Medical-surgical, emergency, alcoholism rehabilitation : registered nurses attitudes towards alcoholism by Phyllis Beatrice Gillespie

A thesis submitted in partial fulfillment of the requirements for the degree of MASTER OF NURSING
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Abstract:
This study was designed to identify the attitudes of registered nurses toward alcoholism. Nurses are in a position to detect alcoholism and provide needed services for alcoholics. Because attitudes can be either an asset or a liability when working with alcoholic clients, nurses' attitudes need to be identified and nurses need to be aware of and acknowledge what attitudes are held. This study presented the first step by identifying what attitudes are held. Three specialty groups of nurses were selected for study because each group represented contact with alcoholic clients at a different phase of illness. The medical-surgical and emergency nurses sample groups were obtained from two general hospitals in Great Falls, Montana, while the alcoholism rehabilitation nurses sample group was obtained from the entire state of Montana. The Marcus Alcoholism Questionnaire (MAQ) concerning knowledge and attitudes about alcoholism was used in this study. The MAQ is a forty item tool from which nine factor scores are derived. Additional data were obtained on age, sex, religion, type of basic nursing program attended, length of time since graduation, and whether education on alcoholism was presented during the basic nursing program or obtained since the basic nursing program.

All three groups of nurses studied held positive attitudes at the time of this study; however, alcoholism rehabilitation nurses held significantly ($p<0.05$) more positive attitudes in six of the nine factor scores derived from the MAQ. When other personal variables were analyzed no significant ($p<0.05$) differences were found except in respondents who have had alcoholism education since the basic nursing program. In this group four of the nine factor scores of the MAQ were found significant ($p<0.05$). Recommendations for further study include exploring the reason for the difference in attitudes between nurses, whether more generalized positive attitudes can be fostered in nurses, and what common factors or traits exist in alcoholism rehabilitation nurses which may help in determining what types of individuals would work well with alcoholic clients.

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Date May 14, 1982

MEDICAL-SURGICAL, EMERGENCY, ALCOHOLISM REHABILITATION:

REGISTERED NURSES' ATTITUDES TOWARD ALCOHOLISM.

by

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A thesis submitted in partial fulfillment
of the requirements for the degree

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ABSTRACT

This study was designed to identify the attitudes of registered nurses toward alcoholism. Nurses are in a position to detect alcoholism and provide needed services for alcoholics. Because attitudes can be either an asset or a liability when working with alcoholic clients, nurses' attitudes need to be identified and nurses need to be aware of and acknowledge what attitudes are held. This study presented the first step by identifying what attitudes are held. Three specialty groups of nurses were selected for study because each group represented contact with alcoholic clients at a different phase of illness. The medical-surgical and emergency nurses sample groups were obtained from two general hospitals in Great Falls, Montana, while the alcoholism rehabilitation nurses sample group was obtained from the entire state of Montana. The Marcus Alcoholism Questionnaire (MAQ) concerning knowledge and attitudes about alcoholism was used in this study. The MAQ is a forty item tool from which nine factor scores are derived. Additional data were obtained on age, sex, religion, type of basic nursing program attended, length of time since graduation, and whether education on alcoholism was presented during the basic nursing program or obtained since the basic nursing program.

All three groups of nurses studied held positive attitudes at the time of this study; however, alcoholism rehabilitation nurses held significantly ($p<0.05$) more positive attitudes in six of the nine factor scores derived from the MAQ. When other personal variables were analyzed no significant ($p<0.05$) differences were found except in respondents who have had alcoholism education since the basic nursing program. In this group four of the nine factor scores of the MAQ were found significant ($p<0.05$). Recommendations for further study include exploring the reason for the difference in attitudes between nurses, whether more generalized positive attitudes can be fostered in nurses, and what common factors or traits exist in alcoholism rehabilitation nurses which may help in determining what types of individuals would work well with alcoholic clients.

Chapter 1

INTRODUCTION

The Problem

Alcoholism constitutes a major health problem and is characterized by significant physiological, psychological, and social dysfunction. Studies indicate that nurses have a direct concern with and for the alcoholic patient, and that nurses' attitudes directly affect the qualitative and quantitative aspects of the care given.

An estimated ten million Americans are alcoholics with the skid row alcoholics comprising only three percent (National Council on Alcoholism). If the alcoholic affects only four or five other people, then 40-50 million people are affected by alcoholism in the United States.

The National Council on Alcoholism estimates alcoholism costs the economy of the nation $32 billion per year in absenteeism, health and welfare services, property damage, and medical expenses. Durkin (1978) estimated the cost to the economy at $40 billion per year and includes the loss of human potential and human suffering of the alcoholic and individuals close to the alcoholic as factors for consideration. In addition to the economic considerations, violent behavior associated with alcohol abuse accounts for 64 percent of all homicides, 41 percent of assaults, 34 percent of rapes, 30 percent of

suicides, and 60 percent of child abuse.

Due to the number of patients with alcohol related problems in general hospitals, nurses are in a position to detect alcoholism and to provide needed services. An estimated 25-35 percent of medical and surgical patients in a general hospital have alcohol related problems (Knott, 1974); the percentage may rise to as high as 50 percent in a general hospital when psychiatric and medical admissions are considered (Heinemann and Estes, 1977). Studies indicate that patients are discharged without any treatment for alcoholism. One study stated that 80 percent of patients in a general hospital with alcohol related problems are discharged without having had any treatment for their alcoholism (Cote and Roche, 1978).

Studies, which will be discussed in more detail in the literature review, have indicated that nurses hold negative attitudes toward alcoholics (Cornish and Miller, 1976; Schmid and Schmid, 1973; Ferneau and Morton, 1968). The care that nurses provide alcoholics is affected by nurses' attitudes (Travelbee, 1971; Heinemann, 1974). The identified negative attitudes adversely affect the quality of care given by nurses; therefore, nurses need to identify and be concerned with attitudes.

Attitudes may be affected by the type of contacts nurses have with alcoholics. In this study, nurses in three specialty areas of nursing were investigated: emergency, medical-surgical, and

alcoholism rehabilitation. Each group represented contact with alcoholics during a different phase of illness. Emergency and medical-surgical nurses have contact with intoxicated patients while medical-surgical nurses have more contact with alcoholics with chronic medical conditions associated with alcohol abuse. Alcoholism rehabilitation nurses have long term contacts with recovering alcoholics both during and after treatment. Due to the estimated number of alcoholic patients that are cared for in a general hospital, emergency and medical-surgical nurses are assumed to have many contacts with alcoholics.

Statement of Purpose

What are the attitudes of registered nurses working in emergency rooms, medical-surgical units, and alcoholism rehabilitation toward alcoholism? Do the attitudes of registered nurses working in the aforementioned specialty areas differ from each other?

Definition of Terms

Alcoholism: Alcoholism is an illness characterized by significant impairment that is directly associated with persistent and excessive use of alcohol. Impairment may involve physiological, psychological or social dysfunction (American Medical Association, 1977).

Attitude: An attitude is a relatively enduring organization of

beliefs about an object or situation predisposing one to respond in some preferential manner (Rokeach, 1968).

Working In: Any registered nurse, full or part-time (at least 15 hours per week), who was employed at the time of the study in medical-surgical, emergency department, or alcoholic rehabilitation nursing and who has worked in the specialty area for at least six months.

Counselor: A registered nurse assisting others either individually or in groups to accept the illness of alcoholism and to obtain or maintain sobriety.

Medical-Surgical Nurse: A registered nurse employed at a general hospital working on a medical or surgical unit.

Emergency Department Nurse: A registered nurse employed at a general hospital working in an emergency department.

Alcoholism Rehabilitation Nurse: A registered nurse employed as a counselor in a rehabilitation program for alcoholics. This does not include nurses working on detoxification units. The counselor may have either short or long term contacts with alcoholics and may include counseling the recovering alcoholic.

Chapter 2

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

Since the purpose of this study is to investigate the attitudes of registered nurses toward alcoholics and alcoholism a basis in attitude theory, attitude development, deviance, and labelling theory had to be established. The literature review covered aspects of attitude development and theory, deviance, and labelling theory with respect to alcoholics and alcoholism, and was directed at people in the medical profession.

An attitude is an enduring characteristic that generally develops over time. Kendal (1978, pp. 27), a registered nurse who is the coordinator of Alcoholism and Drug Abuse Services at Mercy Hospital in New York, defined an attitude as ". . . a persistent disposition to act either positively or negatively toward a person, group, object, situation or value." According to Katz (1960, pp. 168), a professor of psychology and former president of the Society for the Psychological Study of Social Issues, an attitude is the "predisposition of the individual to evaluate some symbol or object or aspect of his world in a favorable or unfavorable manner." Most definitions have certain elements in common, which include a frame of reference an individual draws from when approaching or encountering objects, situations, or people. According to two psychologists, Proshansky and Seidenberg

(1965), an investigation of attitudes includes (1) the distinguishing properties of attitudes, (2) attitude development, and (3) what conditions will precipitate a change.

Attitudes consist of cognitive, affective (Katz, 1960), and behavioral components (Proshansky and Seidenberg, 1965). Each of these components can be further examined in terms of content and structure (Proshansky and Seidenberg, 1965).

The cognitive elements of attitudes concern beliefs or perceptions about an object (Katz, 1960; Proshansky and Seidenberg, 1965). One determines if something is good or bad, true or false. According to Rokeach (1968), a psychologist, the cognitive element also represents a person's knowledge.

The affective component of an attitude is a person's feelings toward the object. Feelings can be expressed in terms of being negative or positive (Proshansky and Seidenberg, 1965; Katz, 1960). The affective component is examined as to its intensity or strength (Rokeach, 1968; Katz, 1960). One may have a strong affective response towards an object but have little knowledge about that object.

The last component of an attitude is behavioral and consists of tendencies to react toward an object in a specific manner (Proshansky and Seidenberg, 1965). Rokeach (1968) stated that because an attitude is a predisposition to respond, it must lead to action. Katz (1960) did not deal with the behavioral component.

Attitudes are different from beliefs, opinions and values. Rokeach (1968) made a distinction between beliefs and attitudes. A belief consists of only cognitive components while an attitude contains cognitive, affective, and behavioral components. Beliefs are considered neutral whereas attitudes have a positive or negative component.

An opinion is easier to differentiate from an attitude than beliefs and values are. An attitude predisposes one to a certain behavior, but an opinion is the verbal expression of an attitude. Attitudes may also be expressed nonverbally (Katz, 1960).

Attitudes may be either part of a value system or independent. Katz (1960) made the distinction that when attitudes are organized into a hierarchical structure, then attitudes comprise a value system. Values and attitudes guide behavior.

