td>13</td>
<td>Poor people experience the same amount of misfortune in their lives as</td>
<td>1.00</td>
<td>5.00</td>
<td>2.42</td>
<td>1.41</td>
<td>1.99</td>
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<td>14</td>
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<td></td>
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<td></td>
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<tr>
<td>15</td>
<td>Poor people have the same moral values as everyone else</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Poor people have the same work ethic as everyone else</td>
<td></td>
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<td></td>
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<tr>
<td>17</td>
<td>Poor people are just as likely to become sick as everyone else</td>
<td></td>
<td></td>
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<tr>
<td>18</td>
<td>Poor people make mostly healthy eating choices</td>
<td></td>
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<tr>
<td>19</td>
<td>Physicians have a responsibility to treat patients even if they cannot pay</td>
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<tr>
<td>20</td>
<td>Physicians treat all patients equally, without regarding their socioeconomic status</td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>21</td>
<td>Everyone in America has access to affordable health insurance</td>
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<td></td>
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<tr>
<td>22</td>
<td>Just as many non-poor people are on disability as poor people</td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td>23</td>
<td>The quality of hospitals in low-income areas is the same as hospitals in middle and upper income areas</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Individuals with public health insurance receive the same level of medical care as individuals with private health insurance</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>25</td>
<td>Poor people take care of themselves about as well as non-poor people do</td>
<td>1.00</td>
<td>5.00</td>
<td>2.68</td>
<td>1.09</td>
<td>1.18</td>
<td>55</td>
</tr>
<tr>
<td>26</td>
<td>Medical services and resources are distributed without influence from patient income</td>
<td>1.00</td>
<td>4.00</td>
<td>1.74</td>
<td>0.84</td>
<td>0.71</td>
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### Table 8.4 Post-Experience Response Data Social Distance

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<th>Std Deviation</th>
<th>Variance</th>
<th>Count</th>
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<tbody>
<tr>
<td>1</td>
<td>Would you consider renting a room in your house to someone living in poverty?</td>
<td>1.00</td>
<td>5.00</td>
<td>3.38</td>
<td>1.18</td>
<td>1.40</td>
<td>55</td>
</tr>
<tr>
<td>2</td>
<td>Would you feel that you could trust a coworker who is impoverished?</td>
<td>2.00</td>
<td>5.00</td>
<td>3.89</td>
<td>0.89</td>
<td>0.79</td>
<td>55</td>
</tr>
<tr>
<td>3</td>
<td>How would you feel about an impoverished individual taking care of your home while you were out of town?</td>
<td>1.00</td>
<td>5.00</td>
<td>3.16</td>
<td>1.29</td>
<td>1.66</td>
<td>54</td>
</tr>
<tr>
<td>4</td>
<td>How would you feel about leaving a family member in the care of someone living in poverty?</td>
<td>1.00</td>
<td>5.00</td>
<td>3.09</td>
<td>1.34</td>
<td>1.79</td>
<td>55</td>
</tr>
<tr>
<td>5</td>
<td>How would you feel about setting up one of your friends on a date with an impoverished individual?</td>
<td>1.00</td>
<td>5.00</td>
<td>3.11</td>
<td>1.27</td>
<td>1.62</td>
<td>55</td>
</tr>
<tr>
<td>6</td>
<td>If you were an organ donor, how would you feel about one of your organs going to an impoverished individual rather than a more affluent individual?</td>
<td>2.00</td>
<td>5.00</td>
<td>4.49</td>
<td>0.87</td>
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### Table 8.5 Post-Experience Response Data Familiarity with Poverty

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<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>I do not know</th>
<th>Total</th>
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<tbody>
<tr>
<td>1</td>
<td>I have observed, in passing, a person I believe may have been impoverished</td>
<td>83.64%</td>
<td>3.64%</td>
<td>12.73%</td>
<td>55</td>
</tr>
<tr>
<td>2</td>
<td>I have observed persons living in poverty on a frequent basis</td>
<td>52.73%</td>
<td>38.18%</td>
<td>9.09%</td>
<td>55</td>
</tr>
<tr>
<td>3</td>
<td>There are persons who live in my neighborhood who are impoverished</td>
<td>29.09%</td>
<td>43.64%</td>
<td>27.27%</td>
<td>55</td>
</tr>
<tr>
<td>4</td>
<td>A friend of the family is impoverished</td>
<td>50.91%</td>
<td>32.73%</td>
<td>16.36%</td>
<td>55</td>
</tr>
<tr>
<td>5</td>
<td>I have a relative who is impoverished</td>
<td>45.45%</td>
<td>38.18%</td>
<td>10.91%</td>
<td>55</td>
</tr>
<tr>
<td>6</td>
<td>I live with someone who is impoverished</td>
<td>9.09%</td>
<td>81.82%</td>
<td>9.09%</td>
<td>55</td>
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### Table 8.6 Post-Experience Response Data Rank Order

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<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Total</th>
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<td>Shelter</td>
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<td>4</td>
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<td>3.64%</td>
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<td>7.27%</td>
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<td>Groceries</td>
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<td>2</td>
<td>1</td>
<td>29.0%</td>
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<td>16.3%</td>
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<td>Practicing religion</td>
<td>12.7%</td>
<td>7</td>
<td>0.00%</td>
<td>0</td>
<td>3.64%</td>
<td>2</td>
<td>1.82%</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>Electricity and water</td>
<td>3.64%</td>
<td>2</td>
<td>23.6%</td>
<td>1</td>
<td>3</td>
<td>38.1%</td>
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<td>21.8%</td>
</tr>
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<td>Medical treatment</td>
<td>1.82%</td>
<td>1</td>
<td>7.27%</td>
<td>4</td>
<td>10.9%</td>
<td>6</td>
<td>21.8%</td>
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<td>Transportation</td>
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<td>7.27%</td>
<td>4</td>
<td>14.5%</td>
<td>8</td>
<td>27.2%</td>
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<td>Prescription medications</td>
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<td>5.45%</td>
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<td>Sig. 2-tailed</td>
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### Table 8.8 Parametric Statistics Survey Data for Paired Samples T-Test

**Social Distance**

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<th>Question</th>
<th>Difference in Means</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>t</th>
<th>Sig. 2 tailed</th>
<th>Percent Change in Means</th>
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### Table 8.9 Pre-Experience Attribution Questionnaire Vignette Responses

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<tr>
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<th>Scenario 1</th>
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<th>Scenario 3</th>
<th>Scenario 4</th>
<th>Percent Change from Scenario 1 to 4</th>
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<td>1.2143</td>
<td>2</td>
<td>2.0667</td>
<td>44.70%</td>
</tr>
</tbody>
</table>