

Reduction of cognitive dissonance in smokers



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Kneer, J., Glock, S., & Rieger, D. (2012). Fast and not furious? Reduction of Cognitive Dissonance in smokers. *Peer reviewed Journal, Vol 43(2), 81-91*

Introduction

Smokers do not wish to injure their wellbeing on purpose or presume a pessimistic self-concept due to irrational behavior. A health-related self-concept and smoking behavior are incoherent with each other. When confronted with individual detrimental behavior, the self is threatened and conflict among attitude and behavior results in an unconstructive drive state. Festinger delineate such pessimistic drive states as cognitive dissonance. Three studies surveyed whether cognitive dissonance in smokers is abridged instantaneously or remains stable due to the alleged health risk. They explored response latencies and psycho physiological stimulation as further implicit measurements, as dissonance-decreasing approaches might arise swiftly. Participants rated their smoking-related health risks twice for diverse maladies in Study 1, 2, and 3. Studies 1, 2 and 3 varied through the first testing. Dissimilarity in study 2 and 3 diminished during the second testing, while ratings did not vary. The results are conversed in provisos of implicit routines as measurements for cognitive dissonance and in provisos of preclusion and intervention courses (Kneer et al., 2012).

Study 1

Response latencies and ratings were assessed to explore arousal and alteration in cognitive dissonance. By evaluating each of 12 smoking-interrelated maladies on a 10-point Likert-scale, smokers' and nonsmokers' <https://assignbuster.com/reduction-of-cognitive-dissonance-in-smokers/>

risk perception was assessed. Response latencies for these ratings were recorded. To examine whether the dissonance provoked by the confrontation with own perils of increasing a smoking-allied malady is instantly abridged, the risk perception was assessed twice (Kneer et al., 2012).

Hypothesis 1: "Because of the own participation of smokers, the health risk ratings of distinctive smoking maladies should be elevated compared to nonsmokers" Hypothesis 2: "Response latencies should augment for smokers compared to nonsmokers".

Hypothesis 3: "There is no dissimilarity among the ratings of the first and second test".

Research Question 1: "Do smokers repress pessimistic thoughts to instantly lessen cognitive dissonance? And is cognitive dissonance in smokers instantaneously abridged by suppressing pessimistic thoughts?" (Kneer et al., 2012).

Method

Participants and Design

20 smokers and 20 nonsmokers from a German university participated in Study 1. Smokers had smoked on average for 6.05 years, $SD = 2.72$, with a mean of 10.25, $SD = 5.68$, cigarettes per day (Kneer et al., 2012).

Procedure

Applicants filled questionnaires assessing smoking behavior. Smoking related maladies were introduced in computer screens for 300ms max and asked to

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press a number key on a range between 0 (no risk of developing this malady) and 9 (utmost risk of developing this malady). Two practice items were introduced initially to familiarize which were excluded later. Response latencies and rating data were recorded. Participants filled out a Sudoku grid of medium complexity in an interpolated task for 10 minutes where once again the rate of developing the same malady was rated (Kneer et al., 2012).

Materials

20 students from a German university rated 40 maladies concerning their reliance on smoking on a Likert-Scale ranging from 1 to 7 . Six maladies with means of 5.75-6.95, averageSD= 0.71, were incorporated (Kneer et al., 2012).

Results

Rating Data

The rating data was submitted to smoker vs. nonsmoker mixed-model analysis of variance together with final varying factor amid participants. Effect of smoking status revealed by analysis of variance $F(1, 38) = 87.43, p < .001, \eta^2 p = .69$. Smokers rated a heightened risk of developing a smoking related malady ($M = 6.60$) than nonsmokers ($M = 2.90$) (Kneer et al., 2012).

Study 2

The 12 maladies were estranged into two diverse lists. The same number of maladies not linked to smoking was presented. Participants were confronted

with diverse smoking-related and other maladies during first and second testing (Kneer et al., 2012).

Hypothesis 4: "Ratings should be elevated for smoking-allied maladies than for other maladies, but should not differ over time". Hypothesis 5: "There should be an interaction result among nature of malady and testing concerning response latencies" (Kneer et al., 2012).

Method

Participants and Design

20 smokers from a German University were recruited. The study included a smoking related vs. other subject design. Participants had smoked on average for 6.2 years, $SD = 3.12$, with a mean of 10.40, $SD = 5.48$, cigarettes per day (Kneer et al., 2012).

Procedure

1. Two diverse lists (A and B) were included to rule out effects grounded by familiarity with the intended maladies. The 12 smoking-related and other maladies were allocated randomly to each list. Participants were confronted with one list before and with the other after an interpolated task.
2. Only smokers participated.
3. Smoking-related and non-smoking-related maladies were presented to examine whether aroused cognitive dissonance was due to confrontation with smoking-related maladies and the triggering of a

smoking-linked self-concept or due to general health peril and the commencement of a health-related self-concept.

