# Cognitive Coping Mechanisms in Patients with Alcohol Addiction

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***Abstract***

***Introduction:*** *In order to cope with daily stress that is present in everyday life, man turns to certain defensive mechanisms against disturbances.*

***Objectives:*** *This paper aims to highlight aspects of cognitive coping mechanisms in men diagnosed with alcohol addiction, given the fact that they turn to substance abuse to handle stressors easily. At this juncture, alcoholic patients develop certain defense mechanisms to minimize the problem they have and the negative effects that are present in alcohol abuse, which are reflected in all areas they have to deal with: family, social area, professional area, but they are also emotionally and morally affected.*

***Methods:*** *We used DMRS questionnaire: The Defense Mechanisms Rating Scales and Beck's Depression Inventory (BDI).*

***Results:*** *Patients diagnosed with alcohol addiction use dysfunctional behavior to cope with everyday stress and repeat it due to irrational beliefs.*

***Conclusions:*** *Excessive alcohol consumption affects the information processing, so they will continue to see the negative side of situations in everyday life. On top of this, we have noticed a relationship between alcohol addiction syndrome and depression.*

***Keywords: alcohol, addiction, abuse, vice***

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## I. Introduction

After analyzing the alcoholics' personality, we highlighted a certain moral fragility of character, a social maladjustment and an emotional-volitional immaturity. (Bonchis, E., Trip, S., Dindelegan, C, Drugaş, M., 2009). Therefore, the moral defective principles which are permissive about alcohol, social adjustment inability, inability to find a job or inability to have interpersonal relationships may be weaknesses in an individual's personality, which are overlapped by the need for alcohol (Grecu, G., Grecu-Gabor, M., 2007). Alcohol abuse will remove emotional deprivation, will increase relational capacity and will become a source of overcoming the psychological complexes that the individual feels (Legeron, 2001).

In a paper from 1988, Strava said that „anxiety and depression, lack of critical sense, impulsivity and aggression are often events that shape the alcoholic's personality, driven by instincts, unable to resist the temptation to drink; the alcoholic ends up in the deepest physical decline, avoided by everyone, even by his closest family members." (apud. Dindelegan, 2012).

Defense mechanisms are considered to be strategies that the individuals resort to, in order to reduce or avoid certain adverse conditions such as stress, anxiety, conflict or frustration (Grecu, G., Grecu-Gabor, M., Gabor-Grecu).

Defensive mechanisms are directed against the id's impulses and their symbolic derivatives. Defensive mechanisms are oriented towards external or internal stress control, while the ego defense mechanisms are oriented towards blocking internal instinctual impulses (Jackuet, 2002).

During its development and evolution, man has been developing various mechanisms in order to relate to what was happening around him, to adapt to new situations and to manage resources to do better against external and internal pressures. These mechanisms act in two ways: once, they act *preventively,* making an individual's necessary elements and structures „to alter or destroy adverse effects of future situations, or *adaptively* in order to reduce distress, if it has already been induced." (apud Miclea, 1997).

**The objectives and hypotheses of this research**

By conducting this research, we try to identify possible correlations between depression and defensive mechanisms, in connection with the diagnosis of alcoholism in men. If the existence of depression in alcoholism is already well established, the defenses of the individual to the double diagnosis are still relevant.

Thus:

Hypothesis 1: Patients diagnosed with alcoholism syndrome use an avoidance coping style to a higher degree compared to men in the control group or those admitted with other clinical diagnoses.

Hypothesis 2: Patients diagnosed with alcoholism syndrome use denial, repression and projection as well as coping mechanisms more often, compared to patients hospitalized with other clinical diagnoses.

## II. Method

**Participants**

The alcoholic patients come from the Municipal Clinical Hospital „Dr. Gabriel Curteanu" - Psychiatric Ward from Oradea, comprising 30 men hospitalized and diagnosed with alcohol addiction syndrome, aged 26-60. Another group of patients hospitalized with clinical diagnosis, consists of 30 men, aged 30-60, from the neurology, orthopedics and cardiology wards. The control group consists of 30 students from the Faculty of Theology in Oradea, aged 19-26, with no hospitalization as a cause of a mental disease state, who do not accuse any distress.

**Instruments**

DMRS questionnaire: The Defense Mechanisms Rating Scales questionnaire contains 23 items in five subscales: denial, repression, projection, rationalization and intellectualization. It measures the overall rate of cognitive avoidance and the use of the 5 defensive mechanisms in specific ratings. Each item is assigned a 5-step scale on which the subject has to mark the extent to which the conduct described in the item corresponds to his way of relating to a stressor.

