

**Gender Role Conflict and Alcohol Metacognitions – Implications for
the Marlatt Model of Relapse Prevention.**

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Thesis Portfolio.

This thesis comprises a portfolio of work and is divided into two parts. The first is a research project entitled *Gender Role Conflict and Alcohol Metacognition – Implications for the Marlatt Model of Relapse Prevention*. The second part is a collection of essays covering: working with groups, a process report and a reflexive essay.

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Reflexive Statement 1.

My involvement with problematic drinkers began while working as a volunteer for a charity dealing with the homeless. What became quickly apparent was the not inconsiderable number of 'street homeless' individuals addicted to alcohol who were the most challenging of all clients. In the majority of cases, these individuals' alcohol and housing problems were compounded by a variety of psychiatric problems, learning difficulties and poor physical health. Initially, my response to this client group was one of confusion and mixed feelings. On the one hand, I would feel frustrated by the impression many of these clients gave of not willing to help themselves, while at the same time I was angered by the hostile reaction of services meant to help. In particular, my experience was that mental health services had washed their hands of this group. The comment of one community psychiatric nurse to me summed up the attitude I generally encounter when attempting to secure some form of treatment "Too difficult, too smelly". At this point I resolved to 'treat' them myself. That decision has culminated in the position I find myself today, a trainee counselling psychologist working, in the main, with drug and alcohol dependent people.

These early experiences have shaped my views about alcohol use. For example, I was struck by the overwhelming number of men who were alcohol dependent compared with women. This observation led me to believe that there are obvious differences in male and female drinking behaviour. Consequently, I came to this research with an awareness of my own confirmation bias. There is a vast literature on alcohol use so the ease with which subtle confirmatory selections can be made is a trap I am keen to avoid. However, it is still true to say that my presuppositions in this regard have influenced the hypotheses generated for this research. Those hypotheses are openly couched in terms of potential sex differences so the line between my examination of the field and my own beliefs is, arguably, blurred. Managing the conflict between presupposition and exploration will, to a large extent, be met through the use of a quantitative design. Hypotheses will be accepted or rejected based on standard statistical techniques. However, the pressure to find and report evidence that might contradict my personal assumptions might lead to less relevant material just to satisfy my sense of fairness.

Allied to the point about assumptions, is the observation about the degree to which I feel comfortable with abductive logic. I am cognisant of my own preference for the 'Eysenckian' *confirmatory* rather than *explanatory* approaches to enquiry and which has had an influence on the design chosen for this study. That position, however, will be fully exposed in the methodology section.

I am also aware of my own, perhaps, crusading approach might lead me to be selective about the participants for this study. My intention, therefore, is to allow the participating branches of Crime Reduction Initiative (the organisation cooperating with the research) to select the participants and eliminate any conscious or non-conscious selection on my part. Of course, that approach might involve someone else's biases but they won't be mine.

Finally, I expect to feel some frustration if the general path of results appears to going away from the position I expect. I need to monitor my feelings as I progress and make an honest judgement about their impact on both myself and the research.

Abstract.

Background – The Marlatt model of alcohol treatment (Marlatt & Gordon, 1986) is widespread. A key component of that model is alcohol expectancies. Alcohol expectancies refer to the effects of alcohol use anticipated by individuals. Metacognitive beliefs about alcohol are considered to be a specific form of alcohol expectancy (Spada, Moneta, & Wells). The present study argues that development of a triphasic metacognitive formulation for problematic drinking (Spada, Caselli, & Wells, 2012) represents the single most important advance in alcohol treatment since the advent of the Marlatt model. The formulation postulates that a reduction in positive and negative alcohol metacognitive beliefs leads to a reduction in alcohol use. A crucial element of the metacognitive formulation is attention allocation (Steele & Josephs, 1990). Internally generated conflict, such as gender role conflict (O’Neil, 1981), it is hypothesised, can disrupt attention allocation thereby reducing efficacy of metacognitive treatment. **Method** – a clinical sample of 102 (male, 74; female, 28) completed the Positive Alcohol Metacognitions Scale (PAM), Negative Alcohol Metacognitions Scale (NAM), Gender Role Conflict Scale (GRCS) and the Alcohol Use Disorders Identification Test (AUDIT). **Results** – regression analysis indicated that gender role conflict moderated the relationship between positive alcohol metacognitions and alcohol use in men but not in women. Similar results were obtained for the GRCS subscale ‘Restricted Emotionality’. **Conclusions** – Findings have implications for gender sensitive interventions in both the Marlatt model generally and metacognitive therapy specifically.

Gender Role Conflict and Alcohol Metacognitions: Implications for the Marlatt Model of Relapse Prevention.

1. Introduction.

It is pertinent in beginning this review to ask why alcohol relapse is important. Perhaps the most common answer is that relapse is such a frequent event that alcoholism has been described as a *chronic relapsing disease* (Becker, 2008). Indeed, if relapse is defined as a return to pre abstinence levels of alcohol consumption then there is considerable evidence to support this view. Within one year of treatment for alcohol abuse or dependence between 50 and 80 per cent of individuals will resume drinking at hazardous levels (Armour, Polich & Stambul, 1978; Monahan & Finney, 1996; Miller & Tonigan, 2001); while non hazardous levels of drinking can be as high as 90 per cent (Orford & Edwards, 1977). More importantly, multiple alcohol withdrawals and relapse have been associated with significant increases in craving (Malcolm, Roberts, Wang, Myrick & Anton, 2000). This implies that failing to prevent alcohol relapse might exacerbate the very problem for which individuals initially sought help.

The poor prognosis for those seeking treatment might contribute to the reason why only 63,000 individuals entered specialist alcohol misuse programmes in 2004-04 out of the estimated 1.6m in England alone thought to be alcohol dependent (Drummond, Oyefeso, & Phillips, 2005; McManus, Meltzer, Brugha, Bebbington & Jenkins, 2009). Also contributing to the problem of alcohol dependence and relapse is its complex aetiology. Factors such as family history, psychological phenomena, personality, psychiatric co morbidity, stress and life events and cultural concerns are thought to be involved in dependence and relapse (National Institute for Clinical Excellence, 2010). However, it can be argued that this very complexity is why alcohol relapse is relevant to Counselling Psychology practice. This is because if Counselling Psychology is to emphasise an approach where “The individual can be seen as existing at the centre of a personal matrix in which biology, social structure, and life events combine with developmental processes to present each individual, at any one time, with a unique set of challenges” (Strawbridge & Woolfe, 2003), then the complex nature of alcohol relapse surely falls within this ambit.

Research into relapse, Allsop & Saunders (1989) argue, did not gain much momentum until the late 1970s, because until then alcohol dependence had been

conceptualised as cravings of such power that they were irresistible. So relapse was considered to be beyond the control of both drinker and therapist. Only when studies demonstrated that an individual's experience of craving could be influenced by their expectations (Maisto, Laverman & Adesso, 1977) and that environmental conditions could be manipulated to influence the quantity and frequency of alcohol consumption (Biglow & Liebson, 1972) did a rejection of the then established notion of relapse begin to change.

At the forefront of this change of view were Gloria Litman (Litman, Eiser, Rawson & Oppenheim, 1979; Litman, Stapleton, Oppenheim, Peleg & Jackson, 1983) and Alan Marlatt (Marlatt & Gordon, 1985). Marlatt and colleagues brought together research published during the previous 15 years to produce a single comprehensive model of relapse. Central to Marlatt's cognitive behavioural model is the notion of relapse as a process that in turn leads to strategies for intervention (Marlatt & Gordon, 1985). Marlatt's model has probably been the most influential development in relapse prevention and alcohol treatment since its original publication and remains substantially unchanged in its application (Raistrick, Heather, & Godfrey, 2006).

This present study, however, argues that recent research in alcohol metacognition (Spada, Caselli, & Wells, 2012), a specific sub-type of alcohol outcome expectancy integral to the Marlatt model, can be regarded as a significant extension to that model. It is that extension (alcohol metacognition) to the Marlatt model that forms one area of focus for investigation in this present study.

No matter which recovery process is chosen, however, overlaying alcohol treatment in almost all countries are notable differences in patterns of alcohol consumption resulting from gender role differences. Researchers and theorists from a number of disciplines have argued that alcohol consumption is part of the male gender role, but is discouraged as part of the female gender role (Chassin, Tetzloff, & Hershey, 1985; Landrine, Bardwell, & Dean, 1988; White & Huselid, 1997). Studies have found that individuals who endorse traditionally feminine traits, such as nurturance or emotional expressivity, report lower consumption and reduced frequency of alcohol use (e.g., Chomak & Collins, 1987; Horwitz & White, 1987; Huselid & Cooper, 1992; Ricciardelli, Connor, Williams, & Young, 2001; Wilsnack & Wilsnack, 1978). Indeed, young women who hold more traditional gender role attitudes are less likely

to drink at all (Parker & Harford, 1992; Zucker, Battistich, & Langer, 1981). In contrast, men who endorse traditionally gendered beliefs toward male and female roles are more likely to consume alcohol, drink more heavily and display more alcohol related problems (Huselid & Cooper, 1992; Mosher & Sirkin, 1984; Pleck, Sonenstein, & Ku, 1994).

Despite these well-documented differences, however, alcohol treatment models do not expressly adapt their approach to take account of such findings leading one well known organization to comment, “Although the research evidence into substance misuse demonstrates that gender is not necessarily a significant predictor of retention, completion or outcome once an individual begins treatment, there may be a number of other factors that might influence treatment outcomes and these may vary according to the gender of the service user” (Alcohol Concern, 2008). Gender role and, specifically, gender role conflict, form the second area of focus for this present study.

Definitions.

Considering the impact that relapse prevention as an intervention has had globally, the lack of an agreed definition of relapse is surprising. As a result, some authors have criticised the use of the term. Miller (1996), for example, in a paper entitled *What is Relapse? 50 Ways to Leave the Wagon* argues that the term relapse has little utility and should not be used. Consequently, in this present study the term alcohol treatment has been adopted to encompass the recovery process.

When referring to sex and gender this present study has adopted the definitions outlined in the World Health Organization’s *Statement on Gender Policy*. “Gender is used to describe those characteristics of women and men, which are socially constructed, while sex refers to those which are biologically determined. People are born female or male but learn to be girls and boys who grow into women and men. This learned behaviour makes up gender identity and determines gender roles” (WHO, 2002, Annex 1).

2. Models of Alcohol Treatment.

Three, overlapping, models of treatment can be said to characterise alcohol recovery programmes in the United Kingdom. They are: the self-help, biomedical and psychosocial models. By far the largest and well organised of the self-help groups is Alcoholics Anonymous (AA) (Babor et al., 2010). Underpinning the AA model is the theory that alcohol dependence is a disease and dependent individuals are, whether abstinent or not, powerless over the drug's effect. Combating the effects of alcohol dependence requires participants to develop a strong spiritual belief system (Gowing, Proudfoot, Henry-Edwards & Teeson, 2001, Alcoholics Anonymous World Services, 1976). This theory implies that individuals have the power to make the decision to stop drinking even if the ability to do so lies with a spiritual entity. The AA treatment approach is referred to as the *12 Step Programme*. This is a stage by stage process where members are inducted by a *sponsor* into admitting powerlessness over the drug, admitting failings and making amends. Regular participation in group sessions is considered essential for success (Emrick & Tonigan, 2004).

Underpinning the biomedical model of treatment is evidence that certain genetic markers increase the likelihood of alcoholism and that changes in brain chemistry lead to a greater likelihood of relapse for those previously dependent. Neuroadaptive changes frequently occur in brain transmission processes that are sensitive to alcohol effects (Gilpin & Koob, 2008). Problematic alcohol use, it is posited, leads to adaption in these systems and has been associated with both negative and positive reinforcement of alcohol use, enhanced anxiety and increased sensitivity to stress. As a result, it is argued, adaptive changes contribute to a vulnerability to relapse in post treatment individuals (Clapp, Bhave, & Hoffman, 2008). Based on this model of alcoholism pharmacological treatments have been developed. It is thought that only nine per cent of individuals in the UK receive medication for relapse prevention (NICE, 2010). Three drugs dominate relapse prevention treatment: disulfiram and two others that operate specifically on the brain's neurotransmission processes, acamprosate and naltrexone.

2.1 Psychosocial Treatment and The Marlatt Model.

At the core of the psychosocial model of alcohol abuse treatment in the UK lies Alan Marlatt's cognitive behavioural approach which attempts to integrate both theoretical perspectives and diverse treatment approaches (Marlatt & Gordon, 1980; Marlatt, 1982; Marlatt & George, 1984; Marlatt & Gordon, 1985; NICE, 2010). It is by far the most comprehensive and holistic model available. Conceptually it has integrated classical and operant conditioning and, especially, social learning theory as espoused by Bandura (1977). A conceptual shift that the Marlatt model introduced to the field is that relapse is a process and that it could take place over a long period of time and is not a reflex-like phenomenon.

