EFFECTS OF DRINKING PATTERN, DRINKING CONSEQUENCES, AND PERCEIVED THREAT ON ATTITUDES TOWARD PROBLEM DRINKERS

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EFFECTS OF DRINKING PATTERN, DRINKING CONSEQUENCES, AND PERCEIVED THREAT ON ATTITUDES TOWARD PROBLEM DRINKERS

by

Katie Elizabeth Russo

A Dissertation
Submitted to the Graduate Studies Office
of The University of Southern Mississippi
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Philosophy

Approved:

December 2007
EFFECTS OF DRINKING PATTERN, DRINKING CONSEQUENCES, AND PERCEIVED THREAT ON ATTITUDES TOWARD PROBLEM DRINKERS

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ABSTRACT

EFFECTS OF DRINKING PATTERN, DRINKING CONSEQUENCES, AND PERCEIVED THREAT ON ATTITUDES TOWARD PROBLEM DRINKERS

by Katie Elizabeth Russo

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Previous research has established that negative attitudes are held toward individuals with alcohol use problems. However, these studies often examined whether stigma was associated with the label “alcoholic” rather than on negative alcohol-related behaviors. The present study examined the separate and combined effects of drinking pattern (e.g. social vs. heavy) and drinking consequences (e.g. no consequences vs. non-threatening consequences vs. threatening consequences) on stigma outcome measures. This study examined different subtypes of consequences in order to determine if the introduction of a threat component would lead to more negative ratings. The types of consequences examined included non-threatening consequences that have everyday effects on the lives of alcoholics, such as failing to tend to family and work obligations, and threatening consequences, such as aggressive behavior toward others. A sample of college students ($N = 168$) watched 1 of 6 stimulus tapes, which included male actors being administered the alcohol dependence section of the SCID-I. After viewing the tapes, participants completed measures that assessed their attitudes toward the interviewees, including a semantic differential scale, Social Interaction Scale (SIS), Big Five Inventory (BFI), perceived IQ of interviewee, perceived threat, Positive and Negative Affect Schedule (PANAS), Self-Assessment Manikin (SAM), and a behavioral
social distance measure. Results supported the hypothesis that participants would rate heavy drinkers more negatively than social drinkers. Results also supported the hypothesis that there would be a significant main effect for drinking consequences on outcome measures. Participants rated the no consequences group more positively than the other groups on all measures. However, on some stigma measures, participants did not indicate significant differences between the non-threatening and threatening consequences groups. The hypothesis that there would be significant interactions between drinking patterns and drinking consequences was not fully supported as interactions were only found with two outcome measures. Although findings should be interpreted cautiously given the number of analyses conducted, they may provide useful information for future studies on drinking consequences and stigma. Theoretical implications, limitations of the present study and recommendations for future research are discussed.
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CHAPTER I
INTRODUCTION

According to the World Health Organization, alcohol dependence is among the most common psychological disorders. It is estimated that approximately 62 million people worldwide are dependent on alcohol. In the United States alone, 8.1 million men and women, or about 3 percent of the population, suffer from alcohol dependence (World Health Organization, 2001).

Compared to other psychological disorders, alcohol dependence appears to have especially negative attitudes associated with it. Alcoholics are often viewed as poorly adjusted (Cash, Briddell, Gillen, & MacKinnon, 1984), unpredictable (Ritson, 1999), and weak in character (Moore, 1992). Alcohol dependence is often regarded as a personal decision and a voluntary act, and therefore those dependent on alcohol are often seen as responsible for his or her behavior (Moore, 1992). Even though there is growing consensus among health professionals that alcoholism is a disease with possible hereditary components (American Psychiatric Association [APA], 2000; Cotton, 1979; Jellinek, 1960; Levine, 1978), rather than a sign of weak will or a character flaw, negative attitudes toward those dependent on alcohol have remained unchanged.

Because individuals with alcohol use disorders are viewed negatively and as belonging to a stigmatized group, others may perceive them as dangerous or a threat (Blascovich, Mendes, Hunter, Lickel, & Kowai-Bell, 2001; Jones, Farina, Hastorf, Markus, Miller, & Scott, 1984; Madon, Smith, & Guyll, 2005). These perceptions may cause people to socially distance themselves from the alcohol abuser and decrease the
likelihood of interacting with him or her (Blascovich et al., 2001; Link, Cullen, Frank, & Wozniak, 1987).

An examination of attitudes toward those dependent on alcohol has important clinical implications. For example, surveys of United Kingdom and United States populations, as well as surveys of adolescent inpatients in a drug and alcohol treatment program have revealed that the stigma attached to being labeled an “alcoholic” is recognized as a barrier to treatment (Copeland, 1997; Grant, 1997; Raniseski & Sigelman, 1992; Ritson, 1999).

Definition and Theories of Stigmatization

There are no defining features that signal that an individual or group is stigmatized (Cantor & Mischel, 1979). However, stigmatized individuals possess negative characteristics or attributes that are devalued in the eyes of society. Therefore, stigma is a devaluing social identity that emerges from a socially constructed categorization (Crocker, Major, & Steele, 1998). Society rather than nature defines the rules used to decide who is included in the stigmatized group (Archer & Lloyd, 1985).

Stigmatization occurs when a deviation from the norm is linked to dispositions that discredit the possessor of the deviation. Other aspects of the possessor are interpreted in terms of this deviation, and people respond to them on the basis of their stigma rather than taking into consideration their individuality (Jones et al., 1984). However, it is argued that stigma is not the same as deviance from the norm because deviance may or may not be devalued but stigma always is. One may be stigmatized without being deviant. For example, women are often stigmatized even when their behavior is not
considered deviant (Archer & Lloyd, 1985). Therefore, in order for stigmatization to occur, the deviation must be flawed in the eyes of others.

Whether one is stigmatized is also dependent on the situation or context. When surrounded by members of the group or category one belongs to, he or she is not likely to be stigmatized (Archer & Lloyd, 1985). Also, when the stigmatizer is in a situation or context where he or she may exert power, he or she may be more likely to stigmatize others because of the availability of power to do so. Possessing power can also decrease the vulnerability of being stigmatized by others (Fiske & Ruscher, 1993; Link & Phelan, 2001).

The concept of stigma has been defined various ways, with each definition requiring the inclusion of various components. This variability among definitions exists because the stigma concept has been applied to many different circumstances, the research on stigma is multidisciplinary, and researchers approach it from different theoretical orientations (Link & Phelan, 2001). Early definitions of stigma were more likely to include physical, visible deviations. According to Goffman (1963), the ancient Greeks used the word “stigma” to refer to marks on the body that exposed individuals’ deviance or separation from society, such as whether they were a slave or a criminal. Today stigma is more likely to refer to disgrace, rather than literal marks on the body (Goffman, 1963). Stigmatization usually refers to the attachment of undesirable characteristics to an individual who is “marked” in some way that deviates from the societal norm (Katz, 1981). Goffman (1963) described three types of stigma, including tribal stigmas that are passed on from one generation to the next (membership in racial and ethnic groups), “abominations of the body” (physical disabilities and disfigurements),
and individual character flaws that may be related to one's personality (substance abuse and homosexuality).

Feree and Smith (1979) distinguish between two types of stigma, social and individual. Social stigma is associated with "minority status" groups that are devalued because of this status. With individual stigma, individuals who possess a discrediting attribute, such as a disability or mental illness are stigmatized (Feree & Smith, 1979).

Recent models of stigma have relied on the convergence of components for the concept to exist, and others specify dimensions that implicate how stigma will affect social interactions. The definition of stigma offered by Link and Phelan (2001) requires the convergence of labeling of human differences, negative stereotyping, a separation of "us" and "them," status loss, and discrimination, as well as the power to create stigma once these components converge. Jones and colleagues identify six dimensions of stigmatizing conditions: whether the stigmatized condition can be concealed, the course and outcome of the condition, the disruptiveness of the condition, degree to which the condition makes the person repulsive or upsetting to others, who is responsible for the occurrence of the condition, and the danger the stigma poses to others. The effect of stigma on social interactions is said to be dependent on the severity and number of dimensions included (Jones et al., 1984).

When an individual is stigmatized on the basis of highly visible characteristics such as sex or race, he or she must cope with possible devaluation from others. Those who can conceal their stigmas can avoid devaluation as long as they conceal. However, individuals who possess concealable stigmas must often deal with the fear that their condition will be revealed. One may be troubled by having to constantly predict how
others will respond to them if their stigma is ever revealed (Goffman, 1963). Individuals with visible stigmas must chronically cope with potential devaluation from others because their stigma is difficult to hide. Therefore, they do not have to exert the same amount of energy monitoring cues that could reveal the stigma or determining with whom they can disclose their stigma as those with a concealable stigma do (Goffman, 1963; Quinn, Kahng, & Crocker, 2004).

Stigma associated with particular groups, including alcoholics, is related to the stereotypical beliefs about such individuals that are shared by many (Dean & Poremba, 1983). Stereotypes linked to being a member of a certain group are often used to classify whether others possess these same negative traits, and are therefore members of the group. Stereotypes are defined as assumptions of similarity between group members. However, the characteristics assumed to be common to group members do not define the group itself (Bethlehem, 1985). Stereotypes can have a strong positive or negative evaluative component and reflect the attitudes held by individuals toward a group (Zanna & Olson, 1994). However, those associated with alcohol dependence are usually negative. Stereotypes associated with alcohol dependence may include physical attributes, such as sick, shaky, and unkempt (Dean & Poremba, 1983), whereas others may include social behaviors, such as dangerous and unpredictable (Ritson, 1999).

The Stigmatization Process

The concept of stigma is often thought of as having cognitive and behavioral components (Lemert, 1967; Link, Struening, Rahav, Phelan, & Nuttbrock, 1997). The cognitive processes include the labeling of an afflicted person as unacceptable or the possessor of undesirable characteristics. The behavioral component involves the rejection
of the stigmatized individual or the behaviors in which the stigmatized individual engages, such as secrecy or withdrawal (Lemert, 1967; Link et al., 1997). Affective components involving negative feelings, such as threat reactions, are also involved (Ashmore, 1970).

Observers’ reactions to the stigmatized individual involve the (a) perception of a negative attribute and the (b) global devaluation of the possessor (Katz, 1981). These two components can each be the cause of the other or causally independent from one another. Each configuration of these components is reflected in a particular theoretical view of the stigmatization process. Three theories or models are often used to describe the process. The models reviewed include a Negative-Attribute Model of Stigmatization (Allport, 1954; Goffman, 1963; Heider, 1944; Wright, 1960), a Scapegoat Model (Campbell, 1967; Ryan, 1971), and a Labeling Perspective (Becker, 1963; Kitsuse, 1962; Lemert, 1951; Schur, 1965).

The Negative-Attribute Model explains how the (a) perception of a negative attribute can cause the (b) global devaluation of the possessor of the attribute. This model involves viewing certain negative qualities in individuals, which may include one’s physical characteristics or social behavior that, in turn, lead to a negative evaluation of the whole person. These negative qualities cause the observer to feel fear or disdain for the individual. Because these characteristics are viewed as core aspects of one’s personality, they can create a tendency for the observer to be unable to differentiate between the attribute and the possessor. The Negative-Attribute Model assumes there are basic cognitive-perceptual tendencies that strengthen the link between noticing an
abnormal characteristic and rejecting the individual who possesses it (Allport, 1954; Goffman, 1963; Heider, 1944; Wright, 1960).

The Scapegoat Model illustrates how the (b) global devaluation of the possessor can cause the (a) perception of a negative attribute. Society often negatively labels groups because of some animosity felt toward them that is an effect of some cause other than the stigmatized itself, such as in cultural stereotypes. The observer views the characteristics of the group as justification for any hostility and rejection toward the group. However, in actuality the hostility and rejection are generated by feelings of being threatened, by ethnocentrism, or by displacement of aggression rather than the characteristics of the stigmatized group. The hostility displayed toward a group or individual is justified because the stigmatized persons are seen as responsible for possessing the attribute. These negative reactions lower the worth of the victim in order to reduce the moral discomfort felt by the labeler (Campbell, 1967; Ryan, 1971).

The Labeling Perspective addresses how the (a) perception of a negative attribute and the (b) global devaluation of the possessor can be causally independent. This model notes that the devaluation of individuals results from their violation of societal norms. However, global devaluation may be a necessary, but not sufficient condition of stigmatization. According to this model, whether an observer labels individuals deviant has to do with whether the majority views these individuals as deviant from society. Observers internalize these stereotypes and use them to guide their actions toward the deviant individual, which often involves social rejection of the individual (Phillips, 1963, 1966; Scheff, 1966). The labeling of deviant acts or people depends upon contextual factors such as the power of the individual, the social distance between the labeled and
the labeler, the tolerance level in the community, and the visibility of the deviant characteristic or behavior (Becker, 1963; Kitsuse, 1962; Lemert, 1951; Schur, 1965).

The first model of stigmatization presented, the Negative-Attribute Model, describes how viewing negative qualities in someone can lead to the negative evaluation of the entire person. The need to assign people to categories and then attach labels to these categories is acquired early in life. These labels, which are primarily evaluative in nature, elicit feelings that may range from good to bad or pleasant to unpleasant (Katz, 1981). The Scapegoat Model explains how negative attitudes are justified. The negative qualities of a stigmatized group are seen as justification for any hostility and rejection experienced. Any suffering on the part of the stigmatized is viewed as one’s own fault. Lowering the worth of the stigmatized reduces any moral discomfort for the observer. This misperception is often seen in negative cultural stereotypes (Katz, 1981). In the Labeling Perspective, individuals are labeled deviant because the majority views them this way. This is mostly seen in the case of defects in character, which can include acts of social deviance such as alcohol use problems, rather than physical defects because of the greater ambiguity of moral attributes as compared to physical attributes (Katz, 1981).

Social Rejection of the Stigmatized

With regard to the function of stigma, authors offer that human beings possess cognitive adaptations that cause them to avoid poor social exchange partners, join cooperative groups, and avoid contact with those who are differentially likely to carry communicable pathogens (Kurzban & Leary, 2001). We avoid those who we consider to pose a physical threat or ideological danger, and deviate from our norms, values, and expectations (Buss, 1999).
The evolutionary approach to stigma states that the mind consists of cognitive systems that solve adaptive problems associated with human beings' social lives. There are systems that are designed to reject or exclude others from social interactions. Stigmatization is the behavioral manifestations of mechanisms of exclusion, and therefore people are stigmatized because they possess a characteristic viewed by society as a basis for avoiding or excluding them (Kurzban & Leary, 2001). Those avoided may include individuals who have the potential to be violent because of a mental illness, or are likely to carry genes for a mental disorder (Buss, 1999).

On a more basic level, humans categorize people in their world into in-groups and out-groups (“us and them”). This act of categorization is entirely normal as it helps to efficiently give order to life (Allport, 1954). The categorization process of ordering people into in-groups and out-groups minimizes within-group differences while maximizing between-group differences (Tajfel, 1982). Individuals have a need for positive social identity within an in-group, which results in the favorable evaluation of the in-group and the devaluation of the contrasting group or the out-group (Tajfel, 1982).

Although the categorization of others can be an efficient way of processing information, misperceptions can occur when people think that category membership is always associated with certain behaviors. This phenomenon, known as illusory correlation, can cause people to overestimate the frequency out-group members behave in a manner that is considered stereotypical for that group (Hamilton & Sanders, 1981). For example, instances of violence committed by a few people with mental illness are likely to be interpreted as being committed by the entire category of individuals that belongs in the category of mental illness (Rothbart & Park, 1986). Because interactions with a
member of an out-group are often distinct experiences, any occurrence of undesirable behavior tends to be overemphasized. This causes a misperception that the undesirable behavior is correlated with the entire out-group, which can limit future contact with the group (Hamilton & Sanders, 1981).

In examining the origins of prejudice, the focus is often on two features of intergroup contexts, group threats and direct contact (Fiske, 1998). With group threats there is perceived threat to one's group whether that be to the group's relative gains or its overall welfare. The out-group members are perceived to be interfering with the in-group's goals (Fiske & Ruscher, 1993). The interruption of the group's goals leads to emotions of anger, frustration, anxiety, and fear directed at the out-group (Fiske, 1998). With regard to direct contact, close personal contact on a one on one basis can also evoke personal prejudice. The rejection experienced by the out-group often involves rejection of intimacy or closeness because of the discomfort experienced by the in-group in dealing with presumed or actual differences from one's familiar in-group (Fiske, 1998). The disruptions in familiarity can cause negative affective responses such as anxiety, discomfort, and irritability. We tend to feel uncomfortable when faced with being near a stigmatized individual, whether he or she is stigmatized because of odd behavior or a physical deformity. To reduce or prevent the uncomfortable feeling, we often avoid the stigmatized as a means of protecting the self, and in turn experience a reduction in anxiety, thus reinforcing the behavior (Haghighat, 2001).
CHAPTER II
REVIEW OF RELATED LITERATURE

Perceptions of Alcohol Abusers

The social stigma that still surrounds alcohol use disorders and the fear of being labeled an alcoholic may therefore affect the willingness of alcoholics to seek treatment (Copeland, 1997; Grant, 1997; Raniseski & Sigelman, 1992). There is evidence that the stigma associated with receiving treatment for certain disorders leads to an increase in the discomfort with and the avoidance of treatment programs by those who need them most. Individuals often view receiving treatment as at least somewhat stigmatizing, and are uncomfortable with disclosing to friends and family that they are being treated for substance abuse (Raniseski & Sigelman, 1992).

In a qualitative study of women who relied on natural recovery to change their alcohol and other drug dependence, data were collected on their decisions not to seek treatment and the social stigma attached to substance dependence (Copeland, 1997). Seventy-eight percent of the women felt that society looked down on them to a greater extent, compared to men with alcohol or drug dependence problems. This perceived stigma often negatively affected the women’s willingness to enter a treatment program. The principal barriers to getting treatment endorsed by the women included social stigma and labeling, and the stereotypical views of the usual clients of treatment services (Copeland, 1997).