Share of overall gross results from summing up the values between 1 and 5, given for each item. Some items are rated the other way around. The share of overall gross denotes the intensity of cognitive avoidance. Elevated overall rate reveals an avoidance of cognitive coping style. Specific rating subscales indicate frequent use of a particular defense mechanism.

Each subject had to mark the scale related to the extent to which each item fits a certain behavior or procedure, on a scale where 1 = never and 5 = always.

Beck's Depression Inventory (BDI) is a basic tool in the investigation of depression and monitors the intensity of depression. Each item contains four statements, placed in order of severity. The patient is instructed to choose the closest to the current state. Scores had been added and afterwards referred to the standard one to obtain scores for: normal state 0-9,

mild depression 10-15, moderate depression 16-24 and severe depression over 25.

**Procedure**

After the subjects have agreed to take the tests, they start filling in Beck's Depression Inventory (BDI) and the DMRS. They were explained how to fill in the questionnaires. The testing was done by paper and pencil procedure. We read the items and answer options to subjects.

**Experimental design:** Intergroup unifactorial design.

**III. Results**

For the first hypothesis - patients diagnosed with alcoholism syndrome using an avoidance coping style to a higher degree compared to men in the control group or those admitted with other clinical diagnoses, we performed a comparative study between the scores of the patients diagnosed with alcoholism syndrome, those with clinical diagnoses and patients admitted with other illnesses. The data distribution has been verified.

**Table 1.1 The distribution of normality for avoidance coping style**

| Subjects | | | DMSR |
|---|---|---|---|
| Alcoholic | N | | 30 |
| | Normal Parameters(a, b) | Mean | 71.70 |
| | | Std. Deviation | 4.94 |
| | Extreme Differences | Absolute | .16 |
| | | Positive | .16 |
| | | Negative | -.07 |
| | Kolmogorov-Smirnov Z | | .89 |
| | **Asymp. Sig. (2-tailed)** | | **.40** |
| Control group | N | | 30 |
| | Normal Parameters(a, b) | Mean | 58.03 |
| | | Std. Deviation | 4.50 |
| | Extreme Differences | Absolute | .21 |
| | | Positive | .15 |
| | | Negative | -.21 |
| | Kolmogorov-Smirnov Z | | 1.19 |
| | **Asymp. Sig. (2-tailed)** | | **.11** |
| Hospitalized patients | N | | 30 |
| | Normal Parameters(a ,b) | Mean | 68.53 |
| | | Std. Deviation | 5.88 |
| | Extreme Differences | Absolute | .13 |
| | | Positive | .13 |
| | | Negative | -.07 |
| | Kolmogorov-Smirnov Z | | .73 |
| | **Asymp. Sig. (2-tailed)** | | **.66** |

As seen in Table 1.1, we obtained Z = 0.89 for alcoholic patients, Z = 1 19 and Z for the control group and Z = 0.73, significant at the threshold p = 0.40, p = 0.11 and p = 0.66, higher than the critical threshold of 0.05. Therefore, we can state that the data meet the criteria for normal distribution.

**Table 1.2. Mean and standard deviations for avoidance coping in the 3 groups of participants**

| Subjects | | N | Minimum | Maximum | Mean | Standard Deviation |
|---|---|---|---|---|---|---|
| Alcoholic | DMRS | 30 | 63.00 | 87.00 | 71.70 | 4.94 |
| Control Group | DMRS | 30 | 48.00 | 69.00 | 58.03 | 4.50 |
| Hospitalized patients | DMRS | 30 | 60.00 | 81.00 | 68.53 | 5.88 |

If we look at Table 1.2., at the means of the three groups, there are differences between them. The highest mean is the one of alcoholic patients followed by the mean of the patients admitted with other diseases, and the lowest is registered in the control group. However, in Table 1.4., significant differences are recorded between the score of the control group and the other two groups.

**Table 1.3. Analysis of variance for scores on avoidance coping style in patients with alcoholism, patients with other diseases and those from the control group**

| | SP | df | PM | F | P |
|---|---|---|---|---|---|
| intergroup | 3070.55 | 2 | 1535.27 | 58.00 | **.00** |
| intragroup | 2302.73 | 87 | 26.46 | | |
| Total | 5373.28 | 89 | | | |

In Table 1.3., we obtained F (2.87) = 58.00, at p = 0.00, which is lower than the critical threshold p = 0.05. Thus, the three groups show significant differences. More detailed data are obtained from additional tests.