Participants filled questionnaires assessing their smoking behavior to trigger smoking linked self concept. Names of smoking and other maladies were presented randomly on a computer screen where participants responded by pressing a number key (Kneer et al., 2012).

Materials

Six maladies with means from 1. 15 up to 2. 20, average $SD = 1. 42$, were rated as not related to smoking and were included in Study 2 as other diseases (Kneer et al., 2012).

Results

Rating Data

Rating data were submitted to smoking-related vs. other analysis of variance with both factors varying within participants. ANOVA revealed $F(1, 19) = 85. 94, p < . 001, \eta^2 p = . 82$. Smokers rated peril of a budding smoking-related malady higher ($M = 5. 11$) than peril of developing another malady($M = 1. 77$) (Kneer et al., 2012).

Study 3

Six smoking-correlated maladies were alienated into two different lists. Galvanic skin response was recorded to measure psycho physiological arousal during perception and evaluation of smoking-related maladies for smokers and nonsmokers. Electro dermal activity was chosen as a coherent

psycho physiological display because of its sensitive information-processing capability for stimulus and thus best reflects data attained with response latencies. Combining smoking related and nonsmoking related maladies even out the effects on the arousing properties of the acknowledgement of dissonance in smokers, a major reason why nonsmokers also did participate as a control for dissonance effects. Participants received 3 diverse smoking related maladies during 1st and 2nd testing randomly. If smokers experienced dissonance during the 1st testing and not 2nd, the following hypothesis is expected:

Hypothesis 6: "The augment in psycho physiological arousal ought to decline in T2 in contrast to T1 for smokers. For nonsmokers, confrontation with smoking-allied maladies should not result incognitivedissonanceand augment in psycho physiological arousal should be equivalent at T1 and T2 due to deficient of individual involvement" (Kneer et al., 2012).

Method

Participants and Design

From a German university, ten smoking and nonsmoking students were recruited. The study had a smoker versus nonsmoker mixed design. Participants had smoked on average for 10.90 years, SD= 3.03, with a mean of 12.50, SD= 6.54, cigarettes per day (Kneer et al., 2012).

Procedure

Once again participants filled out a questionnaire assessing smoking behavior to trigger the smoking-allied self concept. Names of 3 smoking
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maladies were randomly presented on a computer screen one after another through 1st and 2nd testing. GSR was measured with Wild Divine IOM Lightstone Biometrics USB Widget. Repeated procedures in step 1 & 2 (Kneer et al., 2012).

Results

A significant main effect of Smoking Status, $F(1, 19) = 25.69$, $p < .001$, $\eta^2 p = .57$. As in Study 1 2, smokers ($M = 6.05$) rated their risk of developing a smoking-related malady elevated than nonsmokers ($M = 2.78$) (Kneer et al., 2012).

Discussion

As smoking is a health-impairing behavior, smokers must utilize dissonance-plummeting strategies other than attitude alteration in order to uphold their behavior. Response latencies and ratings used for to investigate changes regarding an increase or decrease of cognitive dissonance, which elevates when two cognitions are inconsistent with each other. In the first two studies smokers were confronted with their risk of developing a smoking-related malady. Risk perception of ratings and response latencies were measured twice, indicating the triggering of cognitive dissonance. During the 2nd testing dissimilarity between ratings and response latencies arose, where the former remained unchanged and the latter changed. According to response latencies, via thought suppression, smokers decreased cognitive dissonance immediately after confrontation of health perils. Due to individual involvement and decreased processing time of dissonance elevating

information, for pessimistic smoking-linked information, response latencies arose; afterwards the suppression of thought as a dissonance-reduction strategy paves way to alterations and decreased information processing and changes in response latencies. These changes present applying implicit measures to assess alterations in cognitive dissonance. Downbeat messages attract more attentional capital in contrast with positive or neutral messages.

The concurrent appliance of explicit and implicit techniques provides a deeper insight in to cognitivedissonance (Kneer et al., 2012).

Limitations

First, cognitivedissonancevaries; it's unclear as to what precise lessening strategies smokers pertain to. Furthermore, In addition, only health-related risk perceptions were analyzed, people do not smoke in order to become ill: They accentuate positive upshots and learn to disregard their health perils (Kneer et al., 2012).

Conclusion

Smokers sense cognitive dissonance, reflect about their health-peril, and condense cognitive dissonance instantly. Thus, suggesting cognitive dissonance through health-allied admonition labels may not sway genuine smoking behavior because dissonance is abridged instantaneously. Therefore, warning markers and programs centering on the health-allied facets of smoking may not be ample to inspire smokers to renounce. As declared above, smokers do not smoke to injure their wellbeing but rather to

attain constructive results such as to reduce stress or social rewards.

Intimidating these upshots might provoke lifelong cognitive dissonance than health-allied information and consequently might assist to revolutionize smoking behavior (Kneer et al., 2012).

Reference

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