Marlatt argues that once an individual has resolved to change an addictive behaviour, or has changed behaviour, this state of affairs holds until they encounter a high risk situation. The most common high risk situations are negative mood states, social pressure, interpersonal conflicts, negative physical states and some positive emotional states (Cummings, Gordon, & Marlatt, 1980). An Individual's failure to cope with a high risk situation leads to a series of cognitive processes such as dissonance conflict and alcohol outcome expectancies of the addictive behaviour and reduced self efficacy. Together these factors contribute to relapse.

The Marlatt model can be criticised for a number of reasons. Much of the research that led to the identification of high risk situations as fundamental to the model is based on retrospective accounts of relapse. This implies that individuals' accounts of events could be open to reinterpretation and bias. For example, a general cognitive model suggests mood state might affect the memories to which individuals attend, and that cognitive priming could determine memories and emotions elicited (Clarke, Beck & Alford, 1999; Riskind, 1989). Hence the accounts given by participants in the Marlatt research might not reflect accurately cognitions and emotions experienced at the time of the situation recalled. Indeed, Hall, Havassy and Wasserman (1990) reported that subjects only associated relapse with elevated stress levels after the event (that is retrospectively) not when stress levels were assessed prior (prospectively). This observation suggests, therefore, that high risk situations leading to anxiety might not necessarily result in relapse. It is possible the relapse itself might have contributed to an increase in anxiety which participants then attribute as

the cause of their relapse. Such an observation lends weight to claims that cognitive processes such as positive outcome expectancies of alcohol in reducing anxiety are not sufficient to account for the power with which individuals experience craving (Heather & Stallard, 1989).

On the other hand, a prospective study by Kushner et al., (2005) showed that individuals with an active anxiety disorder when entering treatment for alcohol dependence displayed a significantly greater risk of relapse than those with no anxiety disorder. This result was stable across a variety of relapse definitions (for example, any alcohol use, absolute amounts used and time to first drink). Such conflicting results indicate, perhaps, that situational factors alone might not fully explain the reasons for relapse.

The validity of the notion of high risk situations has been called into question (Sutton, 1993). Sutton notes that post treatment individuals are presumably encountering many and varied high risk situations but that only some of these situations lead to relapse and not at all in certain individuals. So, when and how does a situation become high risk?

Sutton, it seems, fails to make the obvious point that it is not the variety of situations that is important but the variety of individuals. In an outline of personal construct theory, Bannister and Fransella (1971) suggest that no two situations are the same because no two individuals are the same. They argue, individuals differ from others in how they perceive and interpret a situation, what is considered important and what is considered to be its implications. Especially they differ in the degree to which a situation is clear, obscure, threatening or promising.

In treatment settings the Marlatt model of treatment emphasises training people to “identify situations or states where they are most vulnerable to alcohol use, to avoid high risk situations and to use a range of cognitive and behavioural strategies to cope effectively with these situations” (NICE, 2010, p264). Treatment, therefore, instils in the individual a sense of preparedness that has been described as being akin to fire drill training (Wanigaratne & Keaney, 1990). A significant limitation of this approach, however, even where individuals have identified high risk situations they

personally have encountered and have developed appropriate coping skills, is that such situation dependent preparedness might not be sufficient to deal with future novel situations.

It seems reasonable to argue, therefore, that individuals in treatment following this model have little opportunity to explore the subjective world of the self that gives rise to meanings about *why for them* one situation differs from another. Indeed, cultural variables and intrapersonal factors are given relatively little attention in this model (Maisto, Carey & Bradizza, 1999).

On this view, Marlatt's alcohol treatment model lays insufficient emphasis on the subjective experience of the individual that, it is argued, is a primary consideration in Counselling Psychology (Strawbridge & Woolfe, 2003). What this criticism suggests, therefore, is that significant areas of experience, such as gender roles, can go unexplored thus leaving individuals less prepared than originally believed.

A key concept of the Marlatt model is the notion of alcohol outcome expectancies (Wanigaratne, 2003). These expectancies are considered to be an important component among the immediate determinates of relapse and problematic drinking. Such expectancies are thought to become salient in high-risk situations when individuals expect alcohol to help them cope with negative emotions or conflict, that is "when drinking serves as self-medication" (Larimer, Palmer, & Marlatt, 1999, p. 153). Alcohol expectancies are discussed next.

3. Alcohol Expectancy.

Until the 1960s alcohol's effect on human behaviour was considered to be entirely pharmacological (George et al., 2012). However, once this notion was challenged from an anthropological perspective, by claiming that the effect of alcohol on individuals within and between societies were too varied to be explained by pharmacological processes alone, then links with general expectancy theory were made (MacAndrew & Edgerton, 1969). General expectancy theory suggested that individuals anticipate a particular outcome before participating in an activity and that those expected outcomes result from prior learning. Such expectancies, it is argued, are acquired from cultural norms, personal experience as well as through vicarious learning (Goldman, Del Boca, & Darkes, 1999). At that point Marlatt and colleagues articulated a comprehensive synthesis of expectancy theory an alcohol experience to argue for the construction of an 'alcohol expectancy set' (Marlatt, Demming, & Reid, 1973).

The impact of that article is not to be underestimated. A search of the *PsychINFO* database for the terms 'alcohol' and 'expectancies' contained in journal abstracts revealed just three articles in the three years preceding publication compared with an average of 28 per year during the 40 years subsequently. Today, almost all attempts to explain alcohol's causal role in social, sexual, emotional and behavioural outcomes rely on alcohol expectancy theory in some form other (George et al., 2012).

Alcohol expectancy is frequently defined as: beliefs about the cognitive, affective and behavioural effects of alcohol (e.g. Nicolai, Moshagen, & Demmel, 2012; Madison et al. 2013). However, Goldman et al. (1999) argue that the expectancy construct has been so widely used that it has accumulated a variety of meanings as well as subsuming different assumptions. At the very least alcohol expectancy can be considered to be a multidimensional construct and three key dimensions: Implicit-Explicit; Positive-Negative and Cognitive-Metacognitive are discussed next.

3.1. Implicit and Explicit Alcohol Expectancy.

Certain psychological traditions, it is suggested, emphasise the idea that expectancy templates require activation at the highest cognitive levels, implying that such

expectancies are conscious events that must use attentional resources. On the other hand, different models suggest that expectancies can take place outside of conscious awareness. For example, the well-known model of relapse outlined by Beck, Liese, and Najavits (2005) implies that individuals are only partly aware of the chain of cognitions leading to alcohol use. Implicit (non-conscious) cognitions, it is suggested, underlie mental processes that are automatic in nature and rely on a network of associative memories. Explicit (conscious) cognitions, on the other hand, require an awareness of motives and expected outcomes hence are deliberate in nature (George et al., 2012). Recently, research has attempted to unpick the knot of evidence surrounding explicit and implicit alcohol cognitions in subsequent behaviour.

In a meta-analytical review Reich, Below, and Goldman (2010) addressed the uncertainties concerning the independence of implicit and explicit alcohol expectancy constructs. Put simply, the authors were concerned to answer the questions ‘do measures of implicit and explicit alcohol expectancies measure the same alcohol related construct’ and, if they appear to be distinct, ‘what improvement in prediction of alcohol use do implicit measures contribute?’ Analysis revealed that in 11 of the 16 studies reviewed implicit and explicit measures were correlated significantly with one another. More importantly, in 13 of the 16 studies, explicit measures accounted for more of the variance than implicit measures. However, despite the relatively large amount of variance in alcohol consumption explained by explicit measures, implicit measures did account for significant additional variance. Perhaps the most pertinent conclusion from this study is that the preponderance of evidence points away from a binary either-or approach to implicit and explicit alcohol cognitions. What this conclusion implies is that measures of explicit alcohol cognitions might vary with regard to the influence of other implicit cognitions, and vice versa. Indeed, Roediger (2003) contends that explicit measures of expectancy are invariably subject to priming effects outside of participants’ conscious awareness.

3.2. Positive and Negative Alcohol Expectancy.

Positive alcohol expectancies are those that reflect more emotionally arousing properties of alcohol consumption, such as feeling happy. Alternatively, negative alcohol expectancies typically include more adverse and sedating effects of alcohol,

such as feeling sick or sad. Generally, those who consume higher levels of alcohol have been shown to endorse more positive expectancies, while lighter consumers tend to endorse more negative expectancies (Goldman et al., 1999).

Positive alcohol related outcome expectancies have, most notably, been associated with alcohol consumption, for example in Norwegian and Italian students (Anderson, Grunwald, Bekman, Brown, & Grant, 2011; D'Alessio, Baicco, & Laghi, 2006). Furthermore, increased alcohol consumption by adolescents over time has also been demonstrated to operate as a function of such expectancies (Aas, Leigh, Anderson, & Jakobson, 1998). Unsurprisingly, therefore, positive expectancies have been shown to be associated with an increased likelihood of problematic drinking in students (Labbe & Maisto, 2011) as well as its maintenance (Leeman, Toll, Taylor, & Volpicelli, 2009). Additionally, positive expectancies are also associated with greater endorsement of 'pre-gaming' behaviours; that is, consuming alcohol prior to attending social events (Zamboanga, Schwartz, Ham, Borsari, & Van Tyne, 2010), as well as greater consumption once in attendance (Bot, Engels, & Knibbe, 2005; Larsen, Engels, Weirs, Granic, & Spijkerman, 2012).

Perhaps, however, the most widely quoted positive expectancy associated with alcohol's effect is the notion of anxiety reduction. Indeed, the view that alcohol reduced tension was widely accepted among researchers as far back as the 1940s (Greeley & Oei, 1999). This general view later crystallised into Conger's (1956) 'tension reduction theory' and eventually 'stress-response dampening ideas' (Sher & Levison, 1982). When reviewing the literature between 1987 and 1997, Greely and Oei (1999) concluded that views on alcohol's stress reducing properties had changed little during that period. Some individuals, they summarised, might have a greater genetic predisposition, mood enhancing beliefs and or situational stressors that lead them to consume alcohol for its stress reducing effect. Other researchers, however, regarded such a conclusion as little more than "efforts at organising much the same literature" (Kushner, Abrams, & Borchardt, 2000, p. 149). These authors were inclined to the view that previous reviews merely maintained the status quo and did little to add to the understanding of this primary expectancy construct. As a result, they sought to address the subject by reviewing the comorbidity of alcohol and anxiety using a far wider range of literature than previously. The "tentative

conclusion” (Kushner et al. 2000, p. 343) reached was that either an anxiety disorder or alcohol dependence can contribute to the persistence of pathological alcohol use in a ‘feed-forward vicious cycle’. In simple terms, they contended that anxiety can lead to alcohol use and that alcohol use can lead to anxiety. What this conclusion implies, however, is that individuals who consume alcohol, for whatever reason, are likely to adopt a positive expectancy that alcohol will reduce tension. This means that alcohol use and tension reduction are virtually axiomatic and that the greater exposure to alcohol the greater the association. Consequently, it might be expected that individuals with greater experience of alcohol use will demonstrate a greater endorsement of alcohol’s tension reducing properties. However, Nicolai et al. (2012), examining more than 6000 respondents of mean age 36 years, contend that such a view is overly simplistic. Their results indicated that expectancies about tension reduction did not significantly predict alcohol use among younger subjects but were a strong predictor in older age groups. They suggest that such age-related shifts in alcohol expectancies might be explained, at least partially, by the different consumption patterns exhibited by each group. Older participants reported drinking more frequently but consuming less alcohol per occasion and tended to less strongly endorse social assertiveness expectancies than younger subjects. The implication being that younger participants’ drinking motives centre on social rather than anxiolytic factors; an observation consistent with Lundahl, Davis, Adesso and Lukas’ (1997) conclusions concerning the age related preferred settings for alcohol consumption.

At this point it is worth exploring, if only briefly, the model of positive expectancy that has wide currency among both problematic drinkers and the varied professionals working with them, namely the self-medication hypothesis (SMH). Put simply, SMH posits that individuals believe alcohol consumption will alleviate symptoms of distress. Originating with the work of Edward Khantzian, SMH focused initially on heroin use (Khantzian, Mack, & Schatzberg, 1974) then later incorporated alcohol consumption (Khantzian, Halliday, & McAuliffe, 1990). Khantzian takes a psychodynamic approach to SMH, whereby alcohol consumption compensates for parts of the self that are cut off from consciousness by defense mechanisms. According to Khantzian, the development of alcohol dependence involves the gradual incorporation of alcohol’s effects, and the need to sustain these effects, into the

defensive structure of the ego. Alcohol's effects substitute for defective or non-existent ego defence mechanisms.