**Table 1.4 Post-hoc tests used to compare the groups included in the study**

| | (I) Subjects | (J) Subjects | Differences between environments | ES of differences | p | Confidence range 95% | |
|---|---|---|---|---|---|---|---|
| Tukey HSD | alcoholic | Control group | 13.66(*) | 1.32 | .00 | 10.49 | 16.83 |
| | | Hospitalized patients | 3.16 | 1.32 | .05 | -.00 | 6.33 |
| | Control group | Alcoholic | -13.66(*) | 1.32 | .00 | -16.83 | -10.49 |
| | | Hospitalized patients | -10.50(*) | 1.32 | .00 | -13.66 | -7.33 |
| | Hospitalized patients | Alcoholic | -3.16 | 1.32 | .05 | -6.33 | .00 |
| | | Control sample | 10.50(*) | 1.32 | .00 | 7.33 | 13.66 |
| Scheffe | alcoholic | Control sample | 13.66(*) | 1.32 | .00 | 10.35 | 16.97 |
| | | Hospitalized patients | 3.16 | 1.32 | .06 | -.14 | 6.47 |
| | Control group | Alcoholic | -13.66(*) | 1.32 | .00 | -16.97 | -10.35 |
| | | Hospitalized patients | -10.50(*) | 1.32 | .00 | -13.80 | -7.19 |
| | Hospitalized patients | alcoholic | -3.16 | 1.32 | .06 | -6.47 | .14 |
| | | Control group | 10.50(*) | 1.32 | .00 | 7.19 | 13.80 |

The avoidance coping style implies a cognitive denial of negative aspects in which the subject is changing cognitive procedures of attention or minimizing the negative aspects. There is also a repression of traumatic events, reactions and sensations experienced in painful moments. The control group, Theology students, were not involved in the exam session, where, after a failure they could present a high score on this scale and the other two groups of subjects are in a negative situation because the pathological condition affects the way they will react to trauma, adopting an avoidance style, protecting their own image and re-evaluating the current state, which is pathological, thus making the negative symptoms more bearable.

As for the second hypothesis - patients diagnosed with alcoholism syndrome use denial, repression, projection as well as coping mechanisms more often, compared to patients hospitalized with other clinical diagnoses, we present the following:

**Table 2.1. Normal distribution of the samples included in the study in projection, denial and repression**

| | | Projection in patients | Denial in patients | Repression in patients | Denial in alcoholic patients | Repression in alcoholic patients | Projection in alcoholic patients |
|---|---|---|---|---|---|---|---|
| N | | 30 | 30 | 30 | 30 | 30 | 30 |
| Normal Parameters(a, b) | Mean | 11.73 | 16.03 | 14.10 | 20.46 | 17.60 | 17.8 |
| | Std. Deviation | 2.69 | 2.56 | 2.36 | 1.83 | 2.22 | 3.14 |
| Extreme Differences | Absolute | .11 | .14 | .14 | .14 | .20 | .12 |
| | Positive | .11 | .14 | .14 | .08 | .16 | .09 |
| | Negative | -.10 | -.11 | -.12 | -.14 | -.20 | -.12 |
| Kolmogorov-Smirnov Z | | .65 | .81 | .79 | .80 | 1.12 | .66 |
| Asymp. Sig. (2-tailed) | | **.79** | **.52** | **.54** | **.52** | **.16** | **.76** |

As we can see in Table 2.1., the data distribution in the three subscales - denial, repression and projection, in the two samples is symmetrical.

**Table 2.2 Mean and standard deviations for defense, repression, denial and projection mechanisms**

| | Mean | N | Standard deviation | ES of mean |
|---|---|---|---|---|
| Denial in the alcoholic sample | 20.46 | 30 | 1.83 | .33 |
| Denial in patients sample | 16.03 | 30 | 2.56 | .46 |
| Repression in the alcoholic sample | 17.60 | 30 | 2.22 | .40 |
| Repression in the patients sample | 14.10 | 30 | 2.36 | .43 |
| Projection in the alcoholic sample | 17.83 | 30 | 3.14 | .57 |
| Projection in the patients sample | 11.73 | 30 | 2.69 | .49 |

In this table, we can see that the mean of scores registered in the three subscales - denial, repression and projection, are higher in the case of alcoholic sample.