Social stigma is experienced by both men and women, and causes a decrease in willingness to receive treatment in both groups (Grant, 1997; Raniseski & Sigelman, 1992). Among a sample of men and women respondents aged 18 years and up who were
classified with a lifetime DSM-IV alcohol use disorder, 12.7% responded that they had perceived a need for alcohol treatment at some point during their lives but failed to seek treatment (Grant, 1997). Among these individuals, 8% to 12% stated that they did not seek treatment because they were too embarrassed to discuss their alcohol problems with anyone and they feared what family members, friends, and co-workers would think (Grant, 1997).

Researchers questioned 40 adolescents admitted to inpatient drug and alcohol treatment programs to explore whether peer influences shape adolescents’ feelings about being in treatment for substance abuse (Raniseski & Sigelman, 1992). Half of the clients reported that receiving treatment was at least somewhat stigmatizing. Half of the clients did not want their friends to know that they were being treated, and 55% felt uneasy about receiving treatment because of concerns about what others might think about them (Raniseski & Sigelman, 1992). As evidenced in these studies, there is a stigma associated with alcohol use disorders, as well as with receiving treatment for such disorders. The result is a decrease in the willingness for those who need treatment to seek out and receive it.

*Others’ Perceptions of Alcohol Abusers*

Although there has been growing acceptance of the disease concept of alcoholism (Jellinek, 1960), this has done little in decreasing the stigmatization associated with alcoholics. A stigma is still attached to the term “alcoholic” (Caetano, 1987; Dean & Poremba, 1983). Further, many continue to view alcoholism as a reflection of an individual’s weak will (Moore, 1992) or are clearly unsympathetic toward alcoholics because of the self-inflicted nature of the problem (Ritson, 1999).
To assess the extent to which negative attitudes are associated with the label “alcoholic,” respondents from a probability sample answered questions about first-impression images of individuals labeled as alcoholic and gave descriptive words for specific situations involving encountering an alcoholic (Dean & Poremba, 1983). One item stated, “You are walking down the street, round a corner, and encounter an alcoholic. What does the alcoholic look like?” The respondents’ image of the alcoholic was that of a skid row bum. Descriptive responses included, “gray hair, sick, shaky, unkempt, and lower class.” Most (53-100%) respondents gave similar descriptions of what the alcoholic looked like for all hypothetical situations presented. In addition, the majority of respondents (58%) reported that alcoholism is a disease; a minority viewed it as a sin (5%), a moral weakness (10%), an excuse (10%), or a mental illness (14%). This acceptance of alcoholism as a disease did not decrease the stigmatization and negative connotations associated with the term “alcoholic” (Dean & Poremba, 1983).

Another survey study revealed similar results (Caetano, 1987). The majority of respondents surveyed (90%) reported viewing alcoholism as an illness. Among these respondents, 45% thought it was a psychological disease; 25% thought it was a social problem; 4% thought it had genetic origins; 18% thought it was a genetic, social, psychological, and medical problem combined; and 34% classified it as a physical or emotional problem. Among those who viewed alcoholism as an illness, only 6% admitted they would have a lowered opinion of someone if they revealed they had an alcohol problem. However, 24% of those who believed that alcoholism is an illness also agreed with the statement, “I wouldn’t want a place where people with alcohol problems get treated to be near where I live” (Caetano, 1987). These findings also show that although
many view alcoholism as a disease or an illness, this view does not necessarily reduce the stigma.

Another study of alcoholism and stigma examined whether the belief that alcoholism is a disease is accompanied by compassion and acceptance of the alcoholic. In contrast to the results found by Dean and Poremba (1983) and Caetano (1987), Moore (1992) found that alcoholism is not viewed as an illness, but rather as a reflection of an individual's weak will. Specifically, 23% of respondents reported that alcoholism is most accurately described as a disease of the body, whereas 60% stated that alcoholism is a weakness in character. The individuals who viewed alcoholism as a disease were more likely to socially accept the alcoholic, be more tolerant of his or her behaviors, and be more charitable toward the alcoholic (Moore, 1992). These findings reveal that beliefs about the moral character of the alcoholic are perhaps more important than medical beliefs about alcoholism. The results may be due to the fact that the participants were supervisors in Federal nonmilitary installations of the Civil Service, where they may place great value on an individual's moral character and the ability to be in control of one's own actions (Moore, 1992).

Although some studies have shown that viewing alcoholism as a disease may be associated with negative attitudes toward the alcoholic, others have found that this does not occur. Rather (1991) gave college students one of two different "mission" statements regarding the types of services offered by the campus psychological services clinic and the latest scientific information on diagnosis and treatment of alcohol problems. The difference between the two statements was the presentation of either a disease or a social-learning model of alcoholism. Attitudes toward alcoholics were then measured in order to
see if reading the different views of alcoholism would lead to differing attitudes toward alcoholics depending on which statement was read. The disease statement described alcoholism as a chronic and progressive illness (similar to diabetes or heart disease) in which heredity and biological factors play a key role in the development of the illness and the course of the illness is irreversible. The social-learning statement described alcoholism as involving the chronic abuse of alcohol which is a deeply ingrained habit (similar to smoking or overeating), being a learned behavior to cope with life stressors that is influenced by the drinking habits of family and friends, and it is very difficult to change this habit once it is formed. The presentation of the disease or social-learning explanation did not significantly affect the types of attitudes held toward alcoholics. Both the disease and social-learning models were weakly related to stigma, and the acceptance of either view did not play a part in determining whether the participants sympathize with alcoholics (Rather, 1991).

Ritson (1999) assessed the level of stigmatization United Kingdom adults connect to severe depression, panic attacks, schizophrenia, dementia, eating disorders and alcohol and drug addictions. Among these disorders, 65% of adults rated alcohol addiction third with regard to its perceived danger to others. It was preceded only by drug addiction (74%) and schizophrenia (71%). Of the adults surveyed, 59% found it difficult to communicate with alcoholics, and 80% believed alcoholics were unpredictable (Ritson, 1999). The stereotypical behaviors associated with alcoholics, such as dangerous behavior and unpredictability, as well as the belief that alcoholism is self-inflicted, reflects unfavorable attitudes.
There is stigma attached to the label “alcoholic,” as well as to other referents of problematic drinking (Cash et al., 1984). These negative labels placed on alcoholics can contribute to their stigmatization because they have the potential to bias evaluators’ judgments about their behaviors. For example, simply labeling a male interviewee an alcoholic, without mentioning any consequences related to his drinking caused participants to want less contact with him in work and social situations, as compared to a male interviewee who was reported to have a normal drinking pattern (Cash et al., 1984).

In a study of 80 college students, participants listened to a recording of a structured interview with either a non-labeled student or an “alcoholic” student. If the students believed the man was an excessive drinker, they found him to be significantly more poorly adjusted, less likely to have a happy future, less in control of his drinking, and more in need of professional help than if the students believed he was a normal drinker. Also, the students were not as willing to pursue the excessive drinker’s friendship, invite him to a party where alcohol was served, or have him as a co-worker (Cash et al., 1984).

The findings show how the label “alcoholic” can negatively affect perceptions of individuals. It provides evidence for the existence of social stigma attached to the label, as well as the rejection experienced by the stigmatized in a social environment.

In another study, researchers considered the effect substance type may have on the degree of stigmatization of the substance abuser, including the ratings of the likelihood of recovery and the susceptibility to stigmatization of the abuser. In order to measure the stigmatization of a fictional individual (“John Smith”) with regard to his substance abuse (either alcohol, tobacco, or cocaine), researchers formed a stigma score by asking questions such as: “How uncomfortable would you feel about inviting John
Smith to a dinner party?” and “How likely do you think it would be for John Smith to get in trouble with the law because of his substance abuse problem?” (Cunningham, Sobell, & Chow, 1993). Each of the five items was scored on a 7-point Likert-type scale, with higher scores associated with stigma. Tobacco users were rated less stigmatized than alcohol or cocaine users. Also, those in the tobacco condition were significantly more likely to be believed if they made claims of recovery than those in the alcohol or cocaine conditions (Cunningham et al., 1993).

Kilty and Meenaghan (1977) examined how the label “alcoholic” interacted with other characteristics of social status, such as sex, religion, age, and employment status, and the effects this had on social rejection of the labeled individual. When examining ratings of respect, friendship acceptance, and social distance, Kilty and Meenaghan (1977) found that individuals labeled “alcoholic” were less respected than those labeled “problem drinker” or “nondrinker,” regardless of social status characteristics. The factor of respect consisted of scales that indicated whether the respondent would, “ask for the opinion of,” “plead with,” and “admire the character” of the labeled individual. This finding was consistent across their different sample groups, which included a rural community group, a group of graduate students, and a group of inmates at a state correctional facility. In examining ratings of friendship acceptance, however, “problem drinkers” were rated the least acceptable, followed by “alcoholics,” with “nondrinkers” rated the most favorably. The friendship acceptance scales included “be partners with in an athletic game,” “accept as an intimate friend,” and “eat with.” On this scale drinking label interacted with sex and race of respondent. Female respondents from the student sample rated all male stimuli as less acceptable than the male respondents, who rated
"nondrinkers" as most acceptable, with "problem drinkers" rated as more acceptable than "alcoholics." In the inmate group, black respondents placed importance on employment status for "nondrinkers" while employment status for "alcoholics" was important for white respondents. When examining the social distance scales, consisting of "accept as close kin by marriage," "work with," and "permit to do me a favor," drinking labels had no effect on the graduate students' ratings. However, in the community group, ratings of social distance were greatest for the "problem drinkers," and least for the "nondrinkers." Interactions among drinking status, age, and employment status were found in the inmate group. When the stimuli were young, unemployment increased ratings of social distance for "alcoholics" and "nondrinkers" but not for "problem drinkers." When the stimuli were older, unemployment increased social distance ratings for "problem drinkers" and "nondrinkers" but decreased for "alcoholics." This study demonstrated that although labeling led to social rejection, the combination of labels and other relevant social status characteristics is important to consider as well (Kilty & Meenaghan, 1977).

The previous studies revealed that labeling an individual "alcoholic" can negatively affect perceptions of the individual, and can bias observers' judgments. These individuals are not only more likely to be viewed as maladjusted and out of control, but also to interact with them is seen as an uncomfortable experience (Cash et al., 1984). Previous studies have also used measures of personality factors, such as the NEO Five-Factor Inventory (Costa & McCrae, 1989) and the Big Five Inventory (John, Donohue, & Kentle, 1991), to look at the relationship between alcohol use disorders and personality factors (Martin & Sher, 1994), as well as examine the expected personality characteristics of individuals who are dependent on alcohol (Malouff & Schutte, 2002).
In their four-year longitudinal study, Martin and Sher (1994) examined the relationship between alcohol use disorders and the five major personality dimensions in college students. Participants were interviewed to assess the presence of alcohol abuse and dependence, as well as other psychiatric disorders. Alcohol use disorders were found to be positively associated with neuroticism and negatively associated with agreeableness and conscientiousness. Similar personality factors were found to be associated with those dependent on alcohol when participants were asked to rate descriptions of an individual who was believed to be either dependent on alcohol or not dependent (Malouff & Schutte, 2002). Participants rated individuals in written descriptions that mention the person as being dependent on alcohol, as less agreeable and less conscientious than those in descriptions that do not mention any drinking. Other personality factors were related to alcohol dependence in certain situations. When the person was described as an attorney dependent on alcohol, participants rated the person as significantly higher on neuroticism, as well as significantly lower on agreeableness and conscientiousness compared to the description in which drinking was not mentioned. When the person was described as a college student dependent on alcohol, participants rated the person higher on extraversion, as well as lower on agreeableness and conscientiousness (Malouff & Schutte, 2002).

Because the present study used college students as participants, it was necessary to see if college students' views of drinking and their definitions of excessive drinking differed significantly from those of the general population. Although studies have shown that there is a stigma associated with alcoholics, research has shown that college students' definitions of excessive drinking differ from those of experts, which may cause a
difference in the extent to which they stigmatize alcoholics. Posavac (1993) found that 40 percent of college students questioned did not label intoxication as excessive drinking. Thirty-nine percent did not believe that six drinks in a two hour period was excessive for a man, and 44% did not believe that five drinks in a two hour period was excessive for a woman. However, a man less than 220 pounds and a woman less than 180 pounds would become intoxicated with these respective amounts of alcohol. Also, 45% of men failed to endorse a loss of memory after a party as an indication of a drinking problem, even though such memory loss is a sign of neurological damage. A large number of the students seemed to accept this as a part of drinking, but not necessarily an indication of excessive drinking (Posavac, 1993).

The reason college students’ definitions of excessive drinking differ from those of experts may have to do with the regular use of alcohol within this population, and the trivialization of the danger drinking poses. Among adolescents and young adults, alcohol use is extremely common and is even considered to be a part of displaying adult behaviors and internalizing social norms (Barnes, 1977). Although drinking among these age groups may be viewed as a normal, social behavior that may not call for clinical concern, it may cause these individuals to regard all alcohol use, even the physiological dependence on alcohol, as an acceptable behavior and simply a part of drinking. The Benthin, Slovic, Moran, Severson, Mertz, and Gerrard (1995) and the Posavac (1993) studies show that adolescents and young adults may have a different level of acceptance or tolerance for excessive alcohol use than other adult groups, and this may affect the extent to which they stigmatize alcoholics.
Many studies have established that there are negative attitudes held toward alcoholics. The focus of these studies has been on how individuals perceive alcoholics with regard to their physical appearance (Dean & Poremba, 1983), or the degree of social acceptance of alcoholics (Caetano, 1987, Cash et al., 1984, Cunningham et al., 1993, Moore, 1992). However, previous studies suffer from significant threats to internal validity that limit the inferences that can be drawn. For example, in the typical study individuals are asked to read about a hypothetical situation in the form of a vignette (Cunningham et al., 1993) or ask for participants’ attitudes toward alcoholics without providing any hypothetical situation or opportunity for observation (Caetano, 1987; Dean & Poremba, 1983; Moore, 1992; Ritson, 1999). There are limitations associated with using vignettes and hypothetical situations in measuring attitudes. For example, participants’ attitudes are often assessed with explicit attitudinal measures in an attempt to get a general idea of how they perceive a particular group. However, utilizing these means of assessment allows demand characteristics to influence participant attitudes. These attitudes may not be representative of real attitudes found in a non-laboratory setting. Also, the external validity of the study is questionable because vignettes require participants to rate individuals as if they were encountering a real person in a real situation.

Russo, Berman, Ziegler-Hill, Greer, and Mcloskey (2005) addressed some of these limitations by using direct observation of interviewees’ reported drinking patterns in the guise of developing an alcohol use measure. Moreover, this study improved on previous studies in this area by addressing the differentiation between stigma associated
with heavy alcohol use and the stigma associated with the consequences often associated with such drinking (Russo et al., 2005).

**Drinking Quantity versus Consequences**

Russo et al. (2005) examined which negative attitudes are associated with individuals who demonstrate excessive alcohol consumption only or excessive alcohol consumption and negative consequences related to their drinking. It was believed that participants would not stigmatize those who drank heavily, but did not experience negative consequences because they would be viewed as less threatening to survival compared to those who did experience consequences. Therefore, participants would rate them more positively and want to interact with them more than those drinkers who did experience negative consequences related to their drinking. In this study, participants watched an interview in which confederates described their drinking patterns.

Participants were assigned to one of three types of interviews: Heavy Drinkers with consequences related to drinking (or Alcohol Dependent), Heavy Drinkers without consequences, or Social Drinkers without consequences. Participants were then asked to rate the drinker in order to obtain their perceptions about the drinker (Russo et al., 2005).

Heavy Drinkers with consequences were rated more negatively than Social Drinkers who drank normal amounts and did not experience consequences related to drinking. In comparing the Alcohol Dependent drinkers and the Heavy Drinkers, the Alcohol Dependent drinkers were rated more negatively on the majority of the measures. However, participants indicated no significant differences in their willingness to interact with both of these groups. They also did not perceive the intellectual functioning of the interviewees in the Alcohol Dependent and Heavy Drinker groups to be significantly
different from each other. Participants may have viewed the Heavy Drinker group has
having similar problems with family and work as the Alcohol Dependent group, but were
just not reporting these problems (Russo et al., 2005).

Although this study distinguished between groups of Alcohol Dependent drinkers,
Heavy Drinkers, and Social Drinkers, it did not provide a group that drank normatively,
but also happened to experience some negative consequences related to their drinking.
The failure to include a group that experienced negative consequences but drank normal
amounts of alcohol made it impossible to determine the separate effect of drinking
consequences.

This study also lacked an important component of stigma, threat, which is often
the basis of stigmatizing behaviors. A large body of work has indicated that individuals
who are stigmatized are perceived as threatening by others (Angermeyer & Matschinger,
2003; Blascovich et al., 2001; Goffman, 1963; Jones et al., 1984; Katz, 1981; Madon et
al., 2005; Martin, Pescosolido, & Tuch, 2000; Schumacher, Corrigan, & Dejong, 2003).
The current study also included different consequences groups, including no
consequences, non-threatening consequences, and threatening consequences, in order to
determine the role that threat plays in stigmatization and to determine whether
participants would rate the different subtypes of consequences differently.

*The Role of Threat in Stigmatization*

Because attitudes toward the stigmatized are generally negative, stigmatized
individuals tend to be disliked to a greater extent than non-stigmatized individuals
(Crocker et al., 1998; Jones et al., 1984). Perceived threat is considered one form of the
affective component of stigmatizing. This suggests that processes affecting the
expression of negative attitudes or stigma toward the stigmatized are also related to perceived threat (Madon et al., 2005).

When individuals perceive an individual as dangerous or a threat, their desire to socially distance themselves from the individual becomes greater than when they do not perceive the individual as a threat (Link et al., 1987). It is believed that stigmas serve as cues that heighten our evaluation of danger, uncertainty, and required effort in certain situations, especially performance situations. Interactions with stigmatized individuals are viewed as threatening because of the increase in uncertainty and danger evaluations. Also, the decrease in external support, caused by a lack of similarity between the stigmatized and the non-stigmatized, contributes to the lowering of expectations of success in the interaction (Blascovich et al., 2001).