Latterly, however, SMH has also been viewed from a cognitive-behavioural perspective. This view suggests that the negative reinforcement of drinking, stemming from alcohol induced anxiety reduction, results in an escalation of alcohol consumption among anxiety-disordered individuals (Kushner, Sher, & Beitman, 1990). Recently Menary, Kushner, Maurer, & Thuras (2011), investigating a nationally representative sample of US citizens – mean age 46 years, tested the proposition that a self-medicating style of drinking among anxiety disordered individuals would lead to increased alcohol consumption and, ultimately, alcohol dependence.

A striking result of this study is that despite the SMH core tenet, that alcohol is consumed to cope with symptoms of distress, only 20 per cent of drinkers with an anxiety disorder reported using alcohol to cope with anxiety symptoms. This finding, however, must be weighed against the observation that the measure of self-medication used in the study was a single-item self-report question in the American National Epidemiological Survey on Alcohol and Related Conditions (NESARC). Nor had the survey item been validated as an accurate reflection of the conceptual intention of the question; the inference being that the extent of self-medicating behaviour might have been underestimated.

If, however, self-medicating behaviour had been underestimated to a significant degree, then it might be expected that differences between self-medicating and non self-medicating groups would be small. In fact, results indicated that anxiety disordered individuals who report self-medication consumed alcohol at more than twice the daily rate of anxiety disordered individuals not reporting self-medication. Furthermore, rates of alcohol dependence were significantly greater among anxiety disordered individuals reporting self medication (35 per cent of the group) compared with anxiety disordered individuals not reporting self medication (9 per cent of the group). The significant differences between these groups suggest that the survey did not underestimate the proportion of self-medication among anxiety disordered drinkers, and supports the hypothesis that self-medicating expectations are associated with increased rates of alcohol consumption and dependence.

However, what this study fails to examine is the possibility that the 80 per cent of anxiety disordered individuals who reported they did not consume alcohol to self-medicate their distress would not also endorse the notion that alcohol does have a tension reducing effect. It is possible, therefore, that the motive for drinking is more salient to the individual than a simple set of alcohol expectancies. For example, one individual might endorse the view that alcohol helps them relax but their primary motive for drinking is to maintain their sociability, whereas another might drink solely to relax. So an individual's set of alcohol expectations might be called on differentially as and when needs arise. In other words, the study might merely have demonstrated that at any one time approximately 20 per cent of individuals feel the need to call on their expectation that alcohol will help alleviate their symptoms of distress rather than only 20 per cent of anxiety disordered drinkers believe that consuming alcohol will reduce anxiety. What remains unanswered is the proportion of individuals who endorse the idea that consuming alcohol reduces anxiety, the strength with which such a belief is held and the factors that might catalyse its activation.

3.3. Metacognitive and Cognitive Alcohol Expectancy.

Before beginning this section proper it is worth outlining the case to view alcohol metacognitive therapy as an extension or development of the Marlatt model rather than a stand alone and independent form of intervention.

Firstly, "Positive metacognitive beliefs about alcohol use can be conceptualised as a specific form of expectancy" (Spada et al, 2007, p. 568). This statement implies that positive alcohol metacognitions, as a subset of alcohol expectancies, are as likely to feature in individuals' psychological processes resulting from a failure to cope with high-risk situations. This connection from high-risk situation failure to positive outcome expectancies is a central component in the Marlatt model. Indeed, the authors note that the modification of metacognitions "may supplant interventions aimed at restructuring alcohol expectancies" (p. 573). In other words they envisage the possibility that addressing metacognitive beliefs might replace attending to alcohol expectancies within models such as Marlatt but not replacing the model itself.

Secondly, challenging positive and negative metacognitive beliefs is an integral part of the suggested treatment approach to metacognitive therapy (Spada, Caselli, & Wells, 2012). However, challenging beliefs such as “Drinking reduces my anxious feelings” or “Drinking helps me fit in socially” that appear in the Positive Alcohol Metacognitions Scale overlaps completely with the efforts to counteract drinker’s misperceptions about the effects of alcohol in the Marlatt model (see Larimer, Palmer & Marlatt, 1999).

Finally, the holistic nature of the Marlatt model also addresses a number of other immediate determinates of drinking and relapse such as ‘high-risk situations’ and ‘coping strategies’. It seems unlikely that such factors would be omitted from any alcohol treatment programme including one featuring metacognitive interventions.

Metacognitive beliefs concern the information an individual holds about their thoughts and emotions as well as the strategies employed to regulate these factors (Spada, Moneta, & Wells, 2007). For example, the information an individual holds about their cognitions could centre on the significance they attach to a particular thought. For a problematic drinker such a belief might be ‘I need to control my thoughts about opening a can of beer’. Beliefs about strategies they employ to regulate thoughts and emotions might include ‘Worrying about how much I drink will help to keep me safe’ or ‘Drinking will calm me down and help me think straight’.

Metacognitive cognitions, it is argued, can be regarded as a specific subset of alcohol expectancies, where the primary difference between positive alcohol expectancies and positive metacognitive cognitions concerning alcohol use is that the former do not explicitly distinguish between cognitive and metacognitive belief domains (Spada, Moneta, & Wells, 2007). For example, the Balanced Alcohol Expectancy Questionnaire (BAEQ) (Jones & McMahon, 1999) comprises 37 items across four factors that appear to monitor social-cognitive domains when measuring positive alcohol expectancies rather than a metacognitive one: Factor 1 (n=14): SOCIABILITY e.g. ‘I would expect to be more adventurous’; Factor 2 (n=10): LONG TERM SELF-FULFILMENT e.g. ‘I would expect to make more friends’; Factor 3 (n=8): MENTAL/PHYSICAL ACTIVITY e.g. ‘I would expect to have more energy’; Factor 4 (n=5) DESIRABILITY e.g. ‘I would expect to think I was more interesting’.

Crucially, as these examples indicate, the survey items fail to identify beliefs concerning the utility of alcohol as a means of cognitive control and self-regulation. Similarly, negative alcohol expectancies in the BAEQ largely measure more general negative predictions about outcomes (e.g. ‘I would expect to get the DTs’) rather than beliefs about lack of executive control (e.g. ‘Drinking will damage my mind’).

Why, however, is the distinction between metacognitive (i.e. process orientated) compared with cognitive (i.e. content orientated) beliefs important? There are two strands of reasoning. Firstly, from a theoretical perspective, the metacognitive model of psychological disturbance, referred to as the self-regulatory executive function model (S-REF), is considered to offer an explanatory account of the aetiology and maintenance of disordered behaviours such as alcohol dependence (Wells, 2009). Central to this model is a combination of metacognitive beliefs that are considered to be the basis for predisposing individuals to engage in a set of processes about thoughts and emotions that constitute a cognitive attentional syndrome (CAS). These beliefs are characterised by increased self-focused attention, rumination, threat monitoring, thought suppression and maladaptive behaviours (Wells & Matthews, 1994; Wells, 2000). Activation of an individual’s CAS during problematic situations, it is argued, drives particular coping strategies such as alcohol consumption (Spada & Wells, 2009). The implication of this theory is that clinical assessment and treatment might be better facilitated by concentrating on the metacognitive components of an individual’s belief system, rather than general alcohol expectancies as is currently the case in a number of recovery models such as the Marlatt model of relapse prevention.

Secondly, from an empirical perspective, evidence suggests that measures of positive and negative alcohol metacognitions have greater predictive power than measures of general alcohol expectancy (Spada, Moneta, & Wells, 2007). Furthermore, alcohol metacognitions have been demonstrated to predict alcohol use following a course of cognitive behavioural therapy in problematic drinkers (Spada, Caselli, & Wells, 2009) and alcohol dependent individuals (Spada & Wells, 2010). What this means is that clinical instruments, such as positive and negative alcohol metacognition scales could, potentially, identify those most vulnerable to relapse, monitor treatment progress and

target resources.

Underpinning the use of metacognitive instruments and therapy is the notion that they are superior to existing alcohol expectancy tools and treatment approaches. A key study in this regard, Spada, Moneta and Wells (2007), lies at the basis of this claim. A community sample of 355 individuals completed measures of alcohol expectancies (The Alcohol Outcome Expectancies Scale, AOES), positive alcohol metacognitions (PAM), negative alcohol metacognitions (NAM) and drinking behaviour. Drinking behaviour was measured using the Alcohol Use Disorders Test (AUDIT) and the Quantity Frequency Scale (QFS). Structural regression modelling, with drinking behaviour as the dependent variable, was adopted.

Results demonstrated that when drinking behaviour was regressed onto the eight alcohol expectancy sub scales the model fit was satisfactory and accounted for 40 per cent of the variance in drinking behaviour. However, only one (negative social performance) of the eight sub scales was a significant predictor of drinking behaviour. In contrast, as well as demonstrating similar levels of model fit and variance, all four sub scales of the positive and negative alcohol metacognitions scales were significant predictors of drinking behaviour. Furthermore, when drinking behaviour was regressed on to both alcohol expectancies and alcohol metacognitions three of the four metacognition sub scales remained significant predictors of alcohol use while only one of the eight expectancy sub scales did so. This combined model accounted for 54 per cent of the variance in drinking behaviour; a modest increase.

From a technical perspective the study noted and compensated for positively skewed measures common in alcohol studies. Equally, an examination of the correlation matrix of independent variables showed that significant intercorrelations ranged from 0.15 to 0.64, indicating that multicollinearity was unlikely to be a problem in the regression analysis, even though the results of any procedural checks were not given.

Despite, however, the robustness of the design and methods of this study its results are in stark contrast to previous alcohol expectancy research, indeed “A number of reviews show expectancies to be among the strongest predictors of drinking, even after other variables are controlled” (Goldman, Del Boca, & Darkes, 1999). How

then might such a divergence be accounted for between these sets of results? In a meta-analysis, McCarthy and Smith (1996) reported that the length of an alcohol expectancy measure accounted for 18 per cent of the variance in effect sizes, independent of reliability. What this means is that short measures correlate with dependent variables at substantially lower rates, even though they are equally reliable. This finding can occur when the shorter measure does not sample the full content domain of the target construct. As the AOES, a 37 item, questionnaire is designed to measure the broad spectrum of alcohol expectancies and the PAM (12 items) and NAM (6 items) are designed to measure the narrower metacognitive domain of beliefs, then it is possible that the statistical association between these latter set of measures is an artefact that reflects question design and scope. In other words, the predictive power of the alcohol metacognitive measures compared with general alcohol expectancies might be accounted for, if only partially, by differences in questionnaire length and domain specificity. In this regard it is interesting to note the results of an initial investigation of general metacognitions using the 30 item Meta-Cognition Questionnaire (MCQ 30) to predict drinking behaviour (AUDIT and QFS). This study showed that of the five metacognitive dimensions of the MCQ-30 that were entered into the regression equation only one, beliefs about the need to control thoughts, was found to account for a significant amount of variance in alcohol use after controlling for anxiety and depression measured by the Hospital Anxiety and Depression Survey (HADS) (Spada & Wells, 2005).

In a follow up study, Moneta (2011) attempted to address some of the limitations of sample size and power noted by Spada and Wells (2005), as well as investigate moderation effects between metacognition, emotion and alcohol use. A similar cross-sectional design, involving 300 British college students (60 per cent male, 40 per cent female) was employed. Again similarly, the MCQ, AUDIT and HADS instruments used in the Spada and Wells (2005) study were employed; the QFS, however, was not included.

Results were mixed. In contrast to results noted by Spada and Wells (2005), and Hypothesis 1 put forward in Moneta (2011) metacognition was not found to be positively associated with alcohol use. Equally surprising was the rejection of Hypothesis 2a (Moneta, 2011), namely that emotion (measured as anxiety and

depression) would be positively associated with alcohol use. This particular result not only contradicts the results of Spada and Wells (2005) but also runs contrary to the extensive literature on the subject (e.g. see Kushner, Abrams, & Borchardt, 2000 for a review). One possible reason for these contradictory results, and observed by Spada and Wells (2005), is the inappropriateness of using AUDIT as a measure of drinking problems in non-clinical populations thus leading to unstable results. Furthermore, it is also noted that AUDIT scores reported in Moneta (2005) are referred to as measures of “alcohol dependence”; which they are not even for high scores.

