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THE ATTITUDES OF REGISTERED NURSES TOWARD ALCOHOLISM
AND THE ALCOHOLIC

The Ohio State University

Ph.D. 1979

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THE ATTITUDES OF REGISTERED NURSES
TOWARD ALCOHOLISM AND THE ALCOHOLIC

DISSERTATION

Presented in Partial fulfillment of the Requirements for
the Degree Doctor of Philosophy in the Graduate
School of The Ohio State University

By
Jeanne McKeag Steele, B.S., M.Sc.
The Ohio State University
1979

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CHAPTER I
THE PROBLEM AND ITS SIGNIFICANCE

Introduction

In the decade of the 1970's the mass media and many professional publications have reflected a major concern of the general public, educators and providers of health and health-related services. The focus of this concern has been and continues to be on the rapidly increasing incidence of drug abuse within the American population and the serious health and social consequences resulting from this abuse. The use of a wide variety of mood altering drugs which are psychologically and/or physiologically addicting has increased at a rate so rapid that drug abuse, i.e., excessive indulgence in drugs, is now considered one of the most serious problems facing the nation (U. S. Secretary of Health, Education, and Welfare, 1974). Abuse of alcohol, the drug chemically labeled ethanol, however, is more widespread than the abuse of all other drugs, including marijuana, hallucinogens, narcotics, barbiturates and the various tranquilizers.

The problem of alcohol abuse is not new as the history of man's past use of the drug reveals. The human
tendency to seek pleasure from alcohol is probably as old as the recorded history of mankind. Throughout this history, up to and including the present time, alcohol, in addition to its use for medicinal purposes, has been used as an integral part in man's religious ceremonies, social customs, and economic life. Yet, in the past as in the present, alcohol use has been accompanied by the problem of alcohol abuse because in every drinking society there have been those who have been unable to control alcohol use.

In America with the exception of the brief period of prohibition following the passage of the Volstead Act in 1919 until its repeal in 1933, alcohol has been legally sanctioned for persons who have attained a specified age. The reason for this long history of acceptance of the drug is readily apparent when one recognizes that the manufacture, sale, and taxation of alcohol has been incorporated into the basic economic structure of the country from its very beginning to provide monies for various state and national programs (Rublowsky, 1970). However, while the legality of the drug has been established, clearly specified attitudes and norms controlling expectancies and overt behaviors during the course of drinking across the diverse ethnic groups have not yet been established. As a result
the amount, frequency, duration and style of drinking have over time differed according to sex, age, ethnic origin, religion, education, socio-economic status and personality. While diversified drinking behavior have continued to exist, according to Cahn (1970), conflicting attitudes toward the use of alcohol and the abuse of it have prevailed over time. Cahn has posited that alcohol use has been generally condoned despite the fact that norms regarding its consumption have not been well established. Further, he suggested that within this situation alcoholism which is due partially to this lack of norms has always been condemned. This condemnation he viewed as being due to the lack of knowledge about the addictive qualities of alcohol and the long held belief that one who uses alcohol excessively is weak in character. Thus, in addition to a heritage of alcohol use and abuse, Americans in contemporary society have been provided with a heritage of accepting attitudes toward the use of alcohol and rejecting attitudes toward alcoholism and those suffering from it. These rejecting attitudes have become one of the most controversial issues in the nation's approach to solving the increasing problem of alcoholism. It is the prevalence of these attitudes which is the subject of this investigation.

During the present decade the issue of attitudes toward the use of alcohol and alcohol abuse with its consequences
have become critical. This situation is due to the accelerating scope and magnitude of the drinking of alcoholic beverages, problem drinking, and alcoholism. Alcohol is no longer only associated with medical treatment, formal festivities, religious rituals, and family celebrations. At the present time, alcohol is associated with most types of socializing and recreation. In essence, alcoholic beverages have become representative of hospitality, sophistication, and daily relaxation within the American culture. As Hoyt (1977) has pointed out, Americans have become a drinking culture by virtue of the fact that the drinking of alcoholic beverages has become woven into the very fabric of society. Concomitant with this increase in alcohol use, the disease of alcoholism has become the fourth major health problem in the nation. It is outranked only by heart disease, cancer, and mental health diseases, according to the United States National Institute of Mental Health (1972). Additionally, having reached epidemic proportions, alcoholism is now the most serious and costly addictive disease in the nation.

There is ample evidence to show the scope of alcohol use in the country. A 1974 nationwide Gallup poll survey revealed, for example, that a total of 76 percent of men and 61 percent of women in the population are drinkers. Drinkers are defined as those persons who consume alcohol
and can be classified in any of the following categories: social drinker, situational drinker, problem drinker or alcoholic (see definitions, 23-26). The findings from this survey not only show that drinking of alcoholic beverages is an American norm and still predominantly a male behavior but that women drinkers are rapidly approaching the number of men drinkers (Health Communications, 1977b). Evidence cited by Keller and Gurioli (1976) in their statistical survey of alcohol consumption indicated that 77 percent of the boys and 69 percent of the girls in grades seven through twelve were drinkers, suggesting that there has been an upsurge in drinking at an earlier age for both males and females. Assuming then, that 65 percent of the population from 14 to 20 years are drinkers and that 70 percent of adults are drinkers, these researchers placed the total number of drinkers in the U. S. at approximately 113,000,000. Of these drinkers, it has been calculated that 1 out of 8 could be considered moving in the direction of alcoholism (National Association of Blue Shield Plans, 1973). Although the exact number of persons suffering from alcoholism is not precisely known because of the insidious nature of the disease, rough estimates suggest that there are 10 million people in the varying progressive stages of alcoholism (Health Systems Planning, 1977).
In Ohio, the rate of alcohol use and abuse has followed the national pattern rather closely. For the year 1976, the rate of alcoholism in the United States was judged to be 65.9 per thousand population while in Ohio the rate was estimated to be 61.4 per thousand population. Mid-Ohio's rate was calculated to be somewhat lower, 54.2 per thousand. However, this rate shows an increase of ten percent since the year 1973 (Health Systems Planning, 1977).

There is an abundance of proof that personal and societal costs of alcohol abuse are distressingly high in terms of both monetary and emotional costs in addition to the incalculable cost in human life. That the problem drinker or alcoholic is a danger both to himself and society was shown by studies that have indicated: (1) The life span of the alcoholic is shortened by 10 to 12 years due to the development of heart, gastro-intestinal, and neurological diseases; (2) The divorce rate among alcoholics is significantly higher; (3) The alcoholic is absent from work approximately two and one-half times more than other workers; (4) One-half of all homicides and suicides involve persons with alcohol problems; and (5) At least one-half of the automobile deaths and major injuries suffered in auto accidents involve a driver and/or pedestrian under the influence of alcohol (U. S. Department of Health, Education, and Welfare, 1976).
In monetary terms, available figures on the cost of alcoholism place the amount at around $25 billion a year. Nine billion of this total is spent annually on health and welfare services. The remainder is spent on the claims for damages, law enforcement for the protection of the public against persons under the influence of alcohol, and for the time lost from work by industry (U. S. Department of Health, Education, and Welfare, 1976).

In addition to this expanding knowledge about the increase in alcohol use and abuse as well as the costs of the disease of alcoholism to the country, a large body of knowledge about alcoholism has emerged from interdisciplinary research efforts over the past three decades. Theoretical efforts have produced a number of definitions of alcoholism, classifications of its stages, typologies of the alcoholic, and a number of theories directed at an attempt to explain the cause or causes of alcoholism. Further, extensive research has been done on the effects of alcohol upon the human body. Finally, innovative treatment approaches, including hypnosis, behavioral and cognitive therapy, and the use of an increasing number of pharmaceutical agents have been tested, utilized, and compared in a variety of clinical settings.

On the basis of this advancing knowledge about alcoholism, the American Medical Association (1973) subscribed
to the illness concept of alcoholism in 1956. The organization formally stated that alcoholism came under the purview of medicine. A year later and consistent with medicine's position, The American Hospital Association (1957) took the public position that alcoholic patients were best treated in a general hospital if the stigma attached to the disease were to be removed.

Awareness of the increasing problem of alcoholism, the accumulation of theoretical and clinical knowledge about alcoholism, and a change in the public attitudes toward it by the most influential organizations in the nation's health care system appear to have made only slight inroads into the national problem of alcoholism. According to the testimony given before the 94th Congress (Congressional Record, 1976), the single greatest barrier to alcoholics seeking treatment was identified as the perpetual stigma associated with the disease of alcoholism. At the roots of this stigma, in the view of Catanzaro (1968) and Cahn (1970) are the negative attitudes toward alcoholics and alcoholism held not only by the general public but by the health and health-related professions. These negative attitudes, they explained, resulted in alcoholics being stigmatized as inferiors by their affliction. From the position taken by these authorities, two issues can be identified which are cogent to the position taken by them. The first is whether
or not support has been demonstrated for the existence of
a relationship among a stigma, attitudes, and overt be-
havior. The second issue is whether or not negative at-
titudes toward the alcoholic and alcoholism which have
been found in the past among members of the health care
professionals continue to exist and whether or not they
are prevalent.

The studies by Yuker (1965) and Wallston, Wallston,
and DeVellis (1976) respond to the first issue. Yuker
clarified the relationship among attitudes, the stigma re-
sulting from stereotyping, and overt behavior. Using the
attitudes of nondisabled persons toward disabled persons,
he distinguished between two interacting aspects of atti-
tudes which serve as precursors and/or actual determinants
of behavior. These aspects he identified as (1) prejudice
or the tendency to categorize and perceive persons in group
membership rather than non-prejudicially as individuals and
(2) acceptance of rejection. According to him, with the
existence of prejudice a target person such as the disabled
person was prejudged and reacted to in stereotypic fashion
as a representative of a specific group. Whether interac-
tion was sought or avoided depended upon acceptance or re-
jection component contained in the attitude held. If prej-
udice did not operate, Yuker explained, the target person
was reacted to as an individual and solely upon the basis of
the acceptance or rejection aspect of the attitude held toward him or her as an individual.

Wallston et al. (1976) provided research evidence of the relationship between attitudes characterized as stereotyped and overt behavior. Exploring the relationship between a negative stereotype operating a registered nurses' attitudes toward alcoholic patients and their overt behavior in performing assessments of the patient, they found that their subjects assessed alcoholics in more negative psychological, social, and physical terms than non-alcoholic patients with the same admission diagnosis and health status.

A cursory review of the literature reveals support for describing health professionals as having negative attitudes toward the alcoholic and alcoholism which have prevailed over time. For example, researchers in different areas of the nation (Barchha, Stewart, & Guze, 1968; Moore, 1971; Chakerian and Schenkel, 1973; and Gomberg, 1975) have reported that from 25 percent to 70 percent of patients admitted to medical facilities of hospitals were admitted for medical problems which could be traced to alcohol abuse. Yet, in their investigations, according to a survey of the patients' medical records, this fact was ignored or went unrecognized in the medical management of the patient. It appears, therefore, that the attitudes operating are not the same positive attitudes expressed publicly
by the professional organizations representing physicians and hospitals.

Knox (1971) surveyed the attitudes toward alcoholics and alcoholism held by over 550 psychiatrists and psychologists employed by the Veterans' Administration. She used a questionnaire which incorporated items about the prognosis of alcoholism and preferences for treating alcoholics compared to other patients. Her results indicated that the majority of subjects viewed the prognosis of alcoholism as being poor, preferred to spend their time with patients with other types of problems, and would spend no more than 10 percent of their time with an alcoholic clientele.

Research on the attitudes of registered nurses has shown that they hold negative attitudes toward the alcoholic on one hand and a positive attitude toward alcoholism as a disease on the other hand (Pittman & Sterne, 1963). Johnson (1965) discovered in her study that those nurses who were working as staff nurses viewed alcoholic patients more negatively than head nurses or nurses in any other positions. Negative attitudes on the part of registered nurses toward alcoholic patients have also been reported by Ferneau and Morton (1968) Sowa and Cutter (1974), and Larson (1977). Even the attitudes of student nurses during their educational preparation for nurses have been shown to be negative toward the alcoholic patient and alcoholism.
The fact that the research studies which provide evidence of the existence of negative attitudes toward alcoholics and alcoholism have been conducted in diverse and widely separated settings makes it impossible to generalize the findings to other settings and groups of nurses. However, it is clear in view of the results that more than a firm knowledge of alcoholism is needed to effectively deal with the problem of alcohol abuse. Equally important, is the need to understand the complex public and private attitudes which underlie the stigma health care providers attach to the disease of alcoholism and the alcoholic. Unfortunately, there has been less systematic study in the area of attitudes than in any other of the areas which have an impact on the treatment of alcoholism.

Summarizing the background of the problem, it has been revealed that the nation is faced with an enormous and escalating problem of alcoholism. Moreover, the problem exists in a society where there is an absence of clearly prescribed norms governing the quantity, frequency, and style of alcohol consumption. This situation is viewed as contributing to alcohol abuse (Cahn, 1970 and Kinsey, 1966) because the potential problem drinkers are not provided a clear distinction between alcohol use and abuse. Consequently, they are less likely to have an early tendency
toward the abuse of alcohol modified by societal sanctions. Irrespective of the increasing national concern about the problem of alcoholism, research studies have shown that health care professionals, including registered nurses, have held negative attitudes toward the alcoholic and alcoholism. The effects of such attitudes have also been shown. However, these studies are few in number and there is a need for additional studies identifying the attitudes of registered nurses and the personal characteristics related to them.

Statement of the Problem

This study is concerned with the fact that the negative attitudes of health care professionals, among whom are registered nurses, have been identified as the single greatest barrier to the alcoholic seeking treatment for the disease of alcoholism (Proceedings and Debates of the 94th Congress, 1976, and Cahn, 1970). This fact is of particular significance when one considers the rapid increase in both the use of alcohol and the number of patients admitted to general hospitals suffering from varying phases of alcoholism and alcohol-related diseases (Barchha et. al., 1968 and Gomberg, 1975) who require nursing care. Of additional importance is the fact that negative attitudes toward the alcoholic patient on the part of registered nurses have
been reported (Pittman & Sterne, 1963; Wallston et al., 1976; and Larson, 1977). Further, attitudes of the nurse have been directly related to patient improvement (Meyer & Morris, 1977; Chavigny, 1976; and Wiley, 1977). However, little has been done to undertake a systematic study of the attitudes of registered nurses working in general hospitals throughout the nation to determine if the attitudes of these nurses are negative (non-therapeutic) and could be a barrier to the alcoholic person seeking treatment for alcoholism. The research problem is to study the attitudes of registered nurses in general hospitals.

Need for the Study

There are several reasons for concern about the attitudes of registered nurses toward the alcoholic person and alcoholism. Registered nurses are the largest group of health care providers in the nation and the majority of them are employed in general hospitals (The American Nurse, 1979) whose admission policies have been revised to include admission of patients with a primary diagnosis of alcoholism. Secondly, evidence is accumulating that with the rise in alcohol use, there is a corresponding rise in alcoholism and alcohol related health problems among patients admitted to general hospitals (Barchha et al., 1968 and Wiley, 1977). Thus, the possibility that nurses will
encounter and interact with patients or the families of patients with an alcohol problem or alcoholism is increased. Moreover, within the general hospital environment where nurses are employed, the safety with which nurses administer prescribed drugs, interpret patient complaints, evaluate patient progress, and plan teaching for discharge are contingent upon the nurses' knowledge and accurate observation about the patient's consumption of alcohol. Finally, the nature of nurses' attitudes toward the alcoholic and the disease of alcoholism have been shown to influence the type of care the patient with an alcohol related health problem receives (Larson, 1977).

In addition to these reasons for concern, there is also a concern for the generalizability of the limited number of studies done on the attitudes of student and registered nurses' attitudes toward the alcoholic patient and alcoholism. The investigations, as previously mentioned, were conducted in different areas of the country where registered nurses are employed or student nurses are educated. Further, the majority of the studies were done over a period of the past two and one-half decades when nursing education has undergone a distinct change from the three-year diploma programs to the two-year associate degree and four-year baccalaureate programs. Finally, research exploration involving investigation into the
possible variables related to the attitudes of registered nurses toward the alcoholic person and alcoholism has remained an untapped area of research.

At this point, then, continued systematic measurement and assessment of registered nurses' attitudes toward the alcoholic and alcoholism in areas and settings across the country is warranted to determine if the negative attitudes attributed to them are as prevalent as they are inferred to be. Furthermore, before an understanding of the attitudes expressed can be achieved there is a need to explore the variables related to these attitudes.

The need for a study of this type in Mid-Ohio is reinforced by the facts that: (1) The State of Ohio does not differ significantly from the estimated rate of alcoholism nationally; (2) Mid-Ohio has had an increase in alcoholism within a period of the last five years of ten percent; and (3) No data is available in Mid-Ohio on the attitudes of registered nurses toward the alcoholic person and alcoholism so that the resources and needs for dealing with the problem of alcoholism in this area can be fully determined.

It is expected that the data obtained from this study will contribute to empirical knowledge that will have practical significance for the registered nurse practitioner, educators in schools of nursing, and staff development personnel in general hospitals. By obtaining precise
data on the existing attitudes of nurses and those factors which may have a relationship to these attitudes, insight could be provided into the needs for curriculum innovation and continuing education. If the attitudes surveyed are found to be negative, a rationale for educational experiences that afford the nurse the opportunity to identify and analyze these attitudes exists. On the basis of such a rationale, a curriculum component could be developed that focuses on the registered nurse looking inward at the beliefs and deeper values underlying these attitudes and their influence on her relationship with the patient. In this way, the cognitive and affective growth required in the prevention, intervention, and treatment of alcoholism can be facilitated.

Purpose of the Study

This study has three major purposes. The first is to obtain precise, descriptive data on the attitudes of registered nurses in general hospital settings in Columbus, Ohio, toward the alcoholic person and alcoholism. The second purpose is to compare the data obtained with similar data on a group representative of the general population to determine if registered nurses differ in their attitudes toward the alcoholic and alcoholism from the population in general. The third purpose is to explore the relationship
between the personal characteristics of the nurses in the sample and their expressed attitudes.

Hypotheses

An overview of the literature has provided a basis for the problem statement and the development of major research questions for this study. These major research questions function as guidelines for the development of corresponding broad hypotheses which stated in their substantive form are outlined as follows:

**Major Question 1**: What are the attitudes toward the alcoholic and alcoholism of a group of registered nurses in a general hospital setting?

Hypothesis a: Registered nurses from general hospitals have significantly negative attitudes toward the alcoholic person.

Hypothesis b: Registered nurses from general hospitals hold a significantly positive view of alcoholism as a disease or illness.

Hypothesis c: Registered nurses from general hospitals hold significantly pessimistic attitudes toward the prognosis of alcoholism.

**Major Question 2**: Are the attitudes toward the alcoholic and alcoholism of a sample of registered nurses in general hospitals different from the attitudes of a sample representative of the general population?
Hypothesis: The attitudes of registered nurses toward alcoholics and alcoholism do not differ significantly from those held by a sample representative of the general population.

**Major Question 3:** Is there a relationship between the expressed attitudes of a sample of registered nurses toward alcoholics and alcoholism and their need for social approval?

Hypothesis: Attitudes toward the alcoholic and the disease or illness orientation of alcoholism expressed by registered nurses are significantly related to their level of need for social approval.

**Major Question 4:** Do nurses who are employed in general hospitals which have alcoholism units have more positive attitudes toward alcoholics and alcoholism than do those nurses who are employed in a general hospital which does not have an alcoholism unit?

Hypothesis: Registered nurses employed in a general hospital which has an alcoholism unit express significantly more positive attitudes toward alcoholics and alcoholism than registered nurses who are employed in a general hospital which does not have an alcoholism unit.

**Major Question 5:** Does the area of clinical practice have a relationship to the expressed attitudes of nurses
toward the alcoholic and alcoholism?

Hypothesis: Registered nurses employed in an alcoholism unit have significantly more positive attitudes toward alcoholics and alcoholism than a sample of registered nurses employed in other hospital areas.

Major Question 6: Is the personal use of alcohol by registered nurses related to their attitudes toward the alcoholic and alcoholism?

Hypothesis: The attitudes held by registered nurses toward the alcoholic person are significantly related to their personal use of alcohol.

Definition of Terms

For the purposes of clarity the following definitions will be used throughout this study:

1. **Alcoholic**: A person who has become dependent upon the drug alcohol and suffers from the illness of alcoholism.

2. **Alcoholism**: "An illness characterized by preoccupation with alcohol and the loss of control over its consumption such that if drinking is begun it leads to intoxication; by chronicity; by progression; and by the tendency toward relapse. It is associated with physical disability and impaired emotional, occupational and/or social adjustment as a direct consequence of
persistent and excessive use of alcohol" (American Medical Association, 1973).

3. **Attitude:** A predisposition of an individual to evaluate some symbol, object or aspect of his world in a favorable or unfavorable manner that emerges from the two elements, belief (cognition) and feeling (affect). Beliefs describe the object of the attitude, its characteristics, and relations to other objects and the feeling or affective core represents the liking or disliking of the same object (Katz, 1960). Only when several beliefs are focused on a specific object does an attitude develop.

4. **Belief:** The representation of information which an individual holds as true about a stimulus object that results from the cognitive processes of the individual. "Operationally, one has a belief in or about a stimulus object and an attitude toward an object" (Cooper & McGaugh, 1966).

5. **Need:** A state of energy exchange within and external to the human organism that leads to a behavioral response or responses (King, 1971).

6. **Need for approval:** "The motivation to say the right things about oneself, appear to hold the 'proper' attitudes, reflect common language usage in associations, set goals of acceptable intermediate risk, avoid
showing hostility, and seem to in general reflect the association of virtues that define the 'adjusted' individual" (Crowne & Marlowe, 1967).

7. **Nursing**: "The process of action, reaction, interaction and transaction, whereby nurses assist individuals of any age and socio-economic group to meet their basic needs in performing the activities of daily living and to cope with health and illness at one particular point in the life cycle" (King, 1971).

8. **Problem drinker**: "The irregular-symptomatic excessive drinker who retains the ability to stop drinking, or if necessary, can control drinking. This drinker usually drinks daily, may develop physical problems as a consequence of heavy drinking and may be a menace on the highway or at home" (Kinsey, 1966).

9. **Registered Nurse**: An individual licensed to practice nursing in the community or in health care facilities following the successful completion of a state accredited nursing program, successfully passing a State Board Examination, and an annual renewal of the nursing license.

10. **Situational drinker**: "One who as a result of some personal tragedy resorts to excessive drinking but as the shock wears off is able to return to previous, more sober habits" (Kinsey, 1966).
11. **Socially desirable behavior**: Behavior motivated by a need for approval and the expectancy that approval can be attained by behaving in culturally acceptable ways (Crowne & Marlowe, 1967).

12. **Social drinker**: One whose drinking does not result in changes in judgment, inhibitions and voluntary motor actions and in whom the element of control over alcohol intake remains present.

Assumptions

1. Although a specific attitude may not be linear, i.e., could be curvilinear, the intensity of beliefs underlying the attitude can and do progress in a linear direction toward negative and positive extremes.

2. Subjects in the sample will respond affirmatively to the request to give truthful answers on the questionnaires used in the study.

3. The attitudes of registered nurses toward the alcoholic patient are a significant factor influencing the course of convalescence and recovery of the alcoholic patient or a patient with an alcohol problem.

4. Attitudinal differences among health professionals are important to the understanding these professionals have of themselves, each other and their patients.
Delimitation of the Study

The study will be conducted in the setting of three general hospitals in Columbus, Ohio, where representatives of administration were willing to participate in the study.

Limitations

1. There are only a small number of nurses who work in alcoholism units. Thus, it may be difficult to obtain a sample large enough to statistically compare them with other nurses in the sample on attitudes toward the alcoholic and alcoholism.

2. The use of a convenient sampling method will be used and only nurses volunteering to participate will be included in the study.

3. One of the purposes of this study will be to compare the attitudes of the total sample of registered nurses with a sample representative of the general population. The most recent attitude survey of a sample of the general population found in the literature was the Toronto sample reported by Marcus (1963b). The use of this sample for comparison purposes limits the interpretation of the findings to identification of similarities or differences between the present nurse sample and a past sample from the general population.
Overview

The different facets of this study will be discussed in the chapters which follow. Chapter II will provide a general review of the literature on attitude theory; alcohol; alcoholism; and empirical studies conducted on the attitudes of the public and health-related professions toward alcoholic and alcoholism. Within the discussion of attitude theory there will be an indepth discussion of Katz’s Functional Approach to the Study of Attitudes which provides a general understanding of the approach used in this study. There will also be an indepth review of those studies reported in the literature on the attitudes of registered and student nurses which are related to the present investigation. In Chapter III, the details of the design of this investigation and a description of instruments used in the collection of data will be discussed. Then, the procedures for the data collection and the statistical treatment for analysis of the data will be considered. Chapter IV will consist of a report on the analysis and results of the study will be presented followed by a discussion of these results. Having up to this point presented an introduction to the problem and the general nature of the study, the review of the literature will follow.
CHAPTER II
REVIEW OF THE LITERATURE
RELATED THEORY AND RESEARCH

Introduction

Several areas of the literature serve as valuable adjuncts to this study. They are: (1) Attitude Theory; (2) Alcohol Effects and Use; (3) Alcoholism: Classifications, Definitions, and Theory; and (4) Attitudes Toward Alcohol Use, Alcoholics, and Alcoholism, Public and Professional.

Attitude theory provides an insight into the approach used in this study to determine registered nurses' attitudes toward the alcoholic and alcoholism. The areas of alcohol and alcoholism give a general perspective to the nature of the attitudes studied and facilitate an understanding of the alcoholism questionnaire used in the study. Next, the public and professional attitudes toward alcohol use, alcoholics, and alcoholism relate to the current attitudes held by nurses and constitute the basis for the hypotheses which guide the study.
Attitude

In this part of the review of the related literature, a brief overview of selected theories of attitude will be given. In addition, The Functional Approach to the Study of Attitudes by Katz will be discussed in detail because it was used in the approach to the present study.

Attitude Theory

A variety of attitude theories have been developed to explain the nature and influence of attitudes on human development and behavior. Prominent among these are the learning and structural theories. Learning theories are generally concerned with the way attitudes are acquired through the processes of classical and operant conditioning. Relating learning theory to attitudes, Fishbein developed his own theory which states that: "(1) An individual holds many beliefs about a given object, i.e., the object may be seen as related to various attributes, such as other objects, characteristics, goals, etc., (2) Associated with each of the attributes is an implicit evaluative response, i.e., attitude, (3) Through conditioning, the evaluative responses are associated with the attitude object, (4) The conditioned evaluative responses summate, and thus (5) On future occasions the attitude object will elicit this summative evaluative response, i.e., the overall attitude
(Fishbein & Ajzen, 1975)." Thus, in this theory an individual's attitude toward any object or person is a function of his beliefs about the object or person and the implicit evaluative responses associated with the beliefs.

The Structural Theory of Attitude Dynamics was developed by Rosenberg (1960) and is based on the conceptualization of two major components of attitude, the cognitive and affective components. Basing his theory on the results reported from empirical studies on attitude and his own research in this area, he found that attitudinal affect toward a social object correlated consistently and closely with variations in belief about that object. Further, he found that overall belief potency and affect are associated with the achieving or blocking the realization of values. From these studies, Rosenberg concluded that a stable pattern of feelings toward a social object are accompanied by or are organized in close relationship with a pattern of stable beliefs consistent with those affects.

In the theory it is assumed that an individual's attitudes usually enable regulation of adaptive behavior and that it can be predicted an individual attempts to preserve attitudes intact and will reject influences causing temporary alteration of the affective or cognitive components of the attitudes.
The theory proposes that: (1) When affective and cognitive components of an attitude are consistent, the attitude is stable; (2) When the components of attitude are inconsistent to the degree they exceed the 'tolerance level' for such inconsistency, the attitude is unstable in state. (3) An attitude which is unstable will undergo reorganization until one of three possible outcomes is achieved. One is rejection of communication or other forces that engendered the inconsistency between affect and cognition to restore the original stable attitude. A second outcome is that a fragmentation or isolation of the attitude which has affective and cognitive components which are inconsistent may occur. A third outcome is an accommodation of the inconsistency produced to bring about an attitude change to a stabilized attitude.

Katz (1960) developed a psychological framework for the study of private and public attitudes which he labelled The Functional Approach to the Study of Attitudes. This framework is one which is psychological and is based upon the functions attitudes serve in their formation, maintenance, and change. It has been widely used in investigations of attitude (Rosenberg, 1960 and Fishbein & Ajzen, 1975).