The stigma-threat hypothesis was tested to demonstrate the physiological responses individuals have when they must interact with a stigmatized person, as well as how individuals behave in these situations (Blascovich et al., 2001). The stigma-threat hypothesis states that perceivers interacting with stigmatized individuals experience threat (Blascovich et al., 2001). This threat may include a sense of uncertainty, discomfort, anxiety, or danger when interacting with the stigmatized individual (Crocker et al., 1998; Goffman, 1963). An experience of threat is often measured by looking at cardiovascular reactivity of participants when interacting with stigmatized confederates. Blascovich et al. (2001) found that when interacting with stigmatized partners, college students exhibited cardiovascular patterns associated with threat and performed more poorly on word-finding tasks than did those interacting with non-stigmatized others. In the first two studies performed by Blascovich et al. (2001), stigma was manipulated by
using facial birthmarks. In the last study, possible stigma-threat links were examined with regard to socioeconomic status and race. The studies provide evidence that physical stigmata, as well as social stigma, such as alcoholism, both engender threat.

Threat is also experienced by the stigmatized individual, and can negatively impact them in various ways. Stigmatized individuals aware of the negative stereotypes associated with their social identity may be affected by stereotype threat (Steele & Aronson, 1995). When stigmatized individuals are aware of the stereotypes associated with their condition or group, they become aware that they may be treated according to these stereotypes and may behave in a way that confirms these stereotypes. This leads to the state of stereotype threat. Because their social identity is devalued, their self-esteem is challenged and the fear they may behave in a way that threatens the image of their group increases (Steele & Aronson, 1995). They also become sensitive to cues that they will be devalued, and searching for these cues causes emotional distress and disruption of concentration (Steele, Spencer, & Aronson, 2002).

Stereotype threat can negatively affect the stigmatized individual’s performance in certain situations, especially when they are asked to identify the self with the stigmatized group to which they belong. When participants with a history of mental illness were asked to report that history, they performed worse on a standardized test than when they were not asked about their mental health history. Those who were not part of the stigmatized group, those without a history of mental health problems, did not perform significantly better or worse when asked about their mental health history than when they were not (Quinn, Kahng, & Crocker, 2004).
When individuals are categorized as members of a stigmatized group, they devalue themselves because they are now part of a group that the community views negatively. Individuals then use defenses because they are uncertain how others will react toward them. These defenses affect the way they interact with others, leading to uncomfortable interactions and isolation from others. This in turn influences certain abilities, such as obtaining a job, because they devalue themselves or they fear responses of others and withdraw from others, taking away their opportunities (Steele et al., 2002).

**Threat Associated with Alcohol Use Problems**

Perceived threat is often viewed as a necessary component in the stigmatization process (Blascovich et al., 2001; Jones et al., 1984; Madon et al., 2005). In certain situations, such as interacting with those with alcohol use problems, perceiving threat is understandable because of the information we have regarding the danger and violence associated with heavy alcohol consumption.

Some forms of alcohol misuse produce behavioral changes, which can be disturbing and frightening to people because of their unpredictability (Ritson, 1999). Individuals with alcohol use problems have been found to be more anxious, depressed, neurotic, impulsive, and sociopathic than individuals without these problems (John & Srivastava, 1999). They have also been shown to possess socially handicapping characteristics, such as being not as agreeable or conscientious of others than those without alcohol use problems (Malouff & Schutte, 2002).

Many believe that alcohol consumption contributes to crime, and that aggressive behaviors are the result of excessive alcohol consumption (Leigh, 1987; Lindman & Lang, 1994). Studies have found correlations between alcohol use and many different
kinds of violence, such as verbal arguments, aggression, sexual abuse, and homicide (Leonard & Quigley, 1999; Miller, Wilsnack, & Cunradi, 2000; Parker, 1995; Testa & Livingston, 2000; Wells, Graham, & West, 2000). Studies have shown that approximately 50% of violent crimes involved alcohol use of one or both parties (Murdoch, Pihl, & Ross, 1990). Researchers have also shown that alcohol-related aggression is more likely among heavy drinkers that often drink until the point of intoxication than among light drinkers (Dawson, 1997; Rossow, 1996). The link between alcohol use and aggression has also been found in laboratory studies, which have showed that individuals who consumed alcohol responded to provocation more aggressively than those who did not consume alcohol (Bushman & Cooper, 1990; Chermack & Giancola, 1997).

Studies have shown that the lack of contact or interactions with those with alcohol use problems has to do with the belief that these individuals are threatening or unstable, unpredictable figures. In a study of United Kingdom adults, 65% rated alcohol addiction third with regard to its perceived danger to others. Alcohol addiction was only preceded by drug addiction (74%) and schizophrenia (71%). Eighty percent believed that alcoholics exhibited behaviors that were unpredictable (Ritson, 1999). Therefore, the belief that alcoholics pose some type of threat is accurate because of the information we have regarding their behaviors when drinking. Also, studies have shown that individuals are aware of this threat, and allow it to play a part in determining their willingness to interact with alcoholics.
Expected Effects of Alcohol

It is a widely held belief that the pharmacological effects of alcohol on the brain cause individuals to lose inhibition and engage in behaviors they normally would not engage in when sober (MacAndrew & Edgerton, 1969). Alcohol enhances the effectiveness of inhibitory neurotransmitters that reduce fear, thus increasing the likelihood of an intoxicated person responding aggressively when perceiving any type of threat. Other studies have focused on how alcohol alters cortical functioning, affecting the ability to control emotions (Graham, Leonard, Room, Wild, Pihl, Bois, & Single, 1998). The loss of inhibition may result in intoxicated people participating in minor antisocial activities, as well as criminal behavior (Critchlow, 1986).

The pharmacological effects of alcohol, however, might not be the only contributor to behavioral changes that occur when people drink. This approach fails to take into account the influence of social processes on behavior (Pernanen, 1991). The drinking context, such as the people one is drinking with, their relationships with one another, and the type of setting, is an important factor to take into consideration (Graham et al., 1998). The cultural and social attitudes and expectations of alcohol and its effects on aggressive behavior are also important in examining the link between alcohol and aggression (Graham et al., 1998; MacAndrew & Edgerton, 1969). Evidence of the impact of social processes includes the various behavioral changes that occur across cultures and even within the same culture across time (MacAndrew & Edgerton, 1969).

The expectancy model suggests that people are aggressive after consuming alcohol because of their learned beliefs about the effects of alcohol and what is socially acceptable behavior when one is intoxicated (Chermack & Giancola, 1997; MacAndrew
& Edgerton, 1969). These expectations of the effects of alcohol allow intoxicated people to believe that they could engage in bad behavior without being condemned. For example, they could behave aggressively without being viewed as an aggressive person and labeled deviant (MacAndrew & Edgerton, 1969).

When individuals have expectations that alcohol consumption leads to aggressive behavior, this interacts with alcohol consumption to predict alcohol-related aggression (Chermack & Taylor, 1995). Also, when individuals have a more aggressive or irritable disposition, alcohol consumption often leads to aggressive responding (Bailey & Taylor, 1991; Fishbein, Jaffe, Snyder, Haertzen, & Hickey, 1993; Giancola, 2002; Pernanen, 1991). Individuals who had alcohol expectancies for aggression and who also drank heavily were more likely to report aggressive behaviors. As aggressive disposition and alcohol consumption increased, certain aggressive behaviors increased as well. Such behaviors included fighting in bars and breaking things after drinking (Barnwell, Borders, & Earleywine, 2006).

Studies have shown that the general population has learned beliefs about how alcohol affects someone emotionally and behaviorally, depending on the frequency and amount they drink. While social drinkers are expected to become kinder, more fun, more aggressive, louder, more relaxed, and sloppier when intoxicated, alcoholics are expected to become meaner, less fun, more aggressive, louder, less relaxed, and sloppier (Isaacs, 1977). There are a number of expectations about the effects of alcohol that are shared across cultures. Alcohol is expected to release inhibitions, to be a factor in criminal behavior, and to cause relaxation, sociability, and behavioral impairment (Critchlow,
Thus, although people believe alcohol has negative effects on behavior, they believe it has desirable effects as well.

Some beliefs about alcohol result from one’s personal experiences with alcohol use. Light and heavy drinkers have different expectations of the effects of alcohol. While light drinkers may think of the sedative effects of alcohol, heavy drinkers are more likely to think of the positive effects of alcohol, such as sociability and relaxation (Earleywine & Martin, 1993). Heavy drinkers view alcohol in a more positive light, seeing alcohol as less likely to cause crime, aggressive behavior, or loss of control. Although they experience more negative effects of alcohol, such as hangovers, fights, missing work, and accidents, they expect alcohol to have a number of positive effects on them (Cahalan & Room, 1974; Orcutt, 1978).

These expectations of alcohol-related behavior have led to some behaviors becoming acceptable and excusable when a person is intoxicated. The “malevolence assumption” states that merely the known presence of alcohol in a negative situation causes people to conclude that alcohol was responsible for the situation (Hamilton & Collins, 1981). Because of the known effects alcohol has on cognitive processes, the worse the act or behavior, the more likely people are to believe alcohol was involved (Critchlow, 1983). Often the drinker is excused for his or her behavior because the alcohol, not the drinker, is seen as responsible for the behavior (Room, 1983).

People tend to judge an alcohol-related incident as less severe simply because alcohol was involved (Tryggvesson, 2004). This different norm system that is applied to drunken behavior compared to sober behavior allows for society to approve of intoxication as an excuse for certain behaviors (Tryggvesson & Bullock, 2006). If the
victim is also drinking, blame of the aggressor decreases. People are more likely to believe the victim provoked the aggressor, and therefore aggressive acts can be explained as self-defense (Tryggvesson, 2004). When two people who are intoxicated fight, “the fight is not a fight, it is just two drunks who behave as drunken people do” (Tryggvesson & Bullock, 2006, p. 74).

The model that directly links alcohol and violence has often been rejected because alcohol does not always lead to aggressive behavior (Permanen, 1981). It appears that the general population also fails to see a direct link between alcohol and aggression. Although people believe that alcohol changes behavior, they do not see these effects as consistently occurring. People tend to believe that the effects of alcohol on behavior are determined by the substance itself, as well as by situational, social, and emotional factors (Permanen, 1981).

**Limitations of Previous Studies**

Some of the studies previously mentioned are limited with regard to how attitudes toward alcoholics are measured. Rather than using direct observation of a person believed to have an alcohol problem, some studies provide a hypothetical situation in the form of a vignette (Cunningham et al., 1993) or ask for participants’ attitudes without providing any hypothetical situation or opportunity for observation (Caetano, 1987; Dean & Poremba, 1983; Moore, 1992; Ritson, 1999). Another limitation of the previously mentioned studies includes the disregard of an important aspect of problematic drinking, this being the consequences often associated with such drinking. In measuring the attitudes toward the drinker, studies often focus on the label “alcoholic” (Cash et al., 1984; Cunningham et al., 1993), rather than the consequences related to problematic drinking.
drinking. Also, an important component of stigma, threat, has not been examined with regard to its relation to stigma toward alcohol consumption and associated negative consequences.

The purpose of the current study was to examine the separate and combined effects of drinking pattern (e.g. heavy versus social) and drinking consequences (e.g. no consequences, non-threatening consequences, and threatening consequences) on the stigma measures. The current study examined different subtypes of consequences in order to determine if the introduction of a threat component would lead to more negative ratings. Since not all heavy drinkers demonstrate aggressive behaviors when drinking (Pernanen, 1981), it was worthwhile to tease apart the different ways drinking affects people and to examine others’ reactions to these different consequences. The types of consequences examined included non-threatening consequences that may be viewed as harmful to the drinker himself, such as neglecting family and work obligations, and threatening consequences that are harmful to others, such as dangerous, aggressive behavior.

Stigma is measured with regard to the extent to which participants wish to socially interact with the interviewee (Kelly, St. Lawrence, Smith, Hood, & Cook, 1987), what they perceive the interviewee’s intellectual functioning to be, whether they think the interviewee possesses negative qualities such as being dishonest and not responsible (Stafford & Petway, 1977), and whether they expect the interviewee to possess personality characteristics that are often perceived as negative such as low agreeableness and low conscientiousness (Malouff & Schutte, 2002). In addition, perceived interviewee threat will be assessed in order to examine effects of perceived threat on stigma outcome.
measures (Madon et al., 2005). Also, participants’ affective responses toward the
interviewee will be assessed in order to determine if degree of liking for the interviewee
influences stigma (Jussim, Nelson, Manis, & Soffin, 1995).

It was hypothesized there would be a significant main effect for drinking pattern
for the stigma outcome measures. Specifically, heavy drinkers would be rated more
negatively than social drinkers on all outcome measures. It was also hypothesized there
would be a significant main effect for drinking consequences for the stigma measures.
Specifically, the threatening consequences group would be rated more negatively than the
non-threatening and no consequences groups on all outcome measures. Additionally, it
was predicted there would be significant interactions between drinking pattern and
drinking consequences for the stigma outcome measures.
CHAPTER III
PILOT STUDY

Method

Participants

For the pilot study, a separate sample (N = 42; 38 women and 4 men ages 18 to 35, mean age 22.26 [sd = 3.53]) watched the stimulus tapes (each tape was viewed an average of 2.33 times) with the volume turned off. Of the pilot participants, 33.3% self-identified as Caucasian, 61.9% as African-American, 2.4% as Asian, and 2.4% as “other.” Study participants were undergraduate students who received course credit for participation.

All measures used in the main stigma study were also used in the pilot study (see Appendices E, F, G, H, I, and J), except for the Alcohol Use Disorders Identification Test (AUDIT; Saunders et al., 1993), the Short Michigan Alcoholism Screening Test for Fathers (F-SMAST), and the Short Michigan Alcoholism Screening Test for Mothers (M-SMAST) (Selzer, Vinokur, & vonRooijen, 1975). These measures were not administered during the pilot phase of the study because the purpose of this phase was to ensure that nonverbal differences did not exist between the actors and the taped conditions. Comparisons between participants based on their personal and familial alcohol use were reserved for the main manipulation of the study.

Measures

Assessing stigma. The Social Interaction Scale (SIS) (Kelly et al., 1987) (Appendix E) was given to participants as one measure of stigmatization of the interviewee. The SIS is a 7-item scale that describes possible casual interactions with a
designated individual. This scale is rated on a Likert-type scale (1=not at all and 7=very much). Lower total scores are indicative of higher levels of stigma. Items on the SIS include, “If you met this individual, would you be willing to strike up a conversation with him?” and “Would you be willing to work in the same office with this individual?” The SIS has been shown to differentiate between those diagnosed with AIDS and those with no diagnosis, as well as those with a history of intravenous drug usage and those without any such history (Forrester & Murphy, 1992). In their assessment of potential interactions with AIDS patients, Lewis and Range (1992) found an internal consistency of the items to be .93. Internal consistency of the items in the current stigma study was .90.

Participants were given a modified semantic differential scale with 12 five-point bipolar adjective pairs to evaluate their attitudes and stereotypes toward the interviewee (Stafford & Petway, 1977) (Appendix F). The scales represent evaluative factors (good-bad, honest-dishonest, healthy-sick), an activity factor (fast-slow), a potency factor (strong-weak), morality factors (moral-immoral, respectable, not respectable), and accountability factors (responsible-not responsible, reliable-not reliable). Other items that were used include, hopeful-hopeless, unselfish-selfish, and uncritical-critical. Each of these scales has two adjectives that represent the extremes. Participants rated the drinker they viewed using each pair of adjectives. Lower scores reflect a more positive attitude toward the drinker, while higher scores reflect more negative attitudes associated with the interviewee (Stafford & Petway, 1977). Internal consistency of the items in the current stigma study was .91.

In order to examine the expected personality characteristics of the interviewee, participants were given the Big Five Inventory (John et al., 1991) (Appendix G).
measure contains 44 personality characteristics that respondents rated with regard to what they expected the drinker to have based on what they viewed in the video. For example, some characteristics include, “Starts quarrels with others” and “Makes plans and follows through with them.” Each characteristic is rated using a five-point Likert scale (1=disagree strongly to 5=agree strongly). There are five scales for which the scores are produced: agreeableness, extraversion, conscientiousness, neuroticism, and openness to experience. Agreeableness can be described as helpfulness or trust, extraversion as assertiveness or warmth, conscientiousness as competence or order, neuroticism as anxiety or anger, and openness to experience as imagination or aesthetic. The scales of this inventory have good reliability with Cronbach’s alphas ranging from .75 to .90 (John & Srivastava, 1999). In the current stigma study Cronbach’s alphas ranged from .69 to .88. Studies have shown that the scales have good convergent and discriminate validity that is equivalent or better than other validated measures of the Big Five (John & Srivastava, 1999).

In order to assess whether ratings of the interviewees’ perceived intelligence are influenced by alcohol consumption and/or related consequences, participants were asked to estimate the IQ of the drinker using the classification ratings and numerical categories from the Wechsler Tests. The classification ratings and categories include Extremely Low (below 70), Borderline (70-79), Low Average (80-90), Average (90-110), High Average (110-120), Superior (120-130), and Very Superior (130 and above) (Wechsler, 1997).

A behavioral measure of stigma was used to provide an alternative means of measuring participants’ attitudes towards the interviewees that differed from the written
measures. After the written measures were administered, participants were told that they were to briefly interview the drinker they watched using questions provided by the experimenter. They were told that the interview would be videotaped and possibly used in another experiment with the participants’ permission. Participants were also told that prior to this interview they were to arrange two chairs where they would like themselves and the interviewee to sit so that the camera angle could be adjusted. To ensure consistency in initial distance between the chairs, the experimenter placed the two chairs approximately ten inches apart prior to asking participants to move them. The distance between the participants’ and interviewees’ chairs was calculated as a measure of social distance. After participants’ positioned the two chairs, it was revealed to them that they would not be interviewing the drinker.

Assessing affective response. The Positive and Negative Affect Schedule (PANAS) (Watson, Clark, & Tellegen, 1988) (Appendix H) was given to participants as a measure of their affect after watching the interview. The PANAS consists of words that describe different feelings and emotions. It includes ten words that represent positive affect and ten that represent negative affect that are rated on a Likert-type scale (1=very slightly or not at all and 5=extremely). Items that assess positive affect include: attentive, interested, alert, excited, enthusiastic, inspired, proud, determined, strong, and active. Items that assess negative affect include: distressed, upset, hostile, irritable, scared, afraid, ashamed, guilty, nervous, and jittery. The PANAS can assess affect using different time instructions including, right now, today, during the past few days, during the past week, during the past few weeks, during the past year, and in general or on average (Watson et al., 1988). The current study used the right now time instructions.
The scales of this inventory have good reliability with Cronbach’s alphas ranging from .86 to .90 for positive affect, and .84 to .87 for negative affect. In the current stigma study Cronbach’s alphas were .88 for positive affect, and .86 for negative affect. The PANAS scales have been shown to offer good convergent and discriminant validity, correlating highly with their corresponding regression-based factor scores and remaining independent measures of positive and negative affect (Watson et al., 1988).