Behavior and action cannot always be predicted by attitudes. While traveling in California with a Chinese husband and wife, LaPiere (1934) did a study on the relationship between behavior and action. During the actual trip, LaPiere found his companions were refused lodging once. Six months later, LaPiere wrote to each lodging and restaurant establishment encountered and asked if Chinese patrons would be accepted there. One-hundred-eighty-five letters were mailed and 128 were returned. In answer to the mailed letter, only one establishment said it would accept Chinese patrons. A question left

unanswered is whether respondents answered differently because of attitudes or in reality, were forced to behave in a specified manner by law and social pressures? The situational factors that may have occurred during the six month lapse of time must also be considered.

Proshansky and Seidenberg (1965) stated that the ability to predict someone's overt behavior depends on the type of attitude involved and the extent to which the behavioral component is developed. The complexity of the situation must also be taken into account. Even if one holds a certain attitude, situational factors may arouse competing attitudes that are stronger. Someone may detest the welfare system but when his very survival is in jeopardy, he may accept help.

Katz (1960) stated that attitudes serve four functions for the individual. The first is an adjustive function whereby people try to minimize consequences and to maximize rewards in their lives. If someone believes he will be punished for having a certain attitude, that attitude may be repressed or changed altogether. Ego defense is the second function and deals with the way people handle internal conflicts. The ego is protected from threatening forces and unacceptable impulses as the individual tries to decrease anxieties. Katz explained the third function as value expressive, concerning self identity and self image. Attitudes can give function to the individual that the person perceives himself to be. The fourth is the knowledge function in which people seek knowledge to satisfy certain

needs and to give meaning to their environment.

Attitude development is influenced by many factors including group affiliations and personal experience (Proshansky and Seidenberg, 1965). Groups which influence people's opinions and attitudes include cultural, religious, ethnic, family, and professional groups. Haberman and Sheinberg (1969), social scientists, found that Irish, Blacks, and Puerto Ricans are least likely to accept alcoholism on a sickness continuum, and Protestants and American born Jews are more accepting of alcoholism as a sickness. Families influence attitudes in that many individuals hold attitudes similar to their parents' attitudes. Once attitudes are firmly entrenched, they may be difficult to change (Kendal, 1978). Groups influence attitudes by peer pressure; pressure corresponds to the adjustive function of which Katz spoke. People want to be part of a group and obtain the rewards that go with group affiliations. Religious beliefs are complex and usually form a value system. Attitudes in the religious sense, are not usually isolated. Therefore, if one holds certain attitudes about religion, others can be predicted. These organized attitudes form a value system (Proshansky and Seidenberg, 1965).

People belong to many different groups which have conflicting attitudes. A political group may view welfare as acceptable, yet because of cultural affiliation, an individual may view welfare as unacceptable. The degree of influence which groups have on an

individual depends on the degree to which each individual identifies with the group (Kendal, 1978).

Another large area of influence on attitudes concerns personal experience. People are affected by what transpires on a personal level, including negative and positive experiences. Because attitudes affect behavior health professionals need to be concerned with their attitudes toward alcoholism.

Alcoholism is termed a deviant form of behavior in American society and can be viewed from both group and personal perspectives. The group perspective comes into play when group norms are violated. Group pressure is a means of social control. Control may be on the formal, legal level or on the informal level. Informal control involves social avoidance and gossip. According to Lindesmith and Strauss (1968), professors of Sociology, deviant behavior on a personalized level violates internalized norms and is controlled by internal mechanisms such as conscience, feeling guilty.

Deviants are stigmatized because of their actions (Lindesmith and Strauss, 1969). According to Carlson and Blackwell (1970), who are registered nurses, social worth is discredited when individuals are seen as being stigmatized. Nurses react to stigmatized people much as the general public does and use avoidance, regarding the discredited person as worthless (Carlson and Blackwell, 1970). American society places a stigma on alcoholics. The result is the development of

judgmental and moralistic attitudes. While some people display pity and sympathy in response to deviant behavior others are repelled and hostile (Kendal, 1978).

Labelling theory argues that labels encourage the very behavior labelled. According to Robins (1975), a psychologist, labelled people will often act thereafter according to the label. If this is true, the alcoholic would drink more once labelled. Opinions vary whether labelling increases drinking, but studies have not been done to support the concept.

Drinking is accepted in American society, and whether or not someone is labelled an alcoholic relates to a qualitative rather than quantitative difference. The degree to which alcohol intake interferes with performance would be a qualitative difference (Robins, 1975).

Drinking is considered a private matter by most Americans. However, as soon as people are viewed as alcoholics, their drinking is regarded differently. Excessive drinking is differentially regarded depending on whether or not an individual gets in trouble with the law, family, or does not perform well at work. The stereotypical alcoholic is the skid row alcoholic, someone who is weak willed, immoral, perverted, and irresponsible. Alcoholism is seen as a voluntary indulgence by many people (Kendal, 1978).

Kendal (1978) believed people are reluctant to label alcoholics because of the attached social stigma. In a study by Marilyn Johnson, R.N., (1965), 71 nurses were interviewed concerning identifying special problems in the care of alcoholic patients. Two nurses stated physicians avoid making the diagnosis of alcoholism. The question was raised whether the diagnosis was hidden or denied. In either case, if alcoholism is not recognized as an illness, patients are denied professional help.

Labelling theory argues that once labelled, the label remains even if the behavior is changed (Robins, 1975). Dr. Globetti (1974), a professor of Sociology, found support for labelling theory in two rural southern communities which were studied concerning people's attitudes toward recovered alcoholics. A random sample of 327 household heads and homemakers was interviewed. Of the sample, 25 percent said they were unwilling to associate with recovered alcoholics under any circumstances, 40 percent were unwilling to room with them on a business trip, 55 percent said they would discourage a child from marrying one, and 63 percent could not see themselves falling in love with an alcoholic. A stereotypic picture of alcoholics existed in the minds of the sample population. Alcoholism was considered deviant behavior and labelled accordingly.

A study by Cornish and Miller (1976) further substantiated the concept of labelling alcoholics. Cornish (Ph.D. in Counseling

Psychology) and Miller (B.A. in Sociology and Coordinator of Alcoholism Services at the facility studied) randomly selected 60 registered nurses working in a large Veterans Administration hospital in the Midwest and randomly assigned them to two groups. An adjective checklist was used to measure attitudes. One group received a patient profile which indicated the patient was alcoholic. The second group received the same patient profile but indicated there was no alcohol problem. A total of 31 questionnaires were returned, 17 from the first group (no alcohol information) and 14 from the second (alcohol information). Registered nurses viewed the alcoholic patient in a more unfavorable manner than the nonalcoholic patient. The group with "alcohol information" used more unfavorable adjectives in describing the patient, demonstrating that alcoholics were labelled and that a stereotypical alcoholic profile existed. Unfavorable adjectives listed included less self confident, less orderly, less self controlled, less well adjusted, and more labile, passive, and aggressive.

Wallston, Wallston, and DeVellis (1976) also found alcoholics were unfavorably labelled in their study. Forty registered nurses working in an adult medical-surgical unit were asked to respond to a taped case history. The patient was presented with a bleeding stress ulcer. One group listened to the tape, but the only alcohol information given was that the patient had a drink before dinner.

Group two listened to the same tape, but the patient was labelled alcoholic. A third group, the control, responded to an alcoholic patient with the same medical condition; no tape was presented. An 18 item, semantic differential, bipolar adjective checklist was used to measure attitudes. The nurses reacted to the patient labelled an alcoholic with more unfavorable adjectives. Findings were consistent in the control group. It was noted that the nurses reacted to the alcoholic profile in a more neutral way but more negatively than when the patient was not labelled. None of the nurses used the extreme negative end of the scale. The study indicated that nurses stigmatize and label alcoholics.

These studies provided evidence that alcoholics were negatively labelled. Labelling and stereotyping were demonstrated to affect attitudes. Therefore, nurses' negative attitudes would adversely affect the care patients received.

Nurses demonstrated conflicting attitudes about drinking and alcoholism and this ambivalence affected their ability to provide effective services to alcoholics (Kendal, 1978; Heinemann, 1974) and resulted in unpredictable behaviors. Despite education and the emerging perception that alcoholism is an illness, studies demonstrated that society and the medical profession in particular had negative attitudes toward alcoholics (Kendal, 1978; Haberman and Sheinberg, 1969; Fisher, Keeler, Mason, and Fisher, 1975; Ferneau and

Morton, 1968). The conclusion based on the findings of the preceding studies was that the concept of alcoholism as an illness had not been widely accepted.

Haberman and Sheinberg (1969) surveyed a group of the general population in New York City concerning opinions about alcoholism. A random sample of 2,118 people over 20 years of age was selected. One finding of the study was that 64 percent of the sample rated alcoholism as an illness. However, only 47 percent agreed with the concept of alcoholism as an illness and the "spree drinker" as being ill. Haberman and Sheinberg described the 64 percent of the sample as giving "lip service" to the concept of alcoholism as an illness and thereby demonstrated inconsistencies in the ways people viewed alcoholics.

Fisher et al. (1975) studied 35 family practice physicians in a residency training program in a southeastern medical school. The study, conducted over a three year period, found alcoholics were rated as weaker, sicker, more aimless, and more hopeless than the average person. Fisher's study used an adjective semantic differential checklist for attitude measurement. Doctors who rated alcoholism as a disease and doctors who rated it as a behavior disorder did not have significant differences in attitudes. Thus, Fisher's study demonstrated the existence of ambivalent attitudes among health professionals.

Ferneau and Morton (1968) examined the attitudes of nurses and nursing assistants towards alcoholism in a neuropsychiatric hospital. Thirty-one registered nurses, 74 nursing assistants, and 200 randomly selected individuals of the general public comprised the sample group. The Marcus Alcoholism Questionnaire was used to study attitudes toward alcoholism. Ferneau and Morton found nurses subscribed to the concept that alcoholism was an illness but both nurses and nursing assistants perceived alcoholics as more weak-willed than the general public sample group. The nurses held a stronger belief in the illness concept, but they also believed alcoholics could control their drinking. These attitudes support the concept of ambivalence in attitudes of health professionals toward alcoholics. Health care professionals had not accepted the concept of alcoholism as an illness.

Besides substantiating the belief that health care professionals as well as the general public had ambivalent attitudes toward alcoholics and had not internalized the concept of alcoholism as an illness, studies verified that individuals had negative attitudes toward alcoholics. Additional studies not only verified the existence of negative attitudes but also examined what happens to attitudes after presenting a course on alcoholism and/or experience with alcoholics (Schmid and Schmid, 1973; Harlow and Goby, 1980; Chappel, Jordan, Treadway, and Miller, 1977; Distefano, Craig, Henderson, and

Pryer, 1975; Powell, Mueller, and Schwerdtfeger, 1974; Ferneau, 1967).