Although Katz did not claim his psychological framework for the study of attitudes is a formal theory, at the
very least, it contains some of the components of theory. These components are a definition of attitudes, a description of their nature and dimensions, an explanation of the major functions they serve and the dynamics involved in these functions. Also, he has developed a description of the complex variables involved in attitude arousal and attitude change with specifications of the conditions under which people act as they do. Since an individual has many pre-dispositions to act and many influences exerted on him at one and the same time, the precise description of these conditions provide much clarity to an understanding of the attitudes reflected in this and other studies. Moreover, the foundation is laid for testable propositions, particularly, because empirical studies have been used in the development of his framework.

Katz defined attitude as follows: attitudes consist of two elements, beliefs or cognitions which describe the object of the attitude, its characteristics, and relations to other objects and the affective or feeling core of liking or disliking the object. Together, these elements form a predisposition of an individual to evaluate some symbol, object or aspect of his world in a favorable or unfavorable manner. While beliefs are identified as elements of every attitude, every belief does not necessarily become the element of an attitude but may, also, stand
alone as a simple belief. However, when beliefs are elements of a specific attitude, then this attitude may organize with other attitudes into a hierarchial structure that forms the value systems of an individual.

In this framework, four major functions for the individual personality are viewed as being served by attitudes. These functions are related to the psychological needs of an individual and, as such, constitute a motivational force for the formation, maintenance, arousal or modification of specific attitudes. The functions are identified as: (1) Instrumental; (2) Ego-defensive; (3) Value-expressive; and (4) Knowledge functions. With these functions Katz not only described the origin and dynamics involved in each of them but he also precisely described the conditions necessary and/or sufficient for the arousal and change of attitudes in the case of each of the functions served.

The nature and dimensions of attitudes were identified in terms of (1) the intensity of affect; (2) the specificity or generality of beliefs; (3) degree of differentiation based on the number of beliefs involved; (4) number of linkages between the belief structure and the value system which relate to the self-concept; (5) centrality in relation to other attitudes connected to the value system; and (6) action structure or the relation to overt behavior.
Furthermore, beyond describing the functions attitudes serve and the relationship of these functions to motivation and needs, the theorist accounted for the influence of situational and environmental variables interacting with an attitude. Using the concepts of group identification and reference group, he identified implication of global and group influences on a person's attitude and subsequent behavior.

Concomitant with theory development in the area of attitudes, there has been theoretical developments in the measurement of attitude. As Thurstone (1967) made clear, the measurement of attitudes is far from a simple matter. Authorities in attitude measurement (Jahoda & Neil, 1966; Oppenheim, 1966; and Summers, 1971) describe the measurement of attitudes as consisting primarily of the measurement of the attitude dimensions of belief (cognition), and/or affect (feeling) or behavior. By measuring each separately, inference has been relied upon to describe attitudes. The common practice in empirical studies has been to infer attitudes from the components of attitude or behavior.

Alcohol

This section of the review of the literature will consist of a short summary of what is known and accepted as
fact about the affects of alcohol on the human body and its relation to health problems. Included, also, will be current beliefs based on empirical studies about the effects of alcohol. Finally, the types of drinkers who use alcohol will be described.

Effects of Alcohol:

To understand the effects of alcohol on the human body's vital systems, it is helpful to know the metabolic breakdown of alcohol and its pharmacology. Himwich (1968), the American Medical Association (1973), and Turner, Mezey, Esteban, and Kimball (1977a, 1977b) have provided a summary of the findings on metabolism of alcohol which have been widely accepted as fact. According to these authorities, alcohol is absorbed by the process of diffusion at a fairly rapid rate from the stomach and at a lower rate from the small and large intestines. After being transported to the liver where 80 to 85 percent of the metabolism takes place, the alcohol is broken down by a natural body enzyme, alcohol dehydrogenase (ADH), through the process of oxidation into acetaldehyde and then into acetate. These two products, after being released into the hepatic venous blood, are further metabolized in the peripheral tissues and organs of the body. Eventually, 95 percent of the alcohol consumed is metabolized into carbon dioxide and water. The remaining percent is lost in urine,
perspiration, and the breath as free alcohol (Turner et al., 1977a). In spite of the fact that the metabolism of alcohol by the liver is well understood, its metabolism by other body systems is not well understood. However, on the basis of research it is believed that in addition to the metabolism of alcohol by the liver, there is a significant amount of metabolism which occurs within the spleen (Turner et al., 1977a).

Pharmacologically, alcohol is both a chemical compound and a drug which is labelled ethyl alcohol (Burkhalter, 1975). It acts in small concentrations as a stimulant but in large concentrations as a depressant (Himwich, 1963). It is classified as a depressant because of its depressant action on the brain and central nervous system. Further, it is a peripheral vasodilator (Burkhalter, 1975).

The action of alcohol on the gastro-intestinal system are primarily related to its influence on the gastric and pancreatic juices and its irritation to the esophageal and gastric mucosa. In small quantities alcohol acts as a stimulant to the appetite and the flow of gastric and pancreatic juices. The reverse is true, however, when excessive amounts are taken. In this situation there is a depression of both of these juices. The depression of gastric juices is especially serious in that these juices contain the enzymes necessary to break down proteins to
amino acids for tissue synthesis. Alcohol, in a way not entirely understood, interferes with the conversion of carbohydrates into sugars. As a result of these effects of alcohol, individuals who take excessive amounts, are generally observed to be both protein deficient and subject to hypoglycemia (Null & Null, 1976).

Although alcohol is known to have an effect on the brain, all of the mechanisms involved are still unknown. What is known is that up to 30 percent of the brain's ability to consume oxygen and its ability to utilize glucose can be reduced. Alcohol, in working on the higher functions of the brain, reduces anxiety, fear, judgment, learning ability, self-criticism, memory and environmental awareness (Himwich, 1968 and Jones & Jones, 1976). Furthermore, the brain is affected indirectly by alcohol's end product, acetaldehyde, which directly attacks the hypothalamus, changing the function of the cerebral cortex. With this change of patterns, two effects are noted. One is that the physical and emotional behavior becomes more unpredictable. The other is that the cell membranes of the cerebral cortex are disrupted in their ability to exchange sodium and potassium which are necessary to the smooth functioning of the central nervous system (Null & Null, 1976).
The mode of alcohol action on the total central nervous system is not completely understood. Alcohol is believed to interfere with synaptic transmission and neural excitement of the nervous system. The clinical picture of intoxication indicates that the effects of alcohol start in the brain and gradually descend down to the medulla, the vital nerve center for the respiratory and cardiac stimulation. Further, the reticular formation in this area is also depressed. Ultimately, motor functions are affected which is reflected in the lengthening of reaction time and decreasing coordination. In spite of these effects, alcohol also alters its own effects on the central nervous system by reducing sensitivity of the central nervous system to it. This phenomenon, the phenomenon of tolerance, is considered the primary reason for the addictive nature of alcohol (Himwich, 1968 and Jones & Jones, 1976).

The effect of alcohol on the renal system is believed to be due to the indirect effect of alcohol on the hormone system. According to this belief, alcohol suppresses the antidiuretic hormone from the pituitary and an increase in the secretion of urine results. With this increase in secretion there is a significant reduction in body potassium, sodium and chloride during periods of excessive alcohol ingestion (Null & Null, 1976).
Little is known about the effects of alcohol on the heart. However, Mendelson (1966) in his research on male subjects found that cardiac arrhythmias developed with increasing amounts of alcohol intake.

**Sex Differences in Alcohol Effects**

The research done on the effects of alcohol on the human body have systematically excluded women. Only recently have studies emerged in the literature demonstrating differential effects of alcohol related to sex differences. Many of these studies have been conducted by Jones and Jones (1976). The major findings of their studies were that: (1) Women became more intoxicated, i.e., had a higher peak of blood alcohol, than men when given a dose of alcohol calculated on the basis of body weight; (2) When given a small dose of alcohol, i.e., 0.66 ml/kg of body weight, there was no difference between men and women in cognitive behaviors as immediate and delayed recall but at a moderate level of .08 ml/kg women showed a greater inability to perform delayed recall tasks than men; and (3) Estrogen taken in oral contraceptives or for hormonal therapy due to gynecological problems or following hysterectomies slowed the metabolization of alcohol in women.
Alcohol Related Health Problems

The use of alcohol in continuous excessive amounts has been associated with some illnesses that are chronic and irreversible. Unfortunately, the level of daily alcohol consumption at which the risk for these health disorders increases is still unknown (Turner, 1977a).

Chronic relapsing pancreatitis has long been associated with excessive, chronic consumption of alcohol. However, in some instances the pancreatic changes have been insidious and only discovered upon autopsy. Liver cirrhosis has also been closely associated with chronic, excessive alcohol intake. In fact, the association has been convincing enough that the number of deaths from cirrhosis have been used as a basis for one of the formulas used for estimating the rate of alcoholism in given areas of the nation (Health Systems Planning, 1977). Further, gastritis, gastric ulcers, and esophageal varices have been commonly associated with alcohol abuse (Burkhalter, 1975).

Other physical conditions ranging from anemias to specific nutritional deficiencies, respiratory conditions and cardiac abnormalities have been associated with alcohol abuse. Muscular weakness is also a common condition (Null & Null, 1976).

Encephalopathies from alcohol abuse are frequently associated with nutritional deficiencies resulting from
this abuse. Among them are Wernicke's disease which is characterized by mental confusion and ataxia, Korsakoff's psychosis in which there is severe mental impairment, and polyneuropathy distinguished by the existence of numbness and paresthesia (American Medical Association, 1973).

The relationship of alcohol intake during pregnancy to birth defects has been the focus of much of the recent research related to alcohol use and abuse. Jones, Smith, Ulleland, & Streissguth (1973) reported the existence of a "fetal alcohol syndrome" in the infants born of mothers who drank heavily during pregnancy. Their research revealed the syndrome manifested itself in mental retardation, delayed physical development and neurological problems associated with anomalies. An additional observation was that in the deliveries of these women who drank alcohol excessively, there was an increased incidence of breech deliveries. More recently (1978) Galton reported a 1977 study completed in a Boston City Hospital in which it was found that 32 percent of the infants born to heavy drinking mothers possessed fetal abnormalities.

Rawat (1978) tracing the route of alcohol in pregnant rats found that alcohol passes through the placental barriers directly into the fetus. In fact, he found that alcohol appeared in the same concentrations in fetal blood as in maternal blood, indicating that cortical influence
or damage from alcohol could affect both mother and offspring.

Again, the amount of alcohol that can be safely consumed remains unknown. However, extreme caution has been urged in the use of alcohol by pregnant women.

To place this review of alcohol use and alcohol related health problems into proper perspective, it is important to avoid falling into the trap of regarding all users of alcohol as excessive users or alcoholics. As mentioned in the beginning of this study, there is a wide variation of alcohol use and abuse. Therefore, it is obvious that differences exist in the effects of alcohol and the types of health problems related to alcohol abuse. Thus, a consideration of the types of drinkers utilizing alcohol is an important point of reference in this review on alcohol. For this reason, the types of drinkers will be discussed in the section which follows.

Types of Drinkers

Classifications of the types of drinkers using alcohol ordinarily extend on a continuum from those persons who do not use alcohol under any conditions, i.e., total abstainers, to those persons who are addictive drinkers in varying stages of alcoholism. Several of these classifications relate to the term intoxication. Therefore, the
meaning of intoxication requires clarification prior to the discussion of types of drinkers.

Intoxication has been defined since 1960 on the basis of a recommendation from the House of Delegates of the American Medical Association both medically and legally as a level of 0.10 percent of alcohol concentration in the blood. Determination of blood alcohol level is based on measurements of alcohol concentration in the breath, urine, saliva or blood itself.

On the basis of this clarification, the types of drinkers have been described as follows:

1. Moderate or social drinkers: Those "persons who drink on social occasions or with meals, but rarely to excess. They conduct themselves well while drinking and do not suffer any serious consequences because of their drinking" (Catanzaro, 1968). In objective terms, the social drinker can be defined as one whose drinking does not result in changes in judgment, inhibitions and voluntary motor actions and in whom the element of control over alcohol intake remains present.

2. Heavy social drinkers: "Persons who habitually drink heavily mostly on social occasions with frequent or regular episodes of intoxication to the point of obvious muscle incoordination and unpredictable behavior."
This drinking does not seriously handicap the individual in his life adjustment. Many of these people ultimately become alcoholics, but by no means all of them" (Catanzaro, 1968).

3. Situational drinkers: "One who as a result of some personal tragedy resorts to excessive drinking but as the shock wears off is able to return to previous, more sober habits" (Kinsey, 1966). In some classifications this drinker is considered an early alcoholic.

4. Sporadic excessive drinkers: "People who develop a habit of drinking excessively on certain occasions who suffer the consequences of their drinking to the point of intoxication in terms of auto accidents, fights, hangovers, etc., but otherwise show no signs of progressive social or physical deterioration related to drinking" (Catanzaro, 1968). This drinker is also considered in some classifications as an early alcoholic.

5. Alcoholic drinkers: Those individual drinkers who have developed the disease of alcoholism.

The review of the literature on alcohol provided in this section reveals that gaps exist in the knowledge about the effects of alcohol and the illnesses related to it. However, the review provides an overall perspective to the way alcohol is viewed by registered nurses and other health care professionals.
Alcoholism

This section of the literature review will consist of a summary discussion of the beginning of the systematic study of alcoholism, definitions of alcoholism and their implications, and current theories of alcoholism. Under the discussion of theory, however, there will be an in-depth discussion of the psychodynamic theory because of the prevalence of its acceptance by registered nurses.

Beginning of Systematic Study

The first systematic approach to understanding alcoholism as a disease began almost two hundred years ago with the publication of scientific papers by two prominent physicians at the time, Dr. Benjamin Rush and Dr. Thomas Trotter. Dr. Rush first described the effects of alcohol upon the mind and body in his treatise on the prevention and cure of drunkenness. Three years later, Dr. Trotter proposed that drunkenness should be labeled alcoholism and that, as such, it should be called a disease produced by a remote cause that gave rise to the disorders of behavior and health (Catanzaro, 1968). The impact of these early writings was minimal because society generally maintained that inebriates, as alcoholics were then called, did not want help and if they did, effective treatment for them did not exist. This view was also held by the medical profession which as a group appeared to reject treatment of
alcoholics because of the lack of success experienced.

Not until 1900, did an organized effort begin to provide a systematic focus to the problem of alcoholism. At that time, The Quarterly Journal of Alcoholism published 80 scientific papers which identified alcoholism as a disease which could be explained in terms of physiology, neuro-physiology, and genetics. In addition to these scientific approaches, a treatise written by Mary Richmond, a social worker, appeared. Entitled "Social Diagnosis," the treatise initiated the view that underlying biological conditions were a causative factor in inebriation.

From these early and sporadic developments in the field of alcoholism, there gradually emerged the large body of literature on alcoholism which presently exists. Included within this literature are the varying definitions and theories of alcoholism and the research findings supporting them.

Definitions of Alcoholism and Their Implications

Defining alcoholism has been a formidable task for the experts in this field. Several attempts have been made to define alcoholism in terms of the quantity, frequency, rate and style of drinking. None have been successful due primarily to the cultural differences in drinking. Further, even though a large body of literature exists on the
definitions of alcoholism, a comprehensive definition which is universally accepted has not been developed. Therefore, the definition of alcoholism remains unclear to many persons and subject to the influence of moral opinions and judgments.

Existing definitions differ primarily in their orientations to alcoholism. However, they have one commonality. That commonality is that they have all to a degree been influenced by the exhaustive research and theoretical efforts of E. M. Jellinek (1952). His research with alcoholics in 1946 led to a delineation of the progressive phases of alcoholism and the identification of alcoholism as a disease entity. Further, his continued study of alcoholics resulted in a typology of alcoholics. While Jellinek's phases of alcoholism clarified the nature and progression of alcoholism, his typology described the symptoms and consequences of alcoholism. More than this, taken together, these contributions led to the empirical basis for the definitions of alcoholism which presently exist. Therefore, any discussion of the definitions of alcoholism is best understood by initiating it with a discussion of these contributions.

Although Jellinek defined alcoholism in general terms simply as the use of any alcoholic beverages that cause damage to the individual or society or both, he identified
our precise stages or phases of alcoholism. These phases were the pre-alcoholism, early alcoholic, addictive, and chronic phases of alcoholism. In each, the progressive involvement of the individual with alcohol and the consequences of this involvement is described.

The first or pre-alcoholism phase, lasting from six to ten years, is characterized by the initial use of alcohol as a drug to relax. Progression in amounts and frequency in drinking alcohol is required over time to achieve the same relaxation.

The second or early alcoholism phase is described as a period which may or may not be characterized by blackouts or brief periods of amnesia. Lasting from six months to five years, this phase is one in which the drinker resorts to sneaking drinks as he becomes increasingly preoccupied with alcohol. Although physically dependent upon alcohol, the individual is still able to control drinking of alcohol. However, reference to alcohol at this period is avoided because the subject brings into play the defense mechanisms of the drinker. These defenses are denial, rationalization, projection, and fragmentation of reality. In the latter, a small bit of reality is focused upon as the whole of reality.

The third or addictive stage is described as the crucial phase. It is the one in which there is marked
dependence upon alcohol with loss of control over its use. Included in the phase is the exhibition of grandiose and markedly aggressive behaviors, a change of associates resulting from these behaviors, and symptoms of withdrawal, i.e., "shakes" or delerium tremens even with relatively short periods of abstinence. This period is considered crucial because either intervention occurs and life continues or progression into alcoholism continues and death results.

The fourth or chronic phase is simply described as one in which unplanned drinking sprees, continual condemnation of the culture outside of the drinking subculture, ethical deterioration, and rapid worsening in health status occurs. Ethical deterioration is observed in the drastic changes which occur with previously held beliefs and values which had formerly guided the overt behavioral acts of the individual.

From these phases and their descriptions, it is evident that Jellinek relied upon the behavioral aspects of alcoholism in the development of this organized knowledge about the progression of the disease. This, was no doubt, due to the fact that alcoholism remains symptomless as a disease until it has been well entrenched in the addiction process and body cell adaptation to alcohol has progressed
beyond a simple irreversibility of the situation.

The typology of alcoholism organized by Jellinek was developed on the basis of the consequences of alcoholism upon both the psychological and biological systems of man. It consists of four types of alcoholism. They are the Alpha, Beta, Gamma A, and Delta types (Jellinek, 1952).

Alpha alcoholism is the type of alcoholism which represents a purely psychological type of relief to body or emotional pain. It is what Jellinek referred to as symptomatic alcoholism.

Beta alcoholism is that type which is neither a symptom nor yet a disease, although medical illnesses and nutritional deficiencies may be present. Also, complications of gastritis, polyneuropathy or cirrhosis of the liver may occur without a psychological or physiological dependence.

Gamma A alcoholism is that classification that constitutes the disease of alcoholism itself and is marked by the inability to control alcohol use. Present in this type of alcoholism is increased tissue tolerance to alcohol accompanied by adaptive cell metabolism and physical dependence. Absence of alcohol results in withdrawal symptoms. It is within this category that the most serious damage is done to all body systems.
Delta alcoholism is similar to Gamma A except rather than the loss of control there is an inability to abstain from drinking. While in Gamma A type alcoholism the alcoholic is able to have time periods which are short in length where he does not drink, in Delta alcoholism the alcoholic is unable to do so.

Having considered briefly these contributions by Jellinek, the definitions of alcoholism in current usage will become clearer. Also, the empirical basis for the definitions will become apparent as these definitions and implications are discussed in the paragraphs which follows.

The World Health Organization (1952) in an effort to provide a comprehensive and universally accepted definition of alcoholism defined it as "any form of drinking which goes beyond the traditional and customary dietary use, or the ordinary compliance with the social drinking customs of the community concerned. The main problem which has been found with this definition is that it lacks the specificity needed for those who work with patients from widely divergent cultural groups and social and economic sub-groups.

According to the definition in The Psychiatric Dictionary (Hinsie & Campbell, 1970), alcoholism is a personality disturbance in which "(1) a person's use of alcohol
is of such an extent that it interferes with successful physical, personality, and/or social function and (2) he is either unable to recognize the deleterious effects of his habit, or recognizing them, he is nonetheless unable to curtail his alcohol consumption and continues in an almost compulsive way to drink heavily." The ambiguity that exists in this definition is whether alcoholism is the result or cause of the disturbances in personality.

The American Medical Association (1973) defined alcoholism as follows: "Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronic progression; and by the tendency toward relapse. It is typically associated with physical disability and impaired emotional, and/or social adjustments as a direct consequence of persistent and excessive use of alcohol." By this definition, alcoholism is regarded as a type of drug dependency, pathological in extent and pattern, that ordinarily interferes seriously with an individual's health and adjustment to his environment. A clarifying statement is given along with this definition in which it is pointed out that alcohol by itself does not cause alcoholism any more than sugar causes diabetes. It is further specified that the drinking of alcohol is a necessary condition for the
development of alcoholism, but it is not a sufficient condition. Loss of control, however, is specified as both a necessary and sufficient condition for the development of alcoholism. The existence of personality traits, therefore, is not viewed as either a necessary or sufficient condition for alcoholism.

Two pertinent observations can be made about the definitions which have been discussed. The first is that the complex nature of alcoholism is apparent in the confusion, ambiguity, and controversy surrounding its definition among experts in the field. The second is that a part of the problem in defining alcoholism is due to the diversity of orientation about the cause or causes of alcoholism. In the latter observation, it is evident that the problem of defining alcoholism constitutes more than a semantic debate or inconvenience. How alcoholism is defined has serious implications for both the conduct of research and approaches to treatment. More than that, it has implications for whether or not an individual suffering from alcoholism is treated.

An example of the significance of how alcoholism is defined is found in the prevailing medical definition of alcoholism. This definition has placed alcoholism within the medical model of treatment. As a result both advantages and disadvantages have accrued for the problem of
alcoholism. The most obvious advantages have been that (1) some of the moral stigma for those suffering from alcoholism has been removed and (2) medical and psychological treatment modes have replaced the punitive measurers formerly employed in the treatment of alcoholism (Armor, Polich, and Stambul, 1978), which have been described by Seabrook (1935).

The disadvantages of viewing alcoholism on the basis of this definition and within the medical model are several, according to Armor, Polich, and Stambul (1978). They perceived the disadvantages to be as follows: (1) overemphasis on the medical model leads to the probably erroneous assumption that alcoholism is a singular disease entity and increases the risk of obscuring the probability that it may be a symptom of a number of separate conditions; (2) causation in this model is placed inside of man without taking into account the socio-cultural factors that may play a causal role; (3) the responsibility for treatment is directed toward medical practitioners who encourage the patient to assume the passive, sick role; and (4) it can be argued that the alcoholic is frightened away by the dictum of this model that once an alcoholic always an alcoholic.

These limitations were conceptualized by Jellinek (1960) when he made specific reference to the limitations
of the disease concept of alcoholism. He wrote, "If the
formation of the nature of alcoholism as an illness rigidly
claims that alcohol addiction or any other species of al-
coholism is purely a medical problem, any preventive at-
tempt may be seriously impaired. The usefulness of the
idea that alcoholism is a medical and public health prob-
lem depends to a large extent upon the recognition of the
social and economic factors in the etiology of alcoholism."

Recently, a consideration of the etiological factors
in alcoholism along the lines of Jellinek's thinking have
emerged in the "Criteria for the Diagnosis of Alcoholism"
formulated by a committee of the National Council on Alco-
holism (1972). In this criteria alcoholism is divided in-
to two separate tracks of progression: (1) physiological
and clinical, and (2) behavioral, psychological, and at-
titudinal. It was perceived by some experts in the field
as a keystone in the development of a definition of alco-
holism that would eventually provide the basis for an
interdisciplinary model of treatment. Although the American
Medical Association has accepted this criteria, neither an
agreed upon definition or the suggestion of an interdis-
ciplinary model of treatment appears to have emerged.

In the appraisal of these definitions of alcoholism
and their implications, as indicated in Chapter I, the
definition of alcoholism given by the American Medical Society was selected as the definition to be used in this study. The reality of the situation is that the medical definition is the prevailing definition in the hospital health care systems in spite of its recognized shortcomings. Furthermore, it is in the hospital health care system where the subjects of the study, registered nurses, were employed. Therefore, the medical definition appeared the most appropriate definition for the purposes of this study.

In this section definitions of alcoholism and their implications were examined. The medical definition was discussed and appraised in depth because it is believed to be the one which seriously influences the registered nurses' beliefs about where responsibility formally lies not only for the diagnosis of alcoholism but for intervention in the disease process as well. Moreover, the model derived from this definition is the one basis for all treatment approaches within a hospital setting.

Theoretical Models of Alcoholism

The theories of the cause or etiology of alcoholism are numerous and diverse. Each has been developed from a specific focus on some aspect of human development. Therefore, they have been classified as (1) biological, (2) psychological, and (3) socio-cultural theories.
Among the biological theories which have been widely accepted by the public, members of Alcoholics Anonymous, and some health professionals is the genetic theory. In this theory, inherited peculiarities of body biology have been identified as the cause of alcoholism. The research support for this theory rests primarily on the work of Jellinek (Catanzaro, 1968). Compiling a number of studies on the rates of alcoholism in families, he found that an average of 52 percent of persons suffering from alcoholism had at least one alcoholic parent. This study and others with similar findings are interpreted by some experts in alcoholism to mean that a tendency to develop alcoholism is inherited.

Exactly how the genetic biologic factor operates has remained unanswered. However, it is postulated that an inherited metabolic pattern results in nutritional deficiencies which create a craving for alcohol.

On the basis of this theory many persons who treat alcoholics have concluded that some unknown factor in the genetic make-up of an alcoholic makes it impossible for the alcoholic to be a social drinker. This conclusion was disputed by the findings of the 1974 Rand Report and still remains a subject of much heated debate among authorities in the field of alcoholism.
Other theories of alcoholism which have been less well received because of the lack of an empirical base are the biochemical, allergy, and metabolic theories. In the biochemical theory, alcoholism is explained on the basis of an existing chemical deficiency within the individual alcoholic's body. The allergy theory explains alcoholism by stating an individual has or is developing an allergy to alcohol which causes him to develop the symptoms of alcoholism upon intake of alcoholic beverages. The metabolic theory proposes that the absence of enzymes to act upon alcohol is the causative factor in alcoholism.

Theories which can be classified as psychological theories are the psychoanalytic and learning theories. The psychoanalytic theory (also called the psychodynamic or dependency theory) has been and is the prevailing theory used in clinical treatment settings for alcoholism by professional psychotherapists, counselors, clinical psychologists, clinical specialists in psychiatric nursing and social workers. The learning theory has also been used in the clinical setting by many among these groups who utilize the behaviorist approach in the treatment of alcoholism. In addition, it has been widely used in the educational setting.

The psychoanalytic theory of alcoholism began to appear in the literature of alcoholism in 1915. In the
beginning as now, the predominant concept in the theory was that alcoholism is a deviant behavior and, as with other deviant behaviors, alcoholism is explained on the basis of the Freudian model of neurosis. According to this model, alcoholism results from one or more unconscious conflicts or tendencies that find expression in the excessive use of alcohol.

In the first systematic approach to treatment of the alcoholic by Dr. Sandor Ferenzi (Cahn, 1970), alcoholism is an overt behavioral symptom of an underlying, latent homosexuality. Since that time, however, different subthemes have emerged from the writers in the field wherein conceptualizations of the underlying problem of alcoholism have been enlarged using the Freudian neurosis model. Further, a character disorder model has been developed.

Among the newer conceptualizations of the underlying problem of alcoholism are those of Menninger; Rado; Knight; Lolli, Arieti (Catanzaro, 1968; Kinsey, 1966; and Armor, Polich & Stambul, 1978); and Wilsnak (Wilsnak, 1976). Menninger in explaining alcoholism proposed that alcoholism is a slow form of suicide or the inversion of Thanatos, the death wish (Cahn, 1970). Rado, Knight, Lolli, and Arieti used the pleasure effects of alcohol and the underlying rage of the alcoholic searching for a never-found
mother-child relationship to explain the disease of alcoholism. Dickenson (Kinsey, 1966) also conceptualized the etiology of alcoholism within the psychoanalytic framework. He explained it as the result of an early emotional deprivation experience in relation to a significant parental figure.

The most recent explanation within the psychoanalytic framework has been proposed by Wilsnak (1976). Referring to the psychoanalytic theory as dependency theory, she posited drinking is a gratification of passive oral dependency which allows the drinker to project and maintain a facade of the assertiveness and independence characteristic of adult behavior. Her view has been supported by her own studies on sex-role conflict in women.