The Self-Assessment Manikin (SAM) (Lang, 1980; Hodes, Cook, & Lang, 1985) (Appendix I) was given as an additional measure of affective response. The SAM is a non-verbal pictorial measure that assesses the pleasure and arousal dimensions of current affect. The SAM items range from a happy figure to an unhappy figure to assess pleasure, and an excited figure to a relaxed figure to assess arousal level. Participants were asked to place an “X” over any of the five figures in each scale or between any two figures, resulting in a 9-point rating scale for each of the two dimensions (Lang, 1980; Hodes et al., 1985). The SAM pleasure and arousal scores are highly correlated with semantic differential pleasure and arousal scores (Bradley & Lang, 1994).

Assessing perceived threat. In order to assess participants’ threat reactions, participants responded to five semantic differentials. These items include how comfortable versus threatened, calm versus tense, secure versus anxious, safe versus scared, and relaxed versus distressed the interviewee made them feel (Madon et al., 2005) (Appendix J). Participants rated each item on a 7-point scale ranging from one to seven. Higher values indicate greater threat reactions toward the interviewee. Internal consistency of the items in the current stigma study was .94.

Procedure
Before conducting the main stigma study, pilot data were collected in order to ensure that differences did not exist between the stimulus conditions based on non-verbal sources of tape variance. Such differences include behaviors or appearances of the actors that may cause participants to rate them based on these factors instead of the verbal information presented in the stimulus tapes.

Forty-two participants ($N = 42$; 38 women and 4 men) were randomly shown one of six scripted drinking histories with the volume turned off. The scripted drinking histories included Social Drinkers with No Consequences (drink occasionally and do not exhibit any negative behaviors related to drinking) ($n = 7$ women, $n = 0$ men), Social Drinkers with Non-threatening Consequences (drink occasionally, but exhibit non-threatening negative behaviors when drinking, such as missing work or family obligations) ($n = 7$ women, $n = 0$ men), Social Drinkers with Threatening Consequences (drink occasionally, but exhibit threatening behaviors when drinking, such as getting into physical fights) ($n = 7$ women, $n = 0$ men), Heavy Drinkers with No Consequences (drink daily and do not exhibit any negative behaviors related to drinking) ($n = 7$ women, $n = 0$ men), Heavy Drinkers with Non-threatening Consequences (drink daily, and exhibit non-threatening negative behaviors when drinking, such as missing work or family obligations) ($n = 4$ women, $n = 3$ men), and Heavy Drinkers with Threatening Consequences (drink daily, and exhibit threatening behaviors when drinking, such as getting into physical fights) ($n = 6$ women, $n = 1$ man).

After watching the tapes, participants rated the drinkers using the previously described measures. In order to further ensure that physical characteristics or behaviors of the drinker did not influence ratings, three different male actors were used for each of the
six tapes. The three actors were adult, white males, ages 25, 27, and 29 years old. In order to maintain a similar appearance among the actors, they all wore a t-shirt and jeans during filming. To ensure that participants would not recognize the actors, the experimenter recruited untrained volunteers who were not college students. The actors were provided with scripts that they memorized prior to filming the interview. However, cue cards were available for the actors to refer to during filming. The actors practiced the scripts until they could smoothly provide the scripted responses to the interview questions. The experimenter monitored the filming of the interviews to ensure consistency between the tapes, and that they were identical to the scripts.

Results

Pilot data were collected to determine if non-verbal cues or other differences in the interview tapes affected ratings on outcome measures secondary to the verbal information presented in the stimulus tapes. Recall that the pilot phase was conducted to ensure that differences do not exist between the conditions based on non-verbal sources of tape variance. In the pilot phase, three actors were used for all six tapes, 18 tapes total.

The first set of pilot analyses examined the three actors collapsed across the stimulus tape conditions. No significant differences were found between the actors on any of the outcome measures, all ps > .12 (See Table 1).

Table 1

<table>
<thead>
<tr>
<th></th>
<th>Actor 1</th>
<th>Actor 2</th>
<th>Actor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>M (SD)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mean1 (SD1)</td>
<td>Mean2 (SD2)</td>
<td>Mean3 (SD3)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Adjective Descriptors</td>
<td>2.56 (0.76)</td>
<td>2.85 (0.44)</td>
<td>2.86 (0.47)</td>
</tr>
<tr>
<td>Social Interaction</td>
<td>4.19 (1.05)</td>
<td>3.79 (0.73)</td>
<td>3.50 (1.34)</td>
</tr>
<tr>
<td>IQ</td>
<td>102.07 (11.27)</td>
<td>95.79 (9.36)</td>
<td>94.86 (15.02)</td>
</tr>
<tr>
<td>Social Distance</td>
<td>19.89 (6.91)</td>
<td>22.43 (8.12)</td>
<td>24.29 (12.14)</td>
</tr>
<tr>
<td>Positive Affect</td>
<td>24.71 (9.56)</td>
<td>22.43 (8.59)</td>
<td>25.00 (10.35)</td>
</tr>
<tr>
<td>Negative Affect</td>
<td>13.64 (4.92)</td>
<td>14.00 (6.82)</td>
<td>15.14 (6.43)</td>
</tr>
<tr>
<td>SAM (Happy/Unhappy)</td>
<td>4.07 (2.06)</td>
<td>4.21 (1.89)</td>
<td>5.43 (2.03)</td>
</tr>
<tr>
<td>SAM (Excited/Calm)</td>
<td>7.07 (2.87)</td>
<td>6.64 (2.44)</td>
<td>7.21 (1.97)</td>
</tr>
<tr>
<td>Perceived Threat</td>
<td>15.86 (7.69)</td>
<td>12.29 (6.74)</td>
<td>14.00 (6.50)</td>
</tr>
<tr>
<td>Neuroticism</td>
<td>25.21 (7.42)</td>
<td>24.57 (5.35)</td>
<td>26.57 (5.79)</td>
</tr>
<tr>
<td>Extraversion</td>
<td>23.64 (9.24)</td>
<td>19.29 (8.77)</td>
<td>16.71 (8.02)</td>
</tr>
<tr>
<td>Agreeableness</td>
<td>28.93 (8.06)</td>
<td>27.29 (6.58)</td>
<td>31.93 (7.90)</td>
</tr>
<tr>
<td>Conscientiousness</td>
<td>26.57 (6.38)</td>
<td>25.29 (5.72)</td>
<td>25.71 (9.64)</td>
</tr>
<tr>
<td>Openness</td>
<td>27.07 (5.14)</td>
<td>26.71 (6.80)</td>
<td>24.64 (12.14)</td>
</tr>
</tbody>
</table>

Note. All ps > .12

Of course, failure to reject a null hypothesis is not the same as saying groups are equivalent (Tryon, 2001). Equivalence testing is not possible in the current circumstances because we do not have theoretical grounds for identifying a range that defines equivalence (Tryon, 2001). That is, we have no a priori cutoff for determining whether the mean differences lie within an amount that is considered inconsequential on the basis of substantive theoretical considerations. However, we examined whether the inferential confidence intervals overlap for the most distal means in a group of means for each
analysis, above, and found that these all overlapped (Tryon, 2001). These findings do not provide evidence that these groups were statistically equivalent, but we can say that, at worst, the overlapping inferential confidence intervals support the notion that these cases are statistically indeterminate with respect to equivalency (Tryon, 2001).
CHAPTER IV
STIGMA STUDY

Method

Participants

For the main stigma study, participants ($N = 168$; 134 women and 34 men ages 18 to 37, mean age 20.67 [sd = 2.54]) watched the same tapes viewed in the pilot phase with the volume turned on (each tape was viewed an average of 9.33 times). Of the main study participants, 53.6% self-identified as African-American, 41.1% as Caucasian, 2.4% as Asian, 1.8% as Hispanic, and 1.2% as “other.” Participants for this study were undergraduate students who received course credit for participation.

Measures

Stigma study participants were administered the stigma, participant affect, and perceived threat measures (see Appendices E, F, G, H, I, and J). In addition to these measures, which are described in the Pilot Study chapter, participants were also administered measures that assessed personal and familial alcohol use problems.

Assessing personal and familial alcohol problems. To assess participant alcohol consumption, the Alcohol Use Disorders Identification Test (AUDIT) (Claussen & Aasland, 1993; Saunders et al., 1993; World Health Organization, 2001) was given (See Appendix C). The AUDIT was developed by the World Health Organization in order to identify individuals who consume a hazardous and harmful amount of alcohol. The AUDIT includes 10 items that measure amount and frequency of drinking, alcohol dependence, and problems caused by alcohol consumption, and can be completed in 2-5 minutes. Questions on the AUDIT include, “How often do you have a drink containing
alcohol?" and "How often during the last year have you failed to do what was normally expected from you because of drinking?" Scores of zero to four can be given on each item, giving a total score that can range from 0 to 40. Total scores are divided into three groups of drinking patterns: 'normal' (0-8), 'hazardous' (9-18), and 'harmful' (19+). In the present study the AUDIT was used to identify participants who consume hazardous and harmful amounts of alcohol. The AUDIT was selected to identify these individuals because it is more sensitive in detecting less severe drinking problems, rather than more advanced problems such as established alcohol dependence. This is important because participants were college students, and may be less likely to display advanced stages of alcoholism. The alpha reliabilities cited for the total scale of the AUDIT range from .75 to .94 (Allen, Litten, & Fertig, 1997). Internal consistency of the items in the current stigma study was .83. Ninety-two percent of those diagnosed as having hazardous or harmful alcohol use were found to have a score of 8 or more on the AUDIT, while 94% of those with non-hazardous consumption had scores of less than 8 on the AUDIT (Saunders et al., 1993). In a college student sample, discriminate analysis found that 78% of all participants were correctly classified by the AUDIT (Fleming, Barry, & MacDonald, 1991).

To assess parental alcohol use, the Short Michigan Alcoholism Screening Test for Fathers (F-SMAST) and Short Michigan Alcoholism Screening Test for Mothers (M-SMAST) (Crews & Sher, 1992; Hedlund & Vieweg, 1984; Selzer, 1971; Selzer, Vinokur, & vonRooijen, 1975) was given to participants (See Appendix D). The F-SMAST and the M-SMAST are self-administered versions of the Michigan Alcoholism Screening Test (MAST). Each of these measures includes 13 of the 24 items on the original MAST, and
are designed to identify children of alcoholics for clinical and research purposes. Items include, “Was your (mother/father) able to stop drinking when she/he wanted to?” and “Has your (mother/father) ever gone to anyone for help about her/his drinking?” The SMAST is highly correlated with the MAST ($r = .93$ for alcoholic groups, $r = .90$ for non-alcoholic groups, and $r = .97$ for combined groups). The original MAST was initially developed as a questionnaire to be administered by an interviewer to detect alcoholism.

In the present study the F-SMAST and M-SMAST were used to identify a family history of alcoholism in mothers and fathers of participants. The 13 items on the F-SMAST and the M-SMAST require a simple yes or no response and can be given in 10-15 minutes. The items are given scores of 0, 1, 2, or 5 points if they are answered in a particular way, and the total score is the sum of the points received on all of the items. A score of three points or less is considered characteristic of a non-alcoholic, four points is viewed as suggestive of alcoholism, and five points or more is indicative of alcoholism. This interpretation of the scores has been used frequently with different populations of alcoholics and non-alcoholics (Selzer, 1971).

For the SMAST, internal consistency estimates range from .76 to .91. These are slightly less than the estimates for the MAST, which range from .83 to .95 (Hedlund & Vieweg, 1984). Internal consistency estimates in the current study were .92 for the M-SMAST, and .93 for the F-SMAST. Validity coefficients for SMAST total scores and alcoholism versus control group membership were .83 to .94 (Selzer et al., 1975).

Procedure
Prior to the study, participants signed a consent form (See Appendix B). In order to test the hypotheses of interest, certain aspects of the study, including the fact that the drinkers were actors, were withheld from the participants until the end of the experiment.

In order to get the most accurate assessment of the participants’ attitudes toward the drinker in the video, participants were not told that their attitudes would be measured. As a manipulation check, participants were given a scoresheet in accordance with the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I; First, Spitzer, Gibbon, & Williams, 1997) and asked to check whether evaluation criteria were met as they watched the stimulus tapes. Participants were told:

This experiment is a reliability and validity study on an alcohol use measure. The reliability study will examine the consistency with which the individual in the video is rated with regard to his or her alcohol use. The validity study is a way to examine whether the alcohol use measure is accurately measuring only alcohol use and not other problems. You will be watching an interview of an individual in which questions about his alcohol use will be asked. You will be given a scoresheet; please check whether the criteria are absent or present in the drinker you will watch in the video.

One hundred sixty-eight participants \( N = 168 \); 134 women and 34 men) were randomly shown one of six taped stimulus conditions, which included male interviewees being administered the alcohol dependence section of the SCID-I. Participants watched one of the following drinking histories: Social Drinker with No Consequences \( n = 24 \) women, \( n = 4 \) men), Social Drinker with Non-threatening Consequences \( n = 23 \) women, \( n = 5 \) men), Social Drinker with Threatening Consequences \( n = 19 \) women, \( n = 9 \) men),
Heavy Drinker with No Consequences \((n = 21\) women, \(n = 7\) men), Heavy Drinker with Non-threatening Consequences \((n = 22\) women, \(n = 6\) men), and Heavy Drinker with Threatening Consequences \((n = 25\) women, \(n = 3\) men).

The reason for including threat as a negative consequence of drinking is to examine whether the addition of this component further differentiates the drinkers that do experience negative consequences from those who do not experience negative consequences. The reason for using men as the target population is due to the general tendency of men to report more adverse consequences of their drinking than women (Makela & Mustonen, 2000), therefore making the taped conditions more believable to the participants. It has been found that women drink less than men, which leads to women experiencing fewer alcohol-related problems than men. Such consequences include drunken driving (Makela & Mustonen, 2000) and increased aggression and violence (Leonard & Senchak, 1993; Pernanen, 1991). The research looking at aggression in women has been limited, and aggression studies that have been conducted have provided mixed results (Giancola, 2002, 2003; Giancola & Zeichner, 1995). Men are more than twice as likely as women to have been drinking prior to assaulting another person and prior to being victimized, such as in fighting with other males. The reason for using male actors in their twenties was that they are more likely to be involved in alcohol-related violence than older or younger respondents (Pernanen, 1991). Lastly, men are more likely to behave more aggressively than women in any situation, regardless of their alcohol use (Eagly & Steffen, 1986). Also, in adding the component of threat, it is more believable that physical violence and threatening behaviors would be more
representative of men than women. Future studies where collecting larger samples is feasible may examine potential gender differences in stigmatization.

After viewing the tapes, participants indicated their affective responses toward the interviewee by responding to the PANAS and SAM items. Participants indicated how threatening they perceived the interviewee to be by responding to five semantic differentials. These items measure perceive threat by assessing, for example, how calm or tense and how comfortable or threatened the interviewee made them feel (Madon et al., 2005).

Participants were then asked to complete the attitude measures. The SIS was given in order to assess the extent to which the participants would interact with the interviewee in given situations. Participants were given sets of bipolar adjectives in order to measure negative attitudes toward the interviewee. They were also given the Big Five Inventory to determine what personality characteristics participants expect the interviewee to possess. Participants were asked to estimate the IQ of the interviewee given the classification ratings and numerical categories from the Wechsler Tests (Wechsler, 1997). After the written measures were administered, participants completed the behavioral measure, in which participants believed they would be interviewing the drinker and were asked to arrange two chairs for participant and drinker to sit. Social distance was determined by measuring the distance between the participants’ and drinkers’ chairs.

Participants, excluding the pilot study participants, completed brief questionnaires that assessed their fathers’ and mothers’ lifetime alcohol abuse (F-SMAST, M-SMAST), as well as identified alcohol consumption of the participants that is hazardous or harmful.
to his or her health (AUDIT). A score of four or more points on the F-SMAST and the M-SMAST was considered suggestive of a possible alcohol use problem. Participants scoring greater than eight on the AUDIT were considered to have hazardous or harmful drinking patterns. These participants were provided with referral sources after completion of the study. In order to assess any effects the stimulus tapes may have had on the participants’ responses on the F-SMAST, M-SMAST, and AUDIT, half of the participants answered these measures before watching the tapes and half answered them after watching the tapes.

Following the administration of the measures, the experimenter asked the participants what they thought the basis of the study was to ensure that participants were unaware of the actual purpose of the study, which was to examine the effects of alcohol use patterns and consequences related to alcohol use on stigmatization and social rejection related to alcohol use. The participants were then debriefed, thanked for their participation, and questions were answered. They were also asked to refrain from discussing the experiment with any students in order to keep future subjects blind to certain aspects of the study.

**Results**

*Manipulation Check-Criterion Ratings*

Manipulation checks were completed with the stigma study sample in order to ensure that participants attended to the interview scripts and provided correct diagnoses for the interviewees based on the information they obtained from the interview. Participants were provided with the score sheet for the Alcohol Dependence section of the SCID-I, and were asked to rate whether each criterion was met during the interview.
When three or more criteria were met, participants were instructed to give a diagnosis of Alcohol Dependence.

A one-way analysis of variance revealed that the alcohol conditions differed with respect to the number of alcohol dependence criteria endorsed, $F(5, 162) = 65.68, p < .001$. Post hoc mean comparisons indicated that there were no significant differences between the Heavy Drinker with Threatening Consequences ($M = 5.25; sd = 1.27$) and the Heavy Drinker with Non-threatening Consequences conditions ($M = 5.29; sd = 1.21$). Thus, participants endorsed more criteria for both of the heavy drinker with consequences groups compared to all other groups. There were no significant differences between the Heavy Drinker with No Consequences ($M = 1.82; sd = 1.31$), Social Drinker with Threatening Consequences ($M = 2.32; sd = 1.54$), and Social Drinker with Non-threatening Consequences conditions ($M = 2.71; sd = 1.63$). As expected, the least criteria were endorsed for the Social Drinker with No Consequences conditions ($M = .21; sd = .63$).

