

# COGNITIVE DISSONANCE: DENIAL, SELF CONCEPTS AND THE ALCOHOLIC STEREOTYPE

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Alcoholism is a serious problem. In Ontario, 3.89% of the population who are 15 years of age or older are believed to be alcoholic (Marshman, 1978). The Lalonde (1974) report stated that in Canada "one quarter of all first male admissions to psychiatric hospitals are due to alcoholism" (p. 24). The report also related alcohol abuse to "motor vehicle accidents, poisonings, accidental fire deaths, cirrhosis of the liver and falls" (p. 24). Consequently, nurses will frequently encounter patients diagnosed as alcoholic.

In caring for patients diagnosed as alcoholic, two common problems are: denial of alcoholism (Moore & Buchanon, 1966) and negative self concepts (Heinemann, Moore, & Gurel, 1977; Quereshi & Soat, 1976). Nurses may find these problems frustrating and difficult to deal with. Common theoretical frameworks, such as viewing denial as a defence mechanism, are complex and offer few, if any, interventions for the nurse. A study was conducted to examine denial, negative self concepts and acceptance of the alcoholic stereotype within a theoretical framework of cognitive dissonance.

## The Alcoholic Stereotype

Why is the term "alcoholic stereotype" used? A stereotype is an image of a minority group generally accepted within a culture or society. Simpson and Yinger (1972) state stereotypes have the following characteristics: highly exaggerated picture of a few characteristics, invented traits made reasonable by association with other traits that may have a kernel of truth, and failure to show how the majority share these traits. Traits are thought to be intrinsic or even self willed and have little possibility of change. (p. 53) Such a definition seems to apply to what is often called the "alcoholic personality."

The negative stereotype of the alcoholic assumes that the alcoholic is not worthwhile. Specific exaggerated traits depict the alcoholic as "uncontrolled, negligent, insensitive, irresponsible, self-centred,

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careless, hostile, lazy, contentious or foolish" (Tamarin & Neumann, 1974, p. 316). They are also considered "bad" and "weak." Past studies have found that alcoholics themselves (Hoy, 1973; McCartney & O'Donnell, 1981; Pennock & Poudrier, 1978), health professionals (Chalfant, 1979; Cohen, Griffen, & Wiltz, 1982; Kilty, 1975; Sowa & Cutter, 1974; Wallston, Wallston, & DeVellis, 1976), community residents (Kilty, 1975, 1978), graduate students (Gay, 1981) and even 12 year old children (Isaacs, 1977), accept a stereotyped view of alcoholics and/or substance abusers generally.

### Adaptation of Festinger's Theory of Cognitive Dissonance

Cognitive dissonance is a psychological theory developed by Festinger (1957). It alleges that if a person's cognitions (knowledges, opinions or beliefs) are inconsistent with one another, that person will be uncomfortable and will be motivated to make them more consistent.

Acceptance of the alcoholic stereotype indicates acceptance of the cognition "Alcoholics are not worthwhile." The treatment staff must encourage acceptance of the cognition "I am worthwhile" to improve the alcoholic's self concept. They must also encourage acceptance of the cognition "I am alcoholic" to overcome denial of alcoholism. Difficulty with these three cognitions is illustrated in Figure 1.

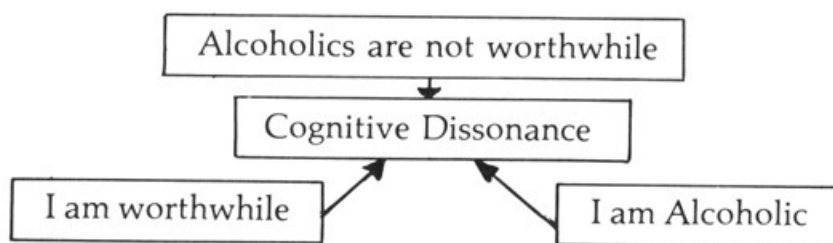


Figure 1. Dissonance with three cognitions.