In spite of the differences in the explanations of alcoholism by experts on the subject all but Menninger and Wilsnak took the position that depression results due to the death or the emotional or physical absence of a warm, giving relationship. When this trauma occurs in the earliest stages of psychosexual development they propose oral fixation results. Thus, gratification by stimulation of the oral mucosa through imbibing large amounts of alcohol and peaceful oblivion is sought. Essentially, in this view, the alcoholic is attempting to achieve the blissful, infantile state.
Retrospective case studies of alcoholics have provided some evidence that early childhood experience of alcoholics is consistent with the theoretical formulations of the psychoanalytic school of thought. Armor, Polich, and Stambul (1978) report several studies supporting psychoanalytic theory. One of the studies they report is the one by Robins et al.

The learning theory of alcoholism upon which behaviorists, educators, and sociologists depend is based upon the assumption that learning is an association between a stimulus and response which requires the presence of a reward or reinforcement. Reinforcement is defined in terms of drive reduction. Thus, if a certain response to a stimulus leads to a reduction in the strength of a drive (a state of tension resulting from an unsatisfied need), the individual will be more likely to repeat that response when confronted with the same or similar situations on subsequent occasions. If the response is not drive or need reducing, then it will not be learned (Kingham, 1958).

At the core of the reinforcement in learning theories are (1) the law of effect, (2) the law of reinforcement, and (3) the law of extinction. The law of effect simply states that when a response which is accompanied or subsequently followed by a satisfactory state of affairs, the strength of the connection is increased. If, a
satisfactory state of affairs does not occur, then, the strength of the connection is decreased. The law of reinforcement which incorporates the law of effect proposes that a response is more likely to be repeated when the occurrence of that re-response is followed by a satisfying reward. If a response is not followed by a satisfying reward, the response is not likely to be repeated or is inhibited.

From the learning theory view which uses the classical conditioning model, alcoholic drinking behavior is acquired when: (1) a drive is aroused; (2) a cue is perceived in relation to that drive; (3) a response is associated with the cue; and (4) a reinforcement connects the response with the cue and drive. The presence of a drive indicates that an individual has a need and the cue assures that the need can be satisfied. The cue in the learning situation, then, is the environmental condition that serves to elicit and/or maintain excessive alcohol consumption.

Kepner (1964) explained the rewards of alcohol use in the terms of learning theory as (1) the induced pleasurable feelings derived from physiological changes and (2) the temporary relief from unpleasant or punitive stimuli in anxiety inducing situations. Therefore, according to Kepner, alcoholics could be people who experience high anxiety and relieve the unpleasant stress of this anxiety with
more than the average amounts of alcohol.

With the development of theories of operant conditioning, the learning theory approach to alcoholism was significantly enlarged. Theories of this type are based on more complex behavioral components than the theories based upon the classical conditioning model. These components represented the process by which human behavior became shaped into certain patterns by external forces and involved the major operations of reinforcement and stimulus-control in this shaping process. In essence, operant behavior in alcoholism was viewed as emitted by the organism rather than being elicited by a stimuli.

Several factors have been found to support the learning theory of alcoholism. Social reinforcement or peer approval, social modeling in parental drinking styles, and situational cues as bars or cocktail parties have been identified and related to alcoholism as a learned behavior (Armor, Polich, & Stambul, 1978).

There is no one sociocultural theory of alcoholism. Rather, there are several sociological theories of alcoholism which are primarily empirical rather than theoretical in nature. As such, they consist primarily of extensive reports of the correlation between alcoholism and attributes of the individual in relation to drinking
practices and cultural identifications. Alcoholism is explained using the deviant behavior theory of sociology.

The symbolic interaction model proposed by Mead and Sumner (Cahn, 1970) is characteristic of the sociocultural theories which represent attempts to move in a more organized direction toward theory. In this model Mead and Sumner relied on learning theory and posited that learning theory was the basis for both deviant and normal behaviors. When deviant or normal behavior was learned, they suggested it was learned from the practitioners of these behaviors. They further posited that once the behaviors are learned, the individual defines and redefines his personal self according to these behaviors by the labeling process. This process, in their view, tended to provide a generalized sign that a person is an outsider or insider of a particular group by virtue of his behaviors. Finally, they posited that on the basis of the reaction of others in the form of acceptance or rejection the foundation was established for the person to move in the direction of a self-fulfilling prophecy. In this explanation of alcoholism, treatment requires the stripping away of the deviant self, setting the stage for the non-deviant self, and developing commitments to normative behavior in order to return to or initiate conventional behavior (Cahn, 1970).
Theoretical attempts have recently been made to include other variables within the broad framework of sociocultural theory. Concepts of cultural and environmental stress factors producing crisis and several factors in familial patterns have been developed but are still incomplete in terms of their relation to each other or existing theory.

An analyses of the existing theories which have been described in detail reveal several commonalities among these theories. First, there is an acceptance of alcoholism as a deviant behavior occurring during a development phenomenon. Second, the likelihood of problem drinking and alcoholism is generally considered to occur when developmental changes are arrested or shift; unresolved conflict prevails within a developmental stage due to the lack of effective coping behaviors; and the cultural context for drinking progresses from the home toward a peer controlled context (Kinsey, 1968). Third, the accepted theories reviewed have empirical evidence to support them. Fourth, each tends to attribute the etiology of alcoholism to a simple cause-effect relationship and tends to view the alcoholic person in isolation from his total context of behavior patterns, ignoring the cluster phenomenon of behavior. Finally, all of the theories assume that women and men drink for the same reasons.
It is the last commonality among theories that has been of concern in the recent past. The majority of theoretical and empirical studies have focused on personal variables and the various types of alcoholism using only male subjects and ignoring gender differences. The underlying assumptions have been: (1) that regular drinking, heavy drinking, and alcoholism were male characteristics and (2) what applied to male alcoholics, also, applied to female alcoholics.

However, changes in the social roles of women concomitant with the women's movement have resulted over the past two decades in a new awareness of the problems of alcohol and alcoholism in women. While men and women have been shown to conceptualize their problems about alcohol use and abuse in some major respects, an increasing amount of research on women and alcoholism has provided compelling reasons to recognize the need for the consideration of gender differences in both theory development and treatment modalities.

The research of Curlee (1969), Schuckit and Morrissey (1976), Kinsey (1966), Wilsnack (1976) and Beckman (1975) has provided strong empirical evidence that women differ from men in their problem drinking and alcoholism. In her 1969 study, Curlee compared 100 men and women alcoholics and found: (1) women tended to progress more rapidly
toward alcoholism than men because of a "telescoping" of alcoholic symptoms; (2) women in traditional female roles progressed faster toward alcoholism than women in non-traditional roles due to a mid-life identity crisis when their children matured and left home, suggesting they suffered from what Curlee called "the empty nest syndrome;" (3) alcoholism in the women was more frequently associated with a particular life situation or problem than alcoholism in men. In her later study (1970), Curlee found that women were more often admitted to psychiatric hospitals than men for treatment of alcoholism and were hospitalized for longer periods of time.

Schuckit and Morrissey (1976) reported that women had fewer school problems and antisocial difficulties prior to becoming alcoholics than men, that women were arrested less often, and lost jobs on fewer occasions than men. Further, they reported differences in drinking patterns in men and women. Women were found to more likely be periodic drinkers while men were found to be more frequently daily drinkers. Supporting the difference between men and women in drinking patterns was the research reported by Kinsey (1966) in which women were found to more often be solitary drinkers than were men.

Wilsnack (1976) found in her research that women viewed drinking as enhancing their feelings of traditional
femininity, suggesting that role-conflict could be a precipitating factor in the etiology of heavy drinking and alcoholism. She also found that specific life crises occurred in women shortly before the onset of drinking.

Beckman's (1975) exhaustive review summarized many of the findings focusing on the differences in alcohol problems and alcoholism between men and women. She concluded that women differ in terms of their drinking histories, the etiological factors precipitating drinking, the social consequences of drinking and the progression of alcoholism.

This section of the review of the literature has been concentrated on the theories of alcoholism with particular in-depth discussion of those theories that have received attention during the educational development and practice of what is believed to be the majority of registered nurses. Particular attention has been paid to the discussion of the need to consider gender differences in theory and practice because registered nurses provide care for both male and female patients who suffer from alcohol related illnesses or alcoholism.

Attitudes Toward Alcohol Use, the Alcoholic and Alcoholism

This section of the review of the literature will center on a summary of the more prominent research studies in the literature which relate to the current attitudes
toward alcohol use, the alcoholic person, and the concept of alcoholism. To accomplish this, the discussion will be divided into the categories of public and professional attitudes in the areas specified. While the review of the public and professional attitudes will, for the most part, be discussed briefly, the attitudes of registered nurses who are the subjects in the present investigation will be discussed in depth.

**Public Attitudes**

In the area of public attitudes toward alcohol use, the Maxwell study conducted in the State of Washington was a pioneer effort (Maxwell, 1952). Maxwell found that 62.8 percent of his probability sample indicated in approval attitude toward the use of alcohol in moderate amounts, 36.7 revealed an attitude of disapproval of alcohol use in moderate amounts, and 4.7 percent were not sure of their attitude. Further and generally speaking, the correlation between expressed attitudes toward drinking and drinking behavior was found to be high. Examining the total responses according to sex, it was found that 67.8 percent of men in the sample approved of moderate drinking compared to 58 percent of the women.

Cahanlan et al. (1969) summarizing previous research and on American drinking patterns concluded: "(1) In the
U.S.A. as a whole, drinking of alcohol is a typical behavior and both abstinence and heavy drinking, especially to escape from life's problems, are typical: (2) Although the level of drinking (as distinct from heavy drinking and problem drinking) varies according to the individual's position in society, in most social groups a higher proportion of men and young persons drink than do women and older people; and (3) Several kinds of evidence indicate that the proportion of women who drink is increasing." From Cahanlan's et al's conclusions which were well-documented it is evident that the use of alcohol is viewed with a positive attitude which is becoming increasingly widespread. Further, this attitude has been noted as the prevailing attitude toward the use of alcohol by many of the authorities in the field of alcoholism (Kinsey, 1966; Catanzaro, 1968; Cahn, 1970; Hoyt, 1977).

Research on the public's attitudes toward the alcoholic and alcoholism have not been conducted. For the most part, these attitudes are inferred from the historical roots of these attitudes which have been found in the past writings about drunkenness or the laws initiated to control or penalize those persons who habitually drank to excess.

The following 3,000 year old description of public attitudes toward the alcoholic written in Egypt reveals the
earliest recorded roots of current attitudes toward alcoholics: "Take not upon thyself to drink a jug of beer. Thou speakest, and an unintelligible utterance issueth from they mouth. If thou fallest down and thy limbs break, there is none to hold out a hand to thee. Thy companions in drink stand up and say, 'Away with this sot.' And thou are like a little child." (U.S. Department of Health, Education, and Welfare, 1976).

A similar attitude toward the alcoholic was conveyed in the laws of Virginia many centuries later. In 1619, the legal penalties for the excessive use of alcohol were specified as follows: (1) For the first incidence of the excessive use of alcohol, the person was privately rebuked by a minister; (2) For the second incidence, a public admonishment was given; and (3) For the third incidence, the person was given a specified fine and sentenced to 12 hours in a yoke at a public square (U.S. Department of Health, Education, and Welfare, 1976). These legal penalties reflected a moralistic attitude in which the alcoholic was viewed as self-indulgent, weak in character, and morally degraded. Obviously in this description, an attitude which suggested treatment for the alcoholic was unknown.

During the present century, two national efforts indicated that attitudes of the public toward alcoholics had remained relatively consistent over the centuries. One was
The Temperance Movement and the other was the Eighteenth Amendment which was in force from 1920 to 1933. Both of these efforts reflected the attitude that the alcoholic was morally weak and could be controlled only if the source of alcohol was eliminated.

Research evidence which identified twentieth century public attitudes toward the alcoholic were the result of studies by Maxwell (1952), Nunnally (1961) Pittman and Sterne (1963), and Marcus (1963a, 1963b). The Maxwell study conducted in Washington State tested the feeling reactions of subjects toward drunkenness in men and women. The findings were that the majority of people felt disgust toward the drunken person, and this disgust was greater for drunken women than drunken men. Other feelings reported were those of pity and loss of respect. Further, it was found that alcoholism was viewed to be primarily the result of environmental influences and a condition which could not be improved solely by individual effort on the part of the alcoholic. Three out of five persons in the study were found to believe that the weak-willed character of the alcoholic made cessation of drinking impossible.

Nunnally (1961) in investigating attitudes toward individuals with various types of mental illness included a measurement of attitudes toward the alcoholic. Subjects
in the study represented a cross-section of people from midwestern communities in Illinois. The researcher, using the Semantic Differential to measure attitudes, reported the subjects viewed the alcoholic as weaker, dirtier, slower, less intelligent, less healthy, and less predictable than the average man.

Pittman and Sterne (1963) studied community agency attitudes toward alcoholism and the impact of these attitudes on alcoholism treatment services within the St. Louis area. They reported that the majority of hospitals had policies which prevented the admission of alcoholic patients under the primary diagnosis of alcoholism. According to them, hospital representatives were fearful that if alcoholics were admitted, the hospitals would have an unfavorable image to the lay persons in the community. The researchers concluded that the moralistic, punitive attitudes toward alcoholics which were reflected in these policies were the result of the influence of public opinion. These findings can be considered an indirect assessment of the negative attitudes toward the alcoholic and alcoholism held by the public in the area where the study was conducted.

Marcus (1963a,b) conducted a study on the attitudes of a sample representative of the Toronto, Canada general population. He found that the respondents tended to view
alcoholism as a disease which was treatable and that the majority of them believed the most sensible way to deal with alcoholics was to compel them to undergo treatment. Although he found that the respondents believed the alcoholic had moral and social characteristics which differed little from persons who were non-alcoholic, he reported their attitudes were less positive than a group of alcoholism experts. He interpreted this finding as being reflective of the reluctance of the general public to completely absolve the alcoholic from the responsibility for the condition of alcoholism.

Authorities such as Cahn (1970) have stated that the public holds negative attitudes toward the alcoholic person and the concept of alcoholism. He was supported in his view by the American Medical Association (1973) which concluded, "... the public has by tradition maintained a moralistic and essentially judgmental attitude of open disapproval, rejection, and condemnation toward the alcoholic and a hesitancy to view alcoholism as a disease."

Summarizing the historical and empirical evidence and the statements by alcoholism authorities on the attitudes of the public toward the alcoholic, it is evident that the findings of a moralistic and punitive attitude have been fairly consistent over time. Evidence of the present public
attitudes toward alcoholics or alcoholism was not found in this review of the literature. Until national studies are conducted and reported on the general public's current attitudes toward alcoholics, researchers desiring to compare the attitudes of health professionals with those of the public will have to rely on the past empirical studies which have been described.

**Professional Attitudes**

Attitudes of a number of professional groups in the health or health-related fields have been investigated. These studies have focused on social workers, psychiatrists, psychologists, physicians, rehabilitation counselors, and registered nurses.

Baily and Fuchs (1960) used a questionnaire to explore the attitudes of social workers in New York City toward the alcoholic person and alcoholism. They found that (1) social workers overwhelmingly viewed alcoholism as a symptom of an underlying emotional disturbance; (2) an attitude of sympathy and understanding was reflected by only 46.1 percent of their sample, (3) the majority (53.9%) of the sample had an attitude of annoyance, indifference, fear or disgust for the alcoholic; and (4) no more than 30 percent of the sample considered the prognosis for alcoholics in a favorable light. Because the majority of subjects in this study
engaged in social drinking, the researchers suggested that it was possible that one who is able to use alcohol without becoming addicted might consider the person suffering from alcoholism as weak. They also proposed that viewing alcoholism as a symptom rather than a disease could result in failure of social workers to meet the alcoholic 'where he is.'

In a survey conducted with a large sample of psychiatrists and psychologists employed in veterans' hospitals, Knox (1971) found that professionals who belong to the group most highly qualified to treat alcoholism did not believe in the disease concept of alcoholism and were reluctant to participate in the treatment of alcoholics. They reflected a very limited interest in spending time individually or in group therapy with alcoholic persons. The majority were found to be willing to spend no more than 10 percent of their time with an alcoholic clientele.

Hart (1976) explored the attitudes of a small group of rehabilitation counselors toward alcoholism. Using The Marcus Alcoholism Questionnaire with a group of six counselors, it was found that counselors not only accepted the disease concept of alcoholism but their attitudes toward treatment of alcoholism was positive. Although the sample was extremely small, the findings reported did show
positive attitudes toward alcoholism which were not found in the Knox Study.

Research based on an intake study of persons coming to the outpatient services of the Massachusetts General Hospital conducted by Hart (1978) focused on the attitudes of hospital members of the alcohol team toward alcoholic persons. She found that patients' self-labeling was a determinant of the view taken of them by the professional members of the alcohol team. Further, she found that alcoholism was considered as a symptom by the team members, and that they saw the alcoholic as a derelict and less stable or socially integrated than other patients. In addition, alcoholic patients were considered to be less likely to have medical insurance. From these findings, it was apparent that the skid-row stereotype of the alcoholic operated in the attitudes of the professional health care providers who worked with alcoholics in a clinic setting.

The prevalence of the reported negative attitudes of health professionals toward the alcoholic person and pessimistic attitude toward treatment of alcoholism as a disease has been attributed to several causes. Three major causes have been identified. The first is the curative concept of illness which prevails among health care professionals tends to influence them to ignore the chronic nature of
alcoholism (Burkhalter, 1975). In addition, with adherence to this concept, the belief persists that remission amounts to failure of treatment (Armor et al., 1975). Second, the measurement of success of treatment rests entirely on the basis of total abstinence which is rarely the case (Popham & Schmidt, 1976 and Armor, Polich & Stambul, 1975). Third, outcomes with different treatment modalities have not reflected the superiority of any one treatment over another. In fact, Alcoholics Anonymous meetings without treatment have been said to have the same percent of remission as all treatment programs together (Armor, Polich & Stambul, 1975).

The general adherence of health professionals to the concept that remission for the alcoholic amounts to failure of treatment was evident in the controversy which arose following the publication of the Rand Report (Armor et al., 1975). In this research study treatment successes were reported in spite of the lack of abstinence of alcoholic patients who were treated in 45 community alcoholism centers across the nation. Although the researchers found a relatively small number of subjects who were long-term abstainers, they rated improvement from treatment on the basis of length and number of remissions, improved employment status, and improved social relations at a 70 percent level. This was interpreted by many authorities simply to mean
that an alcoholic person undergoing treatment could be considered improved and continue drinking alcohol so long as the person experienced remissions at various intervals and for varying lengths of time (Armor, et al., 1975).

In summary, from the empirical studies discussed it has been shown that professions, exclusive of the nursing profession have in some settings generally held negative attitudes toward the alcoholic person and a pessimistic attitude toward the effectiveness of treatment. Also, the reason authorities have given for the negative view of alcoholism as a treatable disease was discussed briefly. Next, the attitudes toward alcoholic persons and the concept of alcoholism on the part of both registered and student nurses based on existing empirical evidence will be discussed.

Most of the literature on the attitudes of nurses toward the alcoholic person and alcoholism has emerged over the past three decades. Although few in number, these empirical studies have been conducted using a variety of approaches. There have been studies conducted in which personal observations, anecdotal case study, descriptive survey, and experimental design methods have been employed. Settings and methods of measuring attitudes have also varied.
The earliest description of the attitudes of nurses toward alcoholism was provided by Golder (1956). Maintaining at that time that alcoholism as an illness was a concept struggling for existence, she described the attitudes of registered nurses from her personal observations. In this description, she stated that registered nurses viewed the alcoholic person as one who was weak-willed, shiftless, unable to help himself, and immoral. These unsympathetic attitudes, she posited, emerged from the experiences in the emergency rooms where chaos developed from the inability of nurses to handle treatment of alcoholics because of a lack of skills and a lack of staffing resources. These negative attitudes, she contended, were translated into the attitude that alcoholics were less able to be helped than other patients. Therefore, she reasoned, nurses believed that focusing attention on alcoholics was wasted energy.

The early pre-experimental study by Berke, Gordon, Levy, and Perrow (1959) of the attitudes of 32 registered nurses, who participated in a pilot demonstration program in which alcoholics were admitted to a general hospital, revealed the nurses held negative attitudes toward alcoholics. Using the interview method, the researchers found that nurses saw alcoholics as a management problem because of their bizarre behavioral problems and believed they required special facilities. Approximately 67 percent of
the persons having negative attitudes related their attitudes to direct experience with alcoholics. These findings, concluded the researchers, pointed to the need for staff development regarding alcoholism and how to intervene with the alcoholic.

The Pittman and Sterne (1963) investigation, a survey of community attitudes toward alcoholics and alcoholism, included a sample of 23 registered nurses, among other professionals. Using a questionnaire developed by Pittman and open-ended interviews, the researchers reported that registered nurses had more negative and moralistic attitudes toward alcoholic patients than social workers or physicians. However, as a group, they were found to have an accepting attitude toward alcoholism as a disease and a belief in its treatability. From these results, the researchers concluded that the registered nurses reflected divergent attitudes toward the alcoholic and alcoholism.

Reznikoff (1963) examined the attitudes of a sample of registered nurses and nurse aides in Hartford, Connecticut toward psychiatric treatment and psychiatric hospitals where, in many instances, alcoholic patients are treated. Using a psychiatric attitude battery test with his non-random sample which included 44 registered nurses, Reznikoff reported that registered nurses who worked as staff nurses tended to be more negative in their attitudes toward
psychiatric treatment than nurses who worked in supervisory positions. Further, those among the sample who reflected the more positive attitudes had longer experience working with individuals in psychiatric units.

Johnson (1965) using a stratified random sample of registered nurses belonging to the Omaha district of the Nebraska Nurses Association investigated the attitudes of registered nurses toward caring for the alcoholic patient and their responsibility for working with the problem of alcoholism. Using the interview approach with a total sample of 71 nurses, she found that (1) 80 percent of the nurses saw themselves as tolerant and understanding of alcoholic patients; (2) 20 percent had ambivalent or negative attitudes, and this group consisted of staff nurses in hospitals and public health agencies; (3) The majority of nurses believed separate treatment facilities should be provided for alcoholic patients; (4) They believed they had need of more education to understand the alcoholic patient; and (5) Although they saw themselves as having a responsibility for working with the problem of alcoholism, they did not believe themselves to be prepared for this responsibility.

In 1965 Linsky, Heinemann, and Sorensen reported on their investigation of attitudes held by an intact group of registered nurses and hospitalized alcoholic-tuberculous
and non-alcoholic-tuberculous patients toward treatment of alcoholism; the alcoholic and alcoholism; and moderate social drinking. In addition to collecting data on the attitudes of each group (37 staff nurses, 28 alcoholic-tuberculous patients, and 31 non-alcoholic-tuberculous patients), the total patient group rated their staff nurses according to what they perceived their attitudes to be in each of the three areas. The three groups responded to three attitude scales. From the responses on these scales, the researchers reported that; (1) Staff nurses were significantly more favorably disposed toward the treatment of alcoholism and the alcoholic and alcoholism than either of the patient groups; (2) Staff nurses revealed a slightly more favorable attitude toward moderate social drinking than patients; (3) Both patient groups perceived the nurse as having less favorable attitudes than responses to the attitude scales measuring treatment of alcoholism and the alcoholic and alcoholism actually revealed; (4) Patients' perceptions of nurses' attitudes toward moderate social drinking were that nurses were less favorable than they actually were; and (5) Alcoholic patients saw nurses' attitudes as less favorable than the attitudes they held toward themselves. The researchers concluded that the attitudes of registered nurses as measured were far more favorable than either group of patients rated them, and posited that the alcoholic
patient in believing himself unworthy may also believe the nurse regards him in the same way. They further suggest that if communication is unclear the alcoholic person is free to a degree to assign any value to the attitudes of others according to his needs. This study is unique in both its finding about the attitudes of registered nurses and its design. It is one of the rare empirical studies found in literature that indicated nurses held positive attitudes toward both the alcoholic and alcoholism in a practice setting. Also, it is the only one in which nurses' expressed attitudes were compared with patients' perception of these attitudes and where the attitudes of nurses toward moderate drinking was measured.

Morton (1966) in studying attitudinal changes in registered nurses following a staff development program at the Brockton Veterans Administration Hospital in Massachusetts used a descriptive approach. Although she did not report the number of nurses in her study, she depicts the attitudes of nurses prior to the staff development program. These attitudes are described as ones in which the alcoholic was viewed as weak-willed, shiftless, immoral, self-destructive, lying, irresponsible, and capable of helping himself or herself if he or she wanted to do so. As a group, Morton says, alcoholics were viewed by the nurses as causing disturbances in wards and creating panic among the nursing
staff. Following the educational program, Morton stated that evidence of attitudinal change was demonstrated by improved nursing care plans and improvement of the treatment milieu because of the supportive attitudes of the nurses. Although it is difficult to analyze this study in terms of the amount of change that took place as a result of the program because of the lack of measurement, the study itself represents a part of the literature supporting the belief that registered nurses have held negative attitudes toward the alcoholic and alcoholism.

Another empirical study on the attitudes of registered nurses toward the alcoholic and alcoholism was conducted in 1968 by Ferneau and Morton. In this investigation, the attitudes of 31 nurses and 74 nursing assistants from a medical-surgical department of a psychiatric hospital were measured using the Marcus questionnaire. The two groups were, then, compared with each other. In addition, the nurses were compared with the Toronto Sample which was representative of the general population. It was found that the nurses believed more than nursing assistants that alcoholism is an illness and alcohol is highly addictive. However, it was also found that nurses revealed a greater tendency than the general population to view the alcoholic as weak-willed. The researchers, therefore, concluded that inconsistency between the simultaneously held beliefs about
the alcoholic and alcoholism existed in their sample. A further finding reported was that nurses were less moralistic in their attitudes toward alcoholics than nursing assistants. This, they posited could be due to differences in educational preparation.

One of the most recent studies done on the attitudes of registered nurses toward the patient suffering from alcoholism was done by Wallston, Wallston, and DeVilllis (1976). They explored the effect of a negative stereotype on registered nurses' attitudes toward the alcoholic patient. Their sample included 40 volunteers who worked primarily with adult medical-surgical patients in a 500 bed Nashville, Tennessee hospital. The subjects were divided into three groups, one experimental and two control groups. Different information was given each group about a simulated patient. The information consisted of statements relevant to the physical and psychological condition of the patient. Following exposure to this information, each group was given the Osgood Semantic Differential to measure their attitudes toward the patient. The researchers found that (1) Where no mention was made of alcoholism, the simulated patient was rated more favorably, saner, and healthier; (2) No difference was demonstrated between the stereotype which prevails about alcoholics and the nurses' attitudes toward the simulated patient as an alcoholic;
and (3) The nurses tended to rate the alcoholic, simulated
patient more neutrally. According to the investigators, a
neutral rating can be construed as a relatively negative
rating. The findings in this study were supported by a
later study conducted by Larson (1977) in which the meth-
odology and design were somewhat similar to the one em-
ployed by Wallston, Wallston, and DeVellis (1976).

In addition to the empirical studies reviewed on the
attitudes of registered nurses toward the alcoholic and al-
coholism, several studies have been conducted on the atti-
tudes of student nurses. In some instances, the samples
varied to include registered nurses who were seeking a de-
gree as well as undergraduate students who had never been
licensed. For the most part, however, the studies were
conducted on senior nursing students in diploma schools of
nursing. Since these students, irrespective of status, in
all likelihood entered nursing practice with the attitudes
identified, the studies involving them are included in this
review.

One of the earliest studies conducted on the attitudes
of student nurses toward alcoholics and alcoholism was the
study by Kuzenski and Reynolds (1966). These researchers
measured the attitudes of 34 senior nursing students in an
Alabama diploma school of nursing. They reported that the
students viewed the alcoholic person negatively and thought
that treatment effort was fruitless for persons suffering from alcoholism.

A year later in 1967 Ferneau conducted a study on 29 student nurses at the beginning of and at the end of a 12-week psychiatric affiliation experience at the Brockton, Massachusetts Veterans' Hospital. Students were given a leaflet containing information about alcoholism, its etiology, phases and treatment at the beginning of the study. Then, The Marcus Alcoholism Questionnaire was administered to measure the pre-affiliation attitudes of students toward the alcoholic and alcoholism. After the affiliation was completed, the same instrument was used as a posttest to measure the same attitudes. The researcher reported that students were relatively positive in their pre-affiliation attitudes toward the alcoholic and alcoholism. The only significant changes reported were in the belief that (1) emotional and psychological problems are important in the development of alcoholism; (2) the alcoholic is unable to control his drinking behavior; and (3) alcohol is a highly addictive substance.

The provision of information about alcoholism prior to the pretest casts some doubt on the findings reported. It might be speculated that the information provided before the pretest contaminated the results of the study. In addition, it might be suggested that students may have
believed they were being evaluated and as a consequence, gave answers on the questionnaire which were consistent with the expectations of the researcher.

