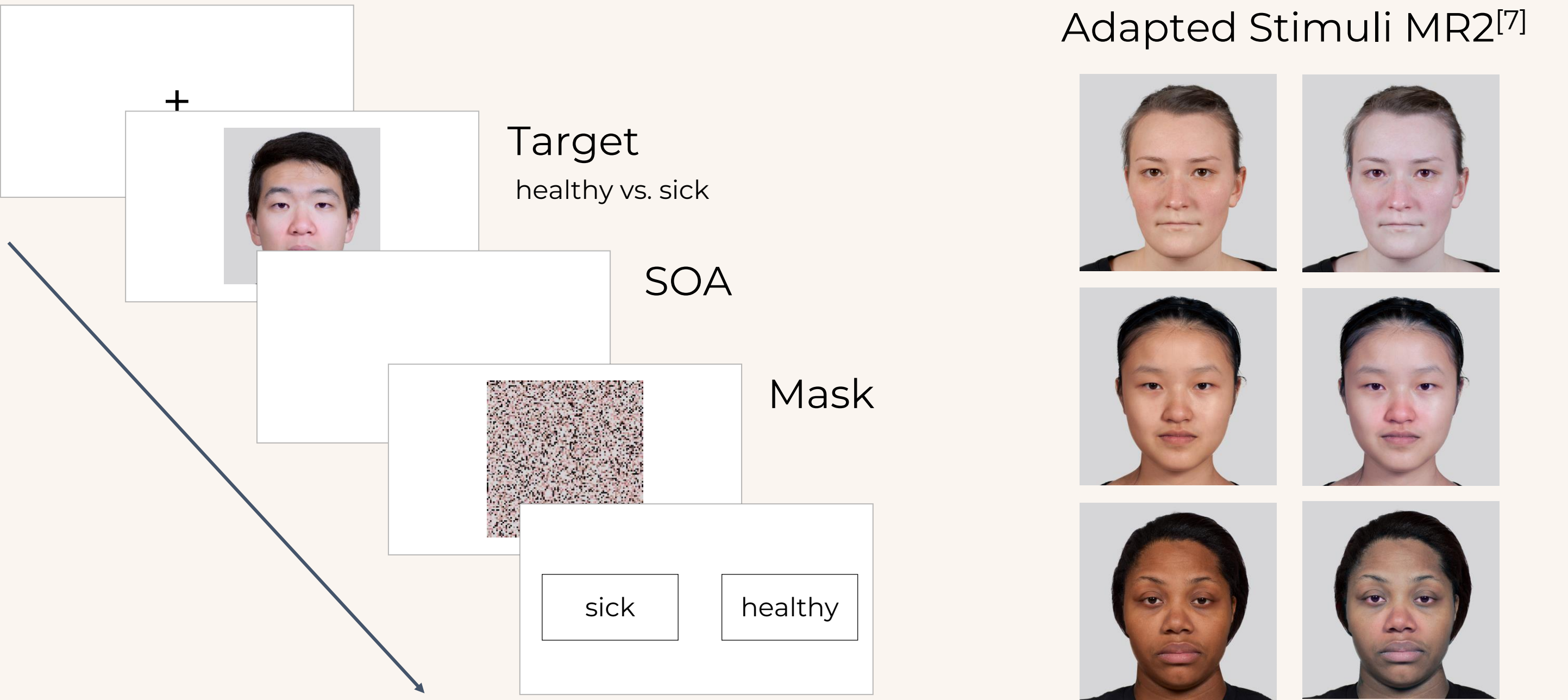


Introduction

Recognizing and avoiding cues of infection is a central challenge of the Behavioral Immune System^[1]. As false-negative decisions (i.e., not recognizing pathogen cues as such) are associated with high risk, individuals should show a bias for positive (i.e., low risk) decisions overall^[2, 3]. Several studies have shown this pattern for cues indirectly related to disease^[e.g., 4]. This could be more pronounced for decisions regarding individuals from rather unfamiliar groups^[3, 5]. One salient marker for group membership is ethnicity^[6].