Within this framework the alcoholic could resolve the dissonance by rejecting or altering one of the cognitions. He/she could (a) deny alcoholism; (b) accept a more negative self concept, or (c) reject the alcoholic stereotype. Those persons who accept their alcoholism and the negative stereotype would have a more negative self concept than if they rejected the stereotype. On the other hand, if the dissonance were reduced through denial, there would not be the same reason to suspect any relationship between self concept and acceptance of the stereotype because the dissonance would already be reduced. Without this motivating factor, the person's normal resistance to change would take precedence. Therefore the hypotheses are: (a) Among those accepting alcoholism or problem drinking there will be a positive

relationship between the "alcoholic" and "self" concepts, and (b) there will be no relationship between "alcoholic" and "self" concepts among those denying alcoholism.

Previous writers have suspected that alcoholics' conflicting feelings about themselves personally and alcoholics generally may cause conflict or cognitive dissonance. Pennock and Poudrier (1978) viewed denial as a means of reducing dissonance between the self and alcoholic concepts among subjects charged with drunken driving. They found an 11 week educational program resulted in subjects having a more positive alcoholic concept but not changing their self concept. Denial was not measured. In a discussion on "Alcoholism from the Inside Out" Wallace (1977) states "Because his actions when intoxicated are so markedly discrepant with his primary personality, the alcoholic experiences ever increasing identity confusion. In a sense, he is caught in a state of massive, painful cognitive dissonance. His private and most cherished beliefs about himself are constantly contradicted by the facts of his overt, intoxicated actions" (p. 11).

Method

The sample consisted of 116 male and female subjects from five in-patient or day-patient alcoholism programs in south-central Ontario, Canada. The ratio of psychiatric hospital-based programs to other hospital-based programs, the percentage of women in the sample and the age of the subjects were similar to those found in a provincial survey of all alcoholism programs in Ontario (Marshman, 1978), (see Table 1). Seventeen patient groups had been addressed to request volunteers for a group administered questionnaire. The potential subjects had been identified as "alcoholic" by the treatment program staff.

Table 1  
Comparison of Study Sample to Marshman Report

	Study Sample	Marshman Report
Ratio of Psychiatric hospital based programs: Other hospital based programs:	2:2.8	2:3
Percentage of women in sample	14 %	23 %
Age	Median 31-40 Mode 41-50	Mean 39.5

Of the subjects, 52.1% were in their first week of treatment, 31.4% were in their second week, 9.9% were in their third week, 4.1% in their fourth week and 2.5% did not answer this question. The large number with shorter lengths of treatment reflects the investigator's attempts to include subjects as soon after admission as possible.

Eleven semantic differential scales were used to measure acceptance of the alcoholic stereotype and self concept. These scales are attitude measuring scales developed by Osgood, Suci and Tannenbaum in 1957. They have been used in many studies, including more than 80 which examined self concept (Wylie, 1974). However, since these scales were not developed specifically for measuring self concept, a supplementary scale, the Rosenberg Self Esteem Scale (1965), was also used. The correlation (Kendall's tau) between the Rosenberg Self Esteem Scale (RSES) and the self concept measurement on the semantic differential scales was .29 ( $p < .001$ ). This may reflect that the two instruments measure different aspects of the self concept. Since this study was more concerned with the parts of the self concept likely to be influenced by the alcoholic stereotype, rather than self esteem per se, the semantic differential results are the most important.

Semantic differential scales consist of adjective pairs. The subjects were asked to rate "alcoholics" and "myself" along seven point scales, for example:

sensitive	_____	_____	_____	_____	_____	_____	_____	insensitive
	1	2	3	4	5	6	7	

The specific adjective pairs are included in Figure 2.

In addition, an item measuring denial was developed. This asked subjects to place themselves in one of three categories: (a) alcoholic, (b) problem drinker but not alcoholic, or (c) neither alcoholic nor problem drinker.

## Results

Of the 116 subjects, 61% accepted their alcoholism, 28% having a problem with drinking but denied alcoholism, and 6% denied any problem with alcohol. The remaining 5% did not answer the item regarding denial. The differences in the sizes of these subgroups influenced the degree of relationship necessary to be statistically significant.

On semantic differential scales the "alcoholic" ratings were similar for all subgroups, but for semantic differential scale ratings of "myself" and RSES results, the self concept/self esteem improved with

increasing denial. Those who did not answer the denial item had the lowest scores. This is consistent with the cognitive dissonance theory, since if the dissonance were reduced through denial, a high self esteem could be maintained.