Moody (1971) investigated the custodial attitudes of 65 sophomore and senior student nurses toward the treatment of alcoholics and the relationship of these attitudes to their scores on an authoritarianism scale. All of the students were enrolled in a southeastern university baccalaureate nursing program. The sample differed widely in that some students were registered nurses and licensed practical nurses working toward a degree and others were students who had never completed a nursing program. Each completed a questionnaire on an inventory which assessed custodial attitudes toward alcoholic treatment (The Custodial attitude Inventory); Srole's version of the F scale for measuring authoritarianism; and information about socioeconomic status. Moody reported that differences were not found in a comparison of the various student groupings on custodial attitudes toward alcoholism treatment. However, by combining the groups into one total group, he reported that a statistically significant positive relationship was found between nurses' custodial attitudes toward alcoholism treatment and their level of authoritarianism. Thus, he concluded that the higher nurses' level of authoritarianism, the more custodial their attitude toward alcoholism
treatment. Further, taking the socio-economic status of nurses into account, Moody reported finding that middle-class nurses had the least custodial attitudes and were the least authoritarian.

The importance of the Moody research lies in its implications for the nursing of patients with alcoholism. According to Armor et al., (1978), health care which has reflected custodial attitudes has produced poor results. Supporting the position of these authorities on the effects of custodial treatment on alcoholics are the nursing studies by Mitchell (1976) and Chavigny (1976).

In another study on the attitudes of nursing students, Schmid and Schmid (1973) examined the attitudes of 41 students at a hospital diploma school of nursing in Buffalo, New York. The focus of their investigation was on the attitudes of these students toward alcoholics and the physically disabled prior to and following two and one-half years of nursing education. The entire class of 1972 was pretested and posttested using Form 0 of the Attitudes Toward Disabled Persons Scale (ATDP-0) which was developed by Yuker et al., and the alcoholic version of the same test was constructed by the researchers. They found that the group did not differ significantly between pretest and posttest scores and that nursing students were significantly less accepting in their attitudes toward alcoholics
than toward the physically disabled.

Gurel (1976) conducted a study on a very small group of undergraduate and graduate nursing students at the University of Washington School of Nursing to investigate their attitudes toward the alcoholic and alcoholism prior to and following a sequence of courses on alcoholism. She reported that initially negative attitudes expressed on the pretest changed to positive attitudes at varying times during and following the sequences of courses in which the students were involved.

Summary

In summary, this review of the literature has included those aspects of the literature on alcohol and alcoholism that pertain to the present study. This review included attitude theory, the effects of alcohol on the human body, theoretical and empirical developments in the field of alcoholism. These facets of the literature were provided to give the study a general perspective. Further, two more specific purposes were served. First, insight into the sources of knowledge that have had an influence on the formation of the beliefs of registered nurses during their preparation for nursing and later, during the course of their professional development was provided. Second, understanding of the nature of the instrument used to measure the attitudes of nurses in this study was made possible.
In reviewing the studies on nurses' attitudes toward the alcoholic person and alcoholism it was apparent that the sample compositions varied widely in relation to employment settings and number of subjects, moreover, instruments and approaches used for measuring the attitudes under investigation differed greatly. Further, in none of the studies were personal and professional attributes of the nurses considered in an effort to look for possible underlying causes of the attitudes expressed. Finally, in spite of these characteristics, the majority of the studies reported registered nurses held negative attitudes toward the alcoholic and alcoholism. Interestingly, the negative attitudes reported were the results of studies in which the researcher developed questionnaires, or Osgood's Semantic Differential, and interview methods were used. The few studies which reported positive attitudes utilized a questionnaire developed by Marcus (1963c) or other researcher developed instruments.
CHAPTER III
RESEARCH METHOD

General Method

The general method used for this study was determined by the purposes of the study. The causal-comparative research method, which is classified under the broad category of descriptive research, was used to obtain a description of the attitudes of registered nurses toward alcoholics and alcoholism and to characterize the relationship between these attitudes and their personal variables.

Research Population

Ideally, the research population for a study of this type would consist of all registered nurses employed in general hospitals in the United States. For the sake of cost and convenience, the population from which the sample was obtained was from three hospitals in Columbus, Ohio.

To gain access to the population of registered nurses employed in general hospitals in the Columbus area and draw upon this population for a sample of nurses who would volunteer for the study, the assistance and cooperation of the Administrators or Directors of Nursing Services of
three general hospitals were sought. The three hospitals whose participation was requested were selected because of their differences in size, location, and areas from which they draw their patient population. This approach was taken so that each type of hospital located in the area would be represented. Further, it was believed that by obtaining registered nurses from each type of hospital, a sample which was unbiased with respect to employment setting would be included in the study (see Appendix A).

In seeking the assistance of the nurse administrators, an appointment was made to discuss the importance, general nature, and requirements of the study. At this meeting a cover letter, copy of the research proposal, and the data packet to be provided each volunteer for the study was given to the nurse administrator. Each was left with these materials to review and to clarify any questions which might arise during the process of making a decision about hospital participation (See Appendixes). Shortly thereafter, an agreement was reached that each of the hospitals whose participation was requested would participate in the study.

Following this agreement, each hospital offered to provide the facilities needed and time off duty for the registered nurses who were willing to volunteer for the study. Then, dates, times, and locations for data
collection were determined. The nurse administrators sent announcements to each of their units announcing the title of the study, the name of the investigator, and information about the collection of data.

Therefore, the research population from which the sample of this study was obtained was the 720 registered nurses employed full or part-time during the months of December, 1978 and January 1979 by the three participating general hospitals.

Research Setting

The hospitals from which the sample of nurses was obtained and in which the research study was conducted were Hospitals A, B, and C. All of them are accredited by the Joint Commission on the Accreditation of Hospitals which sets the standards for patient care and services on a national basis.

Hospital A which is located at the northern part of the city is a large hospital with 882 patient beds which has had a long history of providing health care to the community. It has a wide-range of patient services, including a psychiatric and alcoholism service, and employs approximately 450 registered nurses. A large number of the nurses live in the same area from which the hospital draws its patients. Located in an affluent section of the city
without other hospitals in close proximity, Hospital A, generally speaking, draws patients from a middle or high socio-economic status population. In addition to providing patient services, it is affiliated with a university medical and nursing school and provides a setting for the clinical experience of students from these schools.

Hospital B, a medium-sized hospital with 400 beds, has also provided health care to the community over a long period of time. Located in the central section of the city, it is in close proximity to a larger and smaller hospital. It provides a large number of patient services, but not as many as are provided by Hospital A. For example, it does not have an obstetrical or psychiatric service. However, it does have an alcoholism unit which provides treatment for adolescents and adults. Approximately 200 registered nurses are employed by the hospital and they are drawn from the adjacent areas within and beyond the central city. Patients are also drawn from the same areas, but a large number come from the lower socio-economic status population in the surrounding area. In addition to patient services, Hospital B, also provides a setting for the clinical experience of medical and nursing students.

Hospital C, the newest of the three hospitals, is a small hospital located in the southern section of the city.
It has a bed capacity of 180 and employs approximately 70 registered nurses. It provides services for general medical-surgical, emergency, and intensive care. The patients and nurses are drawn from the southern and adjacent areas of the community. Patients are from a mixed population and tend to be from the low-to-middle socio-economic status population.

The Sample

The sample for the study met five criteria for participation. The subjects were (1) female; (2) currently licensed to practice professional nursing in the State of Ohio; (3) employed by one of the participating general hospitals; (4) employed in a hospital unit with a primary focus on patient care; and (5) willing to volunteer for the study without compensation. The reason for the exclusion of male nurses from the study was because it has been estimated that 98.1 percent of registered nurses are female (The American Nurse, 1979). Further, there was an extremely small number of male nurses employed in the three hospitals where the sample was obtained. One male nurse was employed at Hospital A, two at Hospital B, and one at Hospital C. It was probable that not more than one or two of these male nurses would have volunteered for the study. Therefore, including the sex variable for the study was not considered necessary.
Restatement of the Hypotheses

Eight hypotheses were formulated to answer the major questions of this study. Restated and operationalized for testing they were as follows:

Hypothesis 1: Registered nurses from general hospitals have significantly negative attitudes toward the alcoholic person.

The mean responses of the sample to Factors 5 and 6 on The Marcus Alcoholism Questionnaire which relate to the moral character and social status of the alcoholic were used to measure the attitude of the nurses. Then, the significance of the direction for the expressed attitudes was determined by comparing the nurse sample mean with the sample mean of the experts. The expert sample means are provided in the test administration directions for the person administering the test.

Hypothesis 2: Registered nurses from general hospitals hold a significantly positive view of alcoholism as a disease or illness.

This attitude was measured by the Factor 7 of The Marcus Alcoholism Questionnaire and the significance of the attitude was determined in relationship to the expert group mean on this factor.

Hypothesis 3: Registered nurses from general hospitals hold significantly pessimistic attitudes toward the prognosis of alcoholism.
For measuring this attitude, the sample responses to Factor 3 of The Marcus Alcoholism Questionnaire was used because it reflects the attitude toward the efficacy of treatment. Again, the expert sample was used to determine the significance level of this attitude.

**Hypothesis 4:** The attitudes of registered nurses in general hospitals toward the alcoholic and alcoholism do not differ significantly from those held by a sample representative of the general population.

The mean scores for the nurse sample on Factors 3, 5, 6, and 7 which were previously used from The Marcus Alcoholism Questionnaire were used to measure the attitudes of registered nurses. These means were compared with the means from the Toronto, Canada, population tested by Marcus (1963b) for the testing of this hypothesis.

**Hypothesis 5:** Attitudes toward the alcoholic and the disease or illness orientation of alcoholism expressed by registered nurses are significantly related to their level of need for social approval.

The sample responses on Factors 5, 6, and 7 of The Marcus Alcoholism Questionnaire were used to measure nurses' attitudes toward alcoholics and alcoholism. Responses of the sample on The Marlowe-Crowne Scale were used to determine nurses' need for social approval. According to their scores above or below the sample mean, the subjects were
categorized as having high or low need for social approval respectively.

**Hypothesis 6:** Registered nurses employed in a general hospital which has an alcoholism unit express significantly more positive attitudes toward alcoholics and alcoholism than of registered nurses who are employed in a general hospital which does not have an alcoholism unit.

The attitude of the nurses toward the alcoholic was measured by their mean response to the Marcus factors related to the character and socio-economic status of the alcoholic. Their attitude was measured by their mean response to the factors related to the prognosis and disease concept of alcoholism on the same questionnaire. The independent variable, employed in a hospital with or without an alcoholism unit was obtained from the nature of the setting of the hospitals where the data were collected.

**Hypothesis 7:** Registered nurses employed in an alcoholism unit have significantly more positive attitudes toward alcoholics and alcoholism than registered nurses employed in other hospital areas.

The attitude of registered nurses toward alcoholism was measured by their mean scores on the character and socio-economic factors of the Marcus questionnaire. Their attitudes toward alcoholism was measured by their mean
scores on the prognosis toward and disease or illness of alcoholism. The unit in which the subjects were employed was obtained from the demographic sheet.

Hypothesis 8: The attitudes held by registered nurses toward the alcoholic person are significantly related to their personal use of alcohol.

The attitudes toward the alcoholic was measured by the nurses' responses to the Marcus statements relating to the character and socio-economic level of alcoholics, i.e., Factors 5 and 6. The nurses' personal use of alcohol was measured by their responses on the Alcadd Test.

Instrumentation

The instruments which were used were The Marcus Alcoholism Questionnaire, The Alcadd Test, and The Marlowe-Crowne Social Desirability Scale. All three instruments were administered at the same time and required a total of 30 to 45 minutes. The Marcus Alcoholism Questionnaire was used to determine the nurses' attitudes towards alcoholics and alcoholism. The Alcadd Test was used to determine registered nurses' personal use of alcoholism; and The Marlowe-Crowne Social Desirability Scale was used to identify the level of nurses' need to give socially approved answers in the testing situation (see Appendix B, C, D).
The Marcus Alcoholism Questionnaire

The Marcus Alcoholism Questionnaire is an instrument which was developed by A. M. Marcus (1963a, 1963b) at the Toronto Alcohol and Drug Research Foundation in Toronto, Canada. It was the outcome of a series of empirical studies on popular attitudes and opinions about alcoholic persons and alcoholism. From an original pool of 1,000 statements about alcoholism, a questionnaire on beliefs about alcoholism was developed. In factor analyzing the questionnaire, nine factors were identified that represented the major dimensions of attitudes toward alcoholism. These dimensions are identified as: (1) the alcoholic as an individual with emotional difficulties; (2) the alcoholic as one who has lost control over alcohol; (3) the prognosis for recovery from alcoholism; (4) the alcoholic as a steady drinker; (5) the social status of the alcoholic; (6) alcoholism as a character defect; (7) alcoholism as a harmless, voluntary addiction; and (9) alcoholism as an illness. Each of these nine factors is represented by four statements in the questionnaire, yielding a total of 36 factor-related items for the instrument. Four additional items are included which are not covered by the nine dimensions. They are considered optional items. Thus, the instrument consists of a total of 40 items.
A Likert scale accompanies each question. This scale represents an interval measurement on a continuum of one to seven points and ranges from complete disagreement to complete agreement. Table 1 illustrates the scale with its ratings or points on the scale and the interpretation of each.

**TABLE 1**

Marcus Questionnaire Scale

<table>
<thead>
<tr>
<th>Disagree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
</tbody>
</table>

Rating Score on Scale: Interpretation

1 ................ Completely disagree
2 ................ Mostly Disagree
3 ................ Disagree More Than Agree
4 ................ Neutral
5 ................ Agree More Than Disagree
6 ................ Mostly Agree
7 ................ Completely Agree

The questionnaire with the explanation for its use and completion is included in the Appendix B.

As shown in the Marcus scale, an individual can obtain a score of 1 to 7 on each of the four items of a factor. The statistic of interest in determining the attitudes of an individual or group is the mean factor score.
According to test directions, a person's mean factor score is determined on any factor by summing the subject's scores on the four factor related items. This sum is then divided by 4 or the number of items related to the factor to obtain the mean. For example, if an individual scored 5, 4, 7, and 2 on the items of a particular factor, the sum of the item scores would be 18. Dividing this sum by the number of items (4), yields the individual's mean factor score of 4.5.

The mean factor score for a sample or group, according to test directions, is the average of the factor scores obtained by all individuals comprising the sample or group. Three stages of computation are involved. These are stated as follows:

"1. Compute the sum of the four defining items for each person.

2. Obtain the total of the sums for all persons in the group.

3. Divide this figure by the number of items (4) times the number of persons." (Marcus, 1963c).

A sample computation of the mean score on Factor 1 for a group of ten people is shown on Table 2.

Insert Table 2 about here
### TABLE 2

Computation of Mean Scores on Marcus Factors

<table>
<thead>
<tr>
<th>Code Number</th>
<th>Factor 1</th>
<th>Items:</th>
<th>Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7 19</td>
<td>28 36</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>7 7</td>
<td>6 7</td>
<td>27</td>
</tr>
<tr>
<td>2</td>
<td>7 5</td>
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<td>7 5</td>
<td>23</td>
</tr>
<tr>
<td>10</td>
<td>6 5</td>
<td>5 3</td>
<td>19</td>
</tr>
</tbody>
</table>

Sum 54 52 57 43 206

Mean = 206/(4) = 51.5/(10) = 5.15 (Marcus, 1963c).

The interpretation of mean scores of an individual or sample on Factors of the Marcus Questionnaire is illustrated in Table 3.

Insert Table 3 about here
## TABLE 3
Interpretation of Factor Scores on Marcus Questionnaire

<table>
<thead>
<tr>
<th>Factor</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Emotional Difficulties</td>
<td>High Score: Belief emotional and psychological problems impt. in dev. of alcoholism.</td>
</tr>
<tr>
<td>2. Loss of Control</td>
<td>High Score: Alcoholic is unable to control drinking.</td>
</tr>
<tr>
<td>3. Prognosis for Recovery</td>
<td>High Score: Alcoholics are not and cannot be helped to recover.</td>
</tr>
<tr>
<td>4. Alcoholic as a Steady Drinker</td>
<td>High Score: Periodic excessive drinkers can be alcoholics.</td>
</tr>
<tr>
<td>5. Alcoholism as a Character Defect</td>
<td>High Score: Alcoholics are weak-willed persons.</td>
</tr>
<tr>
<td>7. Alcoholism as an Illness</td>
<td>High Score: Alcoholism is not an illness.</td>
</tr>
<tr>
<td>8. Harmless Voluntary Indulgence</td>
<td>High Score: Alcoholic's drinking is motivated by fondness for alcohol.</td>
</tr>
<tr>
<td>9. Alcohol Addiction Properties</td>
<td>High Score: Alcohol is a highly addictive substance.</td>
</tr>
</tbody>
</table>
In order for the factor scores for different groups tested to be meaningful, Marcus suggested other groups are needed for comparison purposes. Therefore, he conducted studies on five separate samples to obtain factor scores representative of groups (1963c). Among these samples were the Expert Sample and Toronto Sample.

The Expert Sample's mean scores were obtained to serve as a standard against which other groups or professional samples could be judged or compared. The sample consisted of 38 persons who had been with the Toronto Addiction for Alcoholism and Drug Addiction Research Foundation at least six months. There were seven physicians, four psychiatrists, four social workers, three nurses, and several other persons from other departments within the addiction center. These included six persons from the education department, nine from the research division, two from a Chronic Drunkenness Offender Project, two from administration, and one other person from an unnamed department. The registered nurse sample in the present study was compared with the Expert Sample to test Hypotheses 1, 2, and 3.

The Toronto Sample was a quota sample of 200 randomly selected male and female adults who were 20 years of age or over and who resided in the Toronto area. This sample was selected so that it was representative of the general
population. The mean factor scores of this sample are compared with the factor scores of the registered nurse sample in this study in order to test Hypothesis 4.

These samples which were utilized for comparison purposes in this study were not considered comparative groups in the sense that they served as control groups. They obviously differed in certain respects from the sample in this study. For example, both males and females were included in the samples. Therefore, the Marcus samples were considered strictly as groups with which the sample of the present study could be compared. Both samples are included in the test administration directions for the administration, scoring, and interpretation of the questionnaire.

In general, the validity of the Marcus instrument was established during the preliminary testing and development (Marcus, 1963a and Marcus, 1963b). Later research has provided further support of the validity of the instrument (Ferneau, 1967; Ferneau & Morton, 1968; Hart, 1976; and Gurel, 1976).

To test the criterion-related (predictive) validity of the Marcus questionnaire would require comparing the mean Factor scores obtained on the questionnaire with one or more external variables or criteria known to measure the attitudes under study. To date such variables or
criteria have not been identified from the investigator's search of the literature.

Construct validity was tested during the development of the instrument. Approximately 1,000 statements about alcoholism were collected from an analysis of the alcoholism literature, questionnaires, and opinion polls on alcoholism, and protocols of unpublished interview surveys (Marcus, 1963a). Obscure items or those items worded in technical language were eliminated. Items related to the various characteristics of the alcoholic and the seriousness, causes, and disease conception of alcoholism were retained.

The reliability of the Marcus questionnaire was not tested by Marcus. Later researchers (Ferneau, 1967 and Gurel, 1976) provided the empirical support for the reliability of the instrument in their test-retest use of the instrument. However, correlation coefficients have not been reported.

The Alcadd Test

The Alcadd Test was used to measure the personal variable, use of alcohol. This instrument is a brief, single response, objective, paper-and-pencil test developed by Morse P. Manson (1949). It was constructed for the psychometric differentiation of non-alcoholics from alcoholics. However, the results of the test can be used to
differentiate between social drinkers and abstainers (Murphy, 1956). It was for the latter purpose that the test in its revised 1965 form was used in this investigation.

The test instrument in its revised form consists of 60 selected diagnostic questions which are based on the behavior traits of the alcoholic. These traits are: (1) regularity of drinking; (2) preference for drinking over other activities; (3) lack of controlled drinking; (4) rationalization of drinking; and (5) excessive emotionality. Means for abstainers, social drinkers, and alcoholics have been established for both male and female subjects by the use of norm groups. Furthermore, a critical ratio separating the abstainer and social drinker from the alcoholic has been established for male and female persons.

The test which has no right or wrong answers is self-administered and takes from 5 to 15 minutes to complete. Instructions are brief and simple, and the responses are limited to "yes" or "no." (See Appendix C for sample questions.)

Scoring of The Alcadd Test is done with a scoring key which exposes only the alcoholic responses. Each of the marked alcoholic responses counts for one point toward the total score. The critical scores for both males and
and females are provided. Ascending scores from the established critical scores point to pronounced alcoholic characteristics while descending scores indicate non-alcoholic drinking traits in the use of alcohol. The one differentiation which cannot be ascertained in this test is whether a recovering alcoholic is among the subjects. This person reflects a score that characterizes the abstainer if the responses marked are related to the present time-frame and the alcoholic if the responses antedate the present.

Manson established the reliability of The Alcadd Test during its development by using the Richardson-Kuder formula. He reported a coefficient of a reliability for a female group at .96 and that for a male group at .92. Reliability was reported to be slightly higher in later male and female groups which Manson studied. Murphy (1956) reported in a study of females that the reliability of the test was similar to that which had been found by Manson.

The validity of the test instrument was established during the preliminary testing and development of the instrument. Representativeness or adequacy of content was also established at this time.

The predictive validity of the test was established by Manson (1949). Correct predictions were made with 96 percent of the male and 97 percent of the female alcoholics.
tested by Manson (1949).

**The Marlowe-Crowne Social Desirability Scale**

This instrument was developed to deal with the tendency of respondents to give socially acceptable answers in a testing situation, consciously or unconsciously distorting the test results. It was based upon the rationale that individuals with differing needs for social approval would extend these behavioral differences into other situations, especially a situation with an evaluative context. As a consequence, according to the test developers, people describe themselves in a favorable or socially desirable way in order to gain the approval of others (Crowne & Marlowe, 1967). Because the instrument consists of items independent of psychopathology, it was believed to be the most appropriate instrument for the present study. Moreover, it provided additional data for the testing of Hypothesis 5 which states the attitudes of registered nurses are related to their need for social approval.

The Marlowe-Crowne Social Desirability Scale is an indirect measure of social approval based on non-pathological items. It consists of 33 statements which describe behaviors that are culturally sanctioned and approved but which are improbable in occurrence. The test instrument is self-administered, has easily understood directions, and requests only true or false answers. Approximately 5
minutes is required to complete it (see Appendix D).

The total number of items in the instrument are keyed so that 18 of them should be marked true and 15 of them should be marked false. Scoring is not based on content but on whether the items marked are believed to be in a socially desirable direction. After determining the correct number of answers for each individual in a group, a mean score is figured for the total group. Social desirability, i.e., need for social approval, is, then, dichotomized at this mean point. Subjects scoring above the mean are classified as having a high need for social approval. Those scoring below the mean are classified as having a low need for social approval.

Empirical studies on a variety of groups in different settings by Crowne and Marlowe and their followers have provided a number of group means with which other groups may be compared. For example, a group of students from various universities, students from secretarial schools, prisoners from facilities for both male and female groups, and women in the insurance business have been tested and group means established for each of them (Crowne & Marlowe, 1967).

The validity of the instrument was established during its development using a panel of expert judges. In addition, other studies such as the ones by Kent (1975) and
Strickland and Crowne (1963) have provided support for the predictive validity of the instrument. Kent found that the instrument could be predictive of self-disclosure. Strickland and Crowne reported the need for social approval predicted the premature termination of psychotherapy.

Reliability of the instrument was established by Crowne and Marlowe using the Kuder-Richardson Formula 20. They reported a .88 reliability. In addition, later studies using the test-retest situation reported a .89 correlation (Crowne & Marlowe, 1967).

In addition to the three instruments, a demographic sheet was used to obtain information on professional and personal characteristics of the subjects (see Appendix D). As shown, the sheet was devised using a multiple choice format.

Method of Data Collection

Arrangements were made to use conference rooms at each hospital for collecting the data. All rooms had a portable blackboard, small table, and student chairs or portable chairs around a long conference table. Data was collected from individuals or groups. The groups ranged in size from 5 to 20 persons.

On the blackboard several statements were written in addition to a reproduction of the guide for The Marcus Alcoholism Questionnaire. The statements were as follows:
(1) Please do not discuss the test or your answers with others so that other volunteers can come to the sessions with the same amount of information you had when you came.

(2) Place your code number on the letter to you, the participant, and keep the letter for your files in the event that you would like to ask further questions or that your code number is posted requesting you to provide answers you may have missed at a later session.

(3) If you have worked with a person having an alcohol problem or alcoholism in your past professional experience, place an X on the right-hand corner of your packet.

(4) If you have had or now have an alcohol problem or are a recovering alcoholic, would you please share this information with a short notation on the demographic sheet.

(5) There are no right or wrong answers on the instruments you are asked to complete. However if you are not sure of which answer to mark, simply mark the answer which represents your first impression. Remember, if your contribution is to count, all questions need to be answered.

(6) After completion of your instruments, place your consent form in the box marked for that purpose and place your packet in the box marked "Data Packets."

(7) If you have any suggestions about the test instruments or procedure used, please share them with the investigator following your return of the packet and consent form.

(8) The guide for completion of the Marcus questionnaire which is on page 1 of the questionnaire is reproduced below for your convenience (see Appendix F).

As each volunteer subject arrived at the session for data collection, she was given a data packet. The investigator introduced herself and asked the volunteer to check the contents of the data packet to be sure all materials
were included. Then, time was allotted to read the participant's letter and consent form. After this reading, the consent form was reviewed in detail and it was pointed out by the investigator that the responses for each individual participating would remain confidential and that each packet was given a code number, the statements on the blackboard were reviewed and the volunteer nature of the study was reiterated. At that time, opportunity was provided to withdraw from the study. None of the nurses who came to the sessions decided to withdraw so all of them completed the instruments (see Appendix F,G,H).

Data were collected from December 18, 1978 to January 12, 1979. The data collection took place on various days and at various times in order to make it possible for nurses on all shifts of duty to volunteer in the study.

Specification of Variables

There were three dependent variables in this study and three major independent variables. The first dependent variable was the registered nurses' attitude toward the alcoholic, operationalized by their mean factor score on Factors 5 and 6 of The Marcus Alcoholism Questionnaire. The second dependent variable was the registered nurses' attitudes toward alcoholism as an illness or disease which was operationalized by their mean score on Factor 7 of the
same questionnaire. The third dependent variable was the registered nurses' attitudes toward the prognosis of alcoholism as measured by their mean score on Factor 3 of The Marcus Alcoholism Questionnaire.

The major independent variables in the study were registered nurses' (1) level of need for social approval, (2) area of practice within or outside of an alcoholism unit, and (3) personal use of alcohol.

On the basis of the literature some minor independent variables were included. These variables were: years of experience in nursing; age; basic educational program in nursing; religious orientation; and personal relationship or professional experience with a person having an alcohol problem.

The rationale for including these minor independent variables was that Reznikoff (1963) suggested that the attitudes of nurses toward the treatment of psychiatric patients tended to become more favorable the longer they worked in the hospital. Marcus (1963a) found age and number of years of education significantly related to the Factors on the Marcus Alcoholism Questionnaire. According to Pittman (1967) and Rublowsky (1970) religious orientation, has long been recognized as an influence on an individual's attitudes toward the alcoholic and alcoholism. Empirical research supporting this position of experts was
not found in the literature. Further, Catanzaro (1968) and Johnson (1973) described the effects of a personal relationship with an individual having an alcohol problem on attitudes toward alcoholics and alcoholism. (Berke et al., 1959) and Burkhalter 1975) posited that negative attitudes toward alcoholics are related to direct experience with alcoholics.

Analysis of the Data

The Statistical Package For The Social Sciences (SPSS), a computer program located at the Systems Engineering Branch of Instruction and Research Center at The Ohio State University, was used for the analyses of the data obtained for this study. The data were coded and key punched according to the SPSS specifications, and a program was developed to create a data record and compute the statistics needed to test the hypotheses (Nie et al., 1975). Alpha was set at the .05 probability level.

At the beginning of the statistical program, confirmatory matrices were run on the Factors in the Marcus Questionnaire and the Alcadd instrument using a Pearson correlation coefficient with the data collected. The findings on the Marcus instrument were not significantly different than those reported by Marcus (1963a). Where correlations were found between the factors they were low and not
significantly related except to the total score. Thus, the factors were found to be relatively independent of each other.

The matrix using the Pearson correlation coefficient with the data on The Alcadd Test which was subjectively factored, revealed that none of the factors was independent of other factors. Correlations between the factors ranged from high-to-low correlations and all were significant. This situation suggests some reservations in interpreting factor scores.