Results did, however, support the hypothesis that metacognition would moderate the association between emotion and alcohol use. In particular, participants with high MCQ scores tended to drink more alcohol as negative emotion scores rose, compared with the reverse for participants with low MCQ scores. What’s more, the rate of increased problematic drinking for the former group far exceeded the rate of decrease for the latter group. Moneta (2011) suggests this dichotomy can be explained if those with high MCQ scores view the emotion as the problem and seek anxiolytic relief from alcohol. Whereas, those with low MCQ scores recognize environmental factors as the problem and seek to rectify the situation. However, this explanation merely recycles the theoretical proposition put forward in the paper’s rationale for its hypothesis, that high maladaptive metacognition is associated with poor coping strategies, while low rates of maladaptive metacognition are associated with more adaptive coping strategies. A convincing theoretical account as to why these two dichotomous groups exist seems to be lacking in this study’s analysis. Furthermore, while sex differences were reported, in that females had lower alcohol use scores than males, no information was provided as to what these scores were related – emotion, metacognition or their interaction? Nor was an account offered as to why such sex differences might occur.

What these results, taken together, indicate are that on the one hand alcohol metacognition measures might only provide greater predictive power over general alcohol expectancies because they tap a narrower domain with fewer items. On the other hand, what these results also suggest is that greater focus could provide better utility, assuming alcohol metacognitions cover sufficiently the expectancy dimensions

of interests to the researcher. Put simply, researchers or clinicians primarily interested in predicting alcohol use might be better able to do so using measures of a subset of alcohol expectancies such as alcohol metacognitions.

However, is such potential utility sufficient to pursue alcohol metacognition as a research or clinical tool? One further reason to utilise alcohol metacognitions, especially in clinical settings, is the claim that they can provide a model that accounts for problematic drinking (Spada & Wells, 2009).

A key assertion in this model is that the effective monitoring of internal states by attentional processes is disrupted both in the initiation and maintenance of a drinking episode. Problematic drinkers, they suggest, have attentional biases towards alcohol related stimuli that can lead to a reduction in the resources available to monitor internal states thereby more readily triggering alcohol consumption. The chemical effects of alcohol consumption then leads to further disruption of the monitoring process where information about emotional change (e.g. feeling less anxious) and drinking goals (achieving low levels of anxiety) are poorly attended. As a result, the drinking episode persists because the individual fails to access information about the extent to which their affect laden goals have been met. This initial metacognitive model of problematic drinking has subsequently been further refined such that the processes involved are divided into three periods which constitute a triphasic formulation of problem drinking (Spada, Caselli, & Wells, 2012).

In the first phase (pre-alcohol use phase) alcohol related stimuli such as cravings, images or memories trigger positive alcohol metacognitions thereby activating the cognitive attentional syndrome (CAS) characterised by rumination, worry and desire thinking. For example, 'If I study drinking memories it will help me understand why I drink' (rumination), 'If I imagine walking into a pub then I will know how to avoid it' (desire thinking) and 'Thinking about the times I've been drunk will keep me safe' (worry). Once activated, the CAS increases negative affect and craving thus strengthening negative alcohol metacognitions about the need to control thoughts thereby increasing the chance of alcohol consumption. The concluding element of this phase, that strengthening of alcohol metacognitions increases the likelihood of alcohol use, is supported by correlational data from earlier studies of both community

and clinical samples (Spada, Moneta, & Wells, 2007; Spada & Wells, 2009). In each of these studies negative alcohol metacognitions were positively and significantly correlated with alcohol consumption. This conclusion, however, might not be universally accepted. For example, Ciesla, Dickson, Anderson, and Neal (2011) report an inverse relationship between worry and alcohol use among students. Similarly, negative general alcohol expectancies are associated with reduced alcohol consumption among adolescents (e.g. Fromme & D'Amico, 2000). One possible way of accounting for this discrepancy is that the expectancy-alcohol experience continuum is bidirectional (Goldman, Del Boca, & Darkes, 1999). It is postulated that not only do expectancies influence alcohol use but that experience of alcohol use influences expectancies. It appears feasible, therefore, that those with greater experience of alcohol use might be more likely to endorse negative expectancies and, as a result, reduce their alcohol consumption. For example, Jones and McMahon (1994) report that individuals (mean age 44.2 years) leaving treatment with the highest negative alcohol expectancy scores were the most successful in reducing their drinking. As 78 per cent of participants for the studies demonstrating positive correlations between negative alcohol metacognitions and alcohol use were undergraduates, their experience of alcohol could be considered to be in its early stages so less likely to moderate their consumption as a function of negative expectancies or negative alcohol metacognitions.

The second phase (alcohol use) involves an increase in both positive and negative alcohol metacognitions, which serve to reinforce alcohol consumption. At the same time, disruption of the metacognitive monitoring of internal states contributes to dysregulation of alcohol use. The reduction in the metacognitive monitoring component of this formulation owes much to the *attention allocation model* of drinking put forward by Steele and Josephs (1990), (Spada, & Wells, 2009; Spada, Caselli, & Wells, 2012). This model of drinking behaviour suggests “a state of short sightedness in which superficially understood, immediate aspects of experience have a disproportionate influence on behavior and emotion, a state in which we can see the tree, albeit more dimly, but miss the forest altogether” Steele & Josephs, 1990, p. 923). Alcohol, they posit, narrows perception of immediate cues, both internal and external, restricting cognitive abstracting capacity to the most salient aspects of experience. An important implication of attention allocation theory is that certain in

circumstances, such as intoxication, individuals' responses to salient cues can be extreme because response conflict is disinhibited (Goldman, Del Boca, & Darkes, 1999). Indeed, studies examining the effect of alcohol use on social behaviour have reported that individuals' behaviour when intoxicated differs markedly compared with sober behaviour when response conflict is high (Steele & Josephs, 1990; Steele & Southwick, 1985).

The effects of response conflict in relation to metacognitive monitoring and alcohol metacognition, however, have not been studied. This appears to be an important gap in the triphasic formulation proposed, as a number of inter and intrapersonal experiences could impact on the behaviour of individuals and the observed outcomes. In particular, evidence suggests that response conflict linked to self-evaluation could merit closer examination.

Self-evaluation conflict can arise when the wish to view oneself in a positive light is contradicted by an awareness of negative characteristics. For example, it might be an individual's wish to see themselves as physically fit, and at the same time they could also know that they have not undertaken any training for many years. As a result of this oppositional knowledge internal psychological conflict is generated. In this circumstance, it is argued, positive characteristics are more salient than negative ones, but both are accessible to the individual when sober (Bannaji & Steele, 1989). However, an alcohol-induced reduction in attention allocation can ameliorate the conflict experienced by individuals, because positive self-information is more readily accessible. For example, in a study of discrepancies between the actual self and ideal self, alcohol consumption improved participants' self-ratings for high conflict traits but not low ones (Bannaji & Steel, 1989).

One important aspect of self-evaluation concerns gender roles and the degree to which individuals believe they meet expectations of gender stereotypes. Indeed, given the large number of variations in alcohol expectancies between men and women (Monk & Heim, 2013), then an investigation of how conflict associated with gender roles might impact metacognitive beliefs and alcohol consumption seems merited.

During the third phase (post alcohol use) the affective, cognitive and physiological

effects of uncontrolled drinking become the subject of rumination (Spada, Caselli, & Wells, 2012). As a consequence, both negative effect and alcohol-related thoughts increase. At the same time negative alcohol metacognitive beliefs about such thoughts (e.g. 'I can't control my thinking about alcohol') are strengthened. The upshot of this process is that the likelihood of alcohol consumption becomes more likely as the chosen method of emotion regulation.

3.4. Gender Roles and Alcohol Consumption.

Studies have consistently shown significant differences in drinking patterns between men and women (Babor et al., 2010). This difference is reflected in the proportion of men compared with women classified as alcohol dependent; in England, three times as many men than women are alcohol dependent (Drummond et al., 2005; Singleton, Bumpstead & O'Brien, 2001). These differences have implications beyond simple dependence. For example, in England, men have more than twice the number of alcohol attributable deaths than women; 10, 000 compared with 5000 annually (Jones, Bellis, Dedman, Sumnall, & Tocque, 2008). Nor are these gender differences localised to the UK; in most cultures men drink more than women (Heath, 2000). However, such patterns are not immutable. Although men still generally drink more than women in how much and how often they drink, the gap is closing as women's alcohol consumption increases.

In an examination of data from yearly national surveys conducted in the United States between 2002 and 2012 differences between men and women's alcohol consumption and alcohol-related incidents had narrowed along several different measures. Among other things, the study evaluated the number of days an individual drinks each month, incidents of driving while under the influence of alcohol, and the incidence of symptoms of alcohol use disorder, (White et al. 2015). Results indicated that the percentage of those who drank alcohol in the previous month increased for women to 48.3 from 44.9 per cent, but decreased for men to 56.1 from 57.4 per cent between 2002 and 2012. The mean number of days women drank within the previous 30 days also increased, to 7.3 days from 6.8 days, while for men, the number of days decreased to 9.5 days from 9.9. Interestingly, reasons for the emerging patterns

between 2002 and 2012 remained unclear and could not be explained by recent trends in employment, pregnancy or marital status (White et al. 2015). A recent OECD report across all 34 OECD countries also confirmed the changing patterns of alcohol use. It reports that the proportion of children aged under 15 who have not yet drunk alcohol shrank from 44 to 30 of boys and from 50 to 31 per cent of girls during the 2000s. However, over the same period the proportion of children who had experienced drunkenness increased from 30 to 40 per cent for boys and from 26 to 41 per cent for girls. In particular for adults, the report noted that for men those in less educated lower socioeconomic groups were more likely to engage in risky drinking. Whereas, women who engage in risky drinking tend to be more educated and from higher socioeconomic groups (Sassi, 2015). The report confirmed that for the UK in 2012 that a greater proportion of men engaged in hazardous drinking than women. However, from 2000 to 2012 the proportion of men engaging in hazardous drinking increased marginally from 24 to 26 per cent, whereas over the same period the proportion of women engaging in hazardous drinking increased from 15 to 21 per cent.

The antecedents of male drinking patterns are, from an anthropological perspective, rooted in cultural practice (Hunt, MacKenzie, & Joe-Laidler, 2005). For example, the initiation of boys into drinking is often viewed as a rite of passage. “Along with his first sexual experience, [drinking] is one of the fundamental activities by which a boy is initiated as a man” (Lemle & Mishkind, 1989, p.214). Furthermore, it has been argued that not only is drinking alcohol seen as a male activity but drinking heavily is regarded as even more masculine and that such behaviour occurs in men “who are obsessed with manly virtues” (McClelland, 1972, p.248).

The critical observation made by this present study is that alcohol treatment models such as Marlatt including advances such as metacognitive approaches, take little or no account of the cultural antecedents that lead to gender differences in alcohol dependence. These models say nothing about the nature of alcohol outcome expectancies or the subtype of metacognitive beliefs in relation to gender, which in turn, is reflected in the lack of acknowledgement given to it in treatment guidelines.

Gender stereotypes not only create expectancies about how men and women are likely

to behave, argue Rudman and Glick (2008), they also set up social rules that prescribe how they *ought* to behave. Among the traits for which men are most highly rewarded are competence and strength. In contrast, people least tolerate traits such as emotionality in men. In particular, “Men can expect social disapproval for any display of weakness e.g., big boys don’t cry” (Rudman & Glick, 2008, p.123).

At birth, sex is embedded in the biological characteristics based on genitalia, the infant displays, however, the biological distinctions tend to be quickly overlaid with attitudes and behaviours that are stereotypical representations of particular genders. These gender stereotypes have their roots in cultural beliefs about the spectrum on which masculinity and femininity lie. In turn, these cultural beliefs impact on a raft of behaviours, jobs and societal roles with which the emerging individual has to contend.

An Essentialist Approach.

The distinction applied to the terms sex and gender often represents an attempt by those working in the field as a means of avoiding the trap of ‘essentialising’ culture bound conceptions of masculinity and femininity (Rudman & Glick, 2008). The tendency to view members of particular categories, such as all men or all women, is referred to as ‘psychological essentialism’. Category members, it is argued, share absolute properties that determine conceptions of self and others; in simple words ‘who they are’ (Yzerbyt, Rocher, & Schadrin, 1997). From an essentialist perspective, therefore, biological sex differences underpin a number of psychological sex differences. As a result, ‘essentialists’ view the differences in emotion, cognition and behaviour between men and women as biological in basis and immutable. What this means is that changes to the cultural context of human lives, for example equal numbers of males and females in the work place receiving equal pay, would not lead to men and women being more alike.

The extent to which an enduring essentialist attitude has prevailed in the UK so far as alcohol consumption is concerned can be gleaned from two newspaper reports spanning more than 80 years of social change.

“Girls not long from school were to be seen drinking cocktails, champagne and liqueurs, while in time whiskies and sodas were added to the list of stimulants required to keep them going. Scarcely had the age of twenty been reached before the lines that rightly belong to the women of middle age had become evident in such girls. Was it to be supposed that when girls of this kind reached womanhood and became mothers they could produce men and women with anything but the most miserable physique and of the neurotic type?”