With respect to actual diagnoses, all participants who watched the Heavy Drinker with Threatening Consequences ($n = 28$) and the Heavy Drinker with Non-threatening Consequences ($n = 28$) conditions rated the interviewee as Alcohol Dependent; that is, they endorsed three or more criteria. The majority of participants, 18 of 28, who watched the Heavy Drinker with No Consequences condition did not rate the interviewee as Alcohol Dependent. Thus, heavy drinking alone did not lead to participants providing a diagnosis of Alcohol Dependence.

Interestingly, drinking consequences played an important role in rating the Social Drinkers as Alcohol Dependent. Fifteen of 28 of participants rated Social Drinkers with
Threatening Consequences and 16 of 28 rated Social Drinkers with Non-threatening Consequences as Alcohol Dependent. Thus, the pattern of results indicate that Heavy Drinkers without consequences and Social Drinkers with consequences created ambivalence in participant ratings, with some participants giving a diagnosis of Alcohol Dependence to these drinkers and others choosing not to give a diagnosis.

**Deception**

At the end of the experiment, participants were asked what they thought the purpose of the study was and their role in the study. This was done to ensure that participants were unaware of the actual purpose of the study, which was to examine the effects of alcohol use patterns and consequences related to alcohol use on stigmatization and social rejection related to alcohol use. All participants appeared to be unaware of the real purpose of the study. That is, all participants believed that they were assisting in the development of an alcohol use measure.

**Alcohol Use History**

To determine if group differences exist with respect to participant and parental alcohol use, the *Alcohol Use Disorders Identification Test* (AUDIT; Saunders et al., 1993) and the *Short Michigan Alcoholism Screening Test for Fathers* (F-SMAST) and *Short Michigan Alcoholism Screening Test for Mothers* (M-SMAST) (Selzer, Vinokur, & vonRooijen, 1975) were administered to the stigma study participants (Appendices B and C). A 2 (social drinker x heavy drinker) by 3 (no consequences x non-threatening consequences x threatening consequences) analysis of variance (ANOVA) was conducted to assess main effects and interactions. If effects emerged one could argue that differences on the stimulus tapes were due to differences in personal or familial alcohol...
use, and these would be controlled for statistically. See Table 2 for all means and standard deviations for personal and familial alcohol use measures.
Table 2

Means and standard deviations for personal and familial alcohol use measures for social drinkers and heavy drinkers with threatening, non-threatening, or no consequences (N = 168)

<table>
<thead>
<tr>
<th></th>
<th>Social Drinkers</th>
<th>Heavy Drinkers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Threatening</td>
<td>Non-Threatening</td>
</tr>
<tr>
<td><strong>M (SD)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AUDIT</td>
<td>2.14 (2.27)</td>
<td>2.71 (3.66)</td>
</tr>
<tr>
<td>M-SMAST</td>
<td>0.68 (2.14)</td>
<td>0.43 (1.45)</td>
</tr>
<tr>
<td>F-SMAST</td>
<td>1.64 (3.05)</td>
<td>1.54 (3.47)</td>
</tr>
</tbody>
</table>
For the AUDIT, responses were scored from 0 to 40 with higher scores (scores of 9+) reflecting hazardous and harmful use of alcohol. With regard to the AUDIT total score, results indicated that there was no significant main effect for drinking pattern, $F(1, 162) = 0.11, p = .74$. Also, no significant main effect was found for drinking consequences, $F(2, 162) = 1.94, p = .15$. No significant interactions were found between drinking pattern and drinking consequences on AUDIT total scores, $F(2, 162) = 0.47, p = .63$ (See Table 3).

Table 3

*Summary table for two-way analysis of variance for AUDIT scores (N = 168)*

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>$F$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinking Pattern</td>
<td>1</td>
<td>0.11</td>
<td>.74</td>
</tr>
<tr>
<td>Consequences</td>
<td>2</td>
<td>1.94</td>
<td>.15</td>
</tr>
<tr>
<td>Pattern x Consequences</td>
<td>2</td>
<td>0.47</td>
<td>.63</td>
</tr>
<tr>
<td>Error</td>
<td>162</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>168</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For the F-SMAST and the M-SMAST, responses of four or greater are suggestive of alcohol use problems in fathers and mothers. In examining the total score for the F-SMAST, results indicated no significant main effect for drinking pattern, $F(1, 162) = 0.95, p = .33$. Also, no significant main effect was found for drinking consequences, $F(2, 162) = 2.13, p = .12$. No significant interactions were found between drinking pattern and drinking consequences on F-SMAST total scores, $F(2, 162) = 2.21, p = .11$ (See Table 4).

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Similar results were also found with the M-SMAST total scores. No significant main effect for drinking pattern was found, $F(1, 162) = 0.18, p = .67$. Also, no significant main effect was found for drinking consequences, $F(2, 162) = 0.22, p = .80$. No significant interactions were found between drinking pattern and drinking consequences on M-SMAST total scores, $F(2, 162) = 1.77, p = .17$ (See Table 5).

Table 4

*Summary table for two-way analysis of variance for F-SMAST scores (N = 168)*

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>$F$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinking Pattern</td>
<td>1</td>
<td>0.95</td>
<td>.33</td>
</tr>
<tr>
<td>Consequences</td>
<td>2</td>
<td>2.13</td>
<td>.12</td>
</tr>
<tr>
<td>Pattern x Consequences</td>
<td>2</td>
<td>2.21</td>
<td>.11</td>
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<td>Error</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td>168</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 5

Summary table for two-way analysis of variance for M-SMAST scores (N = 168)

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
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<tbody>
<tr>
<td>Drinking Pattern</td>
<td>1</td>
<td>0.18</td>
<td>.67</td>
</tr>
<tr>
<td>Consequences</td>
<td>2</td>
<td>0.22</td>
<td>.80</td>
</tr>
<tr>
<td>Pattern x Consequences</td>
<td>2</td>
<td>1.11</td>
<td>.17</td>
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<tr>
<td>Error</td>
<td>162</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>168</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Stigma and Related Outcome Measures

A 2 (social drinker x heavy drinker) by 3 (no consequences x non-threatening consequences x threatening consequences) analysis of variance (ANOVA) was conducted to assess main effects and interactions for all outcome measures. It was predicted there would be significant main effects for drinking pattern and drinking consequences, as well as significant interactions between drinking pattern and drinking consequences for the stigma outcome measures. Significant main effects were followed by Tukey’s HSD post hoc tests, and significant interactions were followed by simple effects analyses. Significant tests were conducted using alpha = .05. See Table 6 for all means and

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1 An insufficient number of men were included in the study to examine gender as a moderator. Main analyses were rerun separately for women participants only to examine whether the same patterns and effects emerged. Findings did not significantly differ from those reported, which used combined data from both women and men participants.
standard deviations for outcome measures. See Table 7 for bivariate correlations between all stigma outcome measures.
Table 6

Means and standard deviations for outcome measures for social drinkers and heavy drinkers with threatening, non-threatening, or no consequences *(N=168)*

<table>
<thead>
<tr>
<th></th>
<th>Social Drinkers</th>
<th>Heavy Drinkers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Threatening</td>
<td>Non-Threatening</td>
</tr>
<tr>
<td></td>
<td>M (SD)</td>
<td>M (SD)</td>
</tr>
<tr>
<td>Adjective Descriptors</td>
<td>2.98 (.62)</td>
<td>2.75 (.66)</td>
</tr>
<tr>
<td>IQ</td>
<td>93.71 (12.11)</td>
<td>95.36 (10.63)</td>
</tr>
<tr>
<td>Neuroticism</td>
<td>27.86 (5.09)</td>
<td>22.64 (5.45)</td>
</tr>
<tr>
<td>Extraversion</td>
<td>23.54 (5.80)</td>
<td>23.86 (4.44)</td>
</tr>
<tr>
<td>Agreeableness</td>
<td>21.68 (5.91)</td>
<td>28.21 (5.47)</td>
</tr>
<tr>
<td>Conscientiousness</td>
<td>22.07 (4.69)</td>
<td>23.39 (6.88)</td>
</tr>
<tr>
<td>Openness</td>
<td>23.93 (5.54)</td>
<td>25.18 (5.06)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td></td>
<td>3.42 (1.01)</td>
<td>3.74 (1.13)</td>
</tr>
<tr>
<td>Social Interaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Distance</td>
<td>32.52 (6.98)</td>
<td>30.46 (6.62)</td>
</tr>
<tr>
<td>Perceived Threat</td>
<td>16.39 (6.51)</td>
<td>12.68 (5.45)</td>
</tr>
<tr>
<td>Positive Affect</td>
<td>29.07 (8.14)</td>
<td>26.79 (7.15)</td>
</tr>
<tr>
<td>Negative Affect</td>
<td>13.64 (4.57)</td>
<td>13.68 (7.63)</td>
</tr>
<tr>
<td>SAM 1</td>
<td>3.96 (1.69)</td>
<td>3.93 (1.51)</td>
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<tr>
<td>SAM 2</td>
<td>6.68 (2.07)</td>
<td>7.14 (1.56)</td>
</tr>
</tbody>
</table>
Table 7

**Correlation Matrix of Stigma Outcome Measures (N = 168)**

<table>
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<tr>
<th>Measures</th>
<th>1</th>
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<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adjective Descriptors</td>
<td>-.41**</td>
<td>.57**</td>
<td>.06</td>
<td>-.67**</td>
<td>-.69**</td>
<td>-.42**</td>
<td>-.62**</td>
<td>.07</td>
<td>.43**</td>
<td>-.14</td>
<td>.01</td>
<td>.35**</td>
<td>-.06</td>
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<tr>
<td>2. IQ</td>
<td>-.41**</td>
<td>.11</td>
<td>.42**</td>
<td>.47**</td>
<td>.36**</td>
<td>.48**</td>
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<td>-.31**</td>
<td>-.05</td>
<td>.01</td>
<td>-.25**</td>
<td>-.05</td>
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</tr>
<tr>
<td>3. Neuroticism</td>
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<td>-.77**</td>
<td>-.67**</td>
<td>-.41**</td>
<td>-.45**</td>
<td>.28**</td>
<td>.48**</td>
<td>-.01</td>
<td>.07</td>
<td>.18*</td>
<td>-.16*</td>
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<td>4. Extraversion</td>
<td>-.06</td>
<td>.05</td>
<td>.38**</td>
<td>.05</td>
<td>.04</td>
<td>.02</td>
<td>-.01</td>
<td>-.10</td>
<td>-.08</td>
<td>-.06</td>
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<tr>
<td>5. Agreeableness</td>
<td>.73**</td>
<td>.48**</td>
<td>.58**</td>
<td>-.26**</td>
<td>-.51**</td>
<td>.02</td>
<td>-.01</td>
<td>-.18*</td>
<td>.14</td>
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<tr>
<td>6. Conscientiousness</td>
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<td>-.65**</td>
<td>-.18*</td>
<td>-.37**</td>
<td>.03</td>
<td>.10</td>
<td>-.19*</td>
<td>.01</td>
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<tr>
<td>7. Openness</td>
<td>-.46**</td>
<td>-.17*</td>
<td>-.24**</td>
<td>.02</td>
<td>.02</td>
<td>-.14</td>
<td>.02</td>
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<tr>
<td>8. Social Interaction</td>
<td>-.14</td>
<td>-.45**</td>
<td>.11</td>
<td>-.04</td>
<td>-.28**</td>
<td>.03</td>
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<td></td>
</tr>
<tr>
<td>9. Social Distance</td>
<td>-.30**</td>
<td>.01</td>
<td>.10</td>
<td>-.04</td>
<td>-.14</td>
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<td></td>
</tr>
<tr>
<td>10. Perceived Threat</td>
<td>-.02</td>
<td>.19*</td>
<td>.23**</td>
<td>-.40**</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>11. Positive Affect</td>
<td>-.06</td>
<td>-.35**</td>
<td>-.23**</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Negative Affect</td>
<td>-.22*</td>
<td>-.19*</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>13. SAM 1</td>
<td>-.</td>
<td>.10</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>14. SAM 2</td>
<td>-.</td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

*p < .01**, *p < .05*
Semantic differential ratings. For the semantic differential scale, responses were scored from one to five with higher scores reflecting a more negative attitude toward the interviewee ("dishonest") and lower scores reflecting a more positive attitude ("honest"). The mean of the semantic differential ratings were used in the analyses as an overall measure of negative attitudes. A significant main effect for drinking pattern was found, $F(1, 162) = 35.86, p < .01$. Specifically, Heavy Drinkers ($M = 3.13$) were rated more negatively than Social Drinkers ($M = 2.56$). A significant main effect was also found for drinking consequences $F(2,162) = 22.06, p < .01$. Tukey's HSD indicated that the No Consequences group ($M = 2.41$) was rated less negatively than the other two groups, Non-threatening ($M = 2.99$) and Threatening ($M = 3.14$).

A significant two-way interaction was found between drinking pattern and drinking consequences $F(2, 162) = 3.36, p = .04$ (See Table 8 and Figure 1).

Table 8

Summary table for two-way analysis of variance for semantic adjective descriptors ($N = 168$)

<table>
<thead>
<tr>
<th>Source</th>
<th>$df$</th>
<th>$F$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinking Pattern</td>
<td>1</td>
<td>35.86</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Consequences</td>
<td>2</td>
<td>22.06</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Pattern x Consequences</td>
<td>2</td>
<td>3.36</td>
<td>.037</td>
</tr>
<tr>
<td>Error</td>
<td>162</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>168</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Figure 1. Significant interaction between drinking pattern and drinking consequences for semantic adjective descriptors.

This interaction was explored by examining simple effects for the Social and Heavy Drinker drinking patterns. A significant simple effect, $F(2, 81) = 21.38, p < .01$, was found for Social Drinkers. Post hoc mean comparisons indicated that the No Consequences group ($M = 1.95$) was rated less negatively compared to the Non-threatening ($M = 2.75$) and Threatening ($M = 2.98$) groups. No differences were found between the two consequences groups.

A significant simple effect, $F(2, 81) = 4.09, p = .02$, was also found for Heavy Drinkers. However, the pattern of mean differences was somewhat different. Specifically, for Heavy Drinkers the No Consequences group ($M = 2.86$) was rated less negatively...
than the Threatening group ($M = 3.31$), but the Non-threatening group ($M = 3.22$) did not significantly differ from either of these two groups.

**Perceived IQ.** In measuring perceived IQ, participants were instructed to classify the interviewees' estimated level of intelligence by placing them into one of seven categories that include Extremely Low (below 70), Borderline (70-79), Low Average (80-90), Average (90-110), High Average (110-120), Superior (120-130), and Very Superior (130 and above) (Wechsler, 1997). As expected, higher scores on the IQ measure indicate higher perceived IQ.

With regard to perceived IQ of participants, a significant main effect was found for drinking pattern, $F(1, 162) = 15.77, p < .01$. Heavy Drinkers ($M = 91.43$) were given lower scores on perceived IQ than Social Drinkers ($M = 97.76$). A significant main effect was also found for drinking consequences $F(2, 162) = 5.46, p = .01$. Post hoc mean comparisons indicated that there were no differences between the Non-threatening Consequences ($M = 92.75$) and Threatening Consequences ($M = 92.71$) groups, but both were rated lower than the No Consequences group ($M = 98.32$).

There was also a significant interaction between drinking pattern and drinking consequences, $F(2, 162) = 3.26, p = .04$ (See Table 9 and Figure 2).

**Table 9**

*Summary table for two-way analysis of variance for perceived IQ (N = 168)*

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>$F$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinking Pattern</td>
<td>1</td>
<td>15.77</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Consequences</td>
<td>2</td>
<td>5.46</td>
<td>.005</td>
</tr>
</tbody>
</table>
Figure 2. Significant interaction between drinking pattern and drinking consequences for perceived IQ.

This interaction was explored by examining simple effects for Social and Heavy Drinkers. A significant simple effect was found for Social Drinkers $F(2, 81) = 7.43, p < .01$. Post hoc mean comparisons indicated that there were no differences between the Non-threatening ($M = 95.36$) and Threatening ($M = 93.71$) groups, but both of these groups were rated lower than the No Consequences ($M = 104.21$) group.
In contrast to Social Drinkers, no significant simple effect was found for Heavy Drinkers $F(2, 81) = 0.41, p = .67$. Thus, participants rated interviewees that were social drinkers who reported no consequences as having higher intellectual functioning than social drinkers reporting either non-threatening or threatening consequences. However, heavy drinkers were overall reported to have lower IQ scores irrespective of consequences.

*Perceived personality ratings.* The *Big Five Inventory* was used in order to examine the expected personality characteristics of the interviewees. Each characteristic is rated from one (disagree strongly) to five (agree strongly). There are five scales for which the scores are produced: neuroticism, extraversion, agreeableness, conscientiousness, and openness to experience.

For the Neuroticism scale, there was a significant main effect for drinking pattern $F(1, 162) = 26.17, p < .01$, with Heavy Drinkers ($M = 27.51$) rated higher on this scale than Social Drinkers ($M = 22.08$). A significant main effect was also found for drinking consequences $F(2, 162) = 36.23, p < .01$. Post hoc analyses suggested that all three groups differed from each other. The No Consequences group ($M = 19.50$) was rated the least neurotic, with the Non-threatening group ($M = 24.36$) between the other two groups on neuroticism scores. The Threatening Consequences ($M = 30.54$) group was rated as the most neurotic of the groups.

No significant interactions were found between drinking pattern and drinking consequences on the neuroticism scale, $F(2, 168) = 1.23, p = .30$. See Table 10 for summary table for two-way analysis of variance for all *Big Five Inventory* scales.
For the Extraversion scale, there was no significant main effect for drinking pattern, $F(1, 162) = 0.29, p = .59$, or for drinking consequences, $F(2, 162) = 0.81, p = .45$. There was no significant interaction between drinking pattern and drinking consequences, $F(2, 162) = 0.10, p = .91$.