Schmid and Schmid (1973) studied the attitudes of 41 freshman nursing students and found nursing students were less accepting of the alcoholic than the physically disabled person. The study was reconducted with the same individuals two and one-half years later. No significant difference was found when comparing the two scores. Therefore, after two and one-half years of nursing education, attitudes remained less accepting of alcoholics.

Harlow and Goby (1980) examined the effects of alcoholism education on attitudes. They studied two groups of nursing students. The experimental group included 35 nursing students who participated in a three week alcoholism program including experience with alcoholic patients. The control group comprised 20 nursing students in a diploma nursing school. The Marcus Questionnaire was used to examine attitudes. No difference was found in attitudes following the pre-test. However, there was a significant difference in attitudes following the post-test. The alcoholism education group held significantly improved (more positive) attitudes. The theory content of classes and the type and amount of contact with alcoholics was not mentioned. More research needs to be done on what specific kinds of intervention affects an attitude change.

Other studies which support the need for alcohol education include Chappel et al. (1977), Distefano et al. (1975), and Powell et

al. (1974), who examined the affects alcoholism education and/or the effect of experience on attitudes. All found more positive attitudes after some intervention was provided.

Ferneau's (1967) results differed slightly from the other studies presented. Twenty-nine nursing students assigned to a 12 week psychiatric affiliation, were selected as subjects. The Marcus Questionnaire was administered as a pre-test and post-test. The study demonstrated positive and neutral attitudes in the pre-test. As other studies have shown, attitudes were more positive after the psychiatric affiliation. The amount and type of contact students had with alcoholic clients was not described.

Negative attitudes are often expressed through facial expressions and body language (expressions of hostility, anger, disgust, passing judgment, and humor). Nurses, as professionals, must examine personal attitudes toward alcohol, alcoholism and the alcoholic patient if the therapeutic nurse-patient relationship is to exist (Kendal, 1978). Nurses are hampered by their own feelings when caring for alcoholic patients (Johnson, 1965; Kendal, 1978). When health professionals, who are knowledgeable and skilled care givers, view alcoholics negatively, alcoholics are conscious of disapproval, and feelings of worthlessness are reinforced (Kendal, 1978). Since alcoholism is considered a medical and psychiatric emergency, negativism or rejection by the professional can interfere with recovery during

withdrawal (Starkey, 1981).

Tamerin and Neuman (1974) demonstrated that alcoholics did not merit the negative attitudes that were associated with them. Several hundred alcoholics from all over the country were interviewed during psychiatric evaluation and treatment. The results indicated that the sober alcoholic was sensitive, cautious, a hard worker, careful, and over-controlled. Tamerin and Neuman believed it was time to reevaluate the stereotyping that had occurred. Another belief was that seeing the alcoholic as irresponsible, unmotivated, and immature affects the therapeutic relationship. Supportive data on the effects of stereotyping on therapeutic relationships were not documented.

Studies have been done concerning professionals working with alcoholic patients. Mogar, Hilm, Snedeker, Snedeker, and Wilson (1969), and Berger-Gross and Lisman (1979) demonstrated that individuals who worked with alcoholics in alcoholism rehabilitation programs showed more positive attitudes towards alcoholics.

Berger-Gross and Lisman (1979) studied two groups of nurses. One group worked in a state hospital providing long-term treatment. The second group worked in a "sobering-up" station. Individuals who worked in a "sobering-up" station showed less tolerant attitudes than individuals who worked in the state hospital. It could be hypothesized that nurses working in detoxification units had less tolerant or more negative attitudes.

Morgar et al. (1969) studied a group of professionals and non-professionals working with alcoholic patients. The two groups received scores on an optimism-pessimism scale and a moralism-disease scale. Professionals were defined as psychiatrists, psychologists, social workers, and nurses. The non-professional group were technicians, nursing service workers, and secretaries. The staff working with alcoholics were less pessimistic and more inclined to accept alcoholism as a disease than the staff who were not working with the alcoholics. A further finding was that professional staff not working with alcoholics were more moralistic and pessimistic than professional staff working with alcoholics. No statistical data were presented to support the statement that professionals not working with alcoholics were moralistic and pessimistic. Research needs to be done indicating comparisons of attitudes between professionals working with alcoholic patients/clients.

A study conducted by Sowa and Cutter (1974) did not substantiate the previous two findings. The study dealt with attitudes of high status staff (psychiatrists) and low status (clerical and housekeeping) staff who worked with both alcoholics and drug addicts. Although the alcoholic was viewed more favorably than the drug addict, the psychiatrists had less favorable attitudes towards either group than the low status group. The study was conducted at the Washington Center for Addiction. The sample consisted of 85 subjects

representing 80 percent of the facility's staff.

Studies conducted by Knott (1974) and Heinemann and Estes (1977) demonstrated that 25 to 50 percent of the general hospital patient population had alcohol related problems. Nurses in many specialties have contact with alcoholic clients. Studies dealing with attitudes of personnel directly associated with facilities for alcoholism detoxification and rehabilitation have been done but results were conflicting. Studies were conducted to determine the attitudes of nursing students and if attitudes could be changed. Few studies were conducted dealing with attitudes of nurses in general hospitals. Since statistics indicated that all nurses encounter and interact with alcoholic clients, more research should be conducted concerning attitudes of nurses in general hospitals.

Studies indicated conflicting results concerning the attitudes of professionals who worked closely with alcoholics. This study was conducted in an effort to resolve some of the conflict about professionals, particularly professional nurses' attitudes toward alcoholism and alcoholics.

Conceptual Framework

The conceptual framework was derived from attitude theory and development, deviance, and labelling theory. The review of literature demonstrated that a variety of factors affect attitude development

(Figure 1). These factors which affect attitude development include the influence of family, peers and society, personal experience, religious preference, and cultural affiliations.

Nurses' attitudes toward alcoholics are important to consider since nurses are in a position to assist or hinder the recovery of alcoholics. Studies by Cornish and Miller (1976) and Wallston et al. (1976) demonstrated that nurses reacted more negatively to patients labelled as alcoholics. Associated with labelling and stigmatizing was the concept that alcoholism was considered a deviant form of behavior. Tamerin and Neuman (1974) demonstrated that alcoholics do not warrant the labelling and stigmatizing. Attitudes can be either an asset or a liability when working with alcoholic clients and in developing therapeutic relationships (Heinemann, 1974).

Labelling theory stated that labels encouraged the very behavior labelled; and that once labelled, the label remained even if the behavior was changed. Based on labelling theory the associated attitudes and stigmatization by nurses affected alcoholic clients and drove them to drink more. Therefore, research needs to be conducted to determine current attitudes toward alcoholics.

Figure 1 is an illustration showing the relationships of concepts which figure in the affect of attitudes on alcoholics. The left hand side of the diagram shows the factors which contribute to attitude

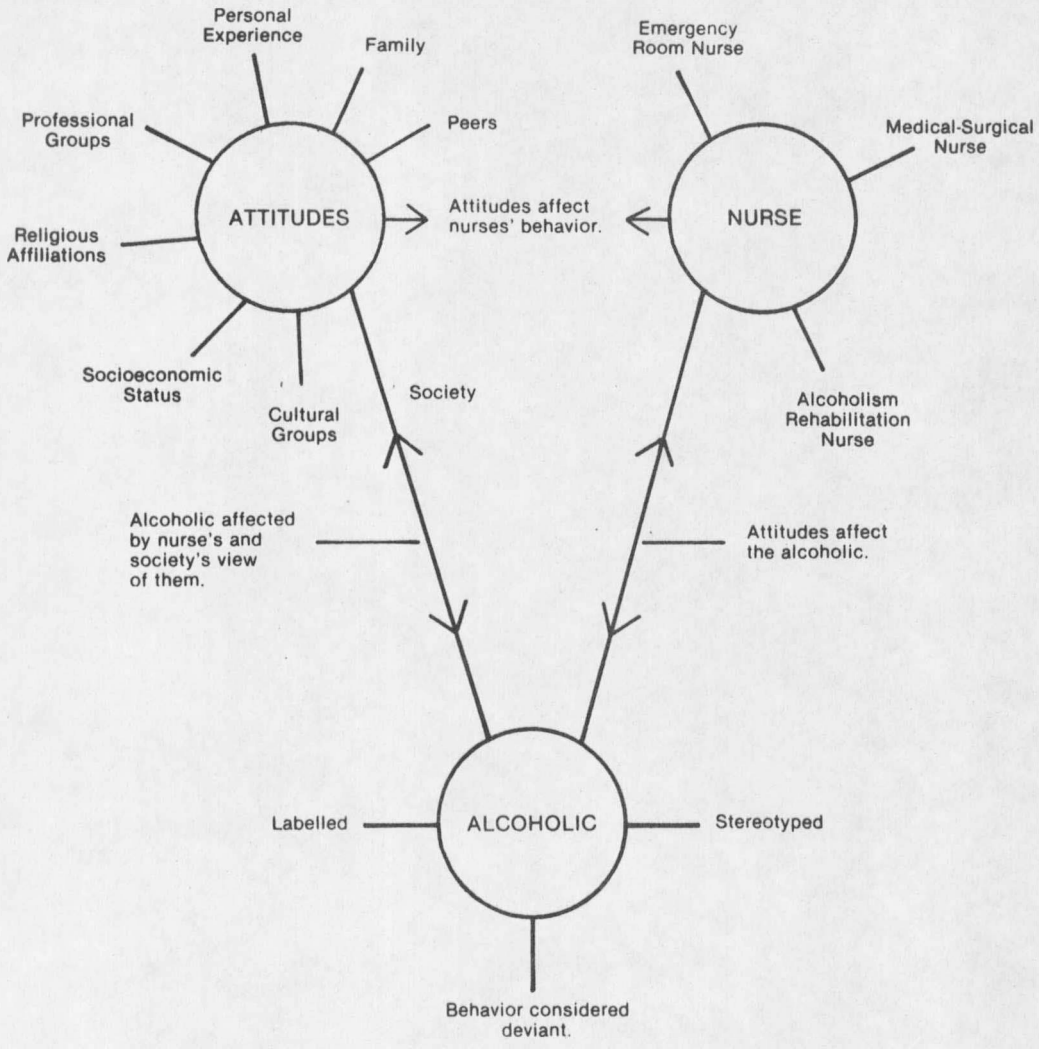

Figure 1. Conceptual Framework Diagram.

formation and results in the configuration of relatively enduring attitudes of an individual. Attitudes affect the behavior of nurses and other people. Alcoholics are aware of negative attitudes held by others (family, friends, co-workers, and society in general) in relation to alcoholism and toward them if they have been labelled alcoholics. Alcoholics are stereotyped, labelled deviant, and suffer from the effects of those attitudes by being stigmatized. Nurses and other professionals are likely to share common social attitudes toward alcoholism and alcoholics. The lines drawn between the circles representing attitudes, nurses, and alcoholics represent the interaction between individuals in relation to pervasive social attitudes.