Manchester Guardian, 18 February, 1926.

Then, 82 years on:

“ The ladette culture epitomises everything that is wrong with young British women. Why do women feel it necessary to act like ‘one of the boys’, are they not proud of their own gender? Generally these girls might be good for a ‘bit of fun’ but they are certainly not relationship material.”

Sun, 11 December, 2008.

Little appears to have changed with regard to attitudes towards gender and alcohol consumption during this extensive period of social change. Indeed, it has been noted that laypeople (those not working professionally sex/gender issues) display an exaggerated tendency to essentialise gender compared with even the most vociferous biologically orientated psychologist (Rudman & Glick, 2008). These authors suggest two reasons why such essentialist views persist. First, they argue, gender is based on what is usually a clear-cut dichotomous grouping, representing males and females, than is evidenced in other social categorisations. For example, individuals might convert from one religion to another thus adopting new beliefs and practices, or acquire new national identities from that they received at birth so imbuing them with a different world view. By contrast men and women retain more permanent biological distinctions. Second, obvious differences in physical characteristics, such height, weight, strength and reproductive organs, only serve to emphasise gender as different social categories. By dividing men and women into irreducible categories, therefore, essentialism tends to engender the attitude that different sexes are complete biological opposites. The implication of this biological ring fencing is that nature trumps nurture (Gelman & Taylor, 2000).

A Cultural Approach.

Gender socialisation, the process by which male and female children learn masculine and feminine identities is perhaps the foremost culturally based psychological theory of gender (Martin & Ruble, 2004). From this essentially social constructionist perspective cultural beliefs underpin observed sex differences in behaviour as individual follow traditional scripts assigned to their gender roles.

Social learning theory (Mischell, 1966) is frequently invoked to explain gendered differences in behaviour that are observed between men and women. A focal point of social learning theory is the modelling of behaviour resulting from observation of same sex others. For example, children are more likely to imitate the behaviour of an individual of the same sex compared with an individual of the opposite sex (Bussey & Bandura, 1999). Other cultural theories emphasise the role of society in communicating shared beliefs about how each gender ought to behave. These gendered cultural norms coalesce into knowledge structures known as gender schemata that influence individuals' perception of self and others. Consequently, the individuals' social world is viewed through a matrix of gendered schemata that constitute a set of expectations around behaviour and preferences for each sex (Bem, 1981). Gendered schemata, it is argued, develop in childhood and persist through adulthood and, given the length of time between the newspaper extracts above, appear also to persist over time through generations.

As the views expressed in those extracts appear in well known newspapers, it is fair to assume that they reflect the values, or gendered schemata, of a significant proportion of the society they serve. What these extracts seem to express, is that excessive drinking might not always be applauded in young men but is by no means seen as unusual. In contrast, the same behaviour in young women is viewed as deplorable and, to some extent, a symptom of societal failure. In many cultures, "alcohol is one of the most powerful symbols of gender roles and identities (Holmila & Raitasolo, 2005). Evidence points to women believing that female intoxication is perceived in a more negative light than intoxication in men. More than 50 per cent of female respondents in one study of adult respondents to a survey across 29 countries held the view that an intoxicated woman would receive strong disapproval from others, while only 30 per cent believed an intoxicated man would receive such disapproval (Rahav,

2006). Indeed, a qualitative study by Lillie (2000) revealed that one of the five categories of self-evaluation identified among women recovering from alcohol dependence was 'In society's spotlight', that comprised a further six sub categories: 'Being blamed/judged', 'Being different/abnormal', 'Desire to achieve/contribute', 'Having a label' and 'Being a woman/making comparisons with men'. What these categories and subcategories reflect is the social stigma experienced by women who drink excessively and the internal distress that results. One participant summed up her experience: "I mean and now of course, I look - I consider myself as being insane because that's what - that's what the stigma came from outside, you know, my family and society at large were, you know, were really blaming me, you know, they were saying, you're probably mad...and so I really started to see myself as an insane person." (Lillie, 2002, p. 104).

3.5. Gender Role Conflict.

As alluded to above one important aspect of self-evaluation concerns gender roles and the degree to which individual believe they meet expectations of gendered stereotypes. A common conceptualisation of adherence to gender roles lies in the construct of gender role conflict. Gender role conflict is considered to be a psychological state that results from the negative consequences of sex role socialisation (O'Neil, 1981). In its original conceptualisation, and majority application, gender role conflict applied particularly to men, however, it has been successfully extended to women (O'Neil, 2008). Gender role conflict can be understood as a measure of individual differences in stereotypical sex role compliance that result from processes concerning the socially constructed expectations applied to each sex. For example, men who subscribe to more stereotypical gender roles might view their problems as a sign of weakness and unusual among other men. Equally, men who place elevated value on adhering to gender roles might believe that certain behaviours, such as drinking, ought to be privileged above others. However, when the reality of an individual's experience fails to match gender role expectations psychological conflict arises. Similar mechanism may apply equally to women (O'Neil, 2008). The Gender Role Conflict Scale (GRCS) was developed to measure gender role conflict (O'Neil, 1986).

An important consideration, however, is the suitability of the GRCS for measuring gender role conflict in women. While the four sub-scales (Restrictive Emotionality; Successes, Power and Competition; Restrictive Affectionate Behaviour Between the Same Sex* and Conflict Between Work and Family) could be conceived as applying equally to women the original conceptualisation of this construct was confined to the experience of men (O'Neil, 2008). What's more, O'Neil's early theorising resulted in "conceptual models of men's GRC that depicted gender role socialization as an interaction of environmental and biological factors that promote certain masculine values (the masculine mystique) and the fear of femininity" (O'Neil, 2008, p. 361). The notion of 'fear of femininity' still forms a core premise in theoretical structure of GRC for O'Neil (see O'Neil, 2008, p. 368). So, on the one hand there is concern whether it is legitimate to apply a construct with a core premise concerning men's experience or 'fear of femininity' to women generally. While, on the other hand, there seems to be evidence that such legitimacy has been achieved.

For example, the subscales reported by O'Neil (1986) were also identified in a factor analysis of women's GRCS responses (Borthick, 1997). In a later study comprising 61 men and 144 women it was reported that "Factor analyses have yielded four factors: (a) Success, Power, Competition; (b) Restrictive Emotionality; (c) Restricted Affection Between Men; and (d) Conflict Between Work and Family; confirmatory factor analyses have verified the veridicality of these factors. Adequate internal consistency indexes for the subscales that correspond to the four factors have been found. Moreover, validity has been established by demonstrating convergence with related constructs, expected correlation with mental health variables, and lack of correlation with social desirability". The researchers then successfully used the GRCS to determine whether the relationship between male gender role conflict variables and mental health generalises to women (Zamarripa, Wampold, & Gregory, 2003). Similarly, Magovcevic & Addis (2005) successfully applied the GRCS to a sample of 60 US men and women undergraduates. In both these latter studies items on the GRCS were made sex appropriate by substituting 'women' for 'men' in certain items and using appropriate personal pronouns.

The theoretical premise linking excessive alcohol use and masculinity is that alcohol is considered to temper gender role expectations and help manage conflict from

restricted gender roles (Capraro, 2000; Isenhart, 2001; Lemle & Mishkind, 1989). In a review of gender role conflict O'Neil (2008) reports that seven studies have found significant relationships between GRCS scores and alcohol use were found. Recent studies have reported similar findings among a clinical sample of adults (e.g. Uy, Massoth, & Gottdiener, 2014).

3.6. Hypotheses.

Previous studies of positive and negative alcohol metacognitions have not reported sex differences in scores of those measures (e.g. Spada & Wells, 2005; Spada & Wells, 2009; Spada, Caselli & Wells, 2012). Such an omission might well be because no such difference was observed, alternatively sex differences might not have been investigated. Given that researchers and theorists from a number of disciplines have argued that alcohol consumption forms a central component of the male gender role but discouraged as part of the female gender role (Chassin, Tetzloff, & Hershey, 1985; Landrine, Bardwell, & Dean, 1988; White & Huselid, 1997) it seem reasonable to theorise that men are likely to endorse positive, and possibly negative, alcohol metacognitions than women. Consequently, the first hypothesis of this study is:

Hypothesis 1: scores of positive and negative metacognitive beliefs predicting alcohol use will differ by sex.

Williams and Ricciardelli (1999) have used the phrase *confirmatory and compensatory drinking* to account for the relationship between culturally bound gender roles and alcohol consumption in men. Confirmatory drinking they argue refers to alcohol consumption that reinforces a perceived view of masculine gender role drinking behaviour. Such a view of masculine gendered behaviour is summed up by McCelland (1972, p. 248) who describes drinking alcohol not only as a male activity but that drinking heavily is regarded as even more masculine, and that such behaviour occurs in men “who are obsessed with manly virtues”. Compensatory drinking, on the other hand, represents an attempt to surmount the internal conflict experienced through a perceived failure to meet notions of the masculine ideal. Indeed, O’Neil (2008) argues that the theoretical premise problematic drinking to masculinity is that alcohol tempers gender role expectations and helps manage internal conflict generated by restricted gender roles. Hence the second hypothesis of this study is:

Hypothesis 2: GRC scores will predict alcohol use in men.

Spada & Wells (2009) argue that positive metacognitive beliefs about alcohol use are associated with a reduction in metacognitive monitoring that, in turn, contributes to alcohol use. Once drinking begins, they contend, a disruption in metacognitive monitoring leading to a continuation in drinking is likely to occur. In particular, it is argued, impairment of attentional functioning appears to play a fundamental role in disrupting metacognitive monitoring. Drawing on Steele and Josephs' (1990) attention allocation theory, they argue that alcohol's pharmacological properties disrupt attentional processes by narrowing perception to immediate cues and reducing cognitive abstracting capacity, so disrupting metacognitive monitoring. However, an important implication of attention allocation theory is that in certain circumstances, such as alcohol consumption, response conflict is disinhibited (Goldman, Del Boca, & Darkes, 1999). An alcohol induced reduction in attention allocation can ameliorate the response conflict (e.g. gender role conflict) experienced by individuals because positive self-information is more readily accessible (Bannaji & Steele, 1989). For example, in a study of discrepancies between the actual self and ideal self, alcohol consumption improved participants' self-ratings for high conflict traits but not low ones (Bannaji & Steele, 1989). Consequently, it can be theorised that the greater the degree to which an individual experiences response conflict (such as gender role conflict) the greater will be the influence on the relationship between alcohol metacognitions and alcohol use. Hence, the third hypothesis of this study is:

Hypothesis 3: positive and negative metacognitive belief scores will not predict alcohol use independently of GRC.

Behavioural factors central to the male gender role model, such as drinking alcohol, have been highlighted above. However, attitudinal factors within both sexes can also frame conceptions of the male gender role. Gender stereotypes not only create expectancies about how men and women are likely to behave, argue Rudman and Glick (2008), they also set up rules that prescribe how they ought to behave. Among the traits for which men are most highly rewarded is strength, both physical and mental. As a result people least tolerate traits such as emotionality in men. In particular, "Men can expect social disapproval for any display of weakness e.g. big boys don't cry" (Rudman & Glick, 2008, p. 123). Consequently, if positive alcohol metacognition is positively associated with a central component of the male gender role (alcohol use) (Spada & Wells, 2009), then positive alcohol metacognition ought

to be associated with other important components of the male gender role (e.g. restricted emotionality). Hence, the fourth, hypothesis of this study is:

Hypothesis 4: scores on the GRC subscale 'Restricted Emotionality' will predict scores of positive metacognitive beliefs.

4. Methodology.

4.1. Epistemological Position.

Psychological research, both mainstream and clinical, have been “largely wedded to quantitative methods within a naively realist epistemological framework”, argues Harper (2008, p 431). This research aims to challenge any naivety by adopting a critical realist position.

In simple terms, critical realism contends there is a reality that exists independently from its human conception and, by extension, that there are unobservable events which cause observable ones (Collier, 1994). This implies that “the world is composed not only of events and our experience or impression of them, but also of (irreducible) structures, mechanisms, powers and tendencies, etc. that although not directly observable, nevertheless underlie actual events that we experience and govern or produce them” (Lawson, 1997, p.8). In a research setting this notion suggests that the researcher might be able to create the conditions necessary (observable events) but that the results are caused by the underlying mechanisms (unobservable events).

It is argued, however, that the application of this view in the social sciences (open systems) is different from the natural sciences (closed systems) (Bashkar, 1979). Society and culture are generated through human endeavours and change dynamically with human activity. So, unlike natural laws, the rules of society and culture are not universal but dependent on situation and open to modification through mutual agreement. This contention chimes with the view, posited by Strawbridge and Woolfe (2003), that counselling psychology consists of bodies of knowledge constructed in cultures and tested pragmatically by its usefulness rather than existing as a single large integrated system.

