

Replication of Ames and Fiske, 2015

“Perceived intent motivates people to magnify observed harms”

PNAS, 2015, 112 (12) 3599-3605.

<https://www.pnas.org/content/112/12/3599>

The original paper includes several studies. We randomly chose study 1. In this between-subject experiment, participants read two different versions of a framed vignette that describes a nursing home employee who mixed up patients’ medications, either intentionally or unintentionally. Participants then freely choose a second task to perform from five options. One of these options is to assign blame, condemnation, and punishment to the harm-doer. Participants in the “Intentional Harm” condition choose the blame task more often than participants in the unintentional vignette.

Hypothesis to replicate and bet on: Reading a vignette describing a nursing home employee who mixed up patients’ medications intentionally results in an increased choice of the “blame” task relative to the choice frequency of the blame task of participants who read a vignette in which the medications were mixed up unintentionally. To evaluate this hypothesis, the authors perform a χ^2 -test ($\chi^2(1) = 6.7, p = 0.009$); p. 3601.

Criteria for replication: The criteria for replication are an effect in the same direction as in the original study and a p -value < 0.05 in a two-sided χ^2 -test.

Power analysis: The original study had 201 participants. The standardized effect size (Cohen’s d) was $d = 0.365$. To have 90% power to detect 67% of the original effect size, a sample size of $n = 710$ is required.

Sample: As in the original study, we will restrict our HITs to US participants. For experiment 1, no further exclusion criteria were applied. We will make sure that participants can only participate once from the same account in this specific study, and we will only recruit participants with a HIT approval rate of 95% or above. We will also check all IP addresses via <https://www.ipqualityscore.com/>; and we will remove any participants where one or more of the following is true: fraud score ≥ 85 ; TOR = True; VPN = True; Bot = True; abuse velocity = high. The replication sample size is the sample size after any exclusions of participants.

Materials: We will code the experiment ourselves based on the information provided in the paper and the Supplementary Information, as the original authors were not able to provide us with the original software. Yet, the authors agreed on providing feedback on the re-programmed software to ensure that the replication closely follows the original implementation.

Procedure: We will closely follow the procedure of the original experiment. The following summary of the experimental procedure is therefore largely based on the description of the experiment in the article (p. 3601) and the Supporting Information.

Participants will first be shown a Captcha, and will thereafter provide informed consent. After this we will include an attention check that participants will need to pass to continue to the study. This attention check is in addition to any other potential attention check(s) used in the original study. Participants will then be asked to read a vignette describing events in a nursing home. Participants will be informed that this vignette is a composite, rather than a veridical report of a specific instance. In particular, the instructions include the following statement: “The

following story is a composite of several true events. We are not asking about any specific instance. Resemblance to any specific person(s) or location(s) is coincidental.”

After reading the vignette, participants answer three questions before proceeding to the reinforcement game: “Did Jake give the wrong medications on purpose, or on accident?” (manipulation check); “Do you feel like you remember hearing/reading about an event like this (e.g., on the news)?” (“yes,” “maybe,” “no”); and “Assume that Jake never mixed up pills again, and that there was no long-term harm done. Do you think that the residents of the nursing home would be better off knowing why they got sick, or not knowing why they got sick?” (“they’d be better off knowing,” “they’d be better off not knowing,” “not sure/no opinion”).

Next, participants complete the main task, and then report their demographic information (age, sex, and race). In the main task, participants see a page with the following instructions: “Thanks—you're about 75% done. Please choose one of the following to complete (pending availability). They all take about the same amount of time.” Participants chose freely among the following five options, presented in random order:

- Offer your opinion about how (if at all) someone like Jake should be punished for what he did, and what amount of blame/moral condemnation he deserves.
- Take a short quiz about the cost of healthcare in the U.S. (answers will be provided at the end of the quiz).
- View a healthcare advertisement and offer your opinions about its tactics and effectiveness.
- Offer your opinion about elder care in the U.S.
- Answer various questions about nursing home situations like one you just read about.

Participants are asked to select one task to complete. Propensity to select the “blame/punish/condemn” option (presented first above, but presented in random order to each participant) is the critical dependent variable.

Analysis: The analysis will be performed as in the original paper: the number of participants choosing the blame task between the two experimental treatments (“Intentional Harm” vs. “Unintentional Harm”) will be compared using a χ^2 -test of equal proportions.

Subject payments: We are standardizing payments across all replications so that studies have a certain show-up fee depending on the expected length of the study, with an hourly wage from the show-up fee of \$8 and a minimum payment of \$1 (for studies with incentive payment we use the same incentive payment as in the original study; and this payment is paid in addition to the show-up fee). If we have problems recruiting, we will increase the show-up fee.