The formation of negative attitudes, labelling of deviance, stereotyping, and stigmatization form a cycle of behavior which may lead to mistreatment of alcoholic patients. It is important to identify nurses' attitudes toward alcoholics since they figure prominently in the care of many alcoholic individuals who are encountered in all of the medical and health care systems.

This study investigated attitudes of three groups of nurses toward alcoholism. The groups included nurses working in medical-surgical departments, emergency departments, and in alcoholism rehabilitation facilities at the time of the study. The study attempted to determine what attitudes were held in relation to

alcoholism and if attitudes differed between groups.

Chapter 3

METHODOLOGY

Introduction

This study examined attitudes toward alcoholism in three specialty areas of nursing. Specialties investigated were emergency departments, medical-surgical units, and alcoholism rehabilitation units. Each group of nurses worked with alcoholic clients in a different phase of alcohol abuse. The emergency department nurse encountered acute alcoholism or people who were intoxicated. Medical-surgical nurses had some contact with alcoholics in the acute stage of alcoholism but usually worked with alcoholics who had chronic illnesses associated with the disease. The nurse who worked in alcoholism rehabilitation encountered alcoholics on a continual basis and during follow-up care. Attitudes of nurses who worked in the three specialty areas were elicited and compared in the following chapters.

Population

The three groups of nurses investigated were:

1. Registered nurses who worked in emergency departments at the time of the study;
2. Registered nurses who worked in medical-surgical departments at the time of the study; and

3. Registered nurses who worked in alcoholic rehabilitation facilities in Montana at the time of the study.

Sample

The sample population consisted totally of registered nurses. Mailed questionnaires were sent to the total accessible populations of nurses who worked in medical, surgical, and emergency departments in two hospitals located in Great Falls, Montana, and nurses who worked at alcoholism rehabilitation facilities in Montana. A list of all registered nurses in emergency, medical, and surgical departments was obtained from the nursing administration of two hospitals after each hospital reviewed the study proposed and granted permission to use the facility. From the list, names were deleted if registered nurses had not worked a minimum of six months in the specialty area or, if part time, worked less than sixteen hours per week. Questionnaires were mailed to the home addresses of the remaining registered nurses on the list.

A list of all alcoholism provider services in Montana was obtained from the Training and Certification Bureau of the Alcohol and Drug Abuse Division in Montana. Telephone calls were made to facilities to determine if registered nurses were employed by the facility, if they were involved with counseling alcoholic clients, and how many registered nurses in the facility met the above criteria.

Registered nurses who worked with alcoholic clients only during detoxification were not included. Telephone calls also served to establish a contact person at each facility. Sufficient questionnaires were mailed to each contact person with instructions to deliver the questionnaires to the registered nurses meeting the specified criteria (Appendices A, B, C, D, and E).

One mailing was used for all respondents. A second mailing would have necessitated sending all respondents a second questionnaire, doubled the cost, and possibly led to duplication of some responses.

Sample Size

Due to the small number of registered nurses working in emergency and alcoholism services in the facilities used for the study, questionnaires were mailed to the total accessible population. The following indicates the numbers of mailed questionnaires sent:

1. 66 to medical-surgical nurses;
2. 25 to alcoholism rehabilitation facility nurses;
3. 24 to emergency department nurses.

Three questionnaires from the medical-surgical nurses were returned due to incorrect or incomplete addresses. Since the medical-surgical nurses comprised the largest group, no attempt was made to remail the questionnaires.

Protection of Human Rights

There are three factors to be considered when dealing with ethical issues in research: (1) "involuntary participation, (2) freedom from physical or psychological harm and stress, and (3) anonymity or confidentiality" (Polit and Hungler, 1978). Protection of human rights was assured in the cover letter to registered nurses (Appendix F). Individuals were assured of anonymity, and participation was voluntary. It was considered unlikely that any physical or psychological harm might result from participation.

Instrument

Selection of Data Acquisition Format

As indicated previously a mailed questionnaire was utilized. Advantages of using a mailed questionnaire were less cost both monetarily and in time, the possibility of assuring complete anonymity, and minimum chance of bias. Disadvantages included low response rates, unanswered questions, misunderstood directions, incomplete responses with no method for clarification, and lack of assurance that the respondent was the intended participant (Polit and Hungler, 1978).

Tool Description

The tool used was the Marcus Alcoholism Questionnaire (Appendix G) developed by Dr. Alan Marcus, a psychologist. Letters of request

to use the questionnaire and response to that letter are included in Appendix H and I, respectively.

The tool was developed to measure knowledge and attitudes concerning alcoholism. The questionnaire, consisting of 40 items, was the outcome of a factor analytic study. The questionnaire took approximately 20 minutes to complete. Each item was rated on a scale of one to seven, with the following being an interpretation of each point on the scale:

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 scoring of the Marcus Alcoholism Questionnaire (MAQ) yields nine mean factor scores (Appendix J). Each factor indicates a particular attitude and/or knowledge base concerning alcoholism and is defined as follows:

1. Factor one is concerned with emotional difficulties or psychological problems as being important contributing factors in the development of alcoholism. A high score indicates agreement.

2. Factor two is concerned with the belief that the alcoholic is unable to control his/her drinking behavior. A high score means agreement with the concept.
3. Factor three is associated with the belief that most alcoholics do not want to and cannot be helped to recover from alcoholism. A high score indicates agreement.
4. Factor four is concerned with the alcoholic as a steady drinker. A high score indicates the belief that periodic excessive drinkers can be alcoholics and a low score indicates the belief that a person must be a continual excessive drinker to be classified an alcoholic.
5. Factor five is associated with alcoholism and character defects. A high score indicates the belief that the alcoholic is a weak-willed person.
6. Factor six addresses the social status of alcoholics. A high score indicates the belief that alcoholics come from the lower socio-economic strata of society.
7. Factor seven is concerned with the concept that alcoholism is an illness, with a low score indicating belief in the concept.
8. Factor eight is concerned with alcoholism as being a harmless voluntary indulgence. A high score indicates acceptance of the concept.

9. Factor nine addresses the idea that alcohol is an addicting substance. A high score indicates agreement.

A high score on factor one, two, four, and nine represents a positive attitude. A low score on factors three, five, six, seven, and eight represents a positive attitude.

Demographic Data

Demographic data (Appendix K) were obtained on the following: age, sex, religion, type of basic nursing education, highest degree held, and the year of graduation from the basic nursing program. Additional information was obtained regarding alcoholism education during the basic nursing program and education obtained beyond the basic nursing program. Respondents were also asked if they had outside work relationships with significant others who have a drinking problem. If relationships existed the respondents were asked to rate up to four of the relationships as either good or poor. No limitations were listed as to which four relationships were rated nor was the term significant other defined.

Reliability and Validity of Tool

The Marcus Alcoholism Questionnaire has established reliability and validity. Gurel, a psychologist from the University of Washington, established reliability of the instrument by the test, retest method. Factor analysis was used to demonstrate validity.

Methods of Data Analysis

The study was descriptive in nature; no assumptions were made regarding outcomes. Each factor of the MAQ was represented by four questions from the total questionnaire. Mean factor scores for individuals were obtained by taking the sum of scores on the four items defined by each factor and dividing by four. Group mean factor scores were the average of the factor scores obtained by all individuals in that group. Four questions were not included in the factor analysis. The four questions were not consistently used by Marcus when administering the questionnaire and therefore were not used during data analysis. Individual and group mean factor scores were then compared to determine the existence of positive or negative attitudes. The Mann Whitney U Test and the Kruskal-Wallis One Factor Analysis of Variance by Ranks were used when comparing mean factor scores between groups to determine if there were significant differences.

Mann-Whitney U Test. The Mann-Whitney U test determines the probability that two independent samples are drawn from the same population and is a useful measurement for research which is at least ordinal and weaker than interval data (Siegel, 1956). In particular, the test evaluates if the summed ranks of one group were significantly higher than those of another group (Kviz and Knafl, 1980).

When using the Mann-Whitney U Test, n_1 equals the number of cases

in the larger group. The scores of two groups were combined and ranked in order of increasing size retaining score identity with respect to group. Ties in ranking were assigned the average rank value. In calculating U when n_2 was greater than 20 the sampling distribution of U rapidly approached the normal distribution. When the sampling distribution approached normal, the significance of an observed value of U was calculated and a z approximation was used.

Standard z tables were used to determine significance levels (Siegel, 1956). For the purpose of this study a significance level (p) of five percent was used (α=0.05). Ties in ranking occurred in this study. A correction value for standard deviation was used when ties occurred between groups, and was incorporated in the computer program used in data analysis.

The Mann-Whitney U Test was compared with the parametric t test; the power efficiency approached $3/\pi$=95.50 percent. Therefore, the Mann-Whitney U Test is an excellent statistical test for use with nonparametric data in which assumptions cannot be made (Siegel, 1956).

Kruskal-Wallis One Factor Analysis of Variance by Ranks. The Kruskal-Wallis test, a nonparametric statistical test, is useful when testing to find if two or more independent samples are drawn from different populations. The technique tests the null hypothesis that independent samples come from the same population with respect to means. Compared with the F test, the power efficiency is $3/\pi$ or 95.50

percent.

When computing the Kruskal-Wallis, all observations were replaced by rank with the smallest rank being one and the largest being N. The sum of the ranks of each sample was found and results determined if samples were drawn from the same population.

If the independent samples were from the same population, then H (the statistic used in the Kruskal-Wallis test) was distributed as chi square with df = k-1. When ties occurred, each score was given the mean of the ranks tied. Since the value of H was influenced by ties a correction was used in computing H (Siegel, 1956).

When H was computed, a standard table of critical values of chi square was used to reject or accept the null hypothesis. For the purpose of this study a five percent level of significance (α=0.05) was used. The Kruskal-Wallis One Factor Analysis of Variance by Ranks was used when comparing two or more groups to determine if they came from the same population.