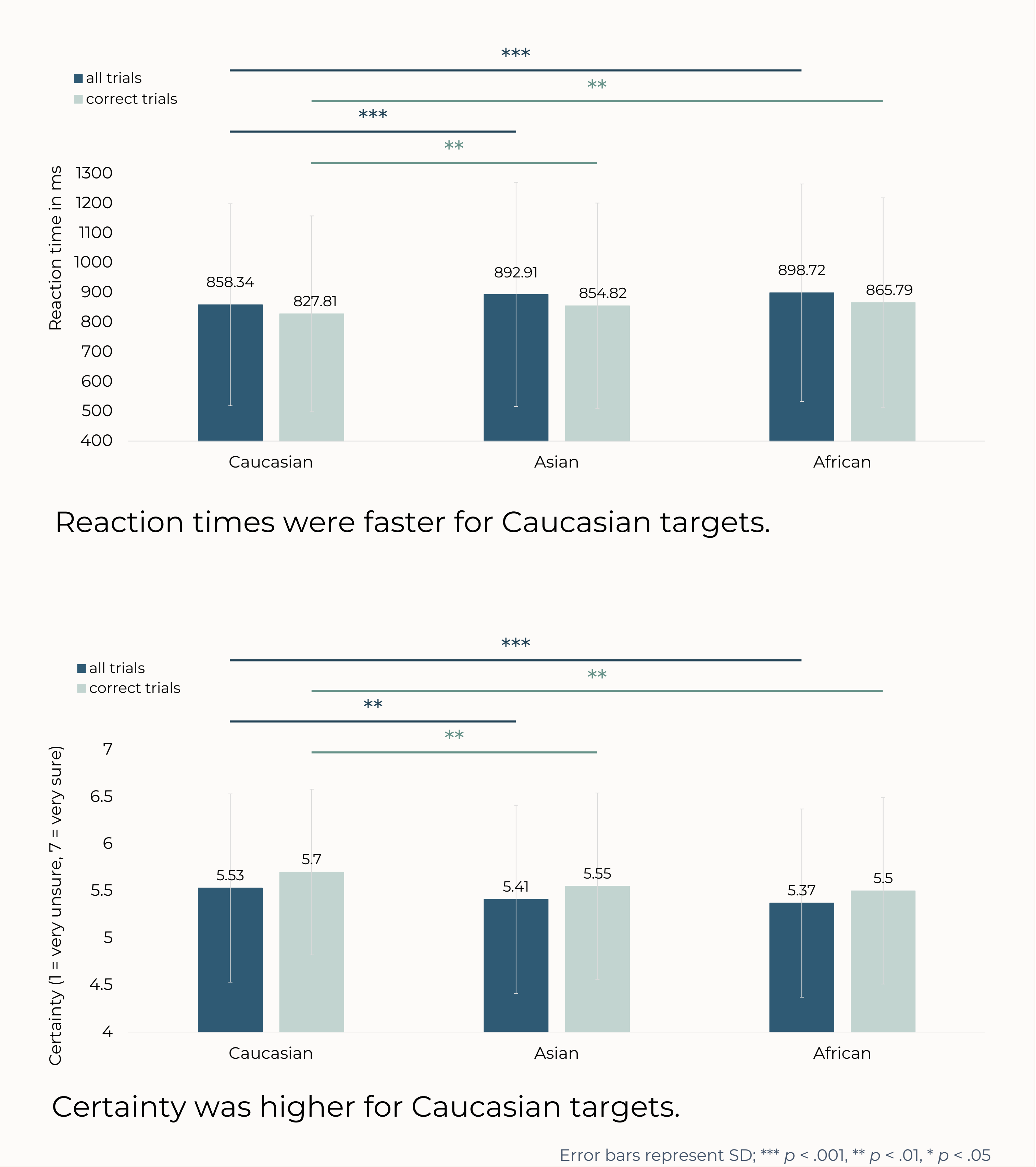
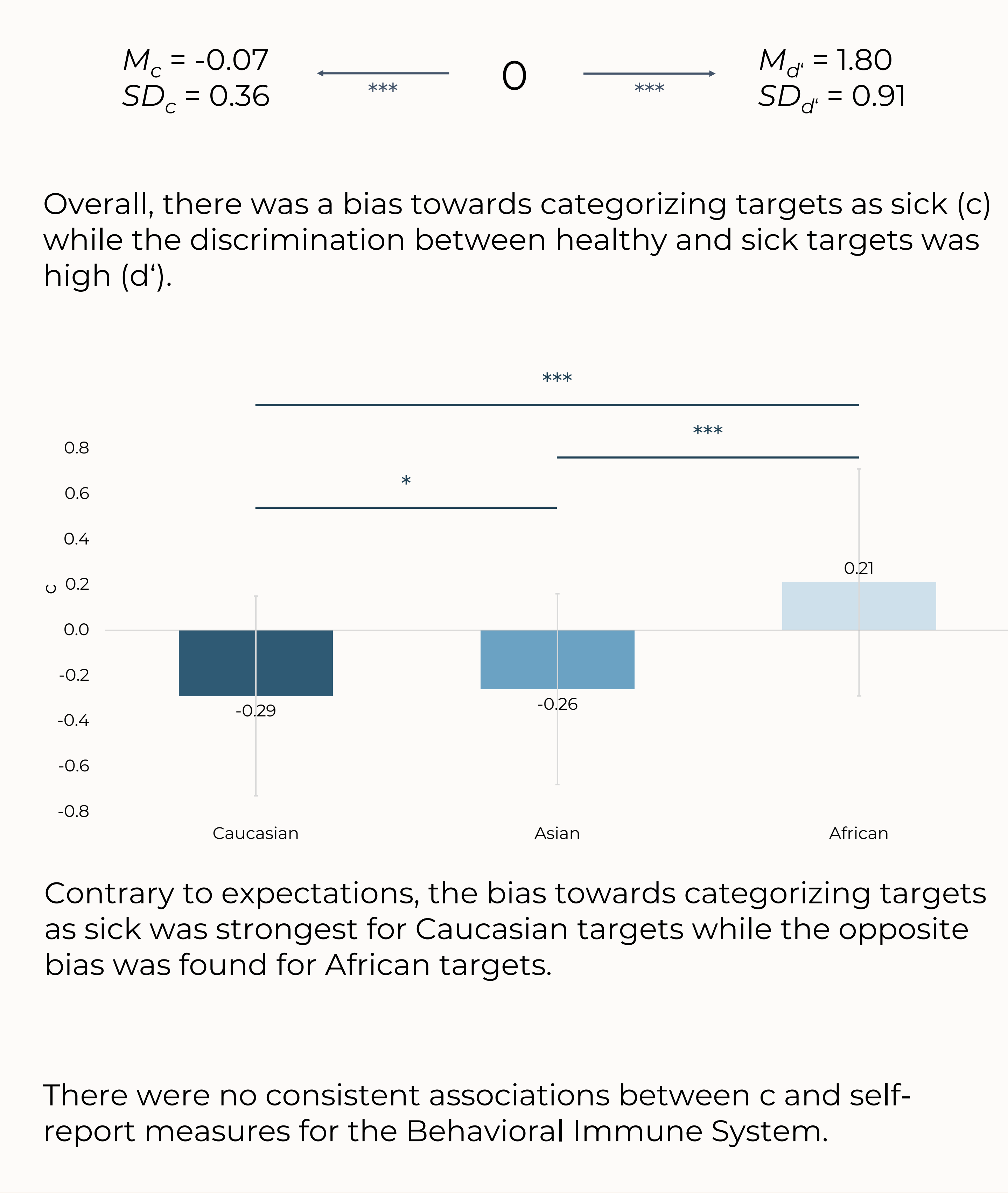
Aim: Development of a behavioral signal detection task to test a bias in categorizing cues directly related to disease in faces of different ethnicities.

Methods



Results

$N = 297$ 18 – 70 years old ($M = 33.49$, $SD = 12.39$) ♀ = 203, ♂ = 93, ♂ = 1 279 Caucasian, 8 African, 2 East-Asian



Regarding total scores, the task seems to capture behavior consistent with the Behavioral Immune System.

Discussion

Despite being consistent with expectations of the Behavioral Immune System, there were no consistent associations with typical measures (e.g., Disgust Sensitivity). Recognition of pathogen cues could be independent from affective responses.

The strongest bias for sick categorizations for Caucasian targets could be explained with an ingroup effect for this sample. In disease contexts, individuals are more likely to contract diseases from ingroup members^[see 8].

African targets were the only group to have a bias toward healthy categorizations. They seem to have a special status which cannot be explained by more difficult or more uncertain decisions.

Conclusion

It is unclear whether these effects are caused by group membership or by specific facial features of different ethnicities.

Reaction times rather than accuracy could be relevant for pathogen decisions regarding unfamiliar groups^[see 9].

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