Bashkar (1979) argues that fundamental difficulties exist with the way notions of prediction and falsification have been applied in open systems that characterise the social world. Investigation of that social world, he argues, is unable to replicate the closed system typical of experiment in the natural sciences. Bashkar contends that this inability means that a critical realist position ought to assert the ascendancy of explanation above prediction. “...given the impossibility of artificially creating

closed systems, the human sciences must confront the problem of the direct scientific study of phenomena that only manifest themselves in open systems – for which orthodox philosophy of science, with its tacit presupposition of closure, is literally useless” (Bashkar, 1979, p. 27).

This analysis, some suggest, leads to important ramifications for the methods used in this research - notably the use of statistical techniques in the prediction of outcomes (e.g. Mingers, 2002). If the *goodness* of a theory, it is argued, is measured by its explanatory power then the predictive use of theories is not possible in open systems, so prediction fails as a measure of goodness. On the other hand, Scott (2007) contends that this dilemma can be resolved.

Scott (2007) argues that a complete explanation of social events and processes cannot be reduced to the intentions of agents without reference to structural properties nor structural forms be envisaged without reference to the intentions and beliefs of agents. Resolution is achieved through *compensation*, which allocates different purposes to different sorts of data (e.g. quantitative and qualitative data). This is because reality is multi-layered and the various layers require different types of symbolic systems to describe them. Such symbolic systems are manifest through *extensionality* and *intentionality*. Extensionality in this sense is defined as ‘any two expressions true of the same objects, i.e. having the same extension,’ being ‘substituted freely for one another without changing the truth of the larger context’ (Wilson, 1990, p. 387). Extensionality, the argument continues, refers to the substitution of an expression and not the meaning. By contrast, intentional expressions such as ‘she believes that...’ and ‘she wishes that....’ reflect the meaning of a proposition, so are inappropriate to standard mathematical or statistical modelling. Hence, a mathematical or statistical explanation may be appropriate if the property of the object can be expressed extensionally; and likewise a qualitative approach is appropriate if the property can be expressed intentionally. The products of this research, it is argued, meet the criteria for extensionality. For example, alcohol consumption can be measured by a number of different, but substitutable, scales without changing *the truth* of an individual’s pattern of drinking.

4.2. Background.

Previous research methods and approaches to the subject.

This research is multifaceted, however, two main fields of enquiry can be delineated: the relationship between alcohol and gender and the relationship between alcohol and metacognition. These fields of enquiry are discussed prior to outlining a rationale for the chosen research method.

A. The relationship between alcohol and gender.

Broadly, five subtypes of investigation of the relationship between alcohol and gender can be discerned.

Subtype 1. Epidemiological Studies.

These studies tend to be large scale national and international surveys of drinking behaviour that compare a number of parameters such as alcohol consumption, health indicators and economic costs between sexes. The methods employed focus on producing comparative statistics (e.g. World Health Organisation, 2010) and rely on large scale sample data from numerous sources.

Subtype 2. Situating sex differences in cultural norms of alcohol use.

These studies tend to blend data from epidemiological research with original material investigating attitudes towards alcohol, gender and notions of femininity and masculinity. Research methods in this area generally comprise cross-sectional self-report Likert scales (e.g. Wilsnack et. al., 2000).

Subtype 3. Situating sex differences within existing psychological theories of alcohol use.

From a cognitive behavioural perspective these include reviews of: tension reduction theory (Greely & Oei, 1999), personality theory (Sher, Trull, Bartholow, & Vieth, 1999), developmental theory (Windle & Davies, 1999), alcohol expectancy theory (Goldman, Del Boca & Darkes, 1999) and behavioural genetic models (McGue, 1999). The methods chosen by researchers in this area centre on the operationalization of cognitive constructs and their measurement in relation to various behavioural outcomes particularly the volume of alcohol consumed. Research designs

on the whole have encompassed both cross-sectional and prospective approaches. Cross-sectional designs are the most frequently employed approach because of their ease of implementation and low cost, however, they have been criticised as they fail to resolve temporal relations between variables. For example, correlations between alcoholic status and personality can reflect causal, consequential or spurious associations (Sher et al., 1999). Prospective designs on the other hand, although useful in resolving temporal patterns, still do not establish causal relations and it is necessary to consider the effect of possible third variables in such studies. From a psychodynamic perspective, methods generally amount to the theoretical explanation of clinical observations. For example, Khantzian's (1985) *self medication* theory which posits addiction is a form of self soothing that is driven by deficits in the function of an individual's ego. Less common is O'Neill's (1981) operationalization of the psychodynamic notions of men's fear of femininity in the GRCS and which has been used in a number of cross sectional studies.

Subtype 4. Situating sex differences in a biomedical model.

In this arena physiological and neurological sex differences as well as genetic markers are considered to be the antecedents of observed behavioural differences (e.g. Acker, 1986; Hommer et al., 2001; Mann et al., 2005; Pfefferbaum et al., 2001).

Experimental as well as prospective and cross sectional studies are the prevalent methods in this area.

Subtype 5. Exploring the subjective experience of alcohol addiction from the perspective of a single sex.

This area of research has employed qualitative methods (generally grounded theory) to provide insights into the male and female experience of alcohol dependency. In doing so, these studies attempt to identify sex specific as well as overlapping themes in individuals' journeys from addiction to recovery (e.g. Owen-Pugh & Allen, 2012; Lillie, 2002).

B. The relationship between alcohol and metacognition.

This area is dominated by cross sectional research designs that aim to demonstrate the relationship between alcohol consumption and metacognitive beliefs about the effects of alcohol use. Methods centre on statistical techniques that and on correlational

methods together with structural equation modelling which has been employed to create causal relationships.

Rationale for the research method chosen.

This research concerns specifically the contention that a causal relationship exists between alcohol metacognitions and alcohol consumption and can be represented by correlational data between these variables (e.g. Spada, Caselli & Wells, 2012; Spada, Moneta & Wells, 2007). If that relationship is to be challenged with regards to a third variable (gender role conflict) then the method of investigation ought to be consistent with previous methods so that results are in an appropriate form for comparison. In that way new information can be added more appropriately to the existing body of knowledge.

Following the typology outlined by Barker, Pistrang and Elliott (2002), qualitative methods are more suited to descriptions of phenomena but are less appropriate for questions relating to correlation, causality and measurement, which are quantitative constructs. Equally, Harper, (2008) argues that qualitative methods cannot address questions based on *factors and outcome logic* such as what is the influence of X on Y? Some form of quantitative method, therefore, seems the most appropriate way of producing results from which valid comparisons with previous data can be drawn and is most capable of meeting the aims of this study.

While acknowledging that the above argument follows the notion that the choice of method often relies on practical considerations (Henwood & Pidgeon, 1992), it is also recognised that choosing the most appropriate method means ensuring the underlying epistemology is consistent with the research aims (Harper, 2008). When the researcher adopts a realist epistemological framework, Harper (2008) concedes, a hypothetico-deductive approach to method is more appropriate.

4.3. Design

The design is a cross sectional study of a purposive sample of 102 participants using previously published and validated survey scales, and analysed via correlational methods.

4.4. Participants.

Purposive sampling was used for selecting participants, consisting of attendees at alcohol recovery groups run by a national third sector organisation providing community based drug and alcohol services. For purposes of inclusion in this study, participants were required to speak English, to have used alcohol regularly (at least within the last year) and be more than 18 years of age. 102 individuals participated in the study between January and May 2013. Participants were included in the study if they scored more than 5 on (AUDIT; Babor, de la Fuente, Saunders, & Grant, 1992). A score of less than 5 on AUDIT is considered an acceptable cutoff for non-problematic drinking (Gual, Segura, Contel, Heather, & Colom, 2002; Piccinelli et al., 1997). All participants completed the Gender Role Conflict Scale (GRCS) (O’Neil, Helms, Gable, David, & Wrightsman, 1986), the Positive Alcohol Metacognitions Scale (PAMS) (Spada & Wells, 2008), the Negative Alcohol Metacognitions Scale (NAMS) (Spada & Wells, 2008), and the AUDIT (Babor, T.F., Higgins-Biddle, J.C., Saunders, J.B., & Monteiro, M.G. 2001). The mean age for the study sample was: male 41 years (standard deviation [SD] = 10.66 years) and female 39 years (SD 10.85). There were 74 males and 28 females.

4.5. Measures.

Gender Role Conflict Scale (GRCS).

Participants’ experience of GRC was assessed using the GRCS (O’Neil, et.al., 1986). This self-report instrument was developed to measure men’s reactions to the gender role expectations they face in current society. The GRCS consists of 37 items that are grouped into four subscales: Success, Power, and Competition (SPC; 13 items); Restrictive Emotionality (RE; 10 items); Restrictive Affectionate Behavior Between Men (RABBM; 8 items); and Conflict Between Work and Family Relations (CBWFR; 6 items). Sample items include “I like to feel superior to other people” (SPC), “I have difficulty telling others I care about them” (RE), “Affection with other men makes me tense” (RABBM), and “My work or school often disrupts other parts of my life (home, health, leisure)” (CBWFR). Participants rate their agreement with each item on a 6-point Likert scale, ranging from 1 (strongly disagree) to 6 (strongly agree), with higher scores indicating greater degrees of conflict associated with the male gender role. Factor analysis of the original sample using Cronbach’s alpha indicated internal consistencies of .85, .82, .83, and .75, and four-week test–retest

reliabilities of .84, .76, .86, and .72 for SPC, RE, RABBM, and CBWFR, respectively (O'Neil et al., 1995). Schaub and Williams (2007) recently reported similar test-retest reliabilities; ranging from .82 to .89. Construct validity is provided by correlations between the GRCS scores and endorsement of traditional male gender role norms. For example, the RE and RABBM subscales were found to correlate with a fear of intimacy measure (Good & Mintz, 1990; Good et al., 1995). Concurrent validity of the GRCS has been found with differentiating the three subscales of the Personality Attributes Questionnaire (O'Neil et al., 1986), correlating the factors with attitudes of masculinity, social desirability, and fear of intimacy (Good et al., 1995). Female versions of the GRCS were constructed by reversing relevant words (e.g. him, her; man, women) (O'Neil, 2008).

Positive Alcohol Metacognitions Scale (PAMS).

Participants' positive alcohol metacognitions were measured using the PAMS (Spada & Wells, 2008). PAMS is a 12-item measure developed to assess positive metacognitive beliefs about alcohol use. It consists of two factors: (1) positive metacognitive beliefs about emotional self-regulation; and (2) positive metacognitive beliefs about cognitive self-regulation. Examples of items relating to emotional self-regulation include: 'drinking reduces my self-consciousness'. Examples of items relating to cognitive self-regulation include: 'drinking helps me to control my thoughts'. Participants rate their agreement on a four-point Likert scale, ranging from 1 (do not agree) to 4 (agree very much). Higher scores represent higher levels of positive metacognitive beliefs about alcohol use. PAMS was constructed and factor analysed initially using a community sample ($n = 261$), and its factor structure replicated in a clinical sample ($n = 80$) (Spada & Wells, 2006b). Results from these studies suggest that PAMS is dimensional and possesses good internal and external reliability in both community ($\alpha = 0.88$ for PAMS total, $\alpha = 0.81$ for factor 1, and $\alpha = 0.87$ for factor 2) and clinical populations ($\alpha = 0.84$ for PAMS total, $\alpha = 0.77$ for factor 1, and $\alpha = 0.81$ for factor 2) (Spada & Wells, 2006b). Mean PAMS scores at testing and retesting over an eight-week period in a community sample ($N = 50$) indicate acceptable test-retest reliability for both factors (factor 1: $\rho = 0.75$, $P < 0.0005$; factor 2: $\rho = 0.65$, $P < 0.0005$), suggesting that they possess relatively stable characteristics (Spada & Wells, 2006b). PAMS factors 1 and 2 have been found to predict problem drinking independently of trait anxiety in a community

population (n = 138) (Spada & Wells, 2008). PAMS factor 1 has been found to predict problem drinking independently of anxiety and depression in a clinical population (n = 80) (Spada & Wells, 2008). PAMS factor 2 has been found to predict classification as a problem drinker independently of emotion in a mixed community and clinical population (n = 163) (Spada & Wells, 2008).

Negative Alcohol Metacognitions Scale (NAMS).