Chapter 4

PRESENTATION OF DATA ANALYSIS

Introduction

The results of this study were analyzed in three steps. The demographic data were utilized to describe the total sample population. The second step was to determine individual and group mean factor scores and to describe the attitudes held. The third step used the Mann Whitney U Test and the Kruskal-Wallis One Factor Analysis of Variance by Ranks to determine significant differences between individuals and groups. The sample was discussed in several groupings: (1) the total sample; (2) emergency department nurses; (3) medical-surgical nurses; and (4) alcoholic rehabilitation nurses.

Demographic Data

One-hundred-fifteen questionnaires were mailed to registered nurses. Three questionnaires were returned from the grouping of medical-surgical nurses for incomplete or inaccurate addresses. Of the remaining 112 questionnaires, 64 (57.14 percent) were returned. Twenty-four questionnaires went to alcoholic rehabilitation nurses, 25 went to emergency department nurses, and 63 went to medical-surgical department nurses.

Of the total questionnaires returned, two (one medical-surgical and one rehabilitation) were not used because respondents did not meet

the requirements of working in the specialty area for at least six months or of working at least sixteen hours per week. Table 1 represents the original and corrected questionnaire response rate. The return rates are as follows: (1) emergency nurses returned eleven questionnaires; (2) medical-surgical nurses returned 31 usable questionnaires; and (3) alcoholism rehabilitation nurses returned 20 usable questionnaires.

Table 1. Response Rate of Mailed Questionnaires.

Sample Groups	Number Mailed	Number Returned	Percent Returned
Emergency Department Registered Nurses	25	11	44.00
Medical-Surgical Department Registered Nurses	63	32/31*	50.79/49.21*
Alcoholism Rehabilitation Unit Registered Nurses	24	21/20*	87.80/83.33*
Total	112	64/62*	57.14/55.36*

*Corrected Usable Responses

Of the 62 returned questionnaires, 59 (95.16 percent) were female and three (4.84 percent) were male. The mean age of nurses who responded was 37.19 years with a range of 20-64 years. The mean ages of emergency, medical-surgical, and alcoholism rehabilitation nurses

were 38.45, 34.12, and 40.00, respectively.

Respondents were asked to specify the length of time elapsed since completion of the basic nursing program. The range was 1-43 years with a mean of 13.65 years. When the total sample was compared according to specialty unit, the mean was 14.55 years for emergency department nurses, 10.77 years for medical-surgical nurses, and 17.60 years for alcoholism rehabilitation nurses.

The religion of respondents was recorded (Table 2). Respondents marking catholic and protestant comprised the largest percent of responses with 43.55 and 46.78, respectively. One respondent marked religion as both catholic and protestant; that answer was categorized as no response.

Table 2. Religious Preferences of Total Sample.

Religion	Number	Percent of Total Return
Protestant	27	43.55
Catholic	29	46.78
Mormon	1	1.61
None	3	4.84
Other	1	1.61
No Response	1	1.61
Total	62	100.00

Respondents were asked to indicate the type of basic nursing education they had attended. Fifty percent (31) of the respondents had attended a diploma program, 33.87 percent (21) a baccalaureate

program, and 16.13 (10) percent an associate degree program (Table 3). From the total sample only three (4.84 percent) had completed any further formal education.

Table 3. Basic Nursing Education of Total Sample.

Basic Nursing Education	Number	Percent
Associate Degree	10	16.13
Diploma	31	50.00
Baccalaureate Degree	21	33.87
Total	62	100.00

Respondents were asked if their basic nursing program included information on alcoholism. Thirty-five (56.45 percent) answered "yes" and 26 (41.94 percent) answered "no." Comments in response to the open ended question to describe the type of alcoholism education varied from "It was mentioned . . ." to "It was adequately covered . . . ."

A majority (53.23 percent) of respondents had received additional education in alcoholism beyond the basic nursing program. Some respondents stated they attended a workshop, one respondent stated that she had 91 college credits while others did not specify courses or credit. The majority of respondents (72.56 percent) did not specify the amount of education.

The majority (95.00 percent) of respondents in the alcoholism

rehabilitation group obtained education in alcoholism beyond the basic nursing program. In the medical-surgical group 29.03 percent reported education beyond the basic nursing program while 45.50 percent of the emergency department nurses received additional education. This study demonstrated that nurses attending alcoholism education offerings were predominantly alcoholism rehabilitation nurses (Table 4).

Table 4. Respondents Having Alcoholism Education Beyond the Basic Nursing Program According to Specialty Area.

Specialty Area	Number	Percent
Emergency Department Registered Nurses	5/11	45.50
Medical-Surgical Department Registered Nurses	9/31	29.03
Alcoholism Rehabilitation Unit Registered Nurses	19/20	95.00

Respondents were asked if they had outside work associations with significant others who have a drinking problem. From the total sample, 44 (70.97 percent) stated that they had one or more such relationships, 17 (27.42 percent) said that they did not, and one did not reply. Of those respondents who stated yes, 27 (61.36 percent) rated all relationships as good while 17 (62.96 percent) rated at least one relationship as poor.

The demographic data from the respondents gave information

concerning specialty area, age, sex, religion, basic type of education, number of years since basic education, alcoholism education in the basic nursing program and beyond, and outside work associations with individuals who have a drinking problem. The remainder of this chapter deals with demographic data in relation to the factor analysis of the MAQ.

Factor Analysis of Marcus Alcoholism Questionnaire

The MAQ is a 40 item questionnaire from which nine mean factor scores were derived for each individual. Mean factor scores were computed for each specialty area in which nurses worked (emergency, medical-surgical, or alcoholism rehabilitation services). Mean factor scores were derived by taking the sum of scores on the four items defined by each factor and dividing by four. Group mean factor scores were the average of the factor scores obtained by all individuals in that group. Mean factor scores per specialty area are listed in Appendix L and a graphic comparison of the scores are presented in Figure 2.

According to Marcus a high score for factor one indicates a positive attitude. Factor one is concerned with emotional difficulties or psychological problems being a contributing factor in the development of alcoholism. Medical-surgical and emergency nurses showed mean scores of 5.27 and 4.86, respectively. The alcoholism

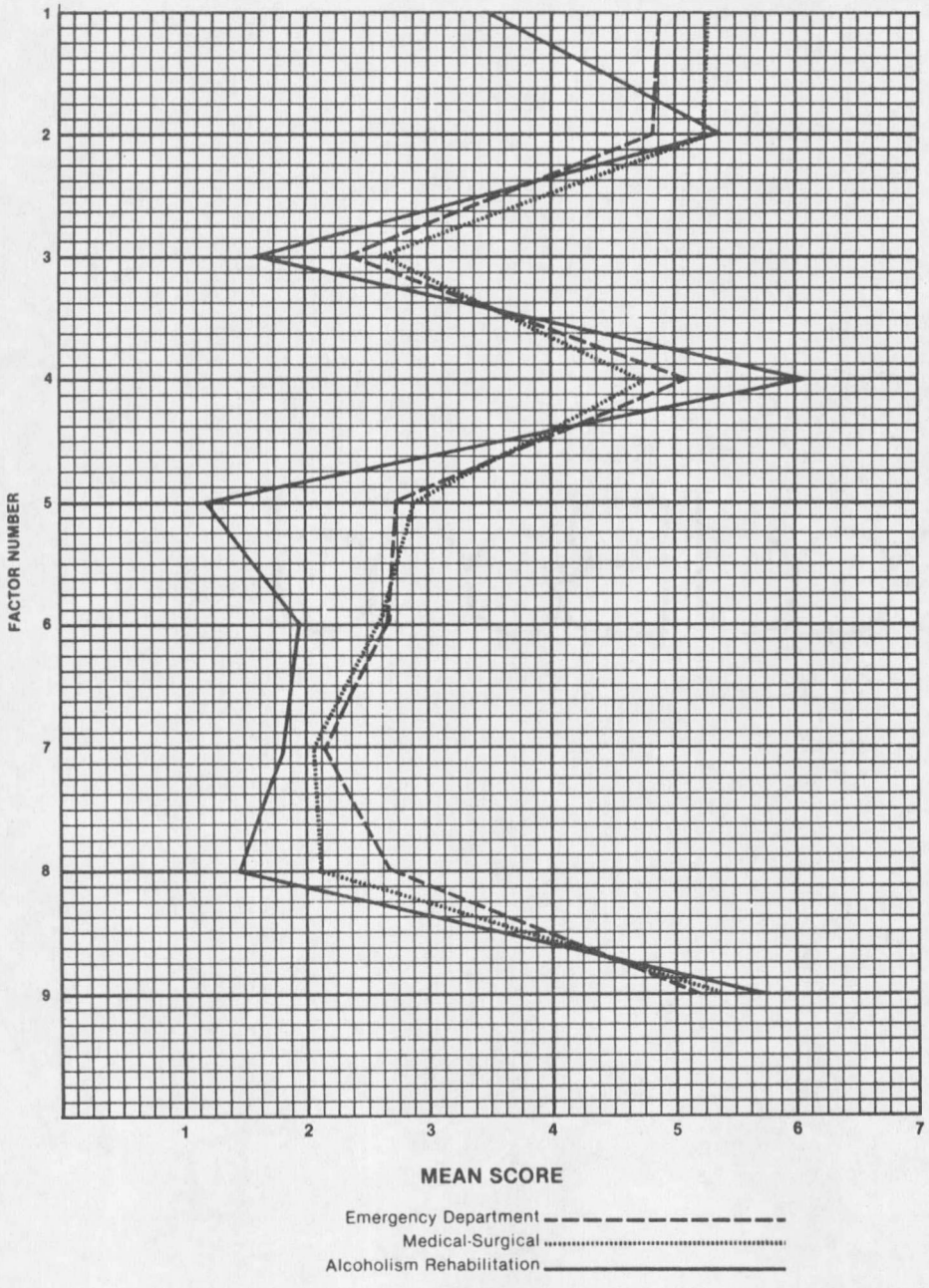

Figure 2. Mean Score Comparisons of Nine Factors Per Specialty Unit.

rehabilitation nurses had a mean score of 3.46. The discrepancy indicated that the latter group held different attitudes from those stated by Marcus (Figure 2).

Table 5. Factor Comparison Between Three Specialty Groups According to Kruskal-Wallis.

Factor	Kruskal-Wallis	α
1. Emotional Difficulties	p = .000	*
2. Loss of Control	p = .629	
3. Prognosis for Recovery	p = .000	*
4. Steady Drinking	p = .001	*
5. Character Defect	p = .000	*
6. Social Status	p = .029	*
7. Illness Concept	p = .383	
8. Harmless Indulgence	p = .009	*
9. Addiction Liability	p = .234	

*Significant to $p < 0.05$ level.