Both "alcoholics" and "myself" were rated more positively than anticipated, possibly because subjects avoided the extreme responses (valued at 1 or 7). Also the subjects had already been exposed to some treatment and had been in the company of a group of alcoholics. The relationship between self or alcoholic concept and length of treatment was not measured in this study but some past research revealed that self concept (Beckman, 1978; Burtle, Whitlock, & Franks, 1974) and alcoholic concept (Pennock & Poudrier, 1978) improved after treatment. Pennock and Poudrier (1978) found no improvement in self concept after treatment.

Profile analyses using the sign test were developed by plotting the means of each semantic differential scale adjective pair for both subject ratings of "alcoholics" and "myself" (see Figures 2, 3, 4, 5). The probability of these two profiles not crossing each other with 11 items is less than .001. In other words, this group of alcoholic subjects consistently rated "alcoholics" more negatively than "myself," the sole exception being those subjects not answering the denial item. The "alcoholics" profile and the "myself" profile appear quite similar in shape, particularly for those accepting their alcoholism. This could indicate that the alcoholic concept influences the self concept. Among those denying their alcoholism, there is a greater variation in the distance between the ratings of "myself" and "alcoholics".

The relationship between subjects' ratings of "alcoholics" and "myself" was examined on each individual scale at varying levels of denial. The bad-good scale (11.) was given particular focus since it was the most general and it was also clearly evaluative. Kendall's tau was .29 ( $p = .01$ ) for those accepting their alcoholism and .45 ( $p = .001$ ) for those only acknowledging a drinking problem. On the other hand, those denying any drinking problem had a very low and insignificant relationship ( $\tau = .06$ ). Several other adjective pairs revealed a similar pattern. For the subgroup who accepted their alcoholism, significant relationships were found on 6 of the 11 scales. For the "problem drinker only" subgroup, significant relationships were found on 7 of the 11 scales. The "problem drinker only" subgroup had stronger relationships on 8 out of the 11 items when compared to the "accepting alcoholism" subgroup. Only 2 significant relationships were found among those denying any problem with alcohol. Similarly, only 2 significant relationships were found among those not answering the denial item.



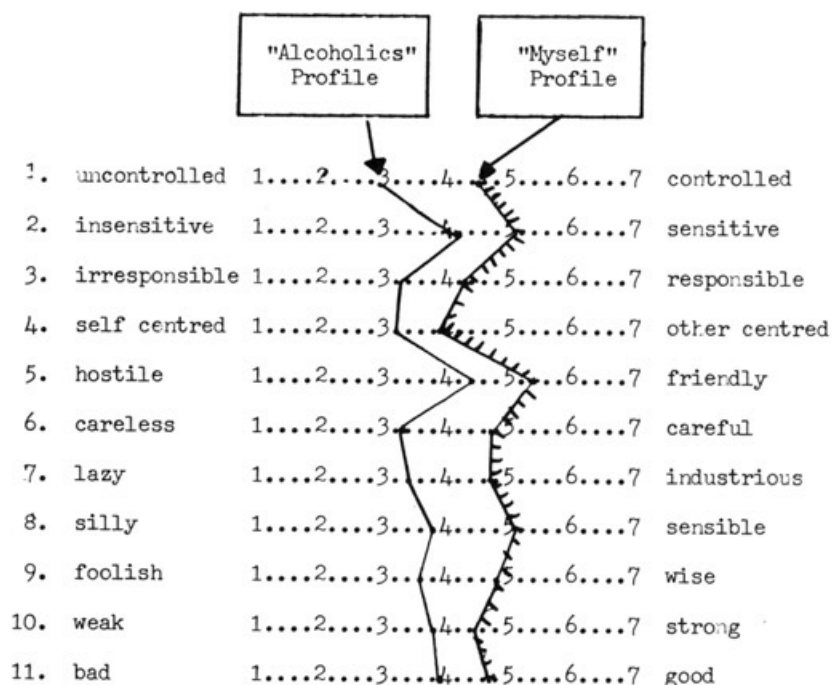


Figure 2. Profile analysis of means of semantic differential scale results for "Alcoholics" and "Myself" among those accepting their alcoholism.