Participants' negative alcohol metacognitions were measured using the NAMS (Spada & Wells, 2008). NAMS is a six-item measure developed to assess negative metacognitive beliefs about alcohol use. It consists of two factors: (1) negative metacognitive beliefs about uncontrollability; and (2) negative metacognitive beliefs about cognitive harm. Items relating to uncontrollability include: 'my drinking persists no matter how I try to control it'. Items relating to cognitive harm include: 'drinking will damage my mind'. Participants rate their agreement on a four-point Likert scale, ranging from 1 (do not agree) to 4 (agree very much).. Higher scores represent higher levels of negative metacognitive beliefs about alcohol use. NAMS was initially constructed and factor analysed in a community sample (n = 261), and its factor structure was replicated in a clinical sample (n = 80) (Spada & Wells, 2008). Results from these studies suggest that NAMS is dimensional and possesses good internal and external reliability in both community ($\alpha = 0.74$ for NAMS total, $\alpha = 0.68$ for factor 1, and $\alpha = 0.72$ for factor 2) and clinical ($\alpha = 0.87$ for PAMS total, $\alpha = 0.87$ for factor 1, and $\alpha = 0.83$ for factor 2) populations (Spada & Wells, 2006b). Mean NAMS scores at testing and retesting over an eight-week period in a community sample (N = 50) indicate acceptable test-retest reliability for factor 2, but poor test-retest reliability for factor 1 (factor 1: $\rho = 0.42$, $P = 0.001$; factor 2: $\rho = 0.68$, $P < 0.0005$) (Spada & Wells, 2006b). NAMS factor 1 has been found to predict problem drinking independently of trait anxiety in a community population (n = 138) (Spada & Wells, 2008). NAMS factor 1 has been found to predict problem drinking independently of anxiety and depression in a clinical population (n = 80) (Spada & Wells, 2008). NAMS factor 1 has been found to predict classification as a problem drinker independently of emotion in a mixed community and clinical population (n = 163) (Spada & Wells, 2008).

The Alcohol Use Disorders Identification Test (AUDIT).

AUDIT (Babor et.al., 2001) was developed as a screening tool by the World Health Organization for early identification of problem drinkers. AUDIT consists of ten questions regarding recent alcohol consumption, alcohol dependence symptoms and alcohol-related problems. Respondents are asked to choose one of between three and five statements (per question) that most applies to their use of alcoholic drinks during the past year. Responses are scored from 0 to 4 in the direction of problem drinking. The summary score for the total AUDIT ranges from 0, indicating no presence of problem drinking behaviour, to 40, indicating marked levels of problem drinking behaviour and alcohol dependence. A score of 5 on AUDIT is considered the lowest acceptable cutoff for problem drinking. A score of 20 or above is considered a cutoff point for severe alcohol dependence (Babor et al., 2001). This instrument has been extensively used and possesses good validity and reliability (Babor et al., 2001).

4.6. Statistical Analyses.

Gender role conflict, metacognition and alcohol consumption characteristics of male and female participants were compared using chi-square and t test analyses. Multiple regression analyses were performed to examine the main and interactive effects of sex and alcohol metacognition with alcohol use as the dependent variable. Tests for mediation were carried out following the method outlined by Barron and Kenny (1986) and a Sobel test for significance applied. Tests for moderation outlined in Howell (2002) were also conducted.

4.7. Ethics.

Approval for this study was sought and given by London Metropolitan University and Crime Reduction Initiative (CRI). CRI centres in Slough, Reading, Watford, Hatfield and Stevenage agreed to facilitate this study. CRI employees are trained to deal with client distress, confidentiality, power relationships and informed consent that facilitated an ethical approach to recruitment and survey completion. Employees received a presentation on the background to the study and a procedural briefing during their regular monthly meetings in advance of the study. An important consideration of employees and the researcher's personal experience is gaining and

maintaining client trust. In the experience of the researcher it is not unusual for clients to be suspicious of questions asked of them. Equally, given the nature of this clinical population and the often difficult personal circumstances they have experienced, questions – oral or written – can appear intrusive and or insensitive. Consequently, the survey battery proposed for this study contained only the minimum amount of personal data (age, sex) required for the analysis.

Employees agreed to ask clients if they would be willing to participate in the study. Clients of CRI agreeing were handed an information sheet (Appendix 2) and reminded of the voluntary nature of the study. Those clients participating were handed the questionnaires (Appendix 1) to complete anonymously in private; subsequently placing them in a sealable envelope; only the researcher saw completed questionnaires. Where requested a debrief session was conducted for both individuals and groups.

5. Results.

1. Statistical Analysis.

Measures of drinking behaviour are often skewed positively therefore questioning the use of analyses that assume an underlying normal distribution. Positively skewed data are routinely transformed using square roots to ameliorate this problem.

Variables in this study that were skewed excessively were reflected and then square root transformed (i.e., the raw value x was transformed as $\sqrt{K-x}$, where K = largest value + 1). The AUDIT and PAM variables exhibited excessive skewness and were transformed using reflected square roots, whereas the NAM and GRC measures were relatively symmetric and not transformed. The effect of these transformations in the correlation matrices is to reverse the sign when the product of a transformed variable against an untransformed variable is reported. However, for ease of interpretation the axes of graphs have been transformed back to the original scales.

2. Means and Standard Deviations.

Means and standard deviations of age and scales are reported. Reliability was assessed using Chronbach's Alpha. Results, split by sex, are given in Table 1.

Table 1. Means and Standard Deviations

	Scale	Mean	SD	N	α
Male	Age	41.03	10.66	74	
	GRC	127.78	23.17	74	.85
	PAM	17.43	1.17	74	.84
	NAM	16.38	5.80	74	.89
	AUDIT	23.60	1.39	74	.91
Female	Age	38.74	10.85	27	
	GRC	124.82	34.95	28	.94
	PAM	18.24	1.24	28	.84
	NAM	15.93	5.31	28	.91
	AUDIT	23.84	1.33	28	.88

Paired samples t-test indicated there were no significant differences in mean ages and test scores between males and females. Reliability scores measured by Chronbach's Alpha are in line with previous estimates outlined in the Methodology chapter.

3. Correlations.

The Pearson product moment correlations were calculated so that overall patterns of relationships between variables could be examined and scores, split by sex, are reported in Table 2.

Table 2. Correlations between GRC, PAM NAM and AUDIT.

		GRC	PAM	NAM	AUDIT
Male	GRC	1	-.20	.36**	-.30**
	PAM		1	-.52**	.44**
	NAM			1	-.66**
	AUDIT				1
Female	GRC	1	-.33	.23	-.16
	PAM		1	-.61*	.45*
	NAM			1	-.76**
	AUDIT				1

** $p < 0.01$ level (2-tailed), * $p < 0.05$ level (2-tailed).

Pearson product moment correlations between GRC sub-scale scores and main scale scores are reported in Table 3.

Table 3. Correlations between GRCS Subscales, PAM, NAM, and AUDIT.

		SPC	RE	RAB	CWLF	GRC	PAM	NAM	AUDIT
Male	SPC	1	.14	-.05	.28*	.57**	-.08	-.03	-.00
	RE		1	.56**	.04	.75**	-.23	.45**	-.44**
	RAB			1	.05	.68**	-.08	.36**	-.28**
	CWLF				1	.42**	.14	.14	-.17
Female	SPC	1	.39*	.18	.38*	.69**	-.19	-.11	.09
	RE		1	.81**	.42*	.88**	-.38*	.43*	-.34
	RAB			1	.46*	.79**	-.31	.33	-.27
	CWLF				1	.66**	-.04	.06	.02

** $p < 0.01$ level (2-tailed), * $p < 0.05$ level (2-tailed).

Gender role conflict (GRC) was positively correlated with alcohol use (AUDIT) (reversed sign), however, this relationship was significant only for males. There was a positive correlation between positive alcohol metacognitions (PAM) and alcohol use (AUDIT) for both males and females; the Pearson product moment correlation was similar to that previously reported (Spada & Wells, 2009).

4. Hypotheses.

Hypothesis 1: *Scores of positive and negative alcohol metacognitions will differ by sex.*

Linear regressions were used to assess whether significant differences occurred between males and females predicting scores on PAM and NAM scales. Sex was included in the model as a dummy variable. Results of the regressions are given in Table 4. Regression coefficients of PAM and NAM on Sex.

	B	SE B	β
Constant	16.38	.60	
Sex	-.45	1.14	-.04 ^b

Dependent variable: NAM.

b. $p > .05$

	B	SE B	β
Constant	4.07	.14	
Sex	-.10	.23	-.04 ^b

Dependent variable: PAM.

b. $p > .05$

Results indicate there is no significant difference in in PAM and NAM scores between males and females.

Hypothesis 2: *GRC scores will predict alcohol use in men but not in women.*

Linear regressions were conducted to assess whether scores of gender role conflict predict alcohol use in males but not females. Effect size for the models was calculated using Cohen's f^2 . Power was assessed following the procedure

recommended in Faul, Erdfelder, Buchner & Lang (2009) using G* Power program ‘Linear bivariate regression: One group, size of slope’. Results of regressions are given in Table 5.

Table 5. Regression coefficients of GRC on AUDIT.

	B	SE B	β
Constant	6.39	.88	
GRC Male	-.02	.01	-.30 ^a

Dependent variable: AUDIT. a. $p < .05$

Effect size: $f^2 = .10$

Power (alpha .05) = .77

	B	SE B	β
Constant	4.79	.96	
GRC Female	-.01	.01	-.16 ^b

Dependent variable: AUDIT. b. $p > .05$

Effect size: $f^2 = .03$

Power (alpha .05) = .13

Results indicate that GRC scores in males predict alcohol use (AUDIT), whereas the relationship between female GRC scores and alcohol use (AUDIT) was non significant. However, the low power reported for the female regression model reduces confidence that a type II error has not resulted, suggesting that non-significance could be due to insufficient power. Stevens (1996) suggests that when small sample sizes are involved it might be necessary to adjust the probability level (alpha). Adjusting the probability (alpha = .10) resulted in revised power of .22.

Hypothesis 3: Scores on the GRC subscale ‘Restricted Emotionality’ will predict scores of positive alcohol metacognitions.

Two series of regression were conducted to examine the predictive power of the GRC subscale ‘Restricted Emotionality’ (RE) against positive alcohol metacognitions PAM. The first series of regressions examined the relationship using the full PAM scale. The second series examined the relationship in terms of the two PAM

subscales ‘Emotional Self Control’ (ESR) and ‘Cognitive Self Control’ (CSR).
 Effect size for the models was calculated using Cohen’s f^2 . Power was assessed as in Hypothesis 2. Results of regressions are given in the tables below.

Series 1: Restricted Emotionality (RE) – Positive Alcohol Metacognition (PAM).

Table 6. Regression coefficients of RE on PAM.

	B	SE B	β
Constant	5.12	.39	
RE Total Sample	-.03	.01	-.28 ^a

Effect size: $f^2 = .08$

Power (alpha .05) = .83

Constant	5.03	.50	
RE Male	-.03	.02	-.23 ^a

Effect size: $f^2 = .06$

Power (alpha .05) = .51

Constant	5.24	.64	
RE Female	-.04	.02	-.38 ^a

Effect size: $f^2 = .1$

Dependent variable: PAM. a. $p < .05$.

Power (alpha .05) = .56

Series 2a: Restrictive Emotionality (RE) – Emotional Self Regulation (ESR).

Table 7. Regression coefficients of RE on ESR.

	B	SE B	β
Constant	4.00	.32	
RE Total Sample	-.03	.01	-.28 ^a

Effect size: $f^2 = .09$

Power (alpha .05) = .83

Constant	4.00	.43	
RE Male	-.03	.01	-.25 ^a

Effect size: $f^2 = .07$

Power (alpha .05) = .58

Constant	4.00	.50	
RE Female	-.03	.02	-.37 ^b

Effect size: $f^2 = .16$ Dependent variable: ESR. a. $p < .05$, b. $p > .05$

Power (alpha .05) = .52

Series 2b: Restrictive Emotionality (RE) – Cognitive Self Regulation (CSR).

Table 8. Regression coefficients of RE on CSR.

	B	SE B	β
Constant	3.35	.26	
RE Total Sample	-.02	.01	-.23 ^a

Effect size: $f^2 = .06$

Power (alpha .05) = .66

Constant	3.22	3.3	
RE Male	-.01	.01	-.16 ^b

Effect size: $f^2 = .03$

Power (alpha .05) = .29

Constant	3.55	.45	
RE Female	-.03	.01	-.36 ^b

Effect size: $f^2 = .14$ Dependent variable: CSR. a. $p < .05$, b. $p > .05$

Power (alpha .05) = .49

Results indicate that PAM scores are predicted by RE for both the total sample as well as males and females separately. Furthermore, RE scores for the total sample predict scores on both PAM subscales (ESR and CSR). However, when split by sex neither male nor female RE scores predicted CSR. While male RE scores predicted ESR female scores did not reach significance ($p = .055$).