For the Agreeableness scale, a significant main effect was found for drinking pattern $F(1, 162) = 23.94, p < .01$, such that Social Drinkers ($M = 28.26$) were rated as more agreeable than Heavy Drinkers ($M = 23.44$). A significant main effect was also found for drinking consequences $F(2, 162) = 48.78, p < .01$. Post hoc analyses indicated that all three groups differed significantly from each other. The No Consequences group ($M = 31.32$) was rated as the most agreeable. The Non-threatening Consequences group ($M = 26.73$) fell between the other two groups. The Threatening Consequences group ($M = 19.50$) was rated as the least agreeable of the groups.

There was no significant interaction between drinking pattern and drinking consequences on the agreeableness scale, $F(2, 162) = 1.55, p = .22$.

For the Conscientiousness scale, there was a significant main effect for drinking pattern $F(1, 162) = 54.31, p < .01$, with Social Drinkers ($M = 25.55$) rated as more conscientious than Heavy Drinkers ($M = 17.18$). A significant main effect was also found for drinking consequences $F(2, 162) = 21.39, p < .01$. Post hoc mean comparisons suggested that there were no differences between the Non-threatening ($M = 19.46$) and the Threatening ($M = 18.07$) groups. However, the No Consequences group ($M = 26.55$) was rated higher on this scale compared to the other two groups.

There was no significant interaction between drinking pattern and drinking consequences for the conscientiousness scale, $F(2, 162) = 0.15, p = .86$. 

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For the Openness scale, a significant main effect was found for drinking pattern $F(1, 162) = 17.30, p < .01$, with Social Drinkers ($M = 24.95$) rated as more open to experience than Heavy Drinkers ($M = 20.61$). There was no main effect for drinking consequences, $F(2, 162) = 2.63, p = .08$. There was no significant interaction between drinking pattern and drinking consequences on the openness scale, $F(2, 162) = 0.54, p = .59$. 
Table 10

Summary table for two-way analysis of variance for Big Five Inventory scales (N = 168)

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Neuroticism</th>
<th>p</th>
<th>Extraversion</th>
<th>p</th>
<th>Agreeableness</th>
<th>p</th>
<th>Conscientiousness</th>
<th>p</th>
<th>Openness</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinking Pattern</td>
<td>1</td>
<td>26.17 &lt; .001</td>
<td>0.29</td>
<td>23.94 &lt; .001</td>
<td>0.69</td>
<td>54.31 &lt; .001</td>
<td>1.70</td>
<td>17.30 &lt; .001</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consequences</td>
<td>2</td>
<td>36.23 &lt; .001</td>
<td>0.81</td>
<td>48.78 &lt; .001</td>
<td>0.46</td>
<td>21.39 &lt; .001</td>
<td>0.26</td>
<td>2.63 .075</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Pattern x Consequences</td>
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<td>0.15</td>
<td>0.54 .586</td>
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<tr>
<td>Error</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Social interaction. With the SIS, responses were scored from one to seven, with higher scores reflecting a more positive attitude toward the interviewee (more willing to interact with the interviewee) while lower scores reflected a more negative attitude (less willing to interact with the interviewee).

A significant main effect was found for drinking pattern $F(1, 162) = 27.51, p < .01$, with participants desiring more social interaction with Social Drinkers ($M = 4.00$) than with Heavy Drinkers ($M = 3.06$). A main effect was also found for drinking consequences $F(2, 162) = 10.47, p < .01$. Post hoc analyses indicated that the No Consequences group ($M = 4.10$) was rated less negatively than the other two groups. There were no differences between the Non-threatening Consequences ($M = 3.35$) and Threatening Consequences ($M = 3.14$) groups.

There was no significant interaction between drinking pattern and drinking consequences on the SIS, $F(2, 162) = 2.23, p = .11$ (See Table 11).

Table 11

Summary table for two-way analysis of variance for Social Interaction ($N = 168$)

<table>
<thead>
<tr>
<th>Source</th>
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<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinking Pattern</td>
<td>1</td>
<td>27.51</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Consequences</td>
<td>2</td>
<td>10.47</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Pattern x Consequences</td>
<td>2</td>
<td>2.23</td>
<td>.111</td>
</tr>
<tr>
<td>Error</td>
<td>162</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td>168</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Social distance. With regard to measuring social distance, recall participants believed they were to interview the drinker at the end of the experiment. Prior to this interview the researcher asked the participants to arrange two chairs where they would like themselves and the interviewee to sit. The distance between the participants’ and interviewees’ chairs was calculated as a measure of social distance.

There was no significant main effect for drinking pattern, $F(1, 162) = 1.45, p = .23$. Thus, there were no significant differences between chair distance for Social Drinkers and Heavy Drinkers. A significant main effect was found for drinking consequences $F(2, 162) = 4.13, p = .02$. Post hoc analyses suggested that the Non-threatening group ($M = 29.68$) was rated less negatively than the Threatening Consequences group ($M = 33.84$). However, the No Consequences group ($M = 30.57$) did not significantly differ from either of the other two groups.

There was no significant interaction between drinking pattern and drinking consequences on the measure of social distance, $F(2, 162) = 1.55, p = .22$ (See Table 12).

Table 12

Summary table for two-way analysis of variance for Social Distance ($N = 168$)

<table>
<thead>
<tr>
<th>Source</th>
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<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinking Pattern</td>
<td>1</td>
<td>1.45</td>
<td>.230</td>
</tr>
<tr>
<td>Consequences</td>
<td>2</td>
<td>4.13</td>
<td>.018</td>
</tr>
<tr>
<td>Pattern x Consequences</td>
<td>2</td>
<td>1.55</td>
<td>.215</td>
</tr>
<tr>
<td>Error</td>
<td>162</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Perceived threat. In order to examine participants’ threat reactions toward the interviewees, participants responded to five semantic differentials, which were rated from one (least perceived threat) to seven (greatest perceived threat).

A significant main effect was found for drinking pattern $F(1, 162) = 5.22, p = .02$. Thus, participants perceived the Heavy Drinkers ($M = 14.68$) as more threatening than the Social Drinkers ($M = 12.57$). There was also a significant main effect for drinking consequences $F(2, 162) = 12.91, p < .01$. Post hoc mean comparisons indicated that the Threatening Consequences group ($M = 16.79$) was rated as more threatening than the other two groups. No differences were found between the No Consequences ($M = 11.18$) and Non-threatening Consequences ($M = 12.91$) groups.

There was no significant interaction between drinking pattern and drinking consequences, $F(2, 162) = 2.59, p = .08$ (See Table 13).

Table 13

Summary table for two-way analysis of variance for Perceived Threat ($N = 168$)

<table>
<thead>
<tr>
<th>Source</th>
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<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinking Pattern</td>
<td>1</td>
<td>5.22</td>
<td>.024</td>
</tr>
<tr>
<td>Consequences</td>
<td>2</td>
<td>12.91</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Pattern x Consequences</td>
<td>2</td>
<td>2.59</td>
<td>.078</td>
</tr>
<tr>
<td>Error</td>
<td>162</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>168</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Participant affect. To examine participants’ affect after watching the interviews, they were administered the PANAS and the SAM. With the PANAS, total scores for positive and negative affect were calculated, with items scored from one (very slightly or not at all) to five (extremely). Higher total scores indicated that participants experienced more positive or more negative affect after watching the interviews. With the SAM, the two items of this measure were examined separately. Participants rated their affect from one to nine on measures of pleasure (happy/unhappy) and arousal (excited/relaxed). Higher scores on the first item indicated that the participant was unhappier, and higher scores on the second indicated they were in a more relaxed state.

No significant main effect for drinking pattern was found for positive affect, $F(1, 162) = 0.01, p = .97$. However, a significant main effect was found for drinking consequences $F(2, 162) = 8.47, p < .01$. Post hoc mean comparisons indicated that participants who watched the No Consequences group ($M = 32.57$) experienced more positive affect than those who watched the Non-threatening Consequences group ($M = 26.27$). However, participants who watched the Threatening Consequences group ($M = 29.77$) did not differ on positive affect from those who watched either of the other two groups.

No significant interaction was found between drinking pattern and drinking consequences for positive affect, $F(2, 162) = 0.32, p = .72$. See Table 13 for the summary table for two-way analysis of variance for measures of participant affect.

In examining negative affect, there was no significant main effect for drinking pattern, $F(1, 162) = 3.07, p = .08$, or for drinking consequences, $F(2, 162) = 0.12, p = .89$. 

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There were no significant interactions between drinking pattern and drinking consequences, $F(2, 162) = 0.69, p = .50$.

For the first SAM item (happy/unhappy), there was no significant main effect for drinking pattern, $F(1, 162) = 0.31, p = .58$ or drinking consequences, $F(2, 162) = 2.16, p = .12$. There was no significant interaction between drinking pattern and drinking consequences, $F(2, 162) = 1.19, p = .31$. Similarly, for the second SAM item (excited/relaxed), there was no significant main effect for drinking pattern, $F(1, 162) = 0.23, p = .63$ or drinking consequences, $F(2, 162) = 1.44, p = .24$. There was no significant interaction between drinking pattern and drinking consequences, $F(2, 162) = 0.13, p = .88$. 

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Table 14

*Summary table for two-way analysis of variance for measures of Participant Affect (N = 168)*

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>F</th>
<th>p</th>
<th>F</th>
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<th>p</th>
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<td>Drinking Pattern</td>
<td>1</td>
<td>0.01</td>
<td>.970</td>
<td>3.07</td>
<td>.082</td>
<td>0.31</td>
<td>.578</td>
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<td>.634</td>
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<td>Consequences</td>
<td>2</td>
<td>8.47</td>
<td>&lt;.001</td>
<td>0.12</td>
<td>.888</td>
<td>2.16</td>
<td>.119</td>
<td>1.44</td>
<td>.241</td>
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<tr>
<td>Pattern x Consequences</td>
<td>2</td>
<td>0.32</td>
<td>.724</td>
<td>0.69</td>
<td>.501</td>
<td>1.19</td>
<td>.308</td>
<td>0.13</td>
<td>.880</td>
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<td>Error</td>
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<td>Total</td>
<td>168</td>
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<td></td>
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</table>
Previous studies have shown that there are negative attitudes associated with alcohol dependence (Cash et al., 1984; Moore, 1992; Ritson, 1999), and stigma attached to the label “alcoholic” (Caetano, 1987; Cash et al., 1984; Dean & Poremba, 1983; Kilty & Meenaghan, 1977). People also tend to perceive alcoholics as dangerous (Blascovich et al., 2001; Jones et al., 1984; Madon et al., 2005), causing them to socially distance themselves from alcoholics (Blascovich et al., 2001; Link et al., 1987). Studies have shown that stigma associated with alcohol use disorders and with receiving treatment decreases the willingness of people to enter treatment programs (Copeland, 1997; Grant, 1997; Raniseski & Sigelman, 1992). Although previous studies were useful in providing evidence that alcoholism is associated with significant social stigma, the present study has attempted to address limitations of these studies and obtain information on the specific alcohol-related behaviors that contribute to stigmatization.

The goal of the present study was to examine separate and combined effects of drinking pattern (e.g. social versus heavy) and drinking consequences (e.g. no consequences versus non-threatening consequences versus threatening consequences) on stigma outcome measures. The present study examined different subtypes of consequences in order to determine if the introduction of a threat component would lead to more negative ratings. Since not all heavy drinkers demonstrate aggressive behaviors when drinking (Pernanen, 1981), it was worthwhile to tease apart the different ways drinking affects people and to examine others’ reactions to these different consequences. The types of consequences examined included non-threatening consequences that have
everyday effects on the lives of alcoholics, such as neglecting family and work obligations, and threatening consequences that are physically destructive to others, such as dangerous, aggressive behavior.

First, it was hypothesized that there would be a significant main effect for drinking pattern on all outcome measures. Significant main effects for drinking pattern were found for most of the stigma outcome measures, indicating that participants rated heavy drinkers more negatively than social drinkers on most measures. These findings reflect those of previous studies which show that people want less contact with heavy drinkers in work and social situations, view them as poorly adjusted, less likely to have a happy future, less in control of their drinking (Cash et al., 1984), respect them less (Kilty & Meenaghan, 1977), and view them as more neurotic, less agreeable, and less conscientious (Malouff & Schutte, 2002). Studies also show that people believe that alcohol consumption contributes to crime and that aggressive behaviors are the result of excessive alcohol consumption (Leigh, 1987; Lindman & Lang, 1994).

A significant main effect for drinking pattern was not found for the Extraversion scale of the Big Five Inventory. These findings differed from those of Malouff and Schutte (2002), in which college students described as alcohol dependent were rated higher on the Extraversion scale than college students who were not alcohol dependent. However, these differences may be the result of the present study’s method, which allowed the participant to view the drinker while they were being interviewed. During this interview the drinker was sober and not exhibiting drunken behavior. Since the drinkers were not exhibiting negative behaviors, participants may have viewed them as pleasant, average individuals rather than drinkers with consequences related to their
drinking. This additional characteristic may have caused a change in attitudes toward the drinker (Wilder, 1984). Also, it can be argued that the Extraversion scale does not indicate more favorable or unfavorable traits in an individual as compared to the other scales of the Big Five Inventory.

A significant main effect was not found for the social distance measure either. It is possible that participants rated social and heavy drinkers similarly on this measure because the drinkers were sober in the interview, and not exhibiting drunken behaviors that would make participants wary of interacting with the drinkers. Also, participants likely felt safer and more comfortable interacting with the drinkers while in a laboratory setting and in the presence of the experimenter compared to in a more realistic setting, such as in a bar. These factors may have a significant impact on participants’ desire to be near the drinkers.

Significant main effects for drinking pattern were not found for measures of participant affect, which included positive and negative affect total scores on the PANAS and both items of the SAM. This finding may have also been due to the laboratory setting and the fact that the drinkers were sober during the interview, possibly preventing participants from experiencing affect they would have normally experienced had they observed the drinkers in another setting while drinking.

Overall findings indicate that participants rated heavy drinkers more negatively than social drinkers on the majority of the stigma outcome measures. Thus indicating that participants took into account quantity of alcohol consumed when rating the drinkers.
It was also hypothesized there would be a significant main effect for drinking consequences for the stigma outcome measures. This hypothesis was supported in that main effects were found for the majority of the stigma outcome measures. The predicted direction of negative ratings (No Consequences < Non-threatening Consequences < Threatening Consequences) was only found with the Neuroticism and Agreeableness scales. When examining the differences between ratings for the threatening consequences, non-threatening consequences, and no consequences groups, there were similarities among the outcome measures in that the no consequences group was often viewed as significantly more favorable than the other two consequences groups. On some measures, specifically the semantic differential ratings, perceived IQ, the Conscientiousness scale of the Big Five Inventory, and the SIS, participants did not indicate significant differences between drinkers disclosing non-threatening or threatening consequences. Rather both of these consequences groups were both rated significantly more negatively than the no consequences group. It should be noted that although there were no significant differences between the consequences groups on these measures, negative ratings were in the predicted direction.

On the measure of perceived threat, participants rated drinkers with threatening consequences as significantly more threatening than drinkers with non-threatening or no consequences. This finding was expected as the questions on this measure targeted how threatened the drinker made the participant feel, and the drinkers in the threatening consequences group disclosed specific information about their threatening behaviors when drinking.
On measures of social distance and participants' positive affect, significant findings were not in the predicted direction. With regard to social distance, participants desired more physical distance from the drinkers with threatening consequences compared to drinkers with non-threatening consequences. However, drinkers with no consequences were not given significantly different ratings than either of the other two groups. With regard to participant affect, positive affect scores were greater with participants who viewed the no consequences group compared to those who viewed the non-threatening consequences group. However, there were no significant differences between participants who viewed the threatening consequences group and those who viewed either of the other two groups. These findings should be interpreted cautiously given the number of analyses conducted. However, they may provide useful information for future studies on drinking consequences and stigma.

Significant main effects for drinking consequences were not found for the Extraversion and Openness scales of the *Big Five Inventory*, for the negative affect scores of the PANAS, or for both items of the SAM. It should be noted, however, that although not significant, negative ratings on the Extraversion and Openness scales were in the predicted directions.

There are several proposed explanations for the present study findings. First, in examining reasons why no differences were found between the two consequences group, it is worth questioning whether participants took into consideration the effects of alcohol on cognitive processes. Although the threatening consequences group exhibited more disturbing behavior when drinking, participants may have viewed their actions as being out of their control or just impulsive behavior. Often people believe that drinkers can be
excused for their behavior, allowing them to be irrational without destroying their moral standing (Room, 1983). Perhaps this may be an explanation for why this group was often given ratings equivalent to those in the non-threatening consequences group. Although their behavior was viewed negatively, their behavior may not be seen as a reflection of their character or the type of person participants believed the drinker to be.

Similarly, participants’ expectations of the effects of alcohol on aggressive behavior may have contributed to findings. Studies have shown the general population has learned beliefs about how alcohol affects someone emotionally and behaviorally depending on the frequency and amount they drink. While social drinkers are often expected to exhibit more benign behaviors, alcoholics are expected to become meaner, less fun, more aggressive, louder, and less relaxed (Isaacs, 1977). Our expectations of alcohol-related behaviors have led us to view some behaviors as excusable or even socially acceptable. The drinker’s behavior is excused as the alcohol is seen as responsible for the behavior rather than the drinker (Hamilton & Collins, 1981).

Other factors to consider include the participants’ beliefs about the drinking contexts in which aggressive behavior was exhibited. People tend to believe that not only are the effects of alcohol determined by the substance itself, but also by situational, social, and emotional factors (Martin, 1992). For example, it is necessary to determine if the participants believed the drinkers were only exhibiting aggressive behavior with people who were also intoxicated or if they were victimizing sober individuals. Tryggvesson (2004) has shown that aggressive acts against victims who are also drinking are often justified as self-defense.
Although people have a tendency to excuse an intoxicated person for their behavior, they also want to punish the person for being deviant and possibly putting others in harm’s way (Critchlow, 1983). Thus, if participants viewed the drinkers’ acts as justifiable but still negative, this may have led to them providing ratings equivalent to those in the non-threatening consequences group.