For factors two through nine, specialty units demonstrated positive attitudes as presented in the Marcus Alcoholism Questionnaire (Table 5). According to Marcus a high score on factor two, four, and nine indicates positive attitudes. When considering factors three, five, six, seven, and eight, a low score indicates a positive attitude. All three groups demonstrated positive attitudes regardless of specialty area. However, nurses who worked in alcoholism rehabilitation at the time of the study indicated significantly more positive attitudes in five of the remaining nine factors (Tables 6 and 7). The significantly more positive factors are three, four, five,

six and eight.

Each factor found significant was further analyzed by using the Mann-Whitney U Test to determine group difference. A significant difference ($p<0.05$) existed between emergency and alcoholism rehabilitation nurses and medical-surgical and alcoholism rehabilitation nurses in all six factors (Tables 6 and 7). When comparing emergency and medical-surgical nurses there was no significant difference in scores (Table 8).

Table 6. Factor Comparison of Emergency Department and Alcoholism Rehabilitation Nurses According to Mann-Whitney U Test.

Factor	z	p	p < 0.05
1. Emotional Difficulties	2.890	.0038	*
3. Prognosis for Recovery	3.118	.0018	*
4. Steady Drinking	2.394	.0168	*
5. Character Defect	3.303	.0010	*
6. Social Status	2.332	.0198	*
8. Harmless Indulgence	2.477	.0132	*

*Significant to p < 0.05

Table 7. Factor Comparison of Medical-Surgical and Alcoholism Rehabilitation Nurses According to Mann-Whitney U Test.

Factor	z	p	p < 0.05
1. Emotional Difficulties	4.765	.00006	*
3. Prognosis for Recovery	3.424	.0006	*
4. Steady Drinking	3.695	.00032	*
5. Character Defect	4.534	.00006	*
6. Social Status	2.113	.0348	*
8. Harmless Indulgence	2.585	.0096	*

*Significant to p < 0.05

Table 8. Factor Comparison of Emergency Department and Medical-Surgical Nurses According to Mann-Whitney U Test.

Factor	z	p	p < 0.05
1. Emotional Difficulties	1.001	.3174	
3. Prognosis for Recovery	.3862	.7040	
4. Steady Drinking	.4863	.6312	
5. Character Defect	.4863	.6312	
6. Social Status	.3862	.7040	
8. Harmless Indulgence	.8296	.4066	

*Significant to p < 0.05

Factors were then examined by age of respondents, with age collapsed into three groups: 20 to 34, 35 to 49, and 50 to 64. Comparison of age groups with the nine factor scores demonstrated no significant differences in the scores of different age groups (Table 9).

Table 9. Factor Comparison by Kruskal-Wallis According to Age Groups of 20-34, 35-49, 50-64.

Factor	Kruskal-Wallis	α
1. Emotional Difficulties	.658	
2. Loss of Control	.146	
3. Prognosis of Recovery	.701	
4. Steady Drinking	.843	
5. Character Defect	.201	
6. Social Status	.969	
7. Illness Conception	.630	
8. Harmless Indulgence	.612	
9. Addiction Liability	.583	

*Significant to p < 0.05 level.

The nine factors of the MAQ were compared to the type of basic nursing education attended, associate, diploma, or baccalaureate degree. As demonstrated in Table 10, there were no significant differences ($p<0.05$) according to the type of basic nursing program attended.

Table 10. Factor Comparison by Kruskal-Wallis According to Type of Basic Nursing Education.

Factor	Kruskal-Wallis	α
1. Emotional Difficulties	.481	
2. Loss of Control	.659	
3. Prognosis for Recovery	.956	
4. Steady Drinking	.071	
5. Character Defect	.609	
6. Social Status	.935	
7. Illness Conception	.349	
8. Harmless Indulgence	.999	
9. Addiction Liability	.875	

*Significant to $p<0.05$ level.

Respondents were asked if the basic nursing program attended contained any education on alcoholism. Table 11 demonstrates that no significant ($p<0.05$) results were obtained when comparing the responses: (1) yes, there was alcoholism education, and (2) no, there was no alcoholism education.

In contrast to these findings respondents were asked if they had had alcoholism education since the basic nursing program. Answers were in the form of yes or no. Table 12 shows that factors one, four,

five, and eight demonstrate a significant level ($p<0.05$) of difference between yes and no responses.

Table 11. Factor Comparison by Kruskal-Wallis According to Education in Basic Nursing Program.

Factor	Kruskal-Wallis	α
1. Emotional Difficulties	.692	
2. Loss of Control	.650	
3. Prognosis for Recovery	.750	
4. Steady Drinking	.676	
5. Character Defect	.766	
6. Social Status	.348	
7. Illness Conception	.291	
8. Harmless Indulgence	.994	
9. Addiction Liability	.834	

*Significant to $p<0.05$ level.

Table 12. Factor Comparison by Kruskal-Wallis According to Alcoholism Education Since Basic Nursing Program.

Factor	Kruskal-Wallis	α
1. Emotional Difficulties	.010	*
2. Loss of Control	.656	
3. Prognosis for Recovery	.107	
4. Steady Drinking	.017	*
5. Character Defect	.001	*
6. Social Status	.098	
7. Illness Conception	.739	
8. Harmless Indulgence	.004	*
9. Addiction Liability	.262	

*Significant to $p<0.05$ level.

Respondents were also questioned regarding relationships outside work with significant others who have a drinking problem. There were no significant findings ($p<0.05$) in the nine factors when the response was analyzed. Those respondents who indicated a relationship outside work were asked to rate the relationship as good or poor. Respondents were classified in two groups: (1) respondents rating all relationships as good, and (2) respondents rating at least one relationship as poor. There were no significant findings in the nine factors when relationships were rated (Appendices M and N).

Summary of Results

In summary, the alcoholism rehabilitation nurses were found to hold significantly more positive attitudes towards alcoholism than nurses who worked in medical, surgical, or emergency units. Of the nine factor scores examined by the MAQ a significant difference was found in the following:

1. Factor one which is concerned with emotional difficulties or psychological problems being related to alcoholism;
2. Factor three which deals with the prognosis for recovery;
3. Factor four which concerns the alcoholic as a steady drinker;
4. Factor five which associates alcoholism and character defects;

5. Factor six which addresses the social status of alcoholics;
6. Factor eight which concerns alcoholism as a harmless voluntary indulgence.

With respect to factor one (emotional difficulties as a contributing factor to the development of alcoholism), the alcoholism rehabilitation nurses' mean factor score was 3.46. According to Marcus a high score indicated a positive attitude. This discrepancy was the only instance where any specialty group of nurses studied varied from the Marcus position of positive or negative attitudes.

Variables of age, religion, type of degree program attended, time elapsed since graduation from the basic nursing program, and alcoholism education contained in the basic nursing program showed no significant results when compared with the nine factors of the MAQ. Respondents who had education in alcoholism since the basic nursing program showed significantly more positive attitudes than those who had had no education in alcoholism since the basic nursing program in factors one (emotional difficulties), four (steady drinking), five (character defect), and eight (harmless indulgence).

Whether or not respondents had associations outside work with significant others who have a drinking problem did not make a difference when the nine factors were examined. In addition, no significant difference was found between individuals regardless of relationship rating.

In the following chapter the results of this study were discussed. Possible explanations for results were presented.

Chapter 5

DISCUSSION

Discussion of Data Analysis

The purpose of this study was to examine what attitudes toward alcoholism were held by registered nurses in three specialty areas of nursing. Specialty areas included emergency departments, medical-surgical units, and alcoholism rehabilitation facilities. In addition to determining what attitudes were held, a comparison of attitudes of the nurses in the three specialty areas was done. Data were analyzed from the standpoint of the total sample as well as according to the three specialty areas studied.

The following pages report the important findings and relate these findings to the literature. Limitations of the study were discussed, implications analyzed, and recommendations for further research presented.

Significant findings were obtained in overall mean factor scores. Factor one showed significance in that one specialty group of nurses had results opposite of those expected by the MAQ. Factors one, five, six, and eight showed significance with respect to alcoholism education after basic training, and factors one, three, four, five, six, and eight exhibited significance when comparing the three specialty groups of nurses.

The literature review indicated that nurses held negative attitudes towards alcoholics (Cornish and Miller, 1976; Schmid and Schmid, 1973). The present study found that the mean scores of nurses working in alcoholism rehabilitation facilities, medical-surgical units, and emergency departments indicated positive attitudes toward alcoholism (Appendix L). The finding of positive attitudes is significant and may be due to an emphasis on alcoholism education in recent years.

When considering factor one (emotional difficulties being positively correlated with alcoholism) nurses working in alcoholism rehabilitation had a mean score of 3.46; whereas, nurses working in emergency departments and medical-surgical units had mean factor scores of 4.86 and 5.27, respectively. According to Marcus a high score (above four) indicated a positive attitude. The finding of a low score in the alcoholism rehabilitation group was significant in that factor one was the only instance where there was a discrepancy between the mean scores of the nurses studies and Marcus' findings. The difference may be due to a change in philosophy since Marcus compiled his questionnaire or that the nurses in the alcoholism rehabilitation facilities demonstrated a particular philosophy of the units on which they worked. Seventy-five percent of the alcoholism rehabilitation nurses sampled worked in the Care Units in Montana.

Respondents were asked if they had had alcoholism education since

the basic nursing program. When these responses (yes or no) were compared with the nine factors of the MAQ, four factors (one, five, six, and eight: Appendix J) were found significant ($p<0.05$). The difference could be due to the education being more recent or that only nurses interested in alcoholism sought additional education. It cannot be said that education is the exclusive cause of the difference in attitudes.

A significant finding of this study is that a difference in attitudes exists, depending on the specialty area in which nurses work (Table 5). Six factors (one, three, four, five, six, and eight) were demonstrated to have significant differences ($p<0.05$) according to whether nurses worked in emergency departments, medical-surgical units, or alcoholism rehabilitation facilities. When emergency department nurses and medical-surgical nurses were compared, no significant difference was found. However, when emergency department nurses were compared to alcoholism rehabilitation nurses and when medical-surgical nurses were compared to alcoholism rehabilitation nurses, all six factors were shown to be significant ($p<0.05$). The differences demonstrated were highly significant, some to $p<0.00006$ and could be related to the type of contacts nurses have with alcoholic clients. Emergency nurses mostly have contact with the intoxicated alcoholic. Medical-surgical nurses have contact with both intoxicated alcoholics and those with long term medical complications

resulting from alcoholism. Nurses on alcoholism rehabilitation units have more long term contacts with recovering alcoholic clients. The types of contacts could influence the attitudes of nurses. Another explanation may be that nurses on alcoholism rehabilitation units have more interest in alcoholism and therefore hold more positive attitudes. Additionally, nurses working in alcoholism rehabilitation have more education with respect to alcoholism than medical-surgical or emergency department nurses.