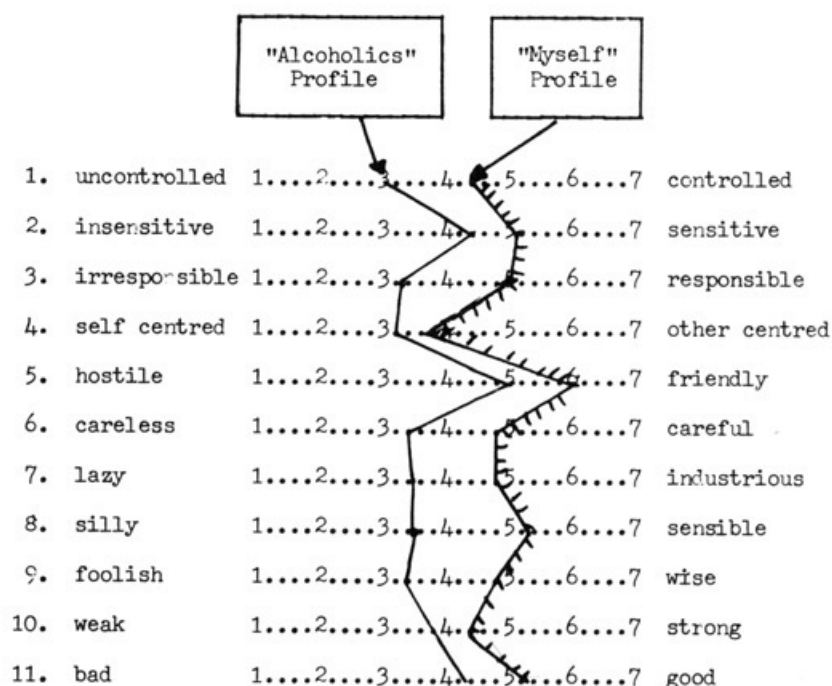


Figure 3. Profile analysis of means of semantic differential scale results of subjects acknowledging "Problem Drinking."

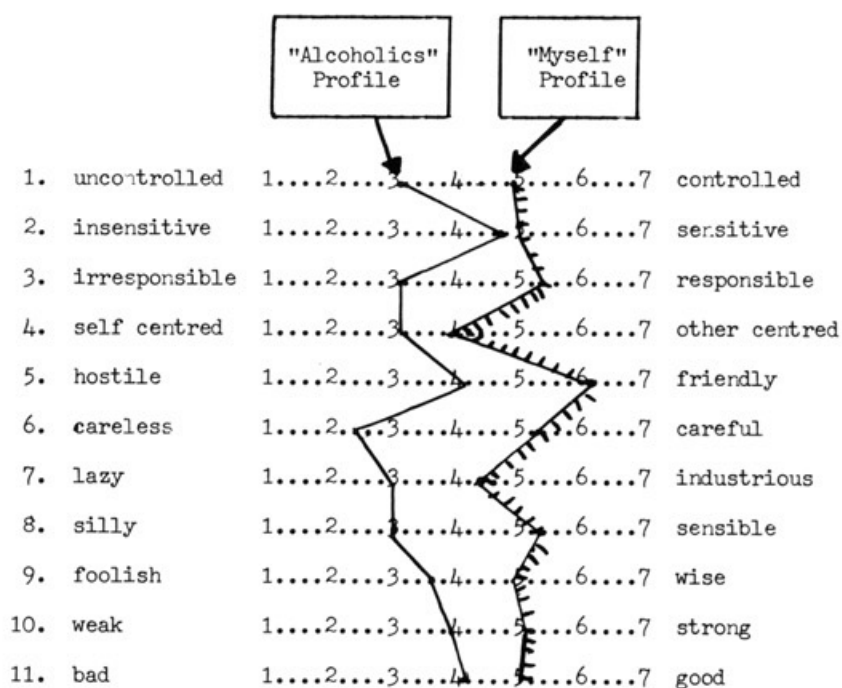


Figure 4. Profile analysis of means of semantic differential scale results of subjects denying alcoholism.