**Table 2.3. T test for comparison of the coping mechanisms means in the two groups**

| | t | df | P |
|---|---|---|---|
| Denial | 7.96 | 28 | .00 |
| Repression | 5.81 | 28 | .00 |
| Projection | 8.31 | 28 | .00 |

In table 2.3., we obtained the first denial variable t (1.28) = 7.96 at a threshold of 0.00, the second on repression t (1.28) = 5.81, at a threshold of 0.00, and the one on projection t (1.28) = 8.31 at a threshold of 0.00, all three thresholds lower than the critical threshold of 0.05. Therefore, we can state that there are significant differences between the two groups in the three coping mechanisms.

The results suggest that specific hypotheses can be supported, alcoholic patients resorting to denial, repression and projection to a higher degree, compared to subjects in the group of patients with different clinical diagnoses.

**IV. Discussions**

Thus, the first hypothesis may be partly presented, because significant differences occur between the control group and the other two. The fact that there are no significant differences between the two groups in the style of avoidance, can be explained by the fact that both groups are hospitalized, which causes a reaction of protection of the self and the awareness of the danger.

Defensive denial represents all procedures to circumvent cognitive mental representation of the traumatic stimulus. It can be seen that alcoholics have used this mechanism to a higher degree. The stoppage of the cognitive representations formation is performed on several levels of information processing. On the attention level of an alcoholic patient, there is a selection of information which will be processed later. This happens because of the influence of the situation he is in, that he can find very humiliating and dehumanizing in some moments of lucidity, when the

access of information is permitted on the conscious level, so he uses defensive methods of self-protection. This is achieved by selecting less negative and more enjoyable, less traumatic or neutral information and by focusing the attention on these pieces of information. The role of this process is to prevent access to information on the consciousness level and avoid the damage of self-esteem or low self-valorization.

This distorted selection and focus, consciously or not, prevents the formation of painful trauma representation, the idea that he has an alcohol problem. In terms of information processing, denial is manifested by under-evaluating the stressor, in this case alcohol, by irrational beliefs like ,,every man drinks a glass now and then" or ,,a glass helps your health" (even if the glass turns into a much larger one) and by overvaluing their own adaptation resources ,,I have always drunk a glass once in a while and I am okay!" They are not aware of the risk, because of the addictive power of alcohol or the adverse consequences that excessive consumption may have.

Thus, by changing the primary characteristics of the stressor - alcohol abuse, the negative parts of the consumption appear less obvious and it will become less harmful in the patient's cognitive system. If defensive denial fails to be so well defined on the level of information processing, it may occur in the behavior - avoiding referral to the doctor, family feuds, the violence directed against oneself or against others.

Repression, unlike denial, which blurs the negative characteristics of the stressor, implies a representation, but its access to consciousness is blocked. This act can be performed both consciously and unconsciously. Alcoholic patient will avoid remembering unpleasant moments caused by excessive consumption. In the prodromal phase, the alcoholic may lose the memory of events that occurred during acute alcohol intoxication for a relatively short time.

Projection refers to the fact that the alcoholic prefers to assign the non-adaptive situation that he is in to an external factor. This external factor can be a particular person or event. During tantrums, an alcoholic often blames his family for the trouble he is in, which can easily lead to violence. Sometimes, the society is to blame for the situation he is in, he is accusing the system, the politics, the boss and, as a consequence, in order to comfort himself, he resorts to alcohol.

The fact that there were significant differences between the two groups is due to the fact that even though both groups use an avoidance coping style, excessive alcohol consumption produces cognitive distortions in information processing, which are associated with organic lesions that lead to the

worsening of the situation in the case of alcoholic patients. The group of patients admitted for other conditions are aware of their current situation to a higher degree, they are more optimistic; alcoholic patients lack optimism maybe because of the emotional liability that excessive consumption causes.

## V. Conclusions

According to the results, we conclude that patients diagnosed with alcohol addiction use dysfunctional behavior to cope with everyday stress and repeat it due to irrational beliefs. Excessive alcohol consumption affects the information processing, so they will continue to see the negative side of situations in everyday life. Although they are aware of the situation they are in, they try to hide it, by minimizing the severity of the problem and by using defensive mechanisms in order to appear better and more efficient. On top of all these, we have noticed a relationship between alcohol addiction syndrome and depression.

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