Additionally, it was predicted there would be significant interactions between drinking pattern and drinking consequences for the stigma outcome measures. This hypothesis was not fully supported, as significant interactions were only found with two of the outcome measures, the semantic differential rating and perceived IQ.

Social drinkers who reported no consequences were rated more positively on adjective descriptors than social drinkers reporting threatening and non-threatening consequences. The pattern of mean differences was somewhat different for heavy drinkers, such that the no consequences group was rated more positively than the threatening consequences group, and the non-threatening consequences group did not differ from either of the other two groups. With regard to perceived IQ, participants provided significantly higher IQ scores for social drinkers with no consequences compared to social drinkers with either non-threatening or threatening consequences. However, for heavy drinkers there were no significant differences on perceived IQ between the different consequences groups. These findings indicate that drinking consequences, regardless of whether they were threatening or non-threatening, played a significant role in rating drinkers. This was especially evident in ratings of social drinkers, such that those reporting either type of consequences were rated more
negatively than those reporting no consequences. However, combining heavy drinking and consequences created findings that were more complicated to interpret.

On the other outcome measures we did not get the predicted interactive effects, but rather additive effects as levels of drinking consequences increased with both social and heavy drinkers. There were no variations in differences between heavy and social drinkers with increase in consequence severity.

Finding more significant main effects than interactions for drinking pattern and drinking consequences may indicate that participants tended to process drinking pattern and drinking consequences separately rather than integrating both in determining ratings. Although all hypotheses were not completely supported, the results of the study indicated that stigma is associated with the alcohol label as well as with patterns of behavior often associated with alcoholics, including both non-threatening and threatening behaviors.

Prior to conducting the present stigma study, pilot data were collected to ensure there were no differences between the stimulus conditions based on nonverbal sources of tape variance. No significant differences were found between the actors or stimulus conditions on the outcome measures, and therefore findings cannot be attributed to variances in stimulus material used in the study.

The full stigma study participant sample completed a manipulation check, which included participants rating the interviewees using the Alcohol Dependence section of the SCID-I and determining whether each criterion was met. This was done to ensure that they attended to the interviews and could provide accurate diagnoses based on the information in the interview.
Participants’ ratings indicated that on average only Heavy Drinkers (with consequences) appeared to meet criteria for alcohol dependence; therefore both the quantity of alcohol consumed as well as consequences related to drinking played a big part in whether participants diagnosed the drinker with alcohol dependence. Participants were more ambivalent in providing a diagnosis of alcohol dependence for Social Drinkers with both Threatening and Non-threatening Consequences and Heavy Drinkers with No Consequences. Perhaps participants’ ambivalence was related to suspicions that Social Drinkers who experienced consequences related to drinking were minimizing the quantity and frequency of alcohol consumption, or that Heavy Drinkers not experiencing consequences were denying any problems related to their drinking.

Participants’ diagnoses of the drinkers demonstrate the importance of consequences in diagnosing Alcohol Dependence. The criteria for diagnosing Alcohol Dependence includes neglecting social, occupational, or recreational activities because of alcohol use, continued use despite physical or psychological problems, and spending lots of time obtaining and using alcohol, or recovering from the effects of alcohol. All of these can be viewed as the negative consequences of alcohol use outside of quantity and frequency of alcohol use.

Participants’ alcohol use histories were examined to determine if there were any group differences on this variable that could have affected research findings. Results of the present study could not be accounted for by participant alcohol use or familial alcohol use in that all groups of participants had similar histories.

*Social Psychological Perspective*
The function of stigma and social rejection include the use of cognitive mechanisms that cause people to be selective in their social interactions (Kurzban & Leary, 2001). This idea has an evolutionary basis in that humans have developed these mechanisms to solve adaptive problems associated with sociality. In this perspective, people are stigmatized because they possess a characteristic that society views as a basis for avoiding or excluding them. Interactions are avoided with those that possess these characteristics because they likely impose fitness costs, and it is adaptive to not interact with these people (Kurzban & Leary, 2001). Because of the lack of similarity between the non-stigmatized individual and the stigmatized individual, interactions may seem threatening to the non-stigmatized individual (Blascovich et al., 2001).

In the present study, quantity of alcohol consumed, as well as consequences related to drinking played a role in participants' attitudes toward the drinkers. Although heavy drinking alone was not viewed as threatening to survival, these drinkers were still rated more negatively than social drinkers. When both non-threatening and threatening consequences were introduced, participants chose to avoid these groups because they represent fitness costs. When an individual experiences consequences related to drinking, this can be viewed as a sign that they have let their drinking get out of their control and they are not in control of their behavior when they are under the influence of alcohol.

It has been suggested that when a stigmatizing condition is visible, people are more likely to treat the stigmatized more negatively (Kurzban & Leary, 2001). Because the negative impact of consequences associated with excessive drinking is more visible than the negative impact of excessive drinking alone, non-stigmatized individuals may have less desire to interact with those who exhibit consequences related to their drinking.
When an individual violates societal norms, whether this be neglecting work and family obligations or getting into fistfights, and behaves in unpredictable ways, it becomes difficult to infer their future actions. The inability to predict how one will behave in certain situations may raise caution as to the suitability of this person as a relational partner. Also, perceiving others as they engage in self-destructive behaviors demonstrates an inability or an unwillingness to follow societal norms, which suggests that they have an agenda that is different from other group member, further differentiating themselves from the non-stigmatized group.

The present study demonstrated strengths such as the use of a cover task that all participants believed, which included participants being told they were conducting a reliability check of an alcohol use measure. Other strengths included the separate analysis of quantity of alcohol consumption and drinking consequences, as well as the introduction of an important component of stigma, threat. This study also included various groups to compare, such as heavy and social drinkers disclosing different levels of consequences.

Another strength of the present study was that participants could observe the drinker prior to rating him on the outcome measures. This goes beyond simply determining whether stigma is associated with the label “alcoholic” (Caetano, 1987; Cash et al., 1984; Dean & Poremba, 1983; Kilty & Meenaghan, 1977). Also, the present study did not outwardly label the heavy drinkers as “alcoholic” but rather allowed participants to determine this for themselves by having them listen to the drinker talk about his drinking pattern and consequences he experienced while drinking. Thus, findings are not based on the label but rather on the reported behaviors of the drinker.
Limitations and Future Directions

There are some limitations of the present study that should be addressed in future studies. Attitudes toward the drinkers were mainly assessed through the use of paper and pencil measures. However, the disadvantage in using such measures is that they only provide partial evidence that participants felt a certain way about the drinker, and provided no information on their physiological reactions when viewing the drinker and providing opinions about the drinker. Thus, future studies may benefit from the use of physiological measures to assess participants' level of arousal when interacting with the drinker.

Although the use of a behavioral measure was included in the present study, it was limited in that it did not involve actual interaction with the drinkers. Drinkers were interviewed while sober, which likely affected how participants rated them. Future studies may consider allowing participants to view different stimulus conditions that portray the drinker as having been drinking. Studies have shown that arousal increases stereotyping, and the anxiety and fear that one experiences in an encounter would provide a more realistic account of attitudes (Dijker, 1987; Islam & Hewstone, 1993; Stephan & Stephan, 1985; Wilder & Shapiro, 1989).

MacAndrew and Edgerton (1969) have suggested that some drunken behavior is accepted even if it breaks societal norms. However, they also report there are norms that are unbreakable, and the intoxicated person is held responsible and blamed for their actions. Future studies should include stimulus tapes featuring behaviors that are not excused as expected drunken behaviors. Perhaps it would be beneficial to include more
severe episodes of violent, aggressive behavior in certain contexts where the drinker would be held accountable for their actions.

Future studies should also take into consideration information about the drinking context, such as whether the victim was intoxicated, and include this information in the stimulus tapes. Studies have shown that when the victim is known to be intoxicated, the aggressive behavior is justified since it can be explained as self-defense (Tryggvesson, 2004). It would be beneficial to see if whether victim intoxication during aggressive acts affects how participants rate the drinker.

Participants' expectations of the effects of alcohol on aggressive behavior should also be determined in the future as a means of understanding their beliefs about what behavior is expected of heavy drinkers and if this behavior is socially acceptable. As studies have shown, many people expect intoxicated individuals to behave aggressively (Isaacs, 1977). If participants have expectancies that heavy drinking leads to violence, they may rate all heavy drinkers, regardless of reported consequences, more negatively because of their expectations of what heavy drinking can lead to.

Although the present study used young adult, Caucasian men as the target population, future studies should consider varying drinker characteristics, such as gender, race, ethnicity, and age. It would be informative to determine if and to what extent these variables influence ratings. Future studies should also consider using a sample of participants with significant personal and familial alcohol use histories to determine if alcohol experience moderates the relationship between drinking pattern, drinking consequences, and stigma. Studies in which collecting larger samples is feasible may
examine potential participant difference, such as in gender, race, ethnic group, and age, on stigmatization.
APPENDIX A

HUMAN SUBJECTS REVIEW FORM

The University of Southern Mississippi
Hattiesburg, MS 39406-5001
Tel: 601.266.6620
Fax: 601.266.5909
www.usm.edu/hsprc

HUMAN SUBJECTS PROTECTION REVIEW COMMITTEE
NOTICE OF COMMITTEE ACTION

The project has been reviewed by The University of Southern Mississippi Human Subjects Protection Review Committee in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services (45 CFR Part 46), and university guidelines to ensure adherence to the following criteria:

- The risks to subjects are minimized.
- The risks to subjects are reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered regarding risks to subjects must be reported immediately, but not later than 10 days following the event. This should be reported to the IRB Office via the "Adverse Effect Report Form".
- If approved, the maximum period of approval is limited to twelve months. Projects that exceed this period must submit an application for renewal or continuation.

PROTOCOL NUMBER: 26032202
PROJECT TITLE: Attitudes Toward Problem Drinkers as a Function of Quantity Consumed, Drinking Consequences, and Perceived Threat
PROPOSED PROJECT DATES: 03/15/06 to 03/31/08
PROJECT TYPE: Dissertation or Thesis
PRINCIPAL INVESTIGATORS: Katie Russo
COLLEGE/DIVISION: College of Education & Psychology
DEPARTMENT: Psychology
FUNDING AGENCY: N/A
HSPRC COMMITTEE ACTION: Expedited Review Approval
PERIOD OF APPROVAL: 04/27/06 to 04/26/07

Lawrence A. Hoeman, Ph.D.
HSPRC Chair

5-01-06 Date
PARTICIPANT _____________________________________________________

PURPOSE OF STUDY: You are being asked to take part in a research study to examine the reliability and validity of an alcohol use interview measure. For this study, you will watch, over a closed-circuit television hookup, a clinician interview another subject about his alcohol use patterns. We are interested in whether you (and other raters) agree with the clinician about the subject's alcohol use (this is what we mean by reliability). The validity part of the study involves whether the alcohol use measure is accurately measuring only alcohol use and not other problems. Both you and the other subject will complete a series of questionnaires to help us examine the interview's validity.

METHODS AND PROCEDURES: You will watch an individual over a closed-circuit television being interviewed by a clinician with regard to his alcohol use. You will be given a ratings form, and will check whether different behaviors related to drinking are absent or present in the person being interviewed. After watching the interview, you will be asked to complete questionnaires about the person being interviewed and about yourself. Your entire participation should take less than an hour.

RISKS AND DISCOMFORT: Risks inherent in this study are minimal. A list of referral sources will be provided if requested by you or the other subject. Some of these resources are free, and some may have a fee associated with them. If you make use of these services, you will be responsible for all fees.

BENEFITS: The information obtained in this study will not directly benefit you. We may briefly discuss with you your impression of the study when you are done. When we complete the study, we will invite you and the other participants to a group discussion about the study results, what they mean, and why they are useful. Course credit will be given for participation. Other options for obtaining course credit may be provided by your instructor.

CONFIDENTIALITY OF RECORDS: All information obtained during this study is confidential. We will protect your privacy by identifying your responses to the questionnaire by a code number only. All information will be kept in a locked file cabinet. Data that we may report in scientific journals will not include information that identifies you as a participant in this study.

VOLUNTARY PARTICIPATION: Your participation in this study is entirely voluntary. You may withdraw from being a research participant anytime without penalty.
If you have any questions regarding your participation in this study, please contact the experimenter, Katie Russo, or Dr. Mitchell Berman at (601) 266-4588.

**PARTICIPANT'S CONSENT:** I have had the purposes and procedures of this study explained to me and have had the opportunity to ask questions. My questions have been answered to my satisfaction, and I am voluntarily signing this form. My signature shows my willingness to participate in this study under the conditions stated. I have received a copy of this consent form.

______________________________  ______________
Participant’s Signature            Date

______________________________  ______________
Investigator’s Signature – Witness Date
APPENDIX C

AUDIT QUESTIONNAIRE ITEMS AND ANSWERS (Saunders, Aasland, & Babor, 1993)

Please answer these questions regarding your own alcohol use habits.

1. How often do you have a drink containing alcohol?
   - never
   - monthly or less
   - 2 to 4 times a month
   - 2 to 3 times a week
   - 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   - 1 or 2
   - 3 or 4
   - 5 or 6
   - 7-9
   - 10 or more

3. How often do you have six or more drinks on one occasion?
   - never
   - less than monthly
   - monthly
   - weekly
   - daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?
   - never
   - less than monthly
   - monthly
   - weekly
   - daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
   - never
   - less than monthly
   - monthly
   - weekly
   - daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
   - never
   - less than monthly
   - monthly
   - weekly
   - daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
   - never
   - less than monthly
   - monthly
   - weekly
   - daily or almost daily

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8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

never  less than monthly  weekly  daily or almost daily
monthly  weekly  daily

9. Have you or someone else been injured as a result of your drinking?

never  less than monthly  weekly  daily or almost daily
monthly  weekly  daily

10. Has a relative or friend or a doctor or the health worker been concerned about your drinking or suggested you cut down?

no  yes, but not in the last year  yes, during the last year
Appendix D

M-SMAST/F-SMAST Questionnaire Items (Crews & Sher, 1992; Selzer, Vinokur, & van Rooijen, 1975)

Please answer these questions about your mother's/father's drinking habits by circling either YES or NO for each item.

1. Do you feel your mother/father has been a normal drinker?
2. Did your mother/father, grandparent, or other near relative ever complain about your mother's/father's drinking?
3. Did your mother/father ever feel guilty about her/his drinking?
4. Did friends and relatives think your mother/father was a normal drinker?
5. Was your mother/father able to stop drinking when she/he wanted to?
6. Has your mother/father ever attended a meeting of Alcoholics Anonymous (AA)?
7. Has your mother's/father's drinking ever created problems between her/him and your mother/father (or step-parent) or another relative?
8. Has your mother/father ever gotten into trouble at work because of drinking?
9. Has your mother/father ever neglected her/his obligations, family, or work for 2 or more days in a row because she/he was drinking?
10. Has your mother/father ever gone to anyone for help about her/his drinking?
11. Has your mother/father ever been in a hospital because of drinking?
12. Has your mother/father ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages?
13. Has your mother/father ever been arrested, even for a few hours, because of other drunken behavior?
APPENDIX E

SIS QUESTIONNAIRE ITEMS (Kelly, St. Lawrence, Smith, Hood, & Cook, 1987)

Please answer each question about the individual you watched in the interview.

1. If you met this individual, would you be willing to strike up a conversation with him?

   Not at all                        Very much
   1  2  3  4  5  6  7

2. Would you attend a party where this individual was present?

   Not at all                        Very much
   1  2  3  4  5  6  7

3. Would you attend a party where this individual was preparing dinner?

   Not at all                        Very much
   1  2  3  4  5  6  7

4. Would you be willing to work in the same office with this individual?

   Not at all                        Very much
   1  2  3  4  5  6  7

5. If you were a friend of this individual, would you be willing to continue the friendship at this time?

   Not at all                        Very much
   1  2  3  4  5  6  7

6. His lease is up in two months. If you were the landlord, would you renew the lease?

   Not at all                        Very much
   1  2  3  4  5  6  7

7. Would you allow your children to visit this individual at home?

   Not at all                        Very much
   1  2  3  4  5  6  7

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APPENDIX F

SEMANTIC DIFFERENTIAL SCALE ITEMS (Stafford & Petway, 1977)

Please rate the individual you watched in the interview.

<table>
<thead>
<tr>
<th>Item</th>
<th>Rating</th>
<th>Semantic Differential</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Good</td>
<td>1 2 3 4 5</td>
<td>Bad 5</td>
</tr>
<tr>
<td>2. Honest</td>
<td>1 2 3 4 5</td>
<td>Dishonest 5</td>
</tr>
<tr>
<td>3. Healthy</td>
<td>1 2 3 4 5</td>
<td>Sick 5</td>
</tr>
<tr>
<td>4. Fast</td>
<td>1 2 3 4 5</td>
<td>Slow 5</td>
</tr>
<tr>
<td>5. Strong</td>
<td>1 2 3 4 5</td>
<td>Weak 5</td>
</tr>
<tr>
<td>6. Moral</td>
<td>1 2 3 4 5</td>
<td>Immoral 5</td>
</tr>
<tr>
<td>7. Respectable</td>
<td>1 2 3 4 5</td>
<td>Not Respectable 5</td>
</tr>
<tr>
<td>8. Responsible</td>
<td>1 2 3 4 5</td>
<td>Not Responsible 5</td>
</tr>
<tr>
<td>9. Reliable</td>
<td>1 2 3 4 5</td>
<td>Not Reliable 5</td>
</tr>
<tr>
<td>10. Hopeful</td>
<td>1 2 3 4 5</td>
<td>Hopeless 5</td>
</tr>
<tr>
<td>11. Unselfish</td>
<td>1 2 3 4 5</td>
<td>Selfish 5</td>
</tr>
<tr>
<td>12. Uncritical</td>
<td>1 2 3 4 5</td>
<td>Critical 5</td>
</tr>
</tbody>
</table>
APPENDIX G

THE BIG FIVE INVENTORY ITEMS (John, Donohue, & Kentle, 1991)

The following statements describe characteristics that may or may not apply to the individual being interviewed. Please mark the number that reflects the extent to which you agree or disagree with each statement.