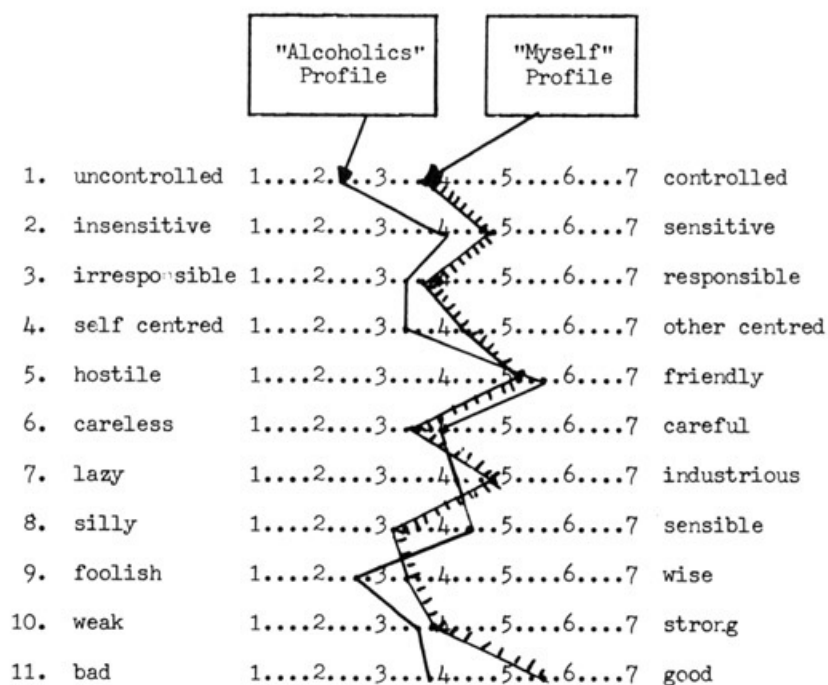


Figure 5. Profile analysis of semantic differential scale results of subjects not answering item re: Denial.

Among those accepting their alcoholism, with a possible range of 11 with the negative opinion to 77 with the most positive opinion, 6 subjects gave high totals for "myself" ( $\leq 55$ ) yet very low totals for "alcoholics" ( $\leq 25$ ). This only occurred among subjects who accepted their alcoholism.

### Discussion

The results of the semantic differential scales were consistent with past studies which found that alcoholic subjects generally accepted the alcoholic stereotype (Hoy, 1973; Pennock & Poudrier, 1978; Powell, 1976) and that alcoholic subjects rated "alcoholics" more negatively than their self concepts (Pennock & Poudrier, 1978; Powell, 1976).

The relationships between the individual scale ratings of "alcoholics" and "myself" at varying levels of denial/acceptance of alcoholism support the theoretical framework of cognitive dissonance. Those subjects who accepted their alcoholism, or admitted to a problem with drinking, had significant relationships between their ratings of "alcoholics" and "myself." However, among those denying any problem with alcohol, no such relationship was found. This was anticipated since the dissonance would already be reduced through denial.

Six subjects who accepted their alcoholism had maintained a high self concept despite their acceptance of the alcoholic stereotype. Partington (1970) found that alcoholics may divide their self concepts into a "sober self" and "high self" ("high self" refers to the self while drinking). This could be an alternate method of reducing dissonance.

Unexpectedly, the highest correlations were found between "alcoholics" and "myself" among those subjects accepting a problem with alcohol, yet denying alcoholism. Why would their self concepts be closer to their concepts of alcoholics than was the case for those subjects who identified themselves as alcoholics? It appears the use of the more socially acceptable label, "problem drinker," does not avoid the influence of the stigma associated with "alcoholics." There are several possible reasons for this. It may be that avoiding a label such as alcoholic reinforces the stigma associated with it. It could be that since the problem drinker category represents only partial denial, the dissonance has not been reduced. More study is needed to understand the differences between alcoholics admitting only to problem drinking and those accepting the alcoholic label.

The results of those not answering the denial item seem quite different from the results of the other groups. Unfortunately, due to lack of further information no interpretations are made.