The matrix developed on the relationship between the Marcus questionnaire and The Alcadd Test revealed some low correlations between the factors. For example, there was a correlation between Factor 7, alcoholism as a disease, and the factor on the Alcadd instrument labeled rationalization for drinking. These correlations do not affect the utility of either of the instruments in the present study.

The initial step in the analyses of the data prior to the hypotheses testing was the calculation of descriptive statistics using the demographic data obtained from the respondents to give a precise description of the sample being studied. The absolute frequencies and adjusted frequency percentages were calculated on the professional and personal characteristics of the subjects for this purpose (see Table 4, Table 5, and Table 6).
Hypothesis 1 which states that registered nurses from general hospitals have significantly negative attitudes toward the alcoholic person was tested using two statistical approaches. First, descriptive statistics were calculated for the nurse sample on Marcus Factors 5 (the moral character of the alcoholic) and Factor 6 (the socio-economic level of the alcoholic). Second, a t test analysis was performed to compare the means of the registered nurse sample on the Marcus factors with the means of the Expert Sample provided in the test administration directions. Although one of the assumptions of the t test is that it is used with a random sample, Boneau (Guilford & Fruchter, 1973) demonstrated the assumption can be violated except in instances where the sample size is very small. A very small sample was defined by Downie (1974) as one in which the number of subjects on which measures are obtained is eight or less. Since there were 159 nurses in this study and 38 persons in the Expert Sample, the use of the t test in the testing of the first four hypotheses of the study which includes Hypothesis 1 was believed to be justified. Calculating the t value for the analysis of the difference between the mean scores of the nurse sample and the Expert Sample, the variance of the study sample was used throughout the formula because of the loss of the original data containing the variances of the sample of experts.
The reasoning used was that the sample variance is the best estimation of the population variance (Hayes, 1963). The one-tailed test of significance was utilized to assess the significance of differences determined. This test of significance was selected because of the directional nature of the hypothesis (see Table 7 and Table 8).

In testing Hypothesis 2 which stated, "Registered nurses from general hospitals view alcoholism as a disease or illness," the same statistics as used in testing Hypothesis 1 were utilized. Descriptive statistics were calculated on the responses of the nurses to Factor 7 (alcoholism as an illness or disease) of the Marcus questionnaire. A t test was performed for the analysis of the means of the nurse sample and Expert Sample: A t value reaching the .05 level of probability using the one-tailed test was considered significant (see Table 9 and Table 10).

To test Hypothesis 3 which was, "Registered nurses from general hospitals hold significantly pessimistic attitudes toward the prognosis of alcoholism," descriptive statistics computed on the responses of the nurse sample to Factor 3 on the Marcus questionnaire (prognosis of alcoholism). Then, a t test analysis of the differences between the nurse sample and the Expert sample was performed using the one-tailed test of significance to test the difference between the means (see Table 11 and Table 12).
For testing Hypothesis 4 which stated, "The attitudes of registered nurses in general hospitals toward alcoholics and alcoholism do not differ significantly from those held by a sample representative of the general population," the same statistical approaches that were used in the testing of Hypotheses 1, 2, and 3 were utilized. However, the descriptive statistics were calculated on the responses of the nurse sample for Marcus Factors 5 (the moral character of the alcoholic); 3 (the prognosis of alcoholism); and 7 (alcoholism as a disease or illness). Next, the means of these Factor scores were compared with the means of The Toronto Sample from the general population by computing a series of $t$ test analyses. To determine the significant differences between the two samples on these measures of their attitude toward the alcoholic and alcoholism the one-tailed test of significance was utilized (see Table 13 and Table 14).

Several statistical tests were required to test Hypothesis 5 which stated, "Attitudes toward the alcoholic and the disease or illness orientation of alcoholism expressed by registered nurses is significantly related to their level of need for social approval. First, descriptive statistics were calculated on Marcus questionnaire Factors 5 (the moral character of the alcoholic); 6 (the socio-economic level of the alcoholic); and 7 (alcoholism
as a disease). A frequency distribution of means for the total sample on the factors was performed. Then, the median was used to classify nurses according to their mean responses on each factor. All responses were in a positive direction. The most positive score possible on all of the factors, however, is 1. Therefore, the nurses in the sample were classified as having either a high positive or low positive attitude toward alcoholics and alcoholism. The median was utilized for this purpose. Nurses whose mean scores were below the median on each factor were classified as having high positive attitudes toward alcoholics and alcoholism. Nurses whose mean scores were less than or equal to the median on the factors were classified as having low positive attitudes.

Next, descriptive statistics were calculated on the responses of nurses on The Marlowe-Crowne Social Desirability Scale. Following the computation of the mean for the total sample, nurses were again categorized as specified in the test directions into two groups. Those who scored below the mean were categorized as having a low need for social approval. Those who scored above the mean were categorized as having a high need for social approval (see Table 15).

The two categorizations described divided the total nurse sample into two groups on their attitudes toward the
alcoholic and alcoholism. The one group consisted of nurses who had low positive attitudes toward the alcoholic and alcoholism and a low level need for social approval. The second group consisted of nurses who had high positive attitudes toward the alcoholic and alcoholism and a high need for social approval. They were further divided according to their score on the Marlowe-Crowne Social Desirability Scale.

As a result of these classifications, the nurses were divided into four sub-samples. These were: (1) nurses low on attitude and low on need for social approval; (2) nurses who were low on attitude and high on need for social approval; (3) nurses who were high on attitude and low on need for social approval; and (4) nurses who were high on attitude and high on need for social approval.

A one-way analysis of variance was performed to assess the significance of differences between and within the two sub-samples. An F value reaching the .05 probability level was considered significant (see Table 16).

Hypothesis 6 was, "Registered nurses employed in a general hospital which has an Alcoholism Unit express significantly more positive attitudes toward alcoholics and alcoholism than of registered nurses who are employed in a general hospital which does not have an Alcoholism Unit." To test this hypothesis, descriptive statistics were
computed on the responses of the total sample of nurses to Marcus Factors 3, 5, 6, and 7. Then a frequency distribution of the sample means on these factors was performed. Utilizing this frequency distribution of means and the median for the sample, nurses were classified into two groups on each Marcus factor. Nurses whose mean scores were equal to or below the median on Factors 3, 5, 6, and 7 were classified as having high positive attitudes toward the alcoholic and alcoholism. Nurses whose mean scores were above the median on Factors 3, 5, 6, and 7 were classified as having low positive attitudes toward the alcoholic and alcoholism.

In addition to classification of the nurses according to high or low positive attitudes, they were further classified according to whether they did or did not work in a hospital with an Alcoholism Unit. Thus, the subjects in the study were divided into four sub-samples (see Table 17).

A one-way analysis of variance was, then, performed to determine if a significant difference existed between the sub-samples from hospitals with and without an Alcoholism Unit and their mean scores on Factor 3. The same analysis was repeated on Factors 5, 6, and 7 (see Table 18).

For testing Hypothesis 7 which was, "Registered nurses employed in an Alcoholism Unit have significantly
more positive attitudes toward alcoholics and alcoholism than a sample of registered nurses employed in other hospital areas," the same statistical approach was used for Hypothesis 6 and was utilized. The classification of the nurses into those who had high and low positive attitudes on Marcus Factors 3, 5, 6, and 7 was performed with the use of descriptive statistics. Nurses were, then, further classified according to whether they practiced within an Alcoholism Unit or in other hospital units (see Table 19).

A one-way analysis of variance was calculated with each of the Marcus factors and the sub-samples of nurses according to their classified area of practice. If the resulting F value was .05 or below, differences were considered significant (see Table 20).

Hypothesis 8 stated, "The attitudes held by registered nurses toward the alcoholic person are significantly related to their personal use of alcohol." Descriptive statistics were computed on the subject's responses to The Alcadd Test to determine the personal use of alcohol for the total sample. Then, to test the hypothesis a Pearson Correlation Coefficient was calculated between the dependent variables, the total sample's mean scores on Marcus Factors 5 (the moral character of the alcoholic) and the independent variable, total Alcadd Test score for the sample (see Table 21 and Table 22).
Subsequent to the testing of the eight hypotheses, analyses were conducted to determine whether nurses in the sample differed in their responses to Marcus Factors 3, 5, 6, and 7 according to their years of experience, age; basic educational program and other attributes of the nurses in the sample. A one-way analysis of variance was performed to make this determination (see Table 23 and Table 24).
CHAPTER IV
ANALYSES OF THE RESULTS

Introduction

Chapter IV presents the results of the data analyses. The chapter is divided into three sections. The first section consists of a description of the sample. The second section includes the answers to the research questions and the results of the hypotheses testing. In the last section of the chapter, a presentation and discussion of the analyses of selected variables related to the attitudes of registered nurses in the sample toward the alcoholic and alcoholism is given. This section concludes with a discussion of the major findings of the study.

The Sample: Nature and Profile

This sample consisted of 159 female, professional nurses who volunteered to participate in the study. They were from a population of 720 registered nurses employed full- or part-time in Hospitals A, B, and C. A total of 39.6 percent of the nurses were from Hospital A, a large hospital with an Alcoholism Unit; 39.0 percent were from Hospital B, a medium-sized hospital which also has an
Alcoholism Unit; and 21.4 percent were from Hospital C, a small hospital which does not have an Alcoholism Unit. Observing that Hospitals A and B have Alcoholism Units, it is apparent that out of the total sample, there were 78.6 percent of the nurses from general hospitals which had an alcoholism unit and 21.4 percent were from a hospital which did not have this type of unit.

As shown on Table 4, the individual nurses in the sample differed on several professional variables. These variables were area of practice; basic educational preparation for nursing; highest educational level; position in which employed; length of experience; and primary source of knowledge about alcoholism.

The subjects varied in their areas of practice with 42.8 percent practicing in medical-surgical units; 5 percent practicing in emergency rooms; 9.4 percent in alcoholism units; and 42.8 percent in other areas. The other areas of practice included neurology, obstetric, orthopedic, outpatient, and continuing education units. The number of subjects from the emergency rooms and alcoholism units were conspicuously smaller than the number of subjects from other hospital units. With respect to the
<table>
<thead>
<tr>
<th>Variable</th>
<th>Absolute Frequency</th>
<th>Percentage (Adjusted Frequency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Employed by Hospital:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>63</td>
<td>39.6</td>
</tr>
<tr>
<td>B</td>
<td>62</td>
<td>39.0</td>
</tr>
<tr>
<td>C</td>
<td>34</td>
<td>21.4</td>
</tr>
<tr>
<td>2. Practice Area:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Med.-Surg. Unit</td>
<td>68</td>
<td>42.8</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>8</td>
<td>5.0</td>
</tr>
<tr>
<td>Alcoholism Unit</td>
<td>15</td>
<td>9.4</td>
</tr>
<tr>
<td>Other</td>
<td>68</td>
<td>42.8</td>
</tr>
<tr>
<td>3. Basic Education:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diploma</td>
<td>98</td>
<td>62.0</td>
</tr>
<tr>
<td>Associate Degree</td>
<td>29</td>
<td>18.4</td>
</tr>
<tr>
<td>Baccalaureate Degree</td>
<td>31</td>
<td>19.6</td>
</tr>
<tr>
<td>4. Highest Edu. Level:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diploma</td>
<td>95</td>
<td>59.7</td>
</tr>
<tr>
<td>Associate Degree</td>
<td>29</td>
<td>18.2</td>
</tr>
<tr>
<td>Baccalaureate Degree</td>
<td>33</td>
<td>20.8</td>
</tr>
<tr>
<td>Master's Degree</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>5. Position:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>108</td>
<td>68.4</td>
</tr>
<tr>
<td>Head Nurse</td>
<td>15</td>
<td>9.5</td>
</tr>
<tr>
<td>Assistant Head Nurse</td>
<td>6</td>
<td>3.8</td>
</tr>
<tr>
<td>Clinical Specialist</td>
<td>12</td>
<td>7.6</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>10.8</td>
</tr>
<tr>
<td>6. Length of Experience:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 year or less</td>
<td>20</td>
<td>12.6</td>
</tr>
<tr>
<td>2 to 3 years</td>
<td>17</td>
<td>10.7</td>
</tr>
<tr>
<td>3 to 4 years</td>
<td>7</td>
<td>4.4</td>
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<tr>
<td>4 to 5 years</td>
<td>22</td>
<td>13.8</td>
</tr>
<tr>
<td>5 + years</td>
<td>93</td>
<td>58.5</td>
</tr>
</tbody>
</table>
majority of nurses practicing in medical-surgical units, this sample was similar to that of the nurse sample in the state of Ohio. Of the 84,605 registered nurses licensed to practice in the state of Ohio for the year 1977, it was reported that 42 percent of these nurses were employed on medical-surgical units of hospitals (Ohio Board of Nursing Education and Nurse Registration Division of Nursing, Office of Health Planning, September, 1978).

The majority of nurses in the sample (62.0%) had received their basic educational preparation for nursing in a diploma school of nursing. Further, 19.6 percent had received their basic educational preparation from baccalaureate programs, and 18.2 percent had received this preparation from associate degree programs. Again, the nurses in this sample were similar to nurses in the state of Ohio. Of the registered nurses in the State for the year 1977, it was reported that 74 percent had received their basic education in a diploma program, 14 percent in an associate degree program, and 19 percent in a baccalaureate program (Ohio Board of Nursing Education and Nurse Registration Division of Nursing, Office of Health Planning, September, 1978).

The highest credential held by the majority of nurses (59.7%) was the nursing school diploma. The next highest credential held was the baccalaureate degree (20.8%)
followed by the associate degree (18.2%) and the master's degree (1.3%). The sample was like that of the nurses throughout the State in terms of highest degree held. State-wide, 71 percent of nurses have a diploma, 14 percent an associate degree, 11 percent a bachelor's degree, and 1 percent a master's degree (Ohio Board of Nursing Education and Nurse Registration Division of Nursing, Office of Health Planning, September, 1978).

In terms of positions held by the nurses in the sample, the majority of them (68.4%) were employed as staff nurses. Slightly over 13 percent were in positions of either head nurses or assistant head nurses, and 7.6 percent were employed as clinical specialists. In addition, there were 10.8 percent who were in positions within staff development departments. This distribution of nurses, according to their positions in the hospital, is like that of nurses throughout Ohio who work in hospitals. Throughout the State, the majority of nurses (72%) were employed in staff positions, 14 percent were in head nurse positions, and 2 percent were in clinical specialist positions (Ohio Board of Nursing Education and Nurse Registration Division of Nursing, Office of Health Planning, September, 1978).

Nurses in the sample varied in their years of practice. As a group, they were experienced practitioners, the
majority having been in practice five years or more. Of the remaining nurses in the sample 13.8 percent had practiced four to five years; 4.4 percent three to four years; 10.7 percent two to three years; and 12.6 percent one year or less.

Almost thirty percent of the nurses had received their primary source of knowledge about alcoholism from their basic nursing education program. Slightly over 22.9 percent indicated their primary source of knowledge was from personal experience which represented knowledge obtained from professional publications, newspapers, television, or life experience in general. Approximately 18 percent stated the primary source was staff development or continuing education programs. A rather large percentage (28.6%) were unable to identify a primary source of their knowledge and resorted to giving various combinations of sources. The responses of the nurses regarding their primary source of knowledge about alcoholism is presented in Table 5.

In addition to these professional characteristics, most of the nurses (62.9%) had had past professional experience with a person having an alcohol problem or alcoholism. The remaining 37.1 percent of the sample indicated
TABLE 5
Registered Nurses' Primary Source of Knowledge About Alcoholism
N = 159

<table>
<thead>
<tr>
<th>Source of Knowledge</th>
<th>Absolute Frequency</th>
<th>Percentage (Using Adjusted Freq.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Basic Educational Program</td>
<td>47</td>
<td>29.9</td>
</tr>
<tr>
<td>b. Post-graduate Course</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>c. Staff Development or Continuing Education</td>
<td>28</td>
<td>17.8</td>
</tr>
<tr>
<td>d. Personal Experience</td>
<td>36</td>
<td>22.9</td>
</tr>
<tr>
<td>e. On-the-Job Training</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>f. Combinations</td>
<td>45</td>
<td>Sub-Total 71.0</td>
</tr>
<tr>
<td>a, b, c, d, e</td>
<td></td>
<td>28.6</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100.0b</td>
</tr>
</tbody>
</table>

^2 Missing Cases
^b Figures rounded to the nearest percent
they had not had experience with a patient of this type.

The personal characteristics of the nurses in the sample are shown in Table 6. As revealed, the greater number of nurses (69%) were 40 years of age or younger. Of the remaining 31 percent, 15.9 percent were 41 to 50 years of age, and 15.1 percent were over 50 years of age. In this respect, nurses in the sample are similar to the nurses in Franklin County, 63 percent of whom have been reported to be under 40 years of age (Ohio Board of Nursing Education and Nurse Registration Division of Nursing, Office of Health Planning, September, 1978).

The majority of nurses were married (58%). There were 24 percent who had never married; 11.4 percent who were divorced; 3 percent who were remarried following the death of a spouse; and approximately 4 percent were widowed.

In religious orientation, half (50%) of the nurses were Protestant; almost 45 percent were Roman Catholic; slightly over 1 percent were Jewish; and approximately 3 percent were of various other religious orientations.

Of the total sample, approximately a fifth (19.5%) of the nurses did not know anyone personally who had an alcohol problem. The remainder of the nurses knew one or more persons who had an alcohol problem. In fact, the majority of the nurses (80.5%) indicated they knew such a person(s). Over one-half of these nurses indicated that they had a
relative or immediate family member who had an alcohol problem. In addition, over half (59.8%) of these nurses revealed that they had a friend or co-worker involved in alcohol abuse. None of the nurses in the study considered themselves, however, as having an alcohol problem. Two did reveal that they were recovering alcoholics.

Insert Table 6 about here

From this description of the 159 registered nurses who volunteered for this study, a professional and personal profile of the sample was drawn. Professionally, these nurses were, for the most part, diploma education nurses who were experienced in practice. Most of them were employed as staff nurses on Medical Units in the general hospitals which had a separate Alcoholism Unit, Hospitals A and B. Further, their knowledge of alcoholism was primarily obtained from their basic educational programs in nursing. Also, in their nursing experience, the majority had provided nursing care to a person or persons with an alcohol problem.

In terms of personal characteristics, the nurses in the sample were generally under 40 years of age, married, and had a Protestant religious orientation. Although the use of alcohol had not been a problem for them personally,
TABLE 6

Personal Characteristics of Total Sample

N = 159

<table>
<thead>
<tr>
<th>Variable</th>
<th>Absolute Frequency</th>
<th>Percentages (Based on Adjusted Freq.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-25</td>
<td>40</td>
<td>25.3</td>
</tr>
<tr>
<td>26-30</td>
<td>33</td>
<td>20.9</td>
</tr>
<tr>
<td>31-35</td>
<td>13</td>
<td>8.2</td>
</tr>
<tr>
<td>36-40</td>
<td>23</td>
<td>14.6</td>
</tr>
<tr>
<td>41-45</td>
<td>11</td>
<td>7.0</td>
</tr>
<tr>
<td>46-50</td>
<td>14</td>
<td>8.9</td>
</tr>
<tr>
<td>50 +</td>
<td>24</td>
<td>15.2</td>
</tr>
<tr>
<td>2. Marital Status:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never Married</td>
<td>38</td>
<td>24.1</td>
</tr>
<tr>
<td>Married</td>
<td>91</td>
<td>57.6</td>
</tr>
<tr>
<td>Divorced</td>
<td>18</td>
<td>11.4</td>
</tr>
<tr>
<td>Remarried</td>
<td>5</td>
<td>3.2</td>
</tr>
<tr>
<td>Widowed</td>
<td>6</td>
<td>3.8</td>
</tr>
<tr>
<td>3. Religious Orientation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protestant</td>
<td>80</td>
<td>50.6</td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>71</td>
<td>44.9</td>
</tr>
<tr>
<td>Jewish</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>3.2</td>
</tr>
<tr>
<td>4. Personal problem with alcohol or recovering alcoholic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>No</td>
<td>157</td>
<td>98.7</td>
</tr>
</tbody>
</table>

a Missing data for 2 cases.
the majority of them knew persons within and outside of their families who had an identifiable alcohol problem.

Results of the Hypothesis Testing

Each of the eight hypotheses in this study was related to a major research question developed from the empirical research on the attitudes of registered nurses and other health care providers toward the alcoholic person or alcoholism. Therefore, the results of each of the hypotheses tested are presented in conjunction with a restatement of the major research question to which the hypothesis was addressed.

Major Question 1: What are the attitudes toward the alcoholic and alcoholism of registered nurses in a general hospital setting?

Hypothesis 1: Registered nurses from general hospitals have significantly negative attitudes toward the alcoholic person.

The mean responses of the sample to Factors 5 and 6 on The Marcus Alcoholism Questionnaire which relate to the moral character and socio-economic status of the alcoholic were used to measure the attitude of nurses. Then, the significance of the direction of the attitude was determined by comparing the mean of the total nurse sample with the mean of the sample of experts.
The mean responses of the sample to Factors 5 and 6 on The Marcus Alcoholism Questionnaire which relate to the moral character and socio-economic status of the alcoholic were used to measure the attitude of the nurses. Then, the significance of the direction of the expressed attitudes was determined by comparing the mean of the total nurse sample with the mean of the sample of experts.

The results of the testing of this hypothesis are shown on Table 7. An analysis of the results indicated that the nurses, as a total sample, expressed a positive attitude toward the alcoholic person in respect to his or her character and socio-economic level. They did not view the alcoholic person as being morally weak. Also, the alcoholic does not differ in terms of education and employment from individuals who are not alcoholics.

Whether these attitudes were significantly positive required a subsequent analysis using a comparison of the nurse with the Expert Sample provided in the test directions. The test results for determining if the positive attitudes were significant are indicated in Table 8.
TABLE 7
Means and Standard Deviations of R.N. Sample on Attitudes Toward the Alcoholic Person
N = 157

<table>
<thead>
<tr>
<th>Source</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
</table>
| 1. Marcus Factors 5<sup>b</sup>  
Questionnaire Items: 2, 18, 26, 34 | 2.50 | 1.245 |
| 2. Marcus Factor 6<sup>c</sup>  
Questionnaire Items: 4, 14, 22, 31 | 2.12 | 0.792 |

<sup>a</sup>Direction of Scores:

<table>
<thead>
<tr>
<th>Completely Disagree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>Neutral</td>
<td>Negative</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>b</sup>Items:

2 Persons who become alcoholics are usually lacking in will power.
18 The alcoholic is a morally weak person.
26 Alcoholism is a sign of character weakness.
34 The alcoholic is basically a spineless person who has found an easy way out of his problems.

<sup>c</sup>Items:

4 The average alcoholic is usually unemployed.
14 Alcoholics, on the average, have a poorer education than other people.
22 Very few alcoholics come from families in which both parents were abstainers.
31 Alcoholics are seldom found in important positions in business.
### TABLE 8

Analysis of Mean Scores on Attitudes Toward the Alcoholic Person
for the R.N. Sample N = 157 and the Expert Sample N = 38

<table>
<thead>
<tr>
<th>Sample</th>
<th>Marcus Factor</th>
<th>Mean</th>
<th>S.D.</th>
<th>Differences Between Means</th>
<th>t Value</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurse</td>
<td>5</td>
<td>2.50</td>
<td>1.245</td>
<td>-.677</td>
<td>-.00001</td>
<td>193</td>
</tr>
<tr>
<td>Experts</td>
<td>5</td>
<td>3.18</td>
<td>1.245</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>6</td>
<td>2.12</td>
<td>.792</td>
<td>-.599</td>
<td>-.00001</td>
<td>193</td>
</tr>
<tr>
<td>Experts</td>
<td>6</td>
<td>2.68</td>
<td>.792</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Due to the lack of standard deviations for the expert sample the standard deviation for the present sample was used as the best estimate of the standard deviation of the expert population (Hayes, 1963).

* p < .00001  
** p < .00001
From the results presented in Table 8, the sample of registered nurses in this study were positive in their attitude toward the alcoholic. This finding was in the opposite direction than was stated in Hypothesis 1. Further, in their attitude toward the alcoholic, they were significantly ($p < .00001$) more positive than the Expert Sample. Therefore, Hypothesis 1 was not accepted.

The finding in this study that registered nurses held a positive attitude toward the alcoholic person is not consistent with the findings of some earlier studies. Pittman and Sterne (1963); Ferneau and Morton (1968); Moody (1971); Schmid and Schmid (1973); Wallston et al., (1976) and Larson (1977) have presented findings that nurses hold or tend to hold negative attitudes toward the alcoholic. Pittman and Sterne reported that registered nurses in their attitudes toward the alcoholic were more moralistic and negative than either physicians or social workers. Ferneau and Morton found that, although nurses were less moralistic and negative in their attitude toward the alcoholic than nursing aides, they tended to view the alcoholic negatively. Furthermore, Larson reported that registered nurses consistently cast the alcoholic patient in negative terms.

The findings, however, are consistent with those of Linsky et al., (1965). These researchers reported
registered nurses held favorable, i.e., positive attitudes toward the alcoholic patient. Plausible explanations of the differences between the findings of this study and those of the studies cited are related to sample composition, location and setting of the studies, and the differences in the time that the studies were conducted. In respect to the sample composition, the samples tested in the previous studies were generally small (68, 38, or less), had both males and females in the sample, and did not include nurses who worked in alcoholism units. Moreover, the instruments used in the studies, with the exception of the Ferneau and Morton study, differed from the one used in this investigation.

Another possible reason for the differences in the findings of the present study and other studies is the increased attention given to continuing education of nurses within the hospital settings within the past few years. Thus, nurses' attitudes could be the result of an increased knowledge about alcoholism.

**Hypothesis 2**: Registered nurses from general hospitals hold a significantly positive view of alcoholism as a disease or illness.

The attitude toward the disease or illness orientation of alcoholism held by the sample of registered nurses was measured by Factor 7 in The Marcus Alcoholism
Questionnaire. The significance of the attitude held was determined by comparing the mean score of nurses with the mean score of the Expert Sample provided in the test administration directions.

The findings from the testing of this hypothesis are illustrated in Table 9 and Table 10. In Table 9, the mean calculated from the data reflects that registered nurses viewed alcoholism as a disease or illness.

Insert Table 9 about here
TABLE 9
Means and Standard Deviation of R.N. Samples on Attitude Toward the Disease or Illness Orientation of Alcoholism
N = 157

<table>
<thead>
<tr>
<th>Source</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marcus Factor 7: Questionnaire Items:</td>
<td>2.06</td>
<td>1.01</td>
</tr>
<tr>
<td>8, 13, 19, 38</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^a\)Direction of Scores:

<table>
<thead>
<tr>
<th>Completely Disagree</th>
<th>Completely Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>Neutral</td>
</tr>
<tr>
<td></td>
<td>Negative</td>
</tr>
</tbody>
</table>

\(^b\)Items:

8. Alcoholism is best described as a habit rather than as an illness.
13. The alcoholic has only himself to blame for his problem.
19. An alcoholic's basic troubles were with him long before he had a problem with alcohol.
38. With proper treatment, some alcoholics can learn to take the occasional social drink without getting into trouble.
Table 10 shows the result of the t test analysis conducted to determine if the view of alcoholism as a disease or illness held by the nurses was significantly different from the view held by the Expert Sample. The two samples did not differ statistically from each other. Therefore, hypothesis 2 was not accepted. The nurses did not hold a significantly positive view of alcoholism as a disease or illness.

**TABLE 10**

Analysis of Mean Scores on the Attitude Toward Disease or Illness Orientation of Alcoholism for the Registered Nurse Sample N = 157 and the Expert Sample N = 38

<table>
<thead>
<tr>
<th>Sample</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Difference</th>
<th>t Value</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurse Sample</td>
<td>2.06</td>
<td>1.012</td>
<td>-.612</td>
<td>-.755</td>
<td>193</td>
</tr>
<tr>
<td>Expert Sample</td>
<td>2.68</td>
<td>1.012</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The results from the present study are consistent with the findings of Pittman and Sterne (1963), Ferneau and Morton (1968), and Gurel (1976). These researchers reported that registered nurses viewed alcoholism as a disease or illness.
Both Pittman and Stern and Ferneau and Morton suggest that the attitude held by nurses is due to the fact that it is both socially desirable and personally necessary for members of the helping profession to assert that alcoholism is an illness or a disease. It may, however, be conjectured that with the increased availability of knowledge professionally and through the public media that nurses have become more knowledgeable about the addiction liability of alcohol and the disease or illness etiology of this addiction.

**Hypothesis 3**: Registered nurses from general hospitals hold significantly pessimistic attitudes toward the prognosis of alcoholism.