0 1 2 3 4 5 6
STRONGLY DISAGREE
AGREE

1. Is talkative.
2. Tends to find fault with others.
3. Does a thorough job.
4. Is depressed, blue.
5. Is original, comes up with new ideas.
6. Is reserved.
7. Is helpful and unselfish with others.
8. Can be somewhat careless.
10. Is curious about many different things.
11. Is full of energy.
12. Starts quarrels with others.
13. Is a reliable worker.
14. Can be tense.
15. Is ingenious, a deep thinker.
16. Generates a lot of enthusiasm.
17. Has a forgiving nature.
18. Tends to be disorganized.
19. Worries a lot.
20. Has an active imagination.
21. Tends to be quiet.
22. Is generally trusting.
23. Tends to be lazy.
24. Is emotionally stable, not easily upset.
25. Is inventive.
26. Has an assertive personality.
27. Can be cold and aloof.
28. Perseveres until the task is finished.
29. Can be moody.
30. Values artistic, aesthetic experiences.
31. Is sometimes shy, inhibited.
32. Is considerate and kind to almost everyone.
33. Does things efficiently.
34. Remains calm in tense situations.
35. Prefers work that is routine.
36. Is outgoing, sociable.
37. Is sometimes rude to others.
38. Makes plans and follows through with them.
40. Likes to reflect, play with ideas.
41. Has few artistic interests.
42. Likes to cooperate with others.
43. Is easily distracted.
44. Is sophisticated in art, music, or literature.
APPENDIX H

PANAS ITEMS (Watson, Clark, & Tellegen, 1988)

This scale consists of a number of words that describe different feelings and emotions. Read each item and then mark the appropriate answer in the space next to that word. Indicate to what extent you feel this way right now, that is, at the present moment.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>very slightly</td>
<td>a little</td>
<td>moderately</td>
<td>quite a bit</td>
<td>extremely</td>
</tr>
<tr>
<td></td>
<td>or not at all</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. interested
2. distressed
3. excited
4. upset
5. strong
6. guilty
7. scared
8. hostile
9. enthusiastic
10. proud

11. irritable
12. alert
13. ashamed
14. inspired
15. nervous
16. determined
17. attentive
18. jittery
19. active
20. afraid

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APPENDIX I

SAM ITEMS (Lang, 1980; Hodes, Cook, & Lang, 1985)

Using the following scales, please rate your current emotional state.

Place an "X" on or between any of the figures to indicate how pleasant or unpleasant you feel in reaction to the interview you just saw.

**Happy**

![Happy Scale](image)

**Unhappy**

![Unhappy Scale](image)

Place an "X" on or between any of the figures to indicate how excited or calm you feel in reaction to the interview you just saw.

**Excited**

![Excited Scale](image)

**Calm**

![Calm Scale](image)
APPENDIX J

RATING ITEMS (Maddon, Smith, & Guyll, 2005)

Rate each item based on how the person in the interview made you feel.

<table>
<thead>
<tr>
<th>Item</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Comfortable</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>Threatened</td>
<td></td>
</tr>
<tr>
<td>2. Calm</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>Tense</td>
<td></td>
</tr>
<tr>
<td>3. Secure</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>Anxious</td>
<td></td>
</tr>
<tr>
<td>4. Safe</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>Scared</td>
<td></td>
</tr>
<tr>
<td>5. Relaxed</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>Distressed</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX K

SCRIPTS

Heavy Drinker with Threatening Consequences

Interviewer: What are your drinking habits like?

Interviewee: I drink pretty much everyday. After work I’ll go to bars with co-workers and drink, and on the weekends I drink when I go out.

Interviewer: How much do you drink?

Interviewee: I usually have at least 6 beers each night I go out, on some occasions I have more, like on New Years.

Interviewer: Have you had any problems related to drinking?

Interviewee: Yea, I guess with work and family. I’ve gotten in trouble before for drinking at work; I got into a fistfight with a guy at work. Things aren’t good with my girlfriend’s family right now. Me and her dad got into an argument after I’d been drinking, and I took a swing at him and pushed him down in front of the whole family and some of his co-workers that were there. I haven’t been invited back to her parents’ house since then. I’ve gotten into a couple of fights at bars while drinking. A couple of times I had way too much to drink and drove; I’m lucky I wasn’t pulled over and arrested.

Interviewer: Have you often found that when you started drinking you ended up drinking much more than you were planning to?

Interviewee: Well, I tell myself that I’m just going to go out with the guys only once or twice a week and that’s it, but then I find myself going out nearly everyday, sometimes even by myself. I usually have about the same number of beers, about 5 or 6, but like I said, I’ve had more on special occasions.

Interviewer: Have you tried to cut down or stop drinking alcohol?

Interviewee: Yea, I guess a few times.

Interviewer: Did you ever actually stop drinking altogether?

Interviewee: Maybe for a day or two.

Interviewer: Have you spent a lot of time drinking or being hung over?
Interviewee: Well, like I just said, I drink nearly everyday after work and on the weekends. I guess I spend quite some time hung over.

Interviewer: Have you had times when you would drink so often that you started to drink instead of working or spending time with your family or friends?

Interviewee: Well, a few of the guys from work drink with me after work and we hang out on the weekends together, going out to bars and stuff, so I see them a good bit. I’ve gotten in trouble at work for drinking on the job. I guess sometimes I can get crazy when I’m drinking, especially with the fighting. I guess I can get a little out of control sometimes.

Interviewer: Has your drinking ever caused any psychological problems like making you depressed or anxious, making it hard to sleep, or causing “blackouts?”

Interviewee: Well, I don’t really sleep that much, especially those nights that I stay out late and then have to get up and go to work the next morning. I probably would get more sleep if I didn’t drink as much as I do. I argue with my family a lot when I’m drinking. I’ve gotten violent with people when I’m drinking. I have blacked out a few times too.

Interviewer: Have you found that you needed to drink a lot more in order to get the feeling you wanted than you did when you first started drinking?

Interviewee: I don’t think so; I usually have the same number of drinks.

Interviewer: Have you ever had any withdrawal symptoms when you cut down or stopped drinking?

Interviewee: Well, like I told you before, I don’t sleep well at night.

Interviewer: Have you ever started the day with a drink, or have you had a drink or taken some other drug or medication to keep yourself from getting the shakes or becoming sick?

Interviewee: No.

Heavy Drinker with Non-Threatening Consequences

Interviewer: What are your drinking habits like?

Interviewee: I drink pretty much everyday. After work I’ll go to bars with co-workers and drink, and on the weekends I drink when I go out.

Interviewer: How much do you drink?
Interviewee: I usually have at least 6 beers each night I go out, on some occasions I’ve had more, like on New Years.

Interviewer: Have you had any problems related to drinking?

Interviewee: Yea, I guess with work and family. I’ve gotten into trouble before at work for drinking at work; I ended up missing an important presentation and didn’t get a promotion I was expecting because of that. Things aren’t good with my girlfriend’s family right now. I stood on the table and started dancing in front of the whole family and some of his co-workers that were there. I haven’t been invited back to her parents’ house since then. I’ve missed family stuff before because I was drinking and forgot where I was supposed to be.

Interviewer: Have you often found that when you started drinking you ended up drinking much more than you were planning to?

Interviewee: Well, I tell myself that I’m just going to go out with the guys only once or twice a week and that’s it, but then I find myself going out nearly everyday, sometimes even by myself. I usually have about the same number of beers, about 5 or 6, but like I said, I’ve had more on special occasions.

Interviewer: Have you tried to cut down or stop drinking alcohol?

Interviewee: Yea, I guess a few times.

Interviewer: Did you ever actually stop drinking altogether?

Interviewee: Maybe for a day or two.

Interviewer: Have you spent a lot of time drinking or being hung over?

Interviewee: Well, like I just said, I drink nearly everyday after work and on the weekends. I guess I spend quite some time hung over.

Interviewer: Have you had times when you would drink so often that you started to drink instead of working or spending time with your family or friends?

Interviewee: Well, a few of the guys from work drink with me after work and we hang out on the weekends together, going out to bars and stuff, so I see them a good bit. I’ve gotten in trouble at work for drinking on the job, and I guess it’s affected my job performance some. I guess the biggest problem my family has with my drinking is that I don’t see them that often because I’m out drinking. I’ve missed family stuff, birthdays, Christmas, you know. And they tell me they get annoyed with how goofy I act when I’ve been drinking.
**Interviewer:** Has your drinking ever caused any psychological problems like making you depressed or anxious, making it hard to sleep, or causing “blackouts?”

**Interviewee:** Well, I don’t really sleep that much, especially those nights that I stay out late and then have to get up and go to work the next morning. I probably would get more sleep if I didn’t drink as much as I do. I don’t do as well at my job as I would if I didn’t drink. I know I sometimes act stupid and irresponsible when I drink. I have blacked out a few times too.

**Interviewer:** Have you found that you needed to drink a lot more in order to get the feeling you wanted than you did when you first started drinking?

**Interviewee:** I don’t think so; I usually have the same number of drinks.

**Interviewer:** Have you ever had any withdrawal symptoms when you cut down or stopped drinking?

**Interviewee:** Well, like I told you before, I don’t sleep well at night.

**Interviewer:** Have you ever started the day with a drink, or have you had a drink or taken some other drug or medication to keep yourself from getting the shakes or becoming sick?

**Interviewee:** No.

*Heavy Drinker without Consequences*

**Interviewer:** What are your drinking habits like?

**Interviewee:** I drink pretty much everyday. After work I’ll go to bars with co-workers and drink, and on the weekends I drink when I go out.

**Interviewer:** How much do you drink?

**Interviewee:** I usually have at least 6 beers each night I go out, on some occasions I have more, like on New Years.

**Interviewer:** Have you had any problems related to drinking?

**Interviewee:** No, not really. If I didn’t drink, I might be more into my job; maybe, maybe not.

**Interviewer:** Have you often found that when you started drinking you ended up drinking much more than you were planning to?
Interviewee: No. The amount that I drink hasn’t changed much since I first started drinking.

Interviewer: Have you tried to cut down or stop drinking alcohol?

Interviewee: No, not really.

Interviewer: Did you ever actually stop drinking altogether?

Interviewee: No.

Interviewer: Have you spent a lot of time drinking or being hung over?

Interviewee: Well, like I said earlier, I drink nearly everyday after work and on the weekends. But I don’t think it’s too much time.

Interviewer: Have you had times when you would drink so often that you started to drink instead of working or spending time with your family or friends?

Interviewee: Not really, a few of the guys from work drink with me after work and we hang out on the weekends together, going out to bars and stuff, so I see them a good bit. I spend quite a bit of time with my family, so I don’t think that my drinking has really affected anything.

Interviewer: Has your drinking ever caused any psychological problems like making you depressed or anxious, making it hard to sleep, or causing “blackouts?”

Interviewee: Not really, I have never been depressed or anxious. I haven’t ever blacked out when drinking. I don’t really sleep that much, but I’ve never been really big on sleep anyway. I don’t think drinking alcohol makes a difference with my sleep.

Interviewer: Have you found that you needed to drink a lot more in order to get the feeling you wanted than you did when you first started drinking?

Interviewee: I don’t think so; I usually have the same number of drinks.

Interviewer: Have you ever had any withdrawal symptoms when you cut down or stopped drinking?

Interviewee: No.

Interviewer: Have you ever started the day with a drink, or have you had a drink or taken some other drug of medication to keep yourself from getting the shakes or becoming sick?

Interviewee: No.
Social Drinker with Threatening Consequences

Interviewer: What are your drinking habits like?

Interviewee: I'm a social drinker. I usually only drink when I go out, which is probably every other weekend.

Interviewer: How much do you drink?

Interviewee: I'll usually have maybe 2 or 3 beers, on some occasions I have more, like on New Years.

Interviewer: Have you had any problems related to drinking?

Interviewee: Yea, things aren't good with my girlfriend's family right now. Me and her dad got into an argument after I'd been drinking, and I took a swing at him and pushed him down in front of the whole family and some of his co-workers that were there. I haven't been invited back to her parents' house since then. I've gotten into a couple of fights at bars while drinking. A couple of times I had way too much to drink and drove; I'm lucky I wasn't pulled over and arrested.

Interviewer: Have you often found that when you started drinking you ended up drinking much more than you were planning to?

Interviewee: I usually drink the same amount every time I do drink, usually 2 or 3 beers, but like I said, I've had more on special occasions.

Interviewer: Have you tried to cut down or stop drinking alcohol?

Interviewee: No, I've never thought there was a need to cut down.

Interviewer: Did you ever actually stop drinking altogether?

Interviewee: Well, when I'm not going out on the weekends, I won't drink.

Interviewer: Have you spent a lot of time drinking or being hung over?

Interviewee: No, I usually drink every other weekend, maybe for a few hours.

Interviewer: Have you had times when you would drink so often that you started to drink instead of working or spending time with your family or friends?

Interviewee: Well, me and a few of the guys from work get together on the weekends, going out to bars and stuff, so I see them a good bit. I guess sometimes I can get crazy
when I’m drinking, especially with the fighting. I guess I can get out of control sometimes.

**Interviewer:** Has your drinking ever caused any psychological problems like making you depressed or anxious, making it hard to sleep, or causing “blackouts?”

**Interviewee:** I argue with my family a lot when I’m drinking. I’ve gotten violent with people when I’m drinking. But I have never been depressed or anxious. I haven’t ever blacked out when drinking, and I have no problems sleeping.

**Interviewer:** Have you found that you needed to drink a lot more in order to get the feeling you wanted than you did when you first started drinking?

**Interviewee:** I don’t think so; I usually have the same number of drinks.

**Interviewer:** What about finding that when you drank the same amount, it had much less effect than before?

**Interviewee:** No, I don’t think that the amount I drink has any less of an effect.

**Interviewer:** Have you ever had any withdrawal symptoms when you cut down or stopped drinking?

**Interviewee:** No.

**Interviewer:** Have you ever started the day with a drink, or did you often drink or take some other drug or medication to keep yourself from getting the shakes or becoming sick?

**Interviewee:** No.

*Social Drinker with Non-Threatening Consequences*

**Interviewer:** What are your drinking habits like?

**Interviewee:** I’m a social drinker. I usually only drink when I go out, which is probably every other weekend.

**Interviewer:** How much do you drink?

**Interviewee:** I’ll usually have maybe 2 or 3 beers, on some occasions I have more, like on New Years.

**Interviewer:** Have you had any problems related to drinking?
Interviewee: Yea, things aren’t good with my girlfriend’s family right now. I stood on the table and started dancing in front of the whole family and some of his co-workers that were there. I haven’t been invited back to her parents’ house since then.

Interviewer: Have you often found that when you started drinking you ended up drinking much more than you were planning to?

Interviewee: I usually drink the same amount every time I do drink, usually 2 or 3 beers, but like I said, I’ve had more on special occasions.

Interviewer: Have you tried to cut down or stop drinking alcohol?

Interviewee: No, I’ve never thought there was a need to cut down.

Interviewer: Did you ever actually stop drinking altogether?

Interviewee: Well, when I’m not going out on the weekends, I won’t drink.

Interviewer: Have you spent a lot of time drinking or being hung over?

Interviewee: No, I usually drink every other weekend, maybe for a few hours.

Interviewer: Have you had times when you would drink so often that you started to drink instead of working or spending time with your family or friends?

Interviewee: Well, me and a few of the guys from work get together on the weekends, going out to bars and stuff, so I see them a good bit. I’ve missed family stuff before because I was drinking and forgot where I was supposed to be. My family tells me they get annoyed with how goofy I act when I’ve been drinking.

Interviewer: Has your drinking ever caused any psychological problems like making you depressed or anxious, making it hard to sleep, or causing “blackouts?”

Interviewee: I know I sometimes act stupid and irresponsible when I drink. But I have never been depressed or anxious. I haven’t ever blacked out when drinking, and I have no problems sleeping.

Interviewer: Have you found that you needed to drink a lot more in order to get the feeling you wanted than you did when you first started drinking?

Interviewee: I don’t think so; I usually have the same number of drinks.

Interviewer: Have you ever had any withdrawal symptoms when you cut down or stopped drinking?

Interviewee: No.
Interviewer: Have you ever started the day with a drink, or have you had a drink or taken some other drug or medication to keep yourself from getting the shakes or becoming sick?

Interviewee: No.

Social Drinker without Consequences

Interviewer: What are your drinking habits like?

Interviewee: I would say that I’m a social drinker. I usually only drink when I go out, which is probably every other weekend.

Interviewer: How much do you drink?

Interviewee: I’ll usually have maybe 2 or 3 beers.

Interviewer: Have you had any problems related to drinking?

Interviewee: No, not at all.

Interviewer: Have you often found that when you started drinking you ended up drinking much more than you were planning to?

Interviewee: No, I usually drink the same amount every time I do drink, usually 2 or 3 beers.

Interviewer: Have you tried to cut down or stop drinking alcohol?

Interviewee: No, I’ve never thought there was a need to cut down.

Interviewer: Did you ever actually stop drinking altogether?

Interviewee: Well, when I’m not going out on the weekends, I won’t drink.

Interviewer: Have you spent a lot of time drinking or being hung over?

Interviewee: No, I usually drink every other weekend, maybe for a few hours.

Interviewer: Have you had times when you would drink so often that you started to drink instead of working or spending time with your family or friends?

Interviewee: I haven’t ever missed work because of my drinking, and I spend quite a bit of time with my family and friends, so I don’t think that my drinking has affected anything.
**Interviewer:** Has your drinking ever caused any psychological problems like making you depressed or anxious, making it hard to sleep, or causing “blackouts?”

**Interviewee:** No. I have never been depressed or anxious. I haven’t ever blacked out when drinking, and I have no problems sleeping.

**Interviewer:** Have you found that you needed to drink a lot more in order to get the feeling you wanted than you did when you first started drinking?

**Interviewee:** No. The amount that I drink hasn’t changed much since I first started drinking.

**Interviewer:** What about finding that when you drank the same amount, it had much less effect than before?

**Interviewee:** No, I don’t think that the amount I drink has any less of an effect.

**Interviewer:** Have you ever had any withdrawal symptoms when you cut down or stopped drinking?

**Interviewee:** No.

**Interviewer:** Have your ever started the day with a drink, or did you often drink or take some other drug or medication to keep yourself from getting the shakes or becoming sick?

**Interviewee:** No.
REFERENCES


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