The literature review indicated that attitudes of nursing students were more positive if education on alcoholism was presented in the basic nursing program (Harlow and Goby, 1980; Ferneau, 1967). This study did not support that finding. Respondents were asked if their basic nursing program contained education on alcoholism. Responses were either yes or no. When respondents from each group (yes and no) were compared with the nine factors of the MAQ, no significance ($p<0.05$) was found. Because this questionnaire was not designed to elicit differences between types of schools, either educational or philosophical, it was not accurate to say no difference actually existed but only that no difference was found in this particular study.

When demographic data such as age, religion, type of the basic nursing program attended, and length of time elapsed since graduation from the basic nursing program were compared to the nine factors of

the MAQ, no significant findings were apparent. These factors were analyzed from the total sample.

When the attitudes of nurses who had associations outside work involving significant others who have a drinking problem were compared to those nurses with no outside associations no significant ($p<0.05$) differences were found. The respondents who reported outside work relationships were asked to rate those relationships as either good or poor. A comparison was done of those respondents who rated all relationships as good versus those respondents who rated at least one relationship as poor. No significant differences were found when comparing the above data with the nine factors of the Marcus Alcoholism Questionnaire. It cannot be determined if, in reality, there are no differences in attitudes whether or not respondents have outside relationships with persons who have a drinking problem or if additional questions would have demonstrated a difference.

Limitations

Limitations of this study include all those limitations associated with mailed questionnaires. Response rates were lower, especially when only one mailing is utilized. Respondents who do not understand particular questions or directions in general have no opportunity for clarification. Responses to mailed questionnaires may be incomplete with no way for the author to gain additional

information. A further limitation involves no assurance that the intended recipient is the same person who responded.

Response rates in this study were low, with the corrected specialty area response rates being 44.00 percent, 49.21 percent, and 83.33 percent (Table 1). Although the total response rate was 55.36 percent which is considered average, responses from the specialty areas may have been different if more emergency department and medical-surgical nurses had responded. There was minimal missing data since most respondents answered all questions. However, some respondents commented that a few questions were confusing. This could have lead to misunderstanding of questions and altered responses. The possibility of confusing questions was a limitation of this study.

The respondents in the alcoholism rehabilitation groups were drawn from the entire state of Montana and were representative of the nurses working in this specialty area. The emergency and medical-surgical nurse respondents were drawn from two general hospitals in one city in Montana. These results cannot be generalized to other areas in Montana.

Use of the Marcus Alcoholism Questionnaire could be interpreted as imposing some limitations. Due to the age of the questionnaire (19 years), the designated factors may no longer be the factors important in determining attitudes. An example involved factor one (emotional difficulties being positively correlated with alcoholism) in the

factor analytic study. The alcoholism rehabilitation nurses responded on the opposite end of the scale from what Marcus had designated as the expert position (Appendix J). Philosophical changes over the years may have mitigated or invalidated some of the factors Marcus believed to be important.

The complexity of issues such as alcoholism and attitudes make it difficult to determine causal relationships. Correlations were found between the specialty area nurses work in and attitudes. Results were described and differences were noted but further studies would be required to determine causal relationship.

Implications and Recommendations

The implications of this study are varied. Many studies have been done concerning attitudes of health care providers including nurses, physicians, nursing students, and nursing attendants. Comparisons of hospital nurses to alcoholism rehabilitation nurses were not found in the review of the literature. This study found significantly more positive attitudes in alcoholism rehabilitation nurses than in emergency or medical-surgical nurses. The significantly more positive attitudes were in relation to: (1) emotional difficulties and alcoholism, (2) prognosis for recovery, (3) the alcoholic as a steady drinker, (4) alcoholism and character defect, (5) the social status of the alcoholic, and (6) harmless

voluntary indulgence. The differences in attitudes need to be explored further to determine prevalence in other populations, reasons for prevalence, and if this knowledge can be used to foster more generalized positive attitudes in all nurses.

The attitudes of registered nurses who work in general hospitals need to be determined. It is estimated that 30 to 50 percent of the patients in general hospitals have alcohol related problems. In addition, the literature states that attitudes do affect behavior. From these facts nurses in general hospitals need to have positive attitudes. Although this study showed that nurses in emergency and medical-surgical units hold positive attitudes it was also shown that nurses in alcoholism rehabilitation facilities have significantly more positive attitudes. If future research can determine why alcoholism rehabilitation nurses hold more positive attitudes then perhaps more positive attitudes can be fostered in nurses working in general hospitals.

A further implication of this study involves nursing education. Information in the literature established that peers and professional groups affect attitudes. When nursing students undergo their basic alcoholism education, associations with registered nurses who hold more positive attitudes are needed. Attitudes of nursing students may be affected positively by placement with nurses working in alcoholism rehabilitation units.

More studies need to be done regarding which factors within alcoholism education found in the basic nursing programs affect positive attitude formation. Determinations of these factors were beyond the scope of this study.

Recommendations for further study are based on these implications:

1. Explore attitude differences between specialty units;
2. Explore the difference in attitudes;
3. Explore whether or not more generalized positive attitudes can be fostered by determining what factors affect attitudes.
4. Explore what components of alcoholism education within basic nursing programs affect attitude formation.
5. Explore what common factors or traits exist in alcoholism rehabilitation nurses which may help in determining what types of individuals would work well with alcoholic clients.

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APPENDICES

Appendix A. Letter to Alcoholism Rehabilitation Unit Regarding Distribution of Questionnaires.

July 18, 1981
P.O. Box 1741
Great Falls, Montana 59403

Ms. Jane Ryan RN
P.O. Box 30374
Billings, Montana 59107

Dear Ms. Ryan:

Thank you for the courtesy extended to me during our telephone conversation on June 15 th. Per our conversation please find enclosed two questionnaires and as discussed you will distribute these among the RN staff who are involved with counseling the alcoholic client.

Thank you for your time and consideration.

Very Truly Yours,

Phyllis Gillespie RN
Graduate Nursing Student
Montana State University

Appendix B. Letter to Alcoholism Rehabilitation Unit Regarding Distribution of Questionnaires.

July 18, 1981
P.O. Box 1741
Great Falls, Montana 59403

Ms. Wilma O'Neil RN
Care Unit 3 rd floor
Silver Bow General Hospital
2500 Continental Drive
Butte, Montana 59701

Dear Ms. O'Neil:

Thank you for the courtesy extended to me during our telephone conversation on June 15 th. Per our conversation please find enclosed nine questionnaires and as discussed you will distribute these among the RN staff who are involved with counseling the alcoholic client.

Thank you for your time and consideration.

Very Truly Yours,

Phyllis Gillespie RN
Graduate Nursing Student
Montana State University

Appendix C. Letter to Alcoholism Rehabilitation Unit Regarding Distribution of Questionnaires.

July 18, 1981
P.O. Box 1741
Great Falls, Montana 59403

Ms. Sheri Barreto
2101 Clark Street
Miles City, Montana 59301

Dear Ms. Barreto:

Thank you for the courtesy extended to me during our telephone conversation on June 15 th. Per our conversation please find enclosed two questionnaires and as discussed you will distribute these among the RN staff who are involved with counseling the alcoholic client.

Thank you for your time and consideration.

Very Truly Yours,

Phyllis Gillespie R.N.
Graduate Nursing Student
Montana State University
Great Falls Extended Campus

Appendix D. Letter to Alcoholism Rehabilitation Unit Regarding Distribution of Questionnaires.

July 18, 1981
P.O. Box 1741
Great Falls, Montana 59403

Ms. Nancy Rosenleaf RN
1817 West Park Street
Anaconda, Montana 59711

Dear Ms. Rosenleaf:

Thank you for the courtesy extended to me during our telephone conversation on June 15 th. Per our conversation please find the enclosed questionnaire concerning attitudes and knowledge about alcoholism.

Thank you for your time and consideration.

Very Truly Yours,

Phyllis Gillespie RN
Graduate Nursing Student
Montana State University

Appendix E. Letter to Alcoholism Rehabilitation Unit Regarding Distribution of Questionnaires.

July 18, 1981
P.O. Box 1741
Great Falls, Montana 59403

Ms. Peggy Jacobson RN
Care Unit
Missoula General Hospital
300 North Second Street
Missoula, Montana 59801

Dear Ms. Jacobson:

Thank you for the courtesy extended to me during our telephone conversation on July 10 th. Per our conversation please find enclosed nine questionnaires and as discussed you will distribute these among the RN staff who are involved with counseling the alcoholic client.

Thank you for your time and consideration.

Very Truly Yours,

Phyllis Gillespie
Graduate Nursing Student
Montana State University

Appendix F. Cover Letter to Registered Nurses Requesting Participation in Study.

Dear Registered Nurse:

I am writing to you to ask your participation in a survey of registered nurses' attitudes toward alcoholism. Alcoholism is a major health problem in our country today. Nurses, by being part of the health care system, are in a position to detect alcoholism and provide needed services. Attitudes need to be identified to assist nurses to deal with alcoholic patients/clients.

Enclosed you will find a questionnaire concerning knowledge and attitudes about alcoholism. The questionnaire was developed by Alan M. Marcus and consists of forty statements. It takes approximately 20-30 minutes to complete. Your assistance in completing the enclosed questionnaire and returning it to me in the stamped self addressed envelope will be greatly appreciated. I hope you will decide to participate. Please return this to me by August 8, 1981.

All answers will be confidential and anonymous, with no likelihood you will be identified. Answers will be analyzed for entire groups of nurses participating and no individuals will be identified. Please answer all items as to your opinions and feelings.

Results will be availabe through the MSU library at the completion of the study. Individuals may acquire an abstract of the study by notifying me directly at the address on the stamped self addressed envelope.

I appreciate your taking time to complete this and thank you for your contribution to the study.

Sincerely,

Phyllis Gillespie R.N.
Graduate Nursing Student
Montana State University
Great Falls Extended Campus

Appendix G. Marcus Alcoholism Questionnaire.

MARCUS ALCOHOLISM QUESTIONNAIRE

The questionnaire concerns knowledge and attitudes about alcoholism. Please mark each statement as to how much you agree or disagree with it. To the right of each statement you will find a rating scale:

1	2	3	4	5	6	7

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

1. completely disagree
2. mostly disagree
3. disagree more than agree
4. neutral
5. agree more than disagree
6. mostly agree
7. completely agree

An example is:

There are very few female alcoholics.

1	2	3	4	5	6	7

If you agree completely with this statement you would mark an X in column 7. If you mostly disagree with the statement, you would place a mark in column 2. Please make all marks clearly within one box of the scale. Do not leave any statements blank and make only one mark for each statement. If it is difficult to make up your mind, make the best quess that you can and go on to the next one.