For measuring this attitude, the sample's responses to Factor 3 of The Marcus Alcoholism Questionnaire was used as it reflects the attitude toward the treatability of alcoholism. The results from the descriptive statistics on the total sample of nurses were compared with those of the expert sample.

Table 11 presents the mean and standard deviation for the attitude of the total sample of nurses toward the prognosis of alcoholism. These descriptive statistics show that the sample of nurses had an optimistic attitude toward the prognosis of alcoholism which was in the opposite direction from the attitude hypothesized. They
TABLE 11
Mean and Standard Deviation of the Registered Nurse Sample on Attitude Toward the Prognosis of Alcoholism
N = 157

<table>
<thead>
<tr>
<th>Source</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marcus Factor 3</td>
<td>2.099</td>
<td>.899</td>
</tr>
</tbody>
</table>

Questionnaire Items:
9, 12, 30, 37

\(^a\) Direction of Scores:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>Neutral</td>
<td>Negative</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^b\) Items:

9 The alcoholic drinks excessively mainly because he enjoys drinking.
12 The alcoholic is seldom helped by any sort of medical or psychological treatment.
30 Most alcoholics could not be rehabilitated even if more help were available for them.
37 Most alcoholics are completely unconcerned about their problem.
viewed the alcoholic as being concerned about his or her problem, drinking excessively because of an addiction, and able to be helped, given the necessary medical or psychological help.

Table 12 presents the analysis to determine if nurses' positive attitude toward the prognosis of alcoholism was significantly positive.

**TABLE 12**

Analysis of Mean Scores on the Attitude Toward the Prognosis of Alcoholism for the Registered Nurse Sample N = 157 and the Expert Sample N = 38

<table>
<thead>
<tr>
<th>Sample</th>
<th>Mean</th>
<th>S.D.</th>
<th>Mean Difference</th>
<th>t Value</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurse</td>
<td>2.099</td>
<td>.899</td>
<td>-.011</td>
<td>-.011</td>
<td>193</td>
</tr>
<tr>
<td>Expert</td>
<td>2.11</td>
<td>.899</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In comparison of the nurse sample with the Expert Sample, it was found that this difference was not significant. The sample of nurses had an attitude toward the prognosis of alcoholism in a positive direction instead of the negative direction hypothesized, although the
attitude was not found to be significantly positive. Therefore, Hypothesis 3 was not supported.

The results of this study on the attitude of the sample of nurses toward the prognosis of alcoholism are inconsistent with those reported by Pittman and Sterne (1963) and Kuzenski and Reynolds (1966). Pittman and Sterne stated that the nurses in their sample reflected pessimistic attitudes toward the prognosis of alcoholism. Kuzenski and Reynolds concluded that their sample of senior nursing students demonstrated feelings that it was fruitless to spend the time, facilities, and personnel for the treatment of alcoholism.

The differences in the findings of the present study and these studies is in all probability due to the differences in sample composition in terms of personal and contextural differences of employment or education setting. Both of these studies were conducted where the nurses were in an environment which did not have an alcoholism unit. Moreover, practitioners in alcoholism counseling were not included in the samples.

Another possible reason for the differences is the time-frame within which the studies were conducted. At the present time, the focus on addiction to alcohol has received more concentrated attention in relation to an increasing number of treatment facilities and modalities.
Evidence pointing to this situation is found in the fact that the alcoholism units of the participating hospitals in this study were added within the last six years.

The results of the present study were, however, consistent with those reported by Ferneau & Morton (1968) and Gurel (1976). They both found that registered nurses in their sample had optimistic, i.e., positive attitudes toward the prognosis of alcoholism. Ferneau and Morton proposed that the reason for these optimistic attitudes was that it is difficult for professionals to entertain the notion that their therapeutic efforts are of no avail.

In addition to other possible explanations for the positive direction of the attitude on the part of the sample in this study is the fact that the majority of subjects knew a person with an alcohol problem who was a friend, co-worker, relative or immediate family member. Because of this relationship, they may be reflecting a desire that treatment for alcoholism results in positive outcomes.

Major Question 2: Are the attitudes toward the alcoholic and alcoholism of a sample of registered nurses in general hospitals different from the attitudes of a sample representative of the general population?
Hypothesis 4: The attitudes of registered nurses toward alcoholics and alcoholism do not differ significantly from those held by a sample representative of the general population.

The mean scores for the nurse sample on Factors 3, 5, 6, and 7 which were previously used from The Marcus Alcoholism Questionnaire was used to measure the attitudes of registered nurses. These means were compared with the means from the Toronto, Canada, population tested by Marcus (1963b) for the testing of this hypothesis.

The results of the descriptive statistics computed in this testing are found in Table 13. The findings illustrated show that as a total group the nurses in the study expressed positive attitudes toward both the alcoholic and alcoholism. Moreover, it was observed that these attitudes were consistently in a positive direction.
TABLE 13

Mean and Standard Deviation of the Registered Nurse Sample on Attitudes Toward the Alcoholic and Alcoholism

N = 157

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Source</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Alcoholic</td>
<td>Marcus Factor Score:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Character</td>
<td></td>
<td>2.50</td>
<td>1.245</td>
</tr>
<tr>
<td>6. SES</td>
<td></td>
<td>2.12</td>
<td>0.792</td>
</tr>
<tr>
<td>2. Alcoholism</td>
<td>Marcus Factor Score:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Prognosis</td>
<td></td>
<td>2.09</td>
<td>.899</td>
</tr>
<tr>
<td>7. Disease/Illness Orientation</td>
<td></td>
<td>2.06</td>
<td>1.012</td>
</tr>
</tbody>
</table>

The results from the analysis of the means for the total nurse sample and the Toronto Sample from the general population are shown on Table 14.
TABLE 14

Analysis of Mean Scores on the Attitudes Toward the Alcoholic and Alcoholism for the Registered Nurse Sample N = 157 and the Sample From the Toronto General Population N = 200

<table>
<thead>
<tr>
<th>Sample</th>
<th>Attitude</th>
<th>Mean</th>
<th>S.D.</th>
<th>Diff. Between Means</th>
<th>t Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurse</td>
<td>1. Alcoholic</td>
<td>2.50</td>
<td>1.245</td>
<td>-1.007 *</td>
<td>-10.102</td>
</tr>
<tr>
<td></td>
<td>-M. Factor 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-M. Factor 6</td>
<td>2.12</td>
<td>0.792</td>
<td>-0.759 *</td>
<td>-11.965</td>
</tr>
<tr>
<td></td>
<td>2. Alcoholism</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-M. Factor 3</td>
<td>2.09</td>
<td>0.899</td>
<td>-0.891 *</td>
<td>-12.378</td>
</tr>
<tr>
<td></td>
<td>-M. Factor 7</td>
<td>2.06</td>
<td>1.012</td>
<td>-1.002 *</td>
<td>-12.366</td>
</tr>
<tr>
<td>Toronto General Population</td>
<td>1. Alcoholic</td>
<td>3.51</td>
<td>1.245</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-M. Factor 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-M. Factor 6</td>
<td>2.88</td>
<td>0.792</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Alcoholism</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-M. Factor 3</td>
<td>2.99</td>
<td>0.899</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-M. Factor 7</td>
<td>3.07</td>
<td>1.012</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Due to the loss of the original data the sample standard deviation is considered the best estimate of the population standard deviation (Hayes, 1963).

*\( p < .00001 \)

The results showed that the registered nurses were more positive as a group in their attitudes toward the alcoholic and alcoholism than the Toronto Sample representative of the general population. They viewed the alcoholic as one who had no particular character defect
and could have any level of education or position in the business world. Further, they were more optimistic about the prognosis of alcoholism and believed more strongly that it was a disease or illness.

Although both the nurse and Toronto sample held positive attitudes toward the alcoholic and alcoholism, the nurse sample was found to hold attitudes significantly \(( p < .00001)\) more positive than those held by the Toronto Sample. Therefore, Hypothesis 4 was not supported.

The results are generally consistent with those of Ferneau and Morton (1968), the only study found in the literature which compared the attitudes of registered nurses with a sample from the general population. These researchers compared a sample of registered nurses from the medical-surgical staff of a neuropsychiatric hospital with the Toronto Sample. They reported that nurses had positive attitudes toward the alcoholic and alcoholism but that they did not differ significantly from the Toronto general population sample except in their more positive attitude toward alcoholism as a disease or illness.

The specific finding of a significant difference between the nurses in this study and the Toronto Sample in their attitudes toward the alcoholic and the prognosis of alcoholism could be explained by the time which has
elapsed between the two studies. Ferneau and Morton assessed the attitudes of their sample five years after the results of the attitude research on the Toronto Sample had been published. Therefore, the time-frame of their study was approximately the same as the time-frame in which Marcus conducted his study. In the present study, attitudes were measured over ten years later than those measured in the Ferneau and Morton sample and over fifteen years later than those measured in the Toronto Sample. Thus, the time factor could account for the specific differences in the findings. Related to the time difference is the knowledge factor. Knowledge about the characteristics of the alcoholic person and alcoholism has increased over time. Therefore, it is possible that nurses in the sample of the present sample had more knowledge about the characteristics of the alcoholic person and alcoholism than nurses in the previous sample.

Major Question 3: Is there a relationship between the expressed attitudes of a sample of registered nurses toward alcoholics and alcoholism and their need for social approval?

Hypothesis 5: Attitudes toward the alcoholic and the disease or illness orientation of alcoholism expressed by registered nurses are significantly related to their level of need for social approval.
The sample of registered nurses' mean scores on Factors 5, 6, and 7 on The Marcus Alcoholism Questionnaire were used to measure the attitude toward the alcoholic and the disease or illness orientation of alcoholism. Responses of the sample on The Marlowe-Crowne Scale were used to determine the level of nurses' need for social approval.

Table 15 shows the results of dividing the total sample of nurses into two sub-samples using the median for the total sample on Marcus Factors 5, 6, and 7 and the mean for the total sample on The Marlowe-Crowne Social Desirability Scale. The median for each of the Marcus factors was as follows: Factor 5: 2.433; Factor 6: 2.063; and Factor 7: 1.917. The mean for the total sample on The Marlowe-Crowne Social Desirability Scale was 15.556.
TABLE 15
Frequency Distribution: R.N. Sub-Samples According to Attitude Toward Alcoholic and Alcoholism and Need for Social Approval
N = 152

<table>
<thead>
<tr>
<th>Sub-Sample</th>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Low Positive Attitude Toward Alcoholic/Alcoholism: Low Need for Social Approval</td>
<td>23</td>
</tr>
<tr>
<td>2</td>
<td>Low Positive Attitude Toward Alcoholic/Alcoholism: High Need for Social Approval</td>
<td>14</td>
</tr>
<tr>
<td>3</td>
<td>High Positive Attitude Toward Alcoholic/Alcoholism: Low Need for Social Approval</td>
<td>55</td>
</tr>
<tr>
<td>4</td>
<td>High Positive Attitude Toward Alcoholic/Alcoholism: High Need for Social Approval</td>
<td>60</td>
</tr>
</tbody>
</table>

An analysis of the sub-samples showed that the greater number of nurses had high positive attitudes toward the alcohol and the disease orientation of alcoholism. Furthermore, it was shown that these nurses also had a high need for social approval.
The standard one-way analysis variance was performed with the calculation of the F statistic to determine if significant differences existed between the attitudes of the sub-samples on the basis of their need for social approval. Table 16 shows the results of the analyses of the test performed using Marcus Factors 5, 6, and 7.

**TABLE 16**

Summary Data: Analysis of Variance for Registered Nurses' Attitudes Toward Alcoholics and the Disease/Illness Orientation of Alcoholism According to Need for Social Approval

\[ N = 152 \]

<table>
<thead>
<tr>
<th>Source</th>
<th>Sum of Squares</th>
<th>Degrees of Freedom</th>
<th>Mean Square</th>
<th>F Value</th>
<th>One-tail Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>63.628</td>
<td>1</td>
<td>63.628</td>
<td>1.821</td>
<td>0.1792</td>
</tr>
<tr>
<td>Within Groups</td>
<td>5240.0494</td>
<td>150</td>
<td>34.934</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

It was revealed that no significant differences existed between the groups. Further, the computed Eta Coefficient which was .35 was not statistically significant. Therefore, the level of need for social approval was not found to be related to the attitudes expressed by the
nurses. On the basis of this finding, Hypothesis 5 was not accepted.

It was particularly interesting to note that in addition to answering the major question posed, the testing of this hypothesis provided information which enhanced the validity of the responses on the Marcus questionnaire. The responses given by the sample of nurses were not distorted by their need to give socially approved answers.

Researchers Pittman and Sterne (1963) and Ferneau and Morton (1968) have inferred that the attitudes expressed by nurses toward alcoholics and alcoholism are influenced by their need to give socially approved answers. However, from this investigator's search of the literature there have not been empirical studies conducted which explored this relationship between nurses' attitudes and need for social approval. Strickland and Crowne (1962) reported a positive correlation between the need for approval scores of introductory psychology students and their favorable attitudes toward boring, repetitive tests. They interpreted their findings to mean that the subjects in their study were yielding to group pressure in the expression of attitudes. Kent (1975) found a correlation between high Marlowe-Crowne scores and the frequency of positive self-disclosures in sub-samples involved in a group counseling effort. She
interpreted this finding as the need for the subjects to respond in socially acceptable ways in order to identify with a group.

The results of the present study were not consistent with the findings reported in the Strickland and Crowne or the Kent studies. The differences in results may be due to the fact that nurses are not as dependent upon social approval as students or persons involved in a group counseling effort. As practicing professionals, nurses are in a more independent role than either students or clients being counseled.

Major Question 4: Do nurses who are employed in general hospitals which have alcoholism units have more positive attitudes toward alcoholics and alcoholism than do those nurses who are employed in a general hospital which does not have an alcoholism unit?

Hypothesis 6: Registered nurses employed in a general hospital which has an alcoholism unit express significantly more positive attitudes toward alcoholics and alcoholism than registered nurses who are employed in a general hospital which does not have an alcoholism unit.

In this hypothesis the attitude of the nurses toward the alcoholic was measured by their mean response to the Marcus factors related to the character (Factor 5) and
socio-economic level (Factor 6) of the alcoholic. Their attitude toward alcoholism was measured by their mean response to the factors related to the prognosis (Factor 3) and disease/illness concept of alcoholism (Factor 7) on the same questionnaire. The independent variable, employed in a hospital with or without an alcoholism unit was obtained from the demographic sheet.

The results of the testing of Hypothesis 6 are shown in Table 17. As can be seen, the nurses were divided into four sub-samples according to whether they were low or high positive attitudes on each of the Marcus factors and whether or not they were employed in a hospital with an alcoholism unit.

Insert Table 17 about here
TABLE 17
Frequency Distribution of Nurses' Attitudes Toward the Alcoholic and Alcoholism According to Location of Alcoholism Unit Within Employment Setting N = 157

<table>
<thead>
<tr>
<th>Attitudes Toward Alcohol and Alcoholism</th>
<th>1 No Alcoholism Unit</th>
<th>2 Alcoholism Unit</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number N = 34</td>
<td>Number N = 123</td>
<td></td>
</tr>
<tr>
<td>Low + Attitude: Factor 3 (Prognosis of Alcoholism)</td>
<td>11</td>
<td>59</td>
<td>70</td>
</tr>
<tr>
<td>High + Attitude: Factor 3 (Prognosis of Alcoholism)</td>
<td>23</td>
<td>64</td>
<td>87</td>
</tr>
<tr>
<td>Low + Attitude: Factor 5 (Character of Alcoholic)</td>
<td>11</td>
<td>65</td>
<td>75</td>
</tr>
<tr>
<td>High + Attitude: Factor 5 (Character of Alcoholic)</td>
<td>23</td>
<td>59</td>
<td>82</td>
</tr>
<tr>
<td>Low + Attitude: Factor 6 (SES of Alcoholic)</td>
<td>14</td>
<td>69</td>
<td>83</td>
</tr>
<tr>
<td>High + Attitude: Factor 6 (SES of Alcoholic)</td>
<td>20</td>
<td>54</td>
<td>74</td>
</tr>
<tr>
<td>Low + Attitude: Factor 7 (Alcoholism as a disease/illness)</td>
<td>13</td>
<td>62</td>
<td>75</td>
</tr>
<tr>
<td>High + Attitude: Factor 7 (Alcoholism as a disease/illness)</td>
<td>21</td>
<td>61</td>
<td>82</td>
</tr>
</tbody>
</table>

From an overview of the table it was observed that the majority of nurses were high on positive attitudes on all
of the Marcus Factors. Further, it appeared that the majority of them were employed in hospital settings with an alcoholism unit, suggesting highly positive attitudes were related to employment in a hospital with an alcoholism unit.

Table 18 shows the findings from the one-way analysis of variance with the calculated F tests used to determine whether or not positive attitudes of the nurses in the sample were related to the hospital in which they were employed having an alcoholism unit. From the results, it was found that the sub-samples of nurses differed significantly on their attitudes toward the alcoholic and the prognosis of alcoholism on the basis of the presence of an alcoholism unit within the hospital where they were employed. The ETA Coefficient computed showed that attitudes toward the alcoholic and alcoholism were related only to a low degree to the location of an alcoholism unit within the employment setting. Calculating an ETA square, it was found that approximately four percent of the variance in this attitude was explained by the presence of an alcoholism unit. However, the sub-samples did not differ significantly in their attitude toward the disease or illness orientation of alcoholism, irrespective of whether the hospital where they were employed had an alcoholism unit or not.
Although employment in an alcoholism unit was related to three of the four attitudes measured, Hypothesis 6 was not totally supported. Major Question 4 which asked whether nurses employed in a hospital with an alcoholism unit held more positive attitudes toward the alcoholic and alcoholism was answered. It was answered in the affirmative with respect to attitudes toward the alcoholic and the prognosis of alcoholism. However, it was answered negatively with respect to the attitude toward the disease or illness orientation of alcoholism.

Empirical studies comparing the attitudes of samples of nurses on the independent variable, employment in a hospital setting, were not available in the literature surveyed by this investigator. The findings in this study are not, however, unexpected. The attitude of the subsample of nurses toward the disease or illness orientation is in all probability due to the wide acceptance of the disease or illness concept of alcoholism which is generally acknowledged in the health professions.

Major Question 5: Does the area of clinical practice have a relationship to the expressed attitudes of nurses toward the alcoholic and alcoholism?
### TABLE 18

Summary of One-Way Analysis of Variance Results Comparing the Attitudes of R.N. Sub Samples Toward
Alcoholics and Alcoholism with Employment Setting

\[ N = 159^2 \]

<table>
<thead>
<tr>
<th>Marcus Factor</th>
<th>Source Variance</th>
<th>Sum of Square</th>
<th>D.F.</th>
<th>Mean Square</th>
<th>F Value</th>
<th>Sig.</th>
<th>ETA Square</th>
<th>ETA Square</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Alcoholic)</td>
<td>Between Groups</td>
<td>11.684</td>
<td>1</td>
<td>11.684</td>
<td>7.868</td>
<td>.0057</td>
<td>.2198</td>
<td>.0483</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>230.189</td>
<td>155</td>
<td>1.485</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 -</td>
<td>Between Groups</td>
<td>4.246</td>
<td>1</td>
<td>4.246</td>
<td>7.033</td>
<td>.0088</td>
<td>.2083</td>
<td>.0434</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>98.579</td>
<td>155</td>
<td>.604</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Alcoholism)</td>
<td>Between Groups</td>
<td>7.510</td>
<td>1</td>
<td>7.510</td>
<td>9.816</td>
<td>.0021</td>
<td>.2440</td>
<td>.0596</td>
</tr>
<tr>
<td>3 -</td>
<td>Within Groups</td>
<td>118.585</td>
<td>155</td>
<td>0.765</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prognosis</td>
<td>Between Groups</td>
<td>0.577</td>
<td>1</td>
<td>0.577</td>
<td>0.562</td>
<td>.4546</td>
<td>.0601</td>
<td>.0036</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>1.027</td>
<td>155</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 -</td>
<td>Disease/Illness</td>
<td>Between Groups</td>
<td>0.577</td>
<td>1</td>
<td>0.562</td>
<td>.4546</td>
<td>.0601</td>
<td>.0036</td>
</tr>
</tbody>
</table>

1 34 nurses practiced in hospital without Alcoholism Unit.
123 nurses practiced in hospital with Alcoholism Unit.

2 Missing data on cases.
Hypothesis 7: Registered nurses employed in an alcoholism unit have significantly more positive attitudes toward alcoholics and alcoholism than a sample of registered nurses employed in other hospital areas.

For this hypothesis, the attitudes of registered nurses toward the alcoholic were measured by their mean scores on the character (Factor 5) and socio-economic factors (Factor 6) of the Marcus questionnaire. Their attitudes toward alcoholism was measured by their mean scores on the prognosis toward alcoholism (Factor 3) and the disease or illness orientation of alcoholism (Factor 7). The unit in which the subjects were employed was obtained from the demographic sheet.

The frequency distribution of the nurse sub-samples which were developed on the basis of nurses' attitudes toward alcoholics and alcoholism and their area of practice within or outside of an alcoholism unit is illustrated in Table 19. An analysis of this distribution indicated that nurses who worked on alcoholism units had different degrees of positive attitudes (low versus high) toward alcoholics and alcoholism.
TABLE 19

Frequency Distribution of Nurses' Attitudes Toward the Alcoholic and Alcoholism According to Practice Within or Outside Alcoholism Unit

\[ N = 157 \]

<table>
<thead>
<tr>
<th>Attitudes Toward Alcohol and Alcoholism</th>
<th>Practice in Alcoholism Unit N = 15</th>
<th>Practice Other Patient Units N = 142</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low + Attitude: Factor 3 (Prognosis of Alcoholism)</td>
<td>10</td>
<td>60</td>
<td>70</td>
</tr>
<tr>
<td>High + Attitude: Factor 3 (Prognosis of Alcoholism)</td>
<td>5</td>
<td>82</td>
<td>87</td>
</tr>
<tr>
<td>Low + Attitude: Factor 5 (Character of Alcoholic)</td>
<td>15</td>
<td>60</td>
<td>75</td>
</tr>
<tr>
<td>High + Attitude: Factor 5 (Character of Alcoholic)</td>
<td>0</td>
<td>82</td>
<td>82</td>
</tr>
<tr>
<td>Low + Attitude: Factor 6 (SES of Alcoholic)</td>
<td>11</td>
<td>72</td>
<td>83</td>
</tr>
<tr>
<td>High + Attitude: Factor 6 (SES of Alcoholic)</td>
<td>4</td>
<td>70</td>
<td>74</td>
</tr>
<tr>
<td>Low + Attitude: Factor 7 (Alcoholism as a disease/illness)</td>
<td>11</td>
<td>64</td>
<td>75</td>
</tr>
<tr>
<td>High + Attitude: Factor 7 (Alcoholism as a disease/illness)</td>
<td>4</td>
<td>78</td>
<td>82</td>
</tr>
</tbody>
</table>

As shown, there were 15 nurses who worked in an alcoholism unit and 142 nurses who worked in other patient care units. The results from the computation of a one-way analysis of variance were used to determine whether significant
differences existed between the attitudes of the nurses toward the alcoholic and alcoholism according to their area of practice within or outside of an alcoholism unit. These results are presented in Table 20.

The findings show that a significant difference existed between the sub-samples of nurses in their attitudes toward the alcoholic and alcoholism. The registered nurses on the alcoholism units viewed the character of the alcoholic in a significantly more positive way (.00001 level of significance) than nurses who worked in other areas. Further, the nurses working on alcoholism units were significantly more positive than other nurses in their attitude that the alcoholic person did not differ from other persons in terms of his or her socio-economic status.

In their attitude toward alcoholism, nurses from alcoholism units were significantly more positive in their view of the prognosis (treatment efficacy) of alcoholism. This difference was significant at the .0080 level of significance. In attitudes toward the disease or illness concept of alcoholism, nurses working in alcoholism units were significantly (.0217) more positive than other nurses.
<table>
<thead>
<tr>
<th>Marcus Factor</th>
<th>Source of Variance</th>
<th>Sum of Square</th>
<th>D.F.</th>
<th>Mean Square</th>
<th>F Value</th>
<th>Sig.</th>
<th>ETA Square</th>
<th>ETA Square</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Alcoholic)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 - Character</td>
<td>Between Groups</td>
<td>37.474</td>
<td>1</td>
<td>37.474</td>
<td>28.417</td>
<td>.0001</td>
<td>0.3936</td>
<td>0.1549</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>204.400</td>
<td>155</td>
<td>1.319</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 - SES Status</td>
<td>Between Groups</td>
<td>2.940</td>
<td>1</td>
<td>2.940</td>
<td>4.802</td>
<td>.0299</td>
<td>0.1734</td>
<td>0.0301</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>94.886</td>
<td>155</td>
<td>0.612</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Alcoholism)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 - Prognosis</td>
<td>Between Groups</td>
<td>5.619</td>
<td>1</td>
<td>5.619</td>
<td>7.229</td>
<td>.0080</td>
<td>0.2111</td>
<td>0.0446</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>120.476</td>
<td>155</td>
<td>0.777</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 - Disease/ Illness</td>
<td>Between Groups</td>
<td>5.359</td>
<td>1</td>
<td>5.359</td>
<td>5.378</td>
<td>.0217</td>
<td>0.1831</td>
<td>0.0335</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>154.467</td>
<td>155</td>
<td>0.0335</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 15 nurses practiced within Alcoholism Unit. 144 practiced outside of Alcoholism Unit.

2 Missing data in two cases on Marcus Questionnaire.
To examine the relationship between the attitudes of nurses toward the alcoholic and alcoholism and their employment within or outside of an alcoholism unit ETA Correlation Coefficients were computed. As shown on Table 20, these coefficients revealed a moderate, positive relationship existed between the significantly positive attitudes expressed by nurses from alcoholism units and their employment in these units.

As a result of these findings, Hypothesis 7 was supported. It stated that nurses who were employed in alcoholism units have significantly more positive attitudes toward alcoholics and alcoholism than nurses who work in other areas. The support for Hypothesis 7 and its acceptance provided an answer to Major Question 5 which asked whether the unit of practice was related to nurses' attitudes toward alcoholics and alcoholism. This question can be answered in the affirmative.

Previous studies comparing the attitudes of nurses who work in alcoholism units with nurses who work outside of alcoholism units were not found in the survey of the literature. However, Ferneau (1967) did conduct a study on student nurses prior to and following an affiliation in which they worked with alcoholics in a psychiatric clinical setting. He reported that the influence of the
setting and courses given during the clinical affiliation resulted in a trend toward positive attitudes toward the alcoholic and alcoholism. Although the sample composition differs with that of the present study, increased contact with alcoholic patients could be a logical reason for the differences found in the sub-samples of this study.

Another possible explanation of the more positive attitudes of the nurses who work on alcoholism units is that they are personally motivated to hold positive attitudes. Perhaps, they have friends or family with an alcoholism problem, and thus, feel more positive in general toward others having the same problem. Also, it may be that some of the nurses working on alcoholism units have more positive attitudes toward alcoholics and alcoholism because they, themselves, have experienced alcohol addiction, and are recovering alcoholics who have developed strongly positive attitudes during the recovery process. Like other persons in the health professions or the population in general, registered nurses can also experience the disease of alcoholism.

The variations within the sub-sample of nurses working within the alcoholism unit (see Table 19) was not unexpected. These differences may be explained by Moore's (1970) description of the difficulties of working with an
alcoholic patient. She suggested that caring for the alcoholic on a daily basis can be difficult because of the low level of tolerance for frustration, impulsive and inconsistent behavior, and psychological defenses characteristically exhibited in the behavior of the alcoholic person.

Major Question 6: Is the personal use of alcohol by registered nurses related to their attitudes toward the alcoholic and alcoholism?

Hypothesis 8: The attitudes held by registered nurses toward the alcoholic person are significantly related to their personal use of alcohol.

For this hypothesis the attitudes toward the alcoholic were measured by the nurses' responses to the Marcus statements relating to the character and socio-economic level of alcoholics, i.e., Factors 5 and 6. The samples' personal use of alcohol was measured by their responses on The Alcadd Test.

The frequency distribution of the nurses' responses on The Alcadd Test are illustrated on Table 21. The scores ranged from 0 to 43.