## Implications for Nursing Practice

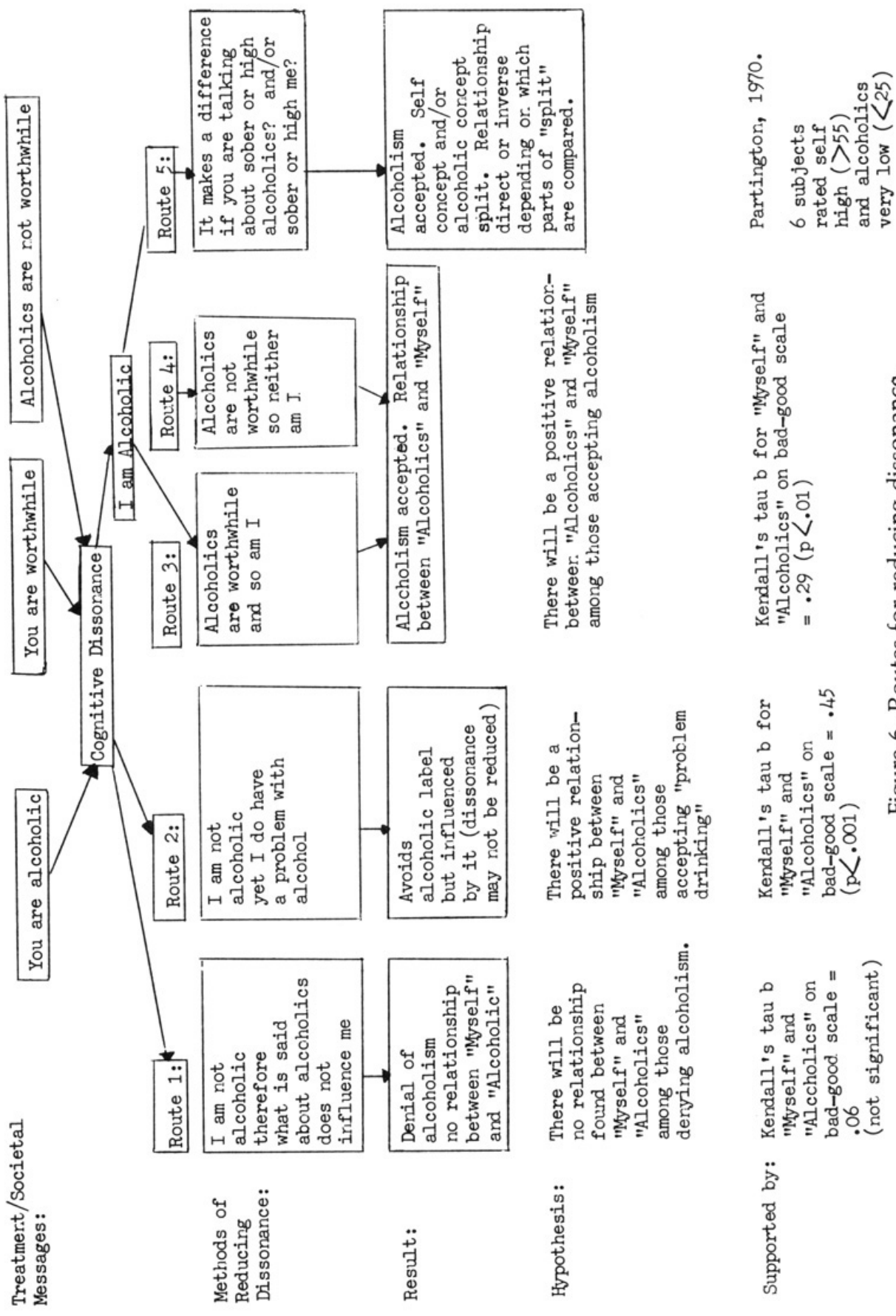
Cognitive dissonance may be an alternate framework to help understand the problems of denial and negative self concepts among patients diagnosed as alcoholic. A flow chart (Figure 6) has been developed to illustrate possible means of reducing the dissonance caused by the conflicting messages received by the alcoholic. This includes simply rejecting any of three messages (Routes 1, 3 and 4). It also includes (Route 5) the suggestion of Partington that alcoholics may split their self concept into "sober self" and "high self" to accommodate the alcoholic stereotype. Route 2 was included for those accepting a drinking problem but denying alcoholism. It would not be uncommon for an individual to change routes. Theoretically, if the treatment staff tried to overcome denial of alcoholism or improve the self concepts of alcoholic patients while still adhering to the stereotype, the patient would be returned to a state of cognitive dissonance.