	1	2	3	4	5	6	7
1. A person who often drinks to the point of drunkenness is almost always an alcoholic.							
2. People who become alcoholics are usually lacking in will power.							
3. Most alcoholics have no desire to stop drinking.							
4. The average alcoholic is usually unemployed.							
5. A person can inherit a weakness for alcohol.							

rating scale

1. completely disagree
2. mostly disagree
3. disagree more than agree
4. neutral
5. agree more than disagree
6. mostly agree
7. completely agree

	1	2	3	4	5	6	7
6. The alcoholic is helpless to control the amount of alcohol he drinks.							
7. Alcoholics usually have severe emotional difficulties.							
8. Alcoholism is best described as a habit rather than an illness.							
9. The alcoholic drinks excessively mainly because he enjoys drinking.							
10. An alcoholic can get into as much trouble drinking beer as by drinking liquor.							
11. A person who frequently stays intoxicated for several days at a time is unquestionably an alcoholic.							
12. The alcoholic is seldom helped by any sort of medical or psychological treatment.							
13. The alcoholic has only himself to blame for his problems.							
14. Alcoholics, on the average, have a poorer education than other people.							
15. Alcoholics seldom harm anybody but themselves.							

rating scale

1. completely disagree
2. mostly disagree
3. disagree more than agree
4. neutral
5. agree more than disagree
6. mostly agree
7. completely agree

	1	2	3	4	5	6	7
16. Hardly any alcoholics could drink less even if they wanted to.							
17. The most sensible way to deal with alcoholics is to compel them to go somewhere for treatment.							
18. The alcoholic is a morally weak person.							
19. An alcoholic's basic troubles were with him long before he had a problem with alcohol.							
20. Once a person becomes an alcoholic, he can never learn to drink moderately again.							
21. The harm done by alcoholics is generally over-estimated.							
22. Very few alcoholics come from families in which both parents were abstainers.							
23. Even if an alcoholic has a sincere desire to stop drinking, he cannot possibly do so without help from others.							
24. Nobody who drinks is immune from alcoholism.							
25. Even if a heavy drinker is able to stop drinking for several weeks at a time, he may still be an alcoholic.							

rating scale

1. completely disagree
2. mostly disagree
3. disagree more than agree
4. neutral
5. agree more than disagree
6. mostly agree
7. completely agree

	1	2	3	4	5	6	7
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 to 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 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 week-ends, are alcoholics.							

rating scale

1. completely disagree
2. mostly disagree
3. disagree more than agree
4. neutral
5. agree more than disagree
6. mostly agree
7. completely agree

	1	2	3	4	5	6	7
36. An alcoholic usually has something in his past which is driving him to drink.							
37. Most alcoholics are completely unconcerned about their problems.							
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 H. Letter Requesting Permission to Use the Marcus Alcoholism Questionnaire.

2301 11 th Stree SW
Great Falls, Montana 59404
406-453-6322
April 16, 1981

Alcoholism and Drug Addiction Research Foundation
33 Russell Street
Toronto, Ontario M5S 2S1
Canada

Gentlemen:

I am a graduate nursing student at Montana State University, currently researching nurse's attitudes toward alcoholism in partial fulfillment for my Master's Degree in Nursing. Nurses, by being part of the health care system, are in a position to detect and identify alcoholism and provide needed services. It is believed that attitudes affect patient care. Identifying what attitudes exist is an important first step in helping nurses deal more effectively with alcoholic patients/clients. The proposed study will describe and compare the attitudes of three groups of nurses (medical-surgical, emergency room, and alcoholism rehabilitation). This research is a beginning at correlating nurses' attitudes with the contacts nurses have with alcoholic patients/clients. A consideration for nurse educators is the fostering of positive attitudes in nursing students. Identifying what attitudes presently exist and which groups of nurses hold particular attitudes could provide valuable information.

I would like to use the Marcus Alcoholism Questionnaire ISBN #0-88868-040-6 by Alan M. Marcus published and copyrighted by you in 1963. Therefore, I am formally requesting written permission to utilize this tool. Thank you for your consideration.

Sincerely,

Phyllis B. Gillespie R.N.
Graduate Nursing Student
Montana State University
Great Falls Extended Campus

Appendix I. Response Granting Permission to Use the Marcus Alcoholism Questionnaire.

Alcoholism and Drug
Addiction Research Foundation

Central Office
33 Russell Street
Toronto, Ontario
Canada M5S 2S1
(416) 595-6000

April 30, 1981

Ms. Phyllis B. Gillespie
2301 11th Street SW
Great Falls, Montana 59404

Dear Ms. Gillespie,

In response to your letter of April 16, 1981 concerning the use of the Marcus Alcoholism Questionnaire, I am pleased to grant you permission to use the Questionnaire in your study, but would ask that you reference the work appropriately.

Sincerely yours,

R.J. Hall
Head
Information & Promotion

RJH/jmh

Appendix J. Marcus Alcoholism Questionnaire Nine Factor Definition and Interpretation.

Factor	Interpretation	Experts' Position
1. Emotional Difficulties	A high score indicates the belief that emotional difficulties or psychological problems are an important contributing factor in the development of alcoholism.	high
2. Loss of Control	A high score indicates the belief that the alcoholic is unable to control his drinking behavior.	high
3. Prognosis for Recovery	A high score indicates the belief that most alcoholics do not and cannot be helped to recover from alcoholism.	low
4. The Alcoholic as a Steady Drinker	A high score indicates the belief that periodic excessive drinkers can be alcoholics. A low score indicates the belief that a person must be a continual excessive drinker in order to be classified as an alcoholic.	high
5. Alcoholism and Character Defect	A high score indicates the belief that the alcoholic is a weak-willed person.	low
6. Social Status of the Alcoholic	A high score indicates the belief that alcoholics come from the lower socio-economic strata of society.	low
7. Alcoholism as an Illness	A high score indicates the belief that alcoholism is not an illness.	low

Factor	Interpretation	Experts' Position
8. Harmless Voluntary Indulgence	A high score indicates the belief that the alcoholic is a harmless heavy drinker whose drinking is motivated only by fondness for alcohol.	low
9. Alcoholic Addiction Producing	A high score indicates the belief that alcohol is a highly addicting substance.	high

Appendix K. Demographic Data.

DEMOGRAPHIC DATA

Age:_____

Sex:_____female

_____male

Religion:_____Catholic
_____Mormon
_____Protestant
_____none
_____other
(please specify)

Employment:_____full time
_____part time _____number of hours per week

Year of graduation from basic nursing program?_____
Length of employment (full/part time) in nursing?_____
Do you work in an emergency department_____
in a medical unit_____
in a surgical unit_____
as an alcoholic counselor_____
How long have you worked in this area?_____

Basic Nursing Education:

Associate_____
Diploma_____
Baccalaureate_____

School & location of basic nursing education:_____

Highest level of education:

Associate_____
Diploma_____
Baccalaureate_____

Practitioner_____
M.S.N._____
other_____
(please specify)

Drug and Alcohol Education:

Did your basic nursing program provide any drug and alcohol education?_____yes _____no

If yes please describe briefly:

Have you had any drug and alcohol education since your basic nursing education?_____yes _____no

If yes was it college credit_____ number of credits_____

continuing ed. units_____ number of CEU's _____

workshop/seminar_____ number of hours of instruction _____

Please describe course briefly:

The following question is of special interest to me as a researcher but I do not want to intrude or offend. Therefore, do not answer the question if the above reasons apply. Thank you for completing the remainder of the questionnaire.

Personal or close involvement, outside the work situation, with individuals who have a drinking problem (family/close friends/ significant other):

Do you presently have or have you had any personal or close involvement with individuals outside the work situation who have or had a drinking problem?_____yes _____no

If yes how many people_____

Please rate how you presently feel about your relationship with these people by placing a check whether you consider your relationship good or poor. Do this for each person. If the total number of individuals exceed four, choose those four that are most significant to you.

person one good_____ poor_____

person two good_____ poor_____

person three good_____ poor_____

person four good_____ poor_____

Any comments concerning the questionnaire:

Appendix L. Mean Score Comparison of Nine Factor Scores.

Group	Factor	Range	Mean
Emergency Department	1	2.50- 6.00	4.86
	2	2.00- 6.00	4.84
	3	1.25- 3.00	2.36
	4	3.00- 6.75	5.07
	5	1.00- 5.50	2.73
	6	1.75- 3.75	2.68
	7	1.00- 3.00	2.16
	8	1.00- 5.00	2.66
	9	3.75- 6.25	5.18
Medical-Surgical	1	3.50- 7.00	5.27
	2	3.50- 7.00	5.24
	3	1.00- 5.75	2.62
	4	2.75- 6.75	4.77
	5	1.00- 6.00	2.89
	6	1.00- 5.25	2.60
	7	1.00- 7.00	2.05
	8	1.00- 4.75	2.11
	9	4.00- 7.00	5.46
Alcoholism Rehabilitation	1	1.50- 5.50	3.46
	2	3.00- 7.00	5.34
	3	1.00- 3.75	1.56
	4	4.75- 7.00	6.07
	5	1.00- 2.50	1.20
	6	1.00- 3.75	1.93
	7	1.00- 2.50	1.81
	8	1.00- 2.75	1.44
	9	4.00- 7.00	5.69

Appendix M. Factor Comparison One Way Analysis and Kruskal-Wallis According to Presence of Outside Work Relationships With Significant Other(s) Who Have or Had a Drinking Problem.

Factor	One Way Analysis	Kruskal-Wallis	α
1. Emotional Difficulties	.3457	.090	
2. Loss of Control	.9779	.915	
3. Prognosis for Recovery	.0606	.194	
4. Steady Drinking	.9790	.742	
5. Character Defect	.0871	.05	
6. Social Status	.7101	.773	
7. Illness Concept	.4707	.875	
8. Harmless Indulgence	.2773	.134	
9. Addiction Liability	.3738	.234	

*Significant to $p<0.05$ level

Appendix N. Factor Comparison One Way Analysis and Kruskal-Wallis According to How Relationships With Significant Other(s) are Rated.

Factor	One Way Analysis	Kruskal-Wallis	α
1. Emotional Difficulties	.1493	.144	
2. Loss of Control	.8473	.619	
3. Prognosis for Recovery	.0912	.377	
4. Steady Drinking	.9426	.889	
5. Character Defect	.0568	.137	
6. Social Status	.4622	.942	
7. Illness Concept	.5490	.463	
8. Harmless Indulgence	.1647	.098	
9. Addiction Liability	.1729	.473	

*Significant to $p<0.05$ level