________________________________________

Insert Table 21 about here

________________________________________
### TABLE 21

**Frequency Distribution of R.N. Scores on Alcadd Test**

Indicating Personal Use of Alcohol

*N = 148*

<table>
<thead>
<tr>
<th>Score</th>
<th>Absolute Freq.</th>
<th>Percentage Adj.</th>
<th>Cumulative Freq.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>6</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>19</td>
<td>13</td>
<td>18</td>
</tr>
<tr>
<td>3</td>
<td>14</td>
<td>9</td>
<td>27</td>
</tr>
<tr>
<td>4</td>
<td>14</td>
<td>9</td>
<td>36</td>
</tr>
<tr>
<td>5</td>
<td>17</td>
<td>11</td>
<td>48</td>
</tr>
<tr>
<td>6</td>
<td>8</td>
<td>5</td>
<td>53</td>
</tr>
<tr>
<td>7</td>
<td>12</td>
<td>8</td>
<td>61</td>
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<tr>
<td>8</td>
<td>4</td>
<td>3</td>
<td>64</td>
</tr>
<tr>
<td>9</td>
<td>9</td>
<td>6</td>
<td>70</td>
</tr>
<tr>
<td>10</td>
<td>5</td>
<td>3</td>
<td>74</td>
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<tr>
<td>11</td>
<td>7</td>
<td>5</td>
<td>78</td>
</tr>
<tr>
<td>12</td>
<td>4</td>
<td>3</td>
<td>81</td>
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<tr>
<td>13</td>
<td>4</td>
<td>3</td>
<td>84</td>
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<td>14</td>
<td>4</td>
<td>3</td>
<td>86</td>
</tr>
<tr>
<td>15</td>
<td>3</td>
<td>2</td>
<td>89</td>
</tr>
<tr>
<td>16</td>
<td>2</td>
<td>1</td>
<td>90</td>
</tr>
<tr>
<td>17</td>
<td>1</td>
<td>1</td>
<td>91</td>
</tr>
<tr>
<td>18</td>
<td>3</td>
<td>2</td>
<td>93</td>
</tr>
<tr>
<td>19</td>
<td>3</td>
<td>2</td>
<td>95</td>
</tr>
<tr>
<td>21</td>
<td>2</td>
<td>1</td>
<td>97</td>
</tr>
<tr>
<td>22</td>
<td>3</td>
<td>2</td>
<td>99</td>
</tr>
<tr>
<td>*35</td>
<td>1</td>
<td>1</td>
<td>99</td>
</tr>
<tr>
<td>*43</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
</tbody>
</table>

1. Mean = 7.878  S.D. = 6.522
2. Missing Cases, 11
3. Total test score interpretation (60 times scored on alcoholic responses) 5 = Mean for non-alcoholic; 37 = Mean for alcoholic (Manson, 1949).

*Recovering alcoholics
The greatest frequency of scores for nurses (54) on this instrument was below the abstainer score of 4 identified by Manson (1949). The largest number of nurses (74) responded with a score of 5 to 14. Thus, 86 percent of the sample had scores smaller than the critical score. Fourteen (14) is the critical score used for females, according to test directions, to separate social drinking from drinking which may suggest the beginning of problem drinking. There were 18 nurses who scored beyond the critical score of 14 but below the mean score of 37 for the female alcoholic. Two respondents scored beyond the mean for the female alcoholic. Because the test does not differentiate between the recovering alcoholic and the alcoholic, respondents had been requested to indicate if they were recovering alcoholics. The two nurses with mean scores above 38 indicated they were recovering alcoholics. These two were included in the group who had completed responses on The Alcadd Test and were identified as those scoring the highest on the test.

The frequency distribution (Table 21) further revealed that the largest number of missing cases in the data collected for this study was on The Alcadd Test. Although almost all of the nurses in the sample provided responses on the test, the results could not be used in several
instances because all items on the test were not completed.

On the nurses' total Alcadd score to test their personal use of alcohol, the mean score for the total nurse sample of 7.88 was far below the alcoholic critical score of 14 which separates social drinkers from problem drinkers. Further, the median and mode were both below the mean for the group, reflecting the distribution on this test was concentrated to the left of the mean. This result points to the reported limited personal use of alcohol by the sample in the study.

The findings from the computation of a Pearson Correlation Coefficient to test the relationship between the dependent variable, nurses' attitude toward the alcoholic, and the independent variable, nurses' personal use of alcohol is shown on Table 22.

The results of the computation of the Pearson Correlation Coefficient showed small negative correlation which was not significant existed between the nurses' Marcus Factor scores and their total Alcadd scores. Therefore, Hypothesis 8 which stated the personal use of alcohol was significantly related to expressed attitudes toward the
TABLE 22
Pearson Correlation Coefficients for R.N.
Sample's Attitude Toward Alcoholic and Personal Use of Alcohol

<table>
<thead>
<tr>
<th>Variables</th>
<th>N Respondents</th>
<th>Sample Mean</th>
<th>Sample S.D.</th>
<th>Pearson Correlation Coefficient</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitude</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcoholic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor 5</td>
<td>157</td>
<td>2.503</td>
<td>1.245</td>
<td>-0.0362</td>
<td>0.332</td>
</tr>
<tr>
<td>Character</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor 6</td>
<td>157</td>
<td>2.121</td>
<td>.792</td>
<td>-0.0627</td>
<td>0.226</td>
</tr>
<tr>
<td>SES of Alcoholic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Alcadd</td>
<td>148</td>
<td>7.878</td>
<td>6.522</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
alcoholic for a sample of registered nurses was not supported. Moreover, Major Question 6 which asked if the nurses' personal use of alcohol is related to their attitudes toward the alcoholic was answered in the negative.

Bailey and Fuchs (1960) speculated in their research study on social workers' attitudes toward alcoholic clients that the generally negative attitudes found could be related to the social workers' own ability to control the personal use of alcohol. In controlling their own use of alcohol, the researchers posited, the social workers were critical of clients who were unable to do so.

Empirical research studies investigating the relationship between the attitudes of helping professions toward the alcoholic persons and their own personal use of alcohol have not been found in the literature by this investigator. The only study found whose purpose was even vaguely related to the purpose of the present study was the one conducted by Globetti (1968). He investigated the attitudes of abstainers toward alcohol and persons who used alcohol. He reported that abstainers who were older, had less education, and were in a lower socio-economic group tended to look unfavorable on alcohol and its users. Those who did not fit this description looked favorably on alcohol and its users. He further suggested that the
abstainer who is favorable toward alcohol use and alcohol users would likely be less reluctant to work with persons who had problems with alcohol misuse.

In regard to the present study and the findings reported by Globetti, it appears that the nurses who were abstainers in this study could be described on the same basis of those whom Globetti described as being favorable toward alcohol and its users. Whether or not they would be less reluctant to work with persons with problems of alcohol misuse remains a moot question since the nurses in this study were not measured on overt behaviors.

The finding that nurses' attitudes toward alcoholics was not significantly related to their personal use of alcohol may be the result of their belief in the disease or illness orientation of alcoholism and their belief about the addictive nature of alcohol. Further, it could be that they ascribe to the belief, strongly supported by Alcoholics Anonymous, that all persons who use alcohol are potential alcoholics.

Analyses of Selected Variables

Descriptive statistics were computed on the responses of the total sample of nurses on other Factors of the Marcus questionnaire. The results of the analyses of the results from these statistics revealed two additional
aspects about the attitudes of the nurse sample toward the alcoholic and alcoholism which have practical significance for the practice of nursing. These aspects deal with the attitudes of the registered nurses in this study toward the intervention in alcoholism and the emotional difficulties and loss of control over alcohol consumption by the alcoholic.

The two items examined which are related to beliefs about intervention in the disease of alcoholism were items 17 and 23 on the questionnaire. Item 17 is a statement that an alcoholic should be compelled to go for treatment. Item 23 states that the alcoholic must have help to stop drinking.

The mean score for the total sample on item 17 was 3.788, indicating that they disagreed more than they agreed with the statement. However, due to the proximity of this mean to the ambiguous position on the statement at point 4, it appears that the nurses were ambiguous in their attitude toward alcoholics being compelled to go for treatment. On item 23, the mean of the entire sample was 5.226, indicating that the nurses as a group believed that the alcoholic needed help to stop drinking. This agreement was not strong, however, considering the strongest position of agreement was at point 7.
From these results, it appears that the attitude toward requiring the alcoholic to seek treatment tended to be weak for this nurse sample. Perhaps, they are best described as having a tendency toward ambivalence about requiring alcoholics to go for treatment. Further, they were moderately positive in respect to their belief that the alcoholic needed help to stop drinking. This moderate agreement with the idea that the alcoholic needs help to stop drinking appears inconsistent with the strong position taken on agreeing alcoholism is a disease.

The other results from this analysis revealed that the registered nurses in the sample tended to be ambiguous in their attitudes toward the alcoholic's emotional difficulties contributing to alcoholism and the loss of control over alcohol by the alcoholic. Their mean scores on these factors of The Marcus Alcoholism Questionnaire were 4.622 and 4.761, respectively. With the most positive attitude possible being at point 7 on the scale, it is evident that the nurses in the sample were more ambiguous in their attitudes about the emotional difficulties and lack of control of alcoholics than they were about compelling the alcoholic to seek treatment and the need of the alcoholic for help.

This sample of nurses tended to be less inclined to view the alcoholic as having emotional difficulties
contributing to alcoholism than the nurses in the Ferneau and Morton (1968) sample which was from a neuropsychiatric hospital. The nurses in this study appeared to be closer to the Ferneau (1967) and Gurel (1976) sample of nurses in this view of the alcoholic. It is possible that the nurses who are less inclined to view emotional difficulties as contributing to alcoholism may, in ascribing to the disease concept of alcoholism, view alcoholism as creating emotional difficulties (American Medical Association, 1973 and Jellinek, 1952).

The ambiguity in nurses' response to the loss of control by the alcoholic in respect to drinking would appear to reflect a possible reason nurses did not respond more positively to the statement (Item 23) that the alcoholic needed help to overcome alcoholism. Further, it could be posited that with the combination of these responses that nurses, in general, did not see the need for nursing intervention in caring for the person who has an alcohol problem or alcoholism. Although intervention in alterations of health have long been accepted as a primary function in the role of the nurse, perhaps, these registered nurses viewed intervention as a responsibility of the clinical nurse specialist or independent nurse practitioner.

The responses to the loss of control over alcohol by the alcoholic and the alcoholic's need for help are
dependent to a large degree upon the nurse's existing knowledge about the effects of alcohol upon the human body and the progressive stages of alcoholism. Gurel's (1976) statement about nurses' knowledge of alcoholism, in general, may be true of the nurses in the present study. She stated that registered nurses are not educationally prepared to work with alcoholic patients by the development of an in-depth understanding of the disease of alcoholism. Her statement was supported earlier by the findings of Johnson (1965) who found that the nurses in her sample believed they lacked the skills to intervene in alcoholism.

A one-way analysis of variance was computed using the personal variables of the sample as the independent variables and the Marcus questionnaire, need for social approval, and Alcadd means as dependent variables. Table 23 and Table 24 present a summary of the results. In the summary are the computed Eta correlations for the variables which were found to be related.

From Table 23, it is shown that registered nurses' past experience in working with an alcoholic was significantly related to a positive attitude toward the alcoholic and the prognosis of alcoholism. The correlation of nurses' past experience with alcoholics and these attitudes was moderate (.22 and .26 respectively) and in a positive direction. Thus, nurses with the past professional
experience of caring for an alcoholic differ significantly from nurses who have not had this experience. Nurses who had past professional experience working with an alcoholic were more positive in their attitudes than those nurses who did not have the past professional experiences of caring for an alcoholic. This finding was contrary to the conclusion drawn by Berke et al. (1959). Improvement in pharmaceutical agents used for the treatment of alcoholics may account for fewer negative experiences on the part of the nurses in dealing with alcoholic patients.

The basic educational preparation of registered nurses was found to be moderately (.2074) correlated to a significant (0.378) level with rationalization for drinking. Thus, the more years spent in educational preparation, the stronger the rationalization for drinking as revealed by the Alcadd scores.

This finding is consistent with that of Orford et al. (1974) who examined the personal correlates and drinking behavior among university students in England. They found the students rationalized in somewhat the same way and did so to the extent that they strongly believed that health status was not strongly affected by their drinking
<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>Dependent Variable</th>
<th>F Value</th>
<th>Significance Level</th>
<th>ETA Correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Past Professional Experience Working with an Alcoholic</td>
<td>(1) Prognosis of Alcoholism</td>
<td>7.924</td>
<td>.0055</td>
<td>0.2205</td>
</tr>
<tr>
<td></td>
<td>(2) SES of the Alcoholic</td>
<td>11.976</td>
<td>.0007</td>
<td>0.2678</td>
</tr>
<tr>
<td>2. Basic Educational Preparation</td>
<td>(1) Rationalization for Drinking</td>
<td>3.349</td>
<td>.0378</td>
<td>0.2074</td>
</tr>
<tr>
<td>3. Years of Nursing Experience</td>
<td>(1) Alcoholic as a Steady Drinker</td>
<td>2.518</td>
<td>.0437</td>
<td>0.2501</td>
</tr>
<tr>
<td></td>
<td>(2) Need for Social Approval</td>
<td>2.620</td>
<td>.0373</td>
<td>0.2571</td>
</tr>
<tr>
<td></td>
<td>(3) Alcadd: Rationalization for Dr.</td>
<td>2.999</td>
<td>.0205</td>
<td>0.2730</td>
</tr>
<tr>
<td></td>
<td>(4) Total Alcadd Score</td>
<td>3.128</td>
<td>.0167</td>
<td>0.2792</td>
</tr>
</tbody>
</table>
behavior. It would be interesting to investigate the attitudes of nurses high on rationalization for drinking and compare these attitudes with knowledge of the effects of alcohol in varying amounts on the health status of a person.

The years of nursing experience was found to be moderately related in a positive direction with nurses' view of the alcoholic as a steady drinker. Further, years of experience was also found to be related significantly with the need for social approval, rationalization for drinking, and the total Alcadd score. The relationship was moderate (.27) and in a positive direction only for the need for social approval and rationalization for drinking. The relationship between the years of experience and the total Alcadd score was in a negative direction, indicating the more years of nurses' experience, the lower the Alcadd scores.

The finding of the inverse relation between years of experience and total Alcadd score suggests years of experience may have stood as a proxy for age. Taking this position, it can be said, then that this finding is consistent with the finding reported by Cahalan et al., that age was a personal correlate of drinking behavior. In their research it was found that in the general population drinking behavior decreased with age.
Table 24: Summary II shows the findings from the one-way analysis of variance resulting from testing personal variables of the sample with the identified dependent variables. It was found that age was significantly related in a positive direction with nurses' attitudes toward the character of the alcoholic, prognosis of alcoholism, and excessive drinking of the alcoholic as a voluntary, harmless indulgence. Additionally, it was found that religious orientation was significantly related to the belief that the alcoholics' drinking is a harmless indulgence.

Insert Table 24 about here

Studies investigating the relationship between these types of personal characteristics of a sample of registered nurses and attitudes toward the alcoholic and alcoholism do not appear to have been reported. Marcus (1963a) however, did report that in his general Toronto population sample that age correlated significantly with the samples' attitude toward emotional problems as a contributory factor to alcoholism and the prognosis of alcoholism. He found younger people in his sample were more likely to have positive attitudes toward the alcoholic and alcoholism. The most significant finding relating personal variables to attitudes toward alcoholism in his study was that
TABLE 24

Summary 2: Analysis of Variance
Personal Variables
and Attitudes, Need for Social Approval, Alcohol Use

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>Dependent Variable</th>
<th>F Value</th>
<th>Significance Level</th>
<th>ETA Correlation Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Age</td>
<td>(1) Prognosis of Alcoholism</td>
<td>4.774</td>
<td>.0002</td>
<td>0.4016</td>
</tr>
<tr>
<td></td>
<td>(2) Character of Alcoholic</td>
<td>3.567</td>
<td>.0025</td>
<td>0.3544</td>
</tr>
<tr>
<td></td>
<td>(3) Alcoholic's Drinking: a Harmless Indulgence</td>
<td>3.961</td>
<td>.001</td>
<td>0.3167</td>
</tr>
<tr>
<td>4. Religious Orientation</td>
<td>(1) Alcoholic's Drinking: a Harmless Indulgence</td>
<td>2.929</td>
<td>0.356</td>
<td>0.2338</td>
</tr>
</tbody>
</table>
education was the most important determinant of attitudes about alcoholism. He reported education showed a significant correlation with four of the nine factors in his questionnaire. Further, he concluded that the more education one has, the more likely one is to believe alcoholism is a disease or illness and that it is marked by a loss of control over alcohol.

Finally, in answer to the question regarding knowledge of alcoholism improving nursing skills, the majority of nurses stated it would (71.6%). Approximately nine percent responded it would not and 19.4 percent were unsure. This finding is interpreted as particularly interesting because of the number of nurses from intensive care responding that they did not believe this knowledge would improve their skills.

Summary of Results

By testing the eight hypotheses in this study, the Major Questions 1 through 6 were answered. From this investigation it was found that the attitudes of registered nurses in this sample were positive toward both the alcoholic and alcoholism. In fact, they were significantly more positive than those of the expert group provided by Marcus (1963b). They viewed the alcoholic person as an individual who is not morally weak, who can come from any
socio-economic level of society, and who can be helped through treatment. These results were found to be contrary to those reported by earlier researchers. The fact that these findings differed from those of previous studies was suggested to be due to several reasons. Among them were the difference in sample composition and the time between the past studies and the present study. Related to the time difference was the increased knowledge available about the alcoholic and alcoholism.

Moreover, it was found that the attitudes of registered nurses in this sample toward the alcoholic and alcoholism differed significantly from the attitudes toward alcoholics and alcoholism held by a sample from the general population. Although this finding was contrary to that which was reported in the literature from both researchers and authorities, it was not unexpected because of the difference in the time between the study of the attitudes of the general population and the present study.

It was also found that a relationship did not exist between the attitudes of a sample of registered nurses toward alcoholics and alcoholism and their need for social approval. From the results, the attitudes expressed by the nurses in this study were independent of the need for social approval, suggesting that the Marcus questionnaire
was answered in accordance with their own beliefs. This finding was viewed as enhancing the validity of the study.

Next, it was discovered that the area of clinical practice has a relationship to the registered nurses' expressed attitudes toward the alcoholic and alcoholism. This finding was consistent with the findings of Ferneau (1967). Nurses who worked in an alcoholism unit were significantly more positive in attitudes toward alcoholism and the alcoholic when compared with nurses from other units. It was suggested this was due to the interpersonal contact with alcoholic patients, and personal motivation.

Finally, it was found that the personal use of alcohol by registered nurses was not significantly related to their attitudes toward the alcoholic. This finding was suggested to be due to nurses' acceptance of alcoholism as a disease or illness.

Several secondary findings were reported which in general are consistent with those reported by Marcus (1963b). These were that (1) level of education influenced attitudes toward the alcoholic and alcoholism more than any other personal variable, (2) age was related to nurses' use of alcohol, and (3) level of education was related to nurses' use of alcohol in terms of rationalization for drinking.
Sources of Error

There were three primary sources of potential error in this investigation. The first was the nonrandomization of the subjects' participating in the study. The sampling procedure involved requesting the cooperation of volunteers for the study, and therefore, represented a nonsystematic departure from random sampling. As a result, the external validity of the study was affected so that the findings from the study are not generalizable beyond the sample of nurses who participated in it.

A second source of error could be the under-reporting on responses by the subjects of the study, particularly where the items in the instruments were considered too personal. For example, some of the items on the Alcadd test and demographic sheet could be viewed in this manner.

The third source of potential error relates to the conditions under which the data collection took place. Some of the subjects completed their instruments toward the end of their work day and may have answered less carefully than they would have had they completed the instruments earlier in their work day. Others came from busy patient care units and in being concerned about being off the units may have concentrated less attention on the accuracy of their responses.
CHAPTER V
SUMMARY

Introduction

This chapter is arranged into four distinct parts. The first part consists of a summary of the problem, purposes, and design of the study. Further, the sample upon which the study focused, the instrumentation, and procedures employed are briefly summarized. A restatement of the questions and hypotheses guiding the study is provided. The second part contains the results from the analyses of the data, including a profile of the sample, results of the hypotheses tested with the answers to the questions posed, and secondary findings. In the third part, a discussion of the results is presented. The final part of the Chapter consists of recommendations for further research which have been identified by the investigator during the conduct of the present research.

Summary: Problem, Procedures, Hypotheses

Background for the Study

Evidence has been accumulating during the past two decades that there has not only been an increase in alcohol use in the nation but an increase in alcohol abuse.
(National Association of Blue Shield Plans, 1973; U. S. Health, Education, and Welfare, 1976; and Keller & Guriolo, 1976). It has been recently estimated that between ten and eleven million Americans are suffering from varying stages of alcoholism (Health Systems Planning, 1977 and Galton, 1978). As the rate of alcoholism has risen, alcoholism has become the fourth major health problem in the nation (Institute of Mental Health, 1972). This fact is underscored by evidence from empirical studies which show that there has been an escalation in the number of patients admitted to general hospitals for alcohol-related health problems who are in various stages of alcoholism (Barchha et al., 1968 and Gomberg, 1975).

With the increase in the number of patients admitted to general hospitals with alcohol-related health problems, the attitudes toward alcoholics and alcoholism of registered nurses, the largest group of health professionals, becomes highly significant. Researchers (Chavigny, 1976; Meyer & Morris, 1977; and Wiley, 1977) and authorities on alcoholism (Morton, 1967 and Burkhalter, 1975) have shown that the attitudes of the nurse are directly related to patient improvement.

The Problem

A systematic study of the attitudes of registered nurses toward the alcoholic person and alcoholism has not
been conducted in hospitals across the nations. However, the limited number of studies conducted over the past two decades generally report that registered nurses hold negative attitudes toward the alcoholic person and alcoholism (Pittman & Sterne, 1963; Johnson, 1965; Moody, 1971; Wallston et al., 1976; and Larson, 1977). Since these studies have been conducted in diversified and isolated settings, it is impossible to apply their findings to other groups of nurses in other settings. Therefore, the research problem in this study was to identify the attitudes of registered nurses who are employed in Columbus, Ohio, general hospitals toward the alcoholic and alcoholism.

**Purposes of the Study**

There were three major purposes of the study. The first was to obtain data on the attitudes of registered nurses employed in Columbus general hospitals toward the alcoholic and alcoholism. The second purpose was to compare the data obtained with similar data on a group representative of the general population to determine if registered nurses differ in their attitudes toward the alcoholic and alcoholism from the population in general. The third purpose was to explore the relationship between the personal characteristics of registered nurses in the sample and their expressed attitudes toward the alcoholic person and alcoholism.
Design of the Study

The causal-correlational research design was used in this study to obtain a precise description of registered nurses' attitudes toward the alcoholic and alcoholism and identify personal characteristics which could be related to these attitudes. This design is classified under the general category of descriptive research.

Sample

Data were collected from 159 female registered nurses who volunteered to participate in the study. These nurses were from a population of 720 registered nurses employed full- or part-time during December, 1978 and January, 1979 by three general hospitals located in Columbus.

Instrumentation

In addition to a demographic sheet which was used to obtain professional and personal data, three instruments were used. These instruments were The Marcus Alcoholism Questionnaire, The Marlowe-Crowne Social Desirability Scale, and The Alcadd Test. The Marcus questionnaire was used to measure the attitudes of registered nurses toward the alcoholic person and alcoholism. The Marlowe-Crowne Social Desirability Scale was used to determine whether the answers provided by the nurses on the Marcus questionnaire were related to their need for social approval. The Alcadd Test was used to determine nurses' personal use of alcohol.
Procedures

The initial procedure involved gaining the cooperation of three general hospitals so that a sample of registered nurses who would volunteer for the study could be obtained. Next, data were collected on the volunteer sample in the three participating hospital settings during the months of December, 1978 and January, 1979.

The data collected were analyzed using the Statistical Package for the Social Sciences Program. In the analyses, descriptive statistics, t tests, one-way analysis of variance, and Pearson and Eta Correlation Coefficients were computed.

Questions and Hypotheses

The research questions for the study were derived from studies of attitudes of registered nurses and others in the health or health-related professions toward the alcoholic and alcoholism. Hypotheses were formulated which corresponded to the questions asked. Questions and hypotheses were:

Major Question 1: What are the attitudes toward the alcoholic and alcoholism of a group of registered nurses in a general hospital setting?

Hypothesis 1: Registered nurses from general hospitals have significantly negative attitudes toward the alcoholic person.
Hypothesis 2: Registered nurses from general hospitals hold a significantly positive view of alcoholism as a disease or illness.

Hypothesis 3: Registered nurses from general hospitals hold significantly pessimistic attitudes toward the prognosis of alcoholism.

Major Question 2: Are the attitudes toward alcoholics and alcoholism of a sample of registered nurses in general hospitals different from the attitudes of a sample representative of the general population?

Hypothesis 4: The attitudes of registered nurses toward alcoholics and alcoholism do not differ significantly from those held by a sample representative of the general population.

Major Question 3: Is there a relationship between the expressed attitudes of a sample of registered nurses toward alcoholics and alcoholism and their need for social approval?

Hypothesis 5: Attitudes toward the alcoholic and the disease or illness orientation of alcoholism expressed by registered nurses are significantly related to their level of need for social approval.

Major Question 4: Do nurses who are employed in general hospitals which have alcoholism units have more positive attitudes toward alcoholics and alcoholism than do
those nurses who are employed in a general hospital which does not have an alcoholism unit?

**Hypothesis 6:** Registered nurses employed in a general hospital which has an alcoholism unit express significantly more positive attitudes toward alcoholics and alcoholism than registered nurses who are employed in a general hospital which does not have an alcoholism unit.

**Major Question 5:** Does the area of clinical practice have a relationship to the expressed attitudes of nurses toward the alcoholic and alcoholism?

**Hypothesis 7:** Registered nurses employed in an alcoholism unit have significantly more positive attitudes toward alcoholics and alcoholism than a sample of registered nurses employed in other hospital areas.

**Major Question 6:** Is the personal use of alcohol by registered nurses related to their attitudes toward the alcoholic and alcoholism?

**Hypothesis 8:** The attitudes held by registered nurses toward the alcoholic person are significantly related to their personal use of alcohol.
Results

Profile of the Sample

The majority of nurses in the sample (42.8\%) were practicing nursing on medical-surgical units, and the majority of them held staff positions (68.4\%) in the hospitals where they were employed. They were primarily (62\%) graduates from a diploma school of nursing. The highest educational credential held by most (59.7\%) of them was the nursing school diploma. In these respects, they were similar to the total sample of registered nurses licensed to practice in Ohio (Ohio Board of Nursing Education and Nurse Registration Division of Nursing, Office of Health Planning, September, 1978). The similarities between the sample in the present study and the sample which includes all nurses registered to practice in Ohio can be found discussed in detail in Chapter IV.

In addition, the majority of the nurses in the sample were experienced nurses (58.5\%) who had had previous experience in providing care for a person with an alcohol problem or the disease of alcoholism (62.9\%). Moreover, most (29.9\%) had received their primary knowledge about alcoholism from their basic nursing education programs.

Further, the majority of the nurses in the sample (69\%) were under 40 years of age, were married (57.6\%), and of a Protestant (50\%) religious orientation. Only
1.3 percent of the nurses reported having ever had a personal problem with alcohol.

**Results of the Tests of the Hypotheses**

A summary of the results of the hypotheses tested in this study is provided in the following paragraphs. In addition to the results, the answers to the major questions corresponding to the hypotheses are given.

**Hypothesis 1** which stated registered nurses from general hospitals have significantly negative attitudes toward the alcoholic person was not supported. Nurses, as a total sample, were found to have a positive attitude toward the alcoholic person with respect to his or her character and socio-economic level. The alcoholic person was not viewed as different in character or socio-economic status from persons who were not alcoholic. In this attitude, the nurses were significantly more positive than a group of experts with whom they were compared.

**Hypothesis 2** stated, Registered nurses from general hospitals hold a significantly positive view of alcoholism as a disease or illness. Although the nurses in the sample were found to hold a positive view of alcoholism as a disease or illness, the analyses of the data showed that they did not differ significantly in this attitude from a group of experts. Therefore, Hypothesis 2 was not accepted.
Hypothesis 3 was, Registered nurses from general hospitals hold significantly pessimistic attitudes toward the prognosis of alcoholism. Testing of this hypothesis revealed that nurses held optimistic attitudes toward the prognosis of alcoholism. However, they were not found to differ significantly in this attitude from a group of experts with whom they were compared. Since the attitude of the sample of nurses toward the prognosis of alcoholism was in the opposite direction of that which was hypothesized, Hypothesis 3 was not supported. The attitudes of the nurses showed that they believed the alcoholic drank excessively because of an addiction to alcohol, and that he or she could be helped to recover, given the proper medical and psychological help.

From the results of the testing of these three hypotheses, an answer to Mayor Question 1 was provided. This question was, What are the attitudes toward the alcoholic and alcoholism of a group of registered nurses in a general hospital setting? The answer to this question is that registered nurses: (1) are positive in their attitudes toward the alcoholic person and alcoholism; (2) believe the alcoholic could have any level of education and can come from any socio-economic group; (3) do not believe the alcoholic has a moral weakness or character defect which accounts for his or her alcoholism; and (4) hold the
attitude that alcoholism is a disease or illness which is amenable to treatment.