When the stereotype is maintained, it may act as a fulcrum while the alcoholic seesaws between denial and a negative self concept. Reducing dissonance, without sacrificing a positive self concept or acceptance of alcoholism, occurs when the alcoholic either (a) rejects the stereotype (Route 3) or (b) splits his/her self concept and/or alcoholic concept (Route 5). The implication for the nurse would be health teaching and counselling to encourage rejection of the alcoholic stereotype. For example, with the patient who says "I am not alcoholic," the nurse could ask the patient how he/she sees alcoholics or how he/she might define alcoholism. Any misconception or negative attitude could then be discussed. This process might take place over a period of time.

Improving self concepts and overcoming denial are important treatment goals. Improving self concepts has been related to continued sobriety (Burtles, Whitlock, & Franks, 1974) and to alleviation of anxiety, depression and other indices of psychological distress (Beckman, 1978). Denial of alcoholism is a common treatment problem among patients diagnosed as alcoholic (Moore & Buchanon, 1966) that can be a barrier to entering treatment, and is also prognostically important (Kendall & Staton, 1966; Moore & Buchanon, 1966).

It is important for nurses to be aware of the potential influences of the alcoholic stereotype. It would also be important for nurses to be aware of their own feelings and assumptions about alcoholics.

Psychiatric nurses are certainly not the only nurses to encounter patients diagnosed as alcoholic. Perhaps if nurses in other areas, for



example in medicine, surgery, community health and emergency, had more effective means of facilitating acceptance of alcoholism, more alcoholic patients would seek further treatment.

### Suggestions for Future Study

1. Self concept, denial, and acceptance of the stereotype could be measured before and after a treatment program which challenged the stereotype.

2. The theoretical framework of cognitive dissonance could be tested among persons diagnosed as alcoholic in other settings such as Alcoholics Anonymous, out-patient treatment, jails, detoxification centres, general hospital wards, half-way houses, or non-specialized psychiatric wards.

3. A similar study could examine the families of alcoholic patients. How do their attitudes toward "alcoholics" affect their acceptance of the diagnosis and/or their concept of the identified alcoholic within their group?

4. A similar study could examine other diagnoses associated with stereotyping and stigma within a framework of cognitive dissonance. Examples could include "drug addicts," "schizophrenics," "psychiatric patients," and the "mentally retarded."

### Summary

This study examined the relationship between the acceptance of the alcoholic stereotype and the self concepts of alcoholic patients at varying levels of denial/acceptance of alcoholism. The results have been consistent with those suggested by a theoretical framework of cognitive dissonance. On a practical level, this framework, if accepted, offers an alternative method of handling denial or negative self concept: challenging the alcoholic stereotype.

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## RÉSUMÉ

### **Discordance cognitive: dénégalation, images négatives de soi et le stéréotype alcoolique**

Des questionnaires ont été remplis par 116 sujets inscrits à des programmes de désintoxication de l'alcool. Les rapports entre l'image de soi et l'acceptation du stéréotype d'alcoolique ont été analysés à divers niveaux de dénégalation/acceptation de l'alcoolisme. Parmi les sujets acceptant l'étiquette "d'alcoolique latent" ou "d'alcoolique," on a constaté respectivement 7 et 6 rapports entre les évaluations de "soi" et "d'alcoolique" sur 11 échelles différentielles sémantiques. Seulement deux de ces rapports importants ont été constatés chez les sujets niant tout problème d'alcool. Ces conclusions sont compatibles avec un cadre théorique de la discordance cognitive. Ce cadre, s'il est accepté, servirait de nouvelle mesure de soins face à la dénégalation de l'alcoolisme ou à l'image négative de soi chez les patients que l'on a diagnostiqués comme alcooliques: il faut contester le stéréotype.