Hypothesis 4 stated, The attitudes of registered nurses toward alcoholics and alcoholism do not differ significantly from those held by a sample representative of the general population. The results of the hypothesis testing showed that nurses held significantly more positive attitudes toward the alcoholic and alcoholism than a sample representative of the general population. Thus, Hypothesis 4 was not supported.

The testing of Hypothesis 4 and its results provided a response to Major Question 2 which asked whether nurses differed from a sample representative of the general population in their attitudes toward the alcoholic and alcoholism. This question can be answered in the affirmative. Registered nurses in the sample differed significantly from the general population sample in their attitudes toward the alcoholic and alcoholism. The nurses were more positive in (1) their view that the alcoholic person did not differ in character and socio-economic level from the person who was not alcoholic; (2) their belief that alcoholism could be treated effectively; and (3) their acceptance of alcoholism as a disease or illness.
Hypothesis 5 was, Attitudes toward the alcoholic and the disease or illness orientation of alcoholism expressed by registered nurses are significantly related to their level of need for social approval. From the statistical computations performed and an analysis of the data, it was found that this hypothesis could not be accepted. The level of nurses' need for social approval was not shown to be significantly related to their high or low positive attitudes toward the alcoholic and alcoholism.

Therefore, Major Question 3 which asked if there was a relationship between the expressed attitudes of a sample of registered nurses toward alcoholics and alcoholism and their need for social approval can be answered. In answer to the question, it can be stated that a significant relationship does not exist between the attitudes of the nurses and their level of need for social approval.

Hypothesis 6 stated, that registered nurses employed in a general hospital with an alcoholism unit express significantly more positive attitudes toward alcoholics and alcoholism than registered nurses who are employed in a general hospital without an alcoholism unit. The results of this hypothesis testing showed that the nurses did differ significantly in their attitudes toward the alcoholic and the prognosis of alcoholism on the basis of
whether the hospital where they were employed did or did not have an alcoholism unit. Nurses who were employed in hospitals which had an alcoholism unit were significantly more positive in their attitudes toward the alcoholic and the prognosis of alcoholism. Examining the relationship between these significantly more positive attitudes and the presence of an alcoholism unit within the employment setting, it was found that a low correlation existed between the two variables. Only four percent of the variance in the attitudes of nurses in the sample could be explained by the presence of an alcoholism unit within the employment setting. It was further found that the nurses in the sample did not differ significantly in their acceptance of alcoholism as a disease or illness on the basis of whether or not the hospital where they were employed did or did not have an alcoholism unit. Hypothesis 6 was, therefore, not totally supported.

Major Question 4 asked whether nurses who work in general hospitals which have an alcoholism unit have more positive attitudes toward alcoholics and alcoholism than nurses who work in hospitals without an alcoholism unit. From the results of the testing of Hypothesis 6, this question can be answered with a qualification. It can be said that nurses who work in hospitals with an alcoholism unit
have significantly more positive attitudes toward the alcoholic and alcoholism. However, they do not differ from nurses who work in hospitals without an alcoholism unit in their acceptance of alcoholism as a disease or illness.

Hypothesis 7 stated, Registered nurses employed in an alcoholism unit have significantly more positive attitudes toward alcoholics and alcoholism than a sample of registered nurses employed in other hospital areas. It was shown in the analysis of the data that nurses working in alcoholism units like other nurses in the sample had high and low positive attitudes toward the alcoholic and alcoholism. However, as a group, they were found to be significantly more positive in their attitudes than nurses who worked in other hospital units. Thus, Hypothesis 7 was accepted.

Acceptance of Hypothesis 7 provides an answer to Major Question 5 which asked whether the area of clinical practice has a relationship to the expressed attitudes of nurses toward the alcoholic and alcoholism. The question can be answered affirmatively if the question is limited to whether the nurses practice within or outside of an alcoholism unit.
Hypothesis 8 stated, that the attitudes held by registered nurses toward the alcoholic person are significantly related to their personal use of alcohol. Results of the hypothesis testing showed that nurses' attitudes were correlated to a slight, negative degree with their personal use of alcohol. This correlation, however, was not significant. Therefore, Hypothesis 8 was not supported. Further, a negative answer was provided for Major Question 6 which asked if nurses' attitudes toward the alcoholic was related to their personal use of alcohol.

Secondary Findings

Secondary findings were that nurses tended to be ambiguous in their attitudes toward: (1) intervention which compelled alcoholics to seek treatment; (2) emotional difficulties contributing to alcoholism; and (3) the loss of control over alcohol use by the alcoholic.

Among the personal characteristics of the nurses in the sample which were found to be related to their attitudes toward the alcoholic and alcoholism were age and level of education. These two variables had the most significant positive relationship of any of the personal variables.

The findings in the present study must be considered with some reservations because the sample consisted only
of nurses who would volunteer for the study. Although the nurses in the sample are similar to nurses in Ohio in general with respect to practice areas, positions held, basic educational preparation, and highest credential held, it is possible that they were a biased sample. They may have been more positive in attitudes toward alcoholics and alcoholism or more positive toward all persons, in general, than another sample might be.

Discussion

The registered nurses in this volunteer sample held positive attitudes toward the alcoholic person and the concept of alcoholism, independent of their level of need for social approval or their personal use of alcohol. They viewed the alcoholic as one who could come from any educational or economic level of society and one who suffered from a disease rather than a character defect. Thus, the traditional moralistic and punitive attitudes described as being held by registered nurses in some of the previous empirical studies (Pittman & Sterne, 1963; Johnson, 1965; Kuzenski & Reynolds, 1966; Schmid & Schmid, 1973; Wallston et al., 1976; and Larson, 1977) and authorities on alcoholism (Golder, 1956; Lewis, 1956; Morton, 1967, and Burkhalter, 1975) are not, relatively speaking, representative of the attitudes of registered nurses in this study.
Moreover, the divergency in nurses' attitudes toward the alcoholic person and alcoholism (a non-accepting attitude toward the alcoholic and an accepting attitude toward alcoholism as a disease) previously found in the early Pittman & Sterne (1963) research does not characterize the attitudes of nurses at the present time.

The differences in the results of this study and those of previous studies can be attributed to the differences in sample composition and/or the time interval between studies. Also, several trends have become evident in both public and nursing education since the earlier studies were conducted. There has been a trend toward incorporating more alcohol and drug education programs into public school programs. Furthermore, the newspaper and television media have focused on the overt and covert problems of alcoholism, the effects of alcohol abuse, and the prevalence of alcoholism in general. In nursing education, there has been a trend toward the preparation of nurses in an academic setting rather than in the hospital based diploma school settings. With the move into academic settings there has been a focus on the humanistic rather than the moralistic philosophy of man; an advancement of the concept of the nurse as the patient advocate (King, 1971); and an increased preparation for the individualization of patient care in hospital and community settings (King, 1971).
In addition to the trends in nursing education, there has been a progressive strengthening of staff development departments within hospitals whose primary function is to provide for the continuing education of nurses and others employed in hospital settings. For a large number of nurses, the programs provided by these departments have provided the major source for updating their knowledge and skills. These programs have generally followed the educational pattern of nursing education in the academic settings.

Among the positive attitudes toward alcoholism expressed by the sample of nurses was a positive attitude toward the prognosis of alcoholism. This finding is viewed with reservation. It is possible that in viewing the prognosis of alcoholism the nurses are viewing alcoholism within the curative orientation of the medical model and are oversimplifying the chronic nature of the disease. With this orientation, there is a tendency to overlook the chronic nature of alcohol with its characteristic remissions (Armor et al., 1978). There are two implications involved in this orientation. One is that if the patient experiences remission, he or she is apt to be blamed for the failure of treatment in the eyes of the nurse. Instead of viewing increasing lengths of time
between remissions as a realistic goal of treatment, the nurse is likely to view treatment as success only if remission does not occur (Burkhalter, 1975). Secondly, in the event that the nurse does not assess alcoholism realistically, she may become discouraged and avoid further contact with patients whom she could help.

Secondary findings of the study were that nurses tended to be ambivalent about (1) compelling alcoholics to seek treatment; (2) the idea that the alcoholic must have help in order to stop drinking; and (3) the belief that the alcoholic has lost control over alcohol use.

These secondary findings relate to the attitude of the registered nurses toward intervention in the progress of alcoholism. They could be interpreted to mean that the nurses in the sample (1) believed alcoholics undergoing treatment are self-referred which is rarely the case; (2) were generally unaware of the psychological dynamics involved in alcoholism which interfere with the rational functioning of the alcoholic person so that he or she can rely on will power to stop drinking; and (3) were unsure about the addiction process which underlies the alcoholic's loss of control over the use of alcohol. These findings and this interpretation of them support Gurel's (1976) contention that nurses are not educated
for an in-depth understanding of alcoholism. Without an in-depth understanding of alcoholism, its effects on the human body, and dynamics, a basis is lacking for the development of intervention skills on the part of the nurse.

Three characteristics of the registered nurses in the sample were found to be significantly and positively related to their attitudes toward the alcoholic and alcoholism. These characteristics were age, level of education, and the previous experience of working with a patient having an alcohol problem or alcoholism. These findings support the earlier ones reported by Marcus (1963) in regard to age and level of education.

In achieving the purposes of this investigation to (1) identify and describe the prevailing attitudes of registered nurses in general hospitals toward the alcoholic and alcoholism and (2) to explore the relationship of personal variables to these attitudes, the problem central to this study has been clarified. Given the limitations of the study, the findings of the study lessen to some degree the concern that registered nurses are working with counter-therapeutic attitudes in caring for persons with alcohol-related health problems or alcoholism.
Despite the results of this study which have provided a positive description of nurses' attitudes toward the alcoholic and alcoholism, some serious questions are raised. The attitudes in this investigation were measured using the Marcus questionnaire which relies on the belief and evaluative components of attitude described by Fishbein (Fishbein & Ajzen, 1975) and Katz (1960). The question raised is whether nurses have accepting attitudes toward the alcoholic and alcoholism only at the intellectual level. Would they respond differently if their attitudes were measured on an instrument which included items which permitted description of their feelings? In other words, are their intellectually based attitudes different from their emotional or feeling based attitudes? Further, is it possible that nurses respond more readily with positive attitudes when the alcoholic person is distant and represented only by stimuli represented in the testing situation? Given a situation in which a response is made toward the actual alcoholic person, would the attitudes revealed in this study be different?
Recommendations for Further Research

One recommendation is for the replication of attitude studies conducted in different general hospital facilities and community agencies where nurses are employed throughout the nation. To strengthen these studies, it is recommended that two important approaches be incorporated in them. One is to focus attention on the nurses' attitudes towards intervention in the disease of alcoholism. For example, if the Marcus questionnaire were used, the optional questions could be reworded so that more than one interpretation of intervention is provided. The other approach is to include at least two different measures of attitude in the research design.

A further recommendation is for the development of additional tools to measure attitudes toward alcoholics and alcoholism. At the present time, the number of instruments to measure attitudes are limited so that the only ones used with any frequency are Osgood's Semantic Differential and the Marcus Alcoholism Questionnaire. Other approaches to measurement have been highly individual. It would be helpful if scales similar to the Marcus scale could be developed so that attitudes toward the alcoholic and alcoholism could be compared with attitudes toward other individuals or groups with health problems.
Another recommendation for further research is a study in which registered nurses, physicians, and counselors are compared on an attitude scale which measures their attitudes toward the alcoholic and alcoholism. Since all are members of the health care team providing health care for the patient, it is important to assess the similarities and differences in their attitudes which can have a direct effect on the patient.

A fourth recommendation for further research is for a study of patients' perceptions of registered nurses' attitudes toward them. By temporarily assigning nurses from other hospital units to an alcoholism unit, the attitudes held by the nurses and the patients' perception of their attitudes could be measured. In addition, actual behaviors could be recorded in protocol form and compared with the measured attitudes. This study could be in some respects similar to that of Linsky et al. (1965) except that the setting would be a general hospital and behaviors would be recorded. Using a follow-up interview with patients it may be possible to compare their observations with the protocols and identify specific nursing behaviors that are related to specific attitudes. If such a study were found to be fruitful, a typology of behaviors indicative of positive attitudes toward the patient is a distinct possibility.
The final recommendation for further research is a survey of both expert and public attitudes toward the alcoholic and alcoholism on a state-by-state basis. This would provide more current samples with which to compare the attitudes of registered nurses and other members of the health care team.

In conclusion, it is apparent from the tenuous nature of the findings, discussion related to them, and recommendations for further research in this Chapter, that much remains to be done in the area of research on the attitudes of registered nurses toward the alcoholic person and alcoholism if research findings are to be more explicit. Further, research into the salience of the attitudes of registered nurses toward the alcoholic and alcoholism needs to be undertaken. In order to accomplish this new research instruments need to be developed. Further, there is a need to conduct research on the attitudes of experts on alcoholism and the general population so that they can provide more recent comparison groups with which to compare the attitudes of nurses and others in the health care professions. In this way, the attitudes in future studies could be determined with increased specificity.
In summary, nurses need to explore their own attitudes toward the alcoholic and alcoholism. This can enable them to be more aware of the impact their attitudes have on caring for patients with alcohol problems.
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BIBLIOGRAPHY


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APPENDIX A

Letter to the Nurse Administrators
of Hospitals A, B, and C
Dear

As a doctoral student in the Department of Education, Special Services, at The Ohio State University, I am in the process of developing a dissertation on the subject of the attitudes of Registered Nurses toward alcoholism and the alcoholic patient. More specifically, I am interested in the attitudes of female Registered nurses employed by a general hospital which has an Alcoholism unit and one which does not have this type of unit. It is my intent to ascertain and describe the attitudes of nurses who are working on Emergency, Medical-Surgical and Alcoholism Units. I am also interested in obtaining information on personal variables other than area of nursing practice which may be correlated with attitudes that are expressed in the course of the study.

In order to carry out this study I need the cooperation of an administrator in charge of the nursing service department in a hospital that provides the range of services listed. Moreover, if the nurses will fill out the questionnaires in their free time, there should be no cost to the hospital for participating in the study.

The study is based on three questionnaires and a sheet of demographic information. These questionnaires and the demographic sheet have short response type of formats and should take no more than 40 minutes to complete in terms of the total time required for completion. Please be assured that the anonymity of all participants in the study will be strictly maintained. In no instances will individual responses be identified.
As a nurse administrator you may be interested in the findings of a study of this type. If given the opportunity to do the study, I will be most happy to share with you, your staff and the administrator of the hospital the results of the study. Your assistance and cooperation of this research effort will be greatly appreciated.

Very truly yours,

Jeanne McKeag Steele

JMS
APPENDIX B

The Marcus Alcoholism Questionnaire
THE MARCUS
ALCOHOLISM QUESTIONNAIRE

On the following pages you will find a number of statements about alcoholism. We want to know how much you agree or disagree with each of the statements. To the right of each statement you can find a rating scale:

<table>
<thead>
<tr>
<th>Disagree</th>
<th>Agree</th>
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<tbody>
<tr>
<td>1 2 3 4 5 6 7</td>
<td></td>
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</tbody>
</table>

The points along the scale (1, 2, 3, ... 7) can be interpreted as follows:

1. Completely disagree
2. Mostly disagree
3. Disagree more than agree
4. Neutral
5. Agree more than disagree
6. Mostly agree
7. Completely agree

The use of the scale can be illustrated with the following statement: "There are very few female alcoholics."

If you agreed completely with this statement, you would place a mark in column 7. If you agreed slightly with the statement, you would place a mark in column 5. If you mostly disagreed with the statement, you would place a mark in column 2. In this manner you can indicate the extent to which you agree or disagree with each of the statements in the following pages.

Like everyone else, you will probably feel that you do not know the answer to some of the statements. When this occurs, please make the best guess you can.
Please make your marks inside the agreement or disagreement boxes of the scales. Do it like this:

<table>
<thead>
<tr>
<th>Disagree</th>
<th>Agree</th>
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<tbody>
<tr>
<td>1 2 3 4 5 6 7</td>
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| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

1. A person who often drinks to the point of drunkenness is almost always an alcoholic. 

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

2. People who become alcoholics are usually lacking in will power.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

3. Most alcoholics have no desire to stop drinking.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

4. The average alcoholic is usually unemployed.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

5. A person can inherit a weakness for alcohol.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

6. The alcoholic is helpless to control the amount of alcohol he drinks.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

7. Alcoholics usually have severe emotional difficulties.

<p>| 1 | 2 | 3 | 4 | 5 | 6 | 7 |</p>
<table>
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<tr>
<th></th>
<th>Disagree</th>
<th>Agree</th>
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<tbody>
<tr>
<td>8. Alcoholism is best described as a habit rather than an illness.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>9. The alcoholic drinks excessively mainly because he enjoys drinking.</td>
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<tr>
<td>10. An alcoholic can get into as much trouble by drinking beer as by drinking liquor.</td>
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<tr>
<td>11. A person who frequently stays intoxicated for several days at a time is unquestionably an alcoholic.</td>
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<tr>
<td>12. The alcoholic is seldom helped by any sort of medical or psychological treatment.</td>
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<tr>
<td>13. The alcoholic has only himself to blame for his problems.</td>
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<tr>
<td>14. Alcoholics, on the average, have a poorer education than other people.</td>
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<tr>
<td>15. Alcoholics seldom harm anybody but themselves.</td>
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<tr>
<td>16. Hardly any alcoholics could drink less even if they wanted to.</td>
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<tr>
<td>17. The most sensible way to deal with alcoholics is to compel them to go somewhere for treatment.</td>
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<td>18. The alcoholic is a morally weak person.</td>
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<tr>
<td>19. An alcoholic's basic troubles were with him long before he had a problem with alcohol.</td>
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<tr>
<td>20. Once a person becomes an alcoholic, he can never learn to drink moderately again.</td>
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<tr>
<td>21. The harm done by alcoholics is generally overestimated.</td>
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<tr>
<td>22. Very few alcoholics come from families in which both parents were abstainers.</td>
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<tr>
<td>23. Even if an alcoholic has a sincere desire to stop drinking, he cannot possibly do so without help from others.</td>
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<td></td>
</tr>
<tr>
<td>24. Nobody who drinks is immune from alcoholism.</td>
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</table>
25. Even if a heavy drinker is able to stop drinking for several weeks at a time, he may still be an alcoholic.

26. Alcoholism is a sign of character weakness.

27. Alcoholism never comes about very suddenly.

28. Unhappy marriages and other unpleasant family situations often lead to alcoholism.

29. Alcoholism is not a disease.

30. Most alcoholics could not be rehabilitated even if more help were available for them.

31. Alcoholics are seldom found in important positions in business.

32. Preferring to drink alone rather than with friends is a sign of alcoholism.

33. Alcoholics are usually in good physical health.
34. The alcoholic is basically a spineless person who has found an easy way out of his problems.

35. Some people who drink heavily, but only on weekends, are alcoholics.

36. An alcoholic usually has something in his past which is driving him to drink.

37. Most alcoholics are completely unconcerned about their problem.

38. With proper treatment, some alcoholics can learn to take the occasional social drink without getting into trouble.

39. Most alcoholics are either drunk or drinking every day.

40. A person usually has very little warning before he becomes an alcoholic.
APPENDIX C

The Alcadd Test
THE ALCADD TEST

(Sample Questions)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>1. I drink only to join the fun.</td>
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<tr>
<td>2. I drink to get over my feelings of inferiority.</td>
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<td>3. I drink much more now than five years ago.</td>
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<td>4. I need the friendship I find in drinking places.</td>
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<td>5. After a few drinks, I swear easily.</td>
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<tr>
<td>6. I get high about once or twice a week.</td>
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<tr>
<td>7. I take a drink or two every day.</td>
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<td>8. My family thinks I drink too much.</td>
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<tr>
<td>9. People who never drink are dull company.</td>
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<tr>
<td>10. All people who drink get drunk at some time or another.</td>
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APPENDIX D

The Marlowe-Crowne Social Desirability Scale
The Marlowe Crowne Social Desirability Scale

Personal Reaction Inventory

Listed below are a number of statements concerning attitudes and traits. Read each item and decide whether the statement is true or false as it pertains to you personally.

1. Before voting I thoroughly investigate the qualifications of all the candidates. ( )

2. I never hesitate to go out of my way to help someone in trouble. ( )

3. It is sometimes hard for me to go on with my work if I am not encouraged. ( )

4. I have never intensely disliked anyone. ( )

5. On occasion I have had doubts about my ability to succeed in life. ( )

6. I sometimes feel resentful when I don't get my way. ( )

7. I am always careful about my manner of dress. ( )

8. My table manners at home are as good as when I eat out in a restaurant. ( )

9. If I could get into a movie without paying and be sure I was not seen I would probably do it. ( )

10. On a few occasions, I have given up doing something because I thought too little of my ability. ( )

11. I like to gossip at times. ( )

12. There have been times when I felt like rebelling against people in authority even though I knew they were right. ( )

13. No matter who I'm talking to, I'm always a good listener. ( )

14. I can remember "playing sick" to get out of something. ( )
15. There have been occasions when I took advantage of someone. ( )

16. I'm always willing to admit it when I make a mistake. ( )

17. I always try to practice what I preach. ( )

18. I don't find it particularly difficult to get along with loud-mouthed, obnoxious people. ( )

19. I sometimes try to get even rather than forgive and forget. ( )

20. When I don't know something I don't at all mind admitting it. ( )

21. I am always courteous, even to people who are disagreeable. ( )

22. At times I have really insisted on having things my own way. ( )

23. There have been occasions when I felt like smashing things. ( )

24. I would never think of letting someone else be punished for my wrongdoings. ( )

25. I never resent being asked to return a favor. ( )

26. I have never been irked when people expressed ideas very different from my own. ( )

27. I never make a long trip without checking the safety of my car. ( )

28. There have been times when I was quite jealous of the good fortune of others.

29. I have almost never felt the urge to tell someone off. ( )

30. I am sometimes irritated by people who ask favors of me. ( )
31. I have never felt that I was punished without cause. ( )

32. I sometimes think when people have a misfortune they only got what they deserved. ( )

33. I have never deliberately said something that hurt someone's feelings. ( )
APPENDIX E

Demographic Sheet
DEMOGRAPHIC DATA

Check the section of the answer sheet provided that corresponds to the answer that pertains to you.

1. Present Position:
   a. ___ Head Nurse               c. ___ Staff Nurse
   b. ___ Assistant Head Nurse     d. ___ Clinical Specialist

2. Type of Unit:
   a. ___ Medical-Surgical         c. ___ Alcoholism
   b. ___ Emergency Room           d. ___ Other

3. Basic Educational Preparation:
   a. ___ Diploma                  c. ___ Baccalaureate
   b. ___ Associate Degree

4. Highest Degree Held:
   a. ___ Diploma                  c. ___ Baccalaureate
   b. ___ Associate Degree         d. ___ Master's

5. Number of years of experience in nursing:
   a. ___ 0-1 years                d. ___ 4-5 years
   b. ___ 2-3 years                e. ___ greater than 5 years
   c. ___ 3-4 years

6. Present knowledge of alcoholism provided primarily by:
   a. ___ a separate course in the basic program
   b. ___ integration in all courses throughout basic program
   c. ___ post graduate course
d. ____ staff development or continuing education course

e. ____ personal experience

7. Your age group:
   a. ____ 20-25     d. ____ 36-40     g. ____ over 50
   b. ____ 26-30     e. ____ 41-45
   c. ____ 31-35     f. ____ 46-50

8. Your marital status:
   a. ____ never married     d. ____ remarried
   b. ____ married
   c. ____ divorced

9. Your religious orientation:
   a. ____ Protestant     d. ____ other
   b. ____ Roman Catholic
   c. ____ Jewish

10. In which of the following relationships have you known a
    person with an identified alcohol problem or one who has
    been diagnosed as an alcoholic?
    a. ____ friend     c. ____ relative
    b. ____ co-worker
    d. ____ immediate
       family

11. If your work assignment was changed so that you would be
    moved from your present position to one in which you worked
    exclusively with individuals having an alcohol problem or a
    diagnosis of alcoholism, would you:
    a. ____ be honestly interested, inquire about and antici-
       pate the assignment
b. ____ accept the assignment for the time being and look for another job

c. ____ accept the assignment and resent it

d. ____ refuse the assignment and quit if necessary

e. ____ say nothing but quit, giving another reason

12. In your area of practice would knowledge about alcoholism improve your skills?

a. ____ yes b. ____ no c. ____ not sure
APPENDIX F

Written Instructions to the Participants
Written Instructions to the Participants

(1) Please do not discuss the test or your answers with others so that other volunteers can come to the sessions with the same amount of information you had when you came.

(2) Place your code number on the letter to you, the participant, and keep the letter for your files in the event that you would like to ask further questions or that your code number is posted requesting you to provide answers you may have missed at a later session.

(3) If you have worked with a person in your past professional experience, place an X on the right-hand corner of your packet.

(4) If you have had or now have an alcohol problem or are a recovering alcoholic, would you please share this information with a short notation on the demographic sheet.

(5) There are no right or wrong answers on the instruments you are asked to complete. However, if you are not sure of which answer to mark, simply mark the answer which represents your first impression. Remember, if your contribution is to count, all questions need to be answered.

(6) If you have any suggestions about the test instruments or procedures used, please share them with the investigator following your return of the packet and consent form.

(7) The guide for completion of the Marcus questionnaire which is on page 1 of the questionnaire is reproduced below for your convenience:

<table>
<thead>
<tr>
<th>Disagree</th>
<th>Agree</th>
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<tbody>
<tr>
<td>1</td>
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<td>7</td>
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</tbody>
</table>
The points along the scale (1, 2, 3, ..... 7) can be interpreted as follows:

1. Completely disagree
2. Mostly disagree
3. Disagree more than agree
4. Neutral
5. Agree more than disagree
6. Mostly agree
7. Completely agree
APPENDIX G

Letter to the Participants in the Study
Dear Participant:

As a part of my doctoral studies in the Department of Education, Special Services at The Ohio State University, I am conducting a study of female Registered Nurses in the Columbus area. The purpose of the study is to describe currently existing attitudes of nurses toward alcoholism and the alcoholic. Further, an attempt will be made to explore personal factors which correlate with the attitudes identified. Some of the factors being investigated are educational program, primary source of knowledge about alcoholism, beliefs about alcohol use and area of nursing practice.

The success of this study in presenting an accurate and comprehensive picture of the attitudes of nurses depends, of course, on the willingness of the participants to respond promptly, honestly, and completely to the questionnaires upon which the study is based. Your assistance in this matter will be very greatly appreciated. Although you are requested to sign an informed consent, please be assured that your own anonymity and that of all other participants will be strictly maintained. In no instances will individual responses be identified. In fact, to avoid this possibility, you will sign the consent form separately and turn it in prior to responding to the instruments being used for data collection. You will note that this form does not have a number attached to it. The instruments and the large packet containing them have been marked with an identical number which appears in the upper right-hand corner. This assigned number is different for each participant and is being used for the convenience of data analysis only. Following the completion of the questionnaires, you may either seal the packet or fasten it securely prior to returning it to the investigator.
The enclosed questionnaires in your packet require only short responses and can be completed in less than 30 to 40 minutes. Written directions for completing these questionnaires accompany each of them and are self-explanatory.

Presently, nurses are faced in their personal and professional lives with an increasing number of persons who are social drinkers, problem drinkers, or, in some instances, alcoholics. Therefore, you may be interested in the findings of this study in terms of what meaning it has for you in both of your roles. At your request, I will be most happy to share these with you.

Very truly yours,

Jeanne M. Steele

JMS
APPENDIX H

Participants Consent
RESEARCH INVOLVING HUMAN SUBJECTS
CONSENT TO SERVE AS SUBJECTS IN RESEARCH

I consent to serve as a subject in the research investigation entitled: A Comparative Analysis of the Attitudes of Registered Nurses Toward Alcoholism and the Alcoholic.

The nature and general purpose of the research procedure have been explained to me. I understand that:

1. This research is to be performed under the direction of Dr. Herman Peters who is authorized to direct or use the services of others in the performance of research.

2. Some of the information requested in the research is of a probing and personal nature and I may prefer to refrain from providing this information. If this is the case, I will withdraw from participation without completing the data requested.

I understand that any further inquiries I make concerning this procedure will be answered. I understand my identity will not be revealed in any publication, document, recording, video tape, photograph, computer data storage, or in any other way which relates to this research. Finally, I understand that I am free to withdraw my consent and discontinue participation at any time following notification of the Project Director.

___________________________ Signed ______________________
Witness (Subject) _________________________
Date _________________________
___________________________ Time _________________________
Investigator