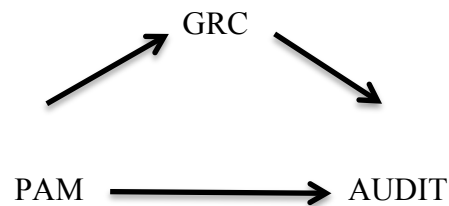
Hypothesis 4: *Positive and negative metacognitive belief scores will not predict alcohol use independently of gender role conflict.*

The independence of metacognitive beliefs' prediction of alcohol use relies on the fact that a third variable, such as GRC, does not play a role in governing that relationship. Both mediating and moderating relationships can indicate the effect of a third variable on the relationship between two variables. A series of studies investigated the presence, or absence, of mediating and moderating relationships.

Mediating Relationships.

Mediation would exist if GRC 'sat between' the relationship between metacognitive beliefs (positive and negative) and alcohol use. The requirements set out by Baron and Kenny (1986) were followed to establish whether GRC mediated the relationship between metacognitive beliefs and alcohol use. In particular, if when the mediator (GRC) and the independent variable (PAM or NAM) are used simultaneously to predict the dependent variable (AUDIT), the previously significant path between the independent and dependent variables is reduced or non significant then a mediating relationship is indicated.

Mediation of PAM-AUDIT by GRC.



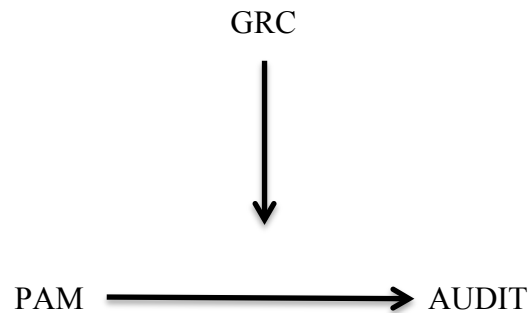
A series of correlations were conducted to establish whether or not further investigation was merited. Results indicated that GRC did not mediate the relationship between positive metacognitive beliefs and alcohol use nor negative metacognitive beliefs and alcohol use.

Moderating Relationships.

While a mediating relationship identifies a variable through which the independent variable (PAM or NAM) influences the dependent variable (AUDIT), a moderating

relationship describes a state where the independent and dependent variables change as a function of a third variable (GRC).

Moderation of PAM-AUDIT by GRC.



The procedure outlined by Howell (2002) was followed to investigate the moderating effect of GRC on the relationship between metacognitive beliefs (PAM and NAM) and alcohol use. A series of multiple regression analyses were conducted to test the above hypothesis.

Series 1: Does GRC moderate PAM – AUDIT?

A series of regression analyses was performed to assess whether gender role conflict (GRC) moderates the relationship between positive alcohol metacognition and alcohol use. Prior to creating a product term to represent an interaction between GRC and PAM, scores of both variables were centred by subtracting the relevant sample means. The regression included GRC, PAM and GRC x PAM interaction term as predictors of alcohol use (AUDIT).

The table below summarises the results of GRC moderation regressions for positive alcohol metacognitions. Power is assessed using G*Power ‘Several Predictors (Multiple Linear Regression)’. The ‘random model’ was chosen over the ‘fixed model’ because predictors are assumed to be random variables with values sampled from an underlying multivariate normal distribution. The fixed-predictors model is more appropriate for experimental research where known predictor values are typically assigned to participants. In contrast, the random predictors model resembles more closely the design of observational studies, such as this instance, where participants together with associated predictor values are sampled from an underlying population (Faul et al., 2009).

Table 9. Regression of GRC and PAM on AUDIT.

Total Sample	B	SE	β
Constant	3.955	.118	
GRC	-.007	.004	-.133 ^b
PAM	-.064	.013	-.434 ^a
Interaction	.002	.000	.278 ^a

Effect size: $f^2 = .44$

Power (alpha .05) = .99

Male	B	SE	β
Constant	3.972	.138	
GRC	-.012	.006	-.193 ^b
PAM	.478	.119	.400 ^a
Interaction	-.015	.005	-.302 ^a

Effect size: $f^2 = .50$

Power (alpha .05) = .99

Female	B	SE	β
Constant	3.920	.246	
GRC	-.001	.007	-.014 ^b
PAM	.512	.205	.477 ^b
Interaction	-.007	.006	-.216 ^b

Effect size: $f^2 = .32$

Dependent variable: AUDIT. a. $p < .05$; b. $p > .05$

Power (alpha .05) = .47

While results for the total sample indicated that gender role conflict moderated the relationship between positive alcohol cognitions and alcohol use, further examination suggested that the total sample was not homogeneous. The male subsample interaction term reached statistical significance, however, the female subsample did not. As a result only the male subsample was investigated further. The overall regression for the Male subsample (N=74) was statistically significant, $R = .576$, $F(3, 70) = 11.574$, $p < .001$. Unstandardised regression coefficients are reported, unless otherwise stated. There was a significant GRC x PAM interaction, $b = -.015$, $t(70) = -3.075$, $p < .01$, $sr^2 = .0906$. There was also a significant effect for PAM, $b = .478$, $t(70) = 4.013$, $p < .001$, $sr^2 = .154$. GRC failed to reach significance,

$b = -.012$, $t(70) = -1.930$, $p > .05$, $sr^2 = .036$. As the interaction term was statistically significant it was retained in the model; although GRC was non-significant by convention it was also retained as it is involved the interaction (Howell, 2002). To visualise the GRC x PAM interaction examine the graph (Figure 1) of the regression prediction lines for High, Medium and Low GRC scores.

Relationship between Alcohol Use and Positive Alcohol Metacognitions split by Gender Role Conflict category.

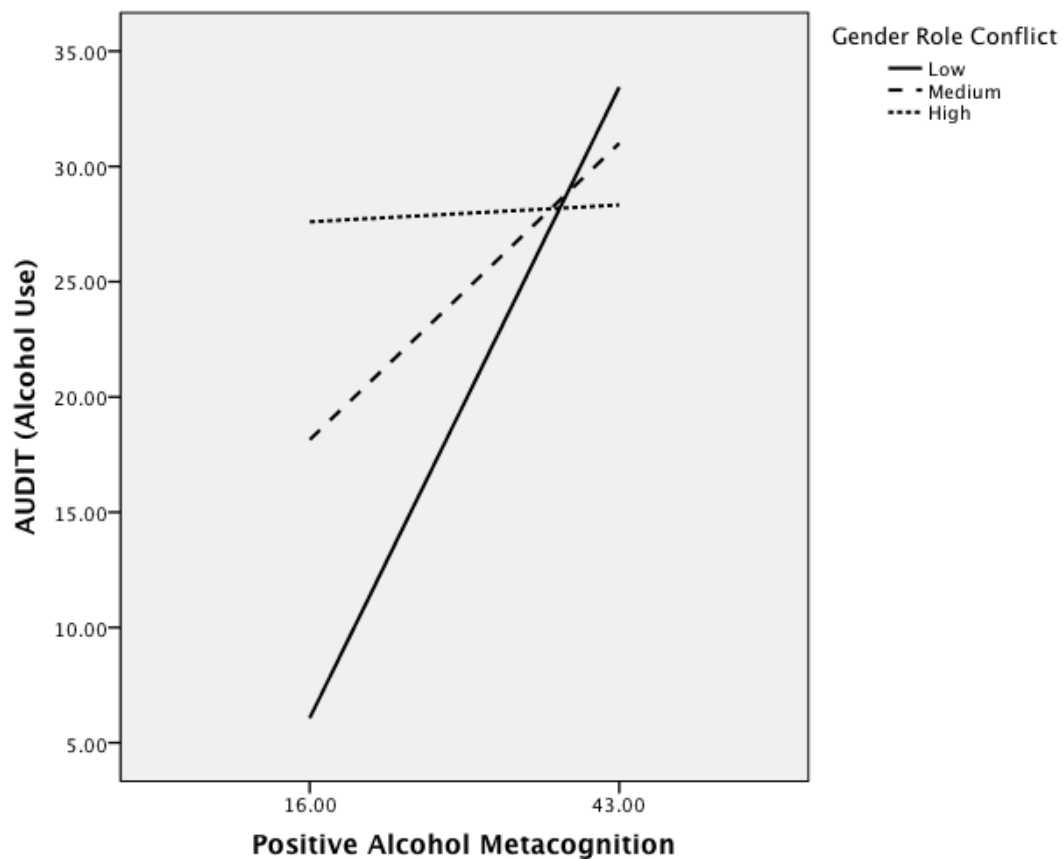


Figure 1. Males: Plot of alcohol use (AUDIT) as a function of positive alcohol metacognitions (PAM) for different levels of gender role conflict (GRC). Three values of GRC (30, 0 and -30) were selected as representative of high, medium and low groups in this subsample. Scores of 1.7 and -1.7 were chosen as representative values for PAM. The graph in Figure 1 was constructed by substituting these values into the regression equation:

$$Y = 3.972 - .012 \text{ GRC} + .478 \text{ PAM} - .015 \text{ Interaction}$$

To assess whether the regression slopes for each of the individual GRC group are statistically significant further analyses were conducted. Regressions were run to predict alcohol use from positive alcohol metacognitions separately within each GRC group. Based on an examination of the frequency distribution, GRC scores were divided into three groups. The lowest 33% of the subsample had GRC scores lower than -9, the middle 33% had GRC scores between -8 and 10, and the highest 33% had GRC scores above 11. The mid points of these groups corresponded to the values of GRC for which the line graph above was calculated. This distribution split gave the largest number of participants in each group. Within the Low GRC group the PAM variable was statistically significant as a predictor of alcohol use, $t(22) = 3.521$, $p < .01$. Within the Medium GRC group the PAM variable was statistically significant as a predictor of alcohol use, $t(22) = 4.206$, $p < .001$. Within the High GRC group the PAM variable did not reach statistical significance, $t(22) = -.445$, $p = .661$.

A causal inference cannot be made from non-experimental data that is correlational in basis, however, results appear to indicate that the higher an individual's gender role conflict, the less likely a reduction in alcohol use if treatment were to focus on reducing positive alcohol metacognitions or alcohol expectancies generally.

Series 2: Does GRC moderate NAM – AUDIT?

Results from a series of multiple regression analyses indicate that GRC does not moderate negative alcohol metacognitions (NAM) in the sample as a whole or subsamples of males and females.

Series 3: Does the GRC subscale Restricted Emotionality (RE) moderate PAM – AUDIT.

Results from the correlation matrix indicate that of the four GRC subscales 'Restricted Emotionality' (RE) has the strongest association with alcohol use. The idea that masculine gender roles are problematic for men has led to various attempts to measure individual differences in men's adherence to these gender roles

(Smiler, 2004). Applied to the context of men’s emotional behavior and problematic outcomes by far the most widely used measure has been the RE subscale of the GRC scale (Wong, Rochlen & Pituch, 2006). To investigate how ‘restricted emotionality’ might be associated with problematic alcohol use in men compared with women, a series of regression analyses was conducted.

Table 10. Regression coefficients of RE and PAM on AUDIT.

Male	B	SE	β
Constant	3.94	.13	
RE	-.02	.02	-.15 ^b
PAM	-.57	.12	.48 ^a
Interaction	-.05	.01	.39 ^a

Dependent variable: AUDIT

Effect size: $f^2 = .63$

Power (alpha .05) = .99

a. $p < .05$, b. $p > .05$

Female	B	SE	β
Constant	3.81	.24	
RE	-.01	.02	-.13 ^b
PAM	.50	.20	.46 ^a
Interaction	-.04	.02	-.35 ^{bc}

Dependent variable: AUDIT.

Effect size: $f^2 = .52$

Power (alpha .05) = .61

Power (alpha .10) = .83

a. $p < .05$, b. $p > .05$, c. $p = .055$

The male subsample interaction term reached statistical significance, however, the female subsample did not. As a result only the male subsample was investigated further. The overall regression for the Male subsample (N=74) was statistically

significant, $R = .622$, $F(3, 70) = 14.724$, $p < .001$. Unstandardised regression coefficients are reported. There was a significant RE x PAM interaction, $b = -.050$, $t(70) = -3.919$, $p < .001$, $sr^2 = .180$. There was also a significant effect for PAM, $b = .570$, $t(70) = 4.801$, $p < .001$, $sr^2 = .248$. RE failed to reach significance, $b = -.023$, $t(70) = -1.491$, $p > .05$, $sr^2 = .031$. The interaction term was statistically significant and retained in the model; RE was non-significant but retained as it is involved the interaction (Howell, 2002). The GRC x PAM interaction is represented the graph (Figure 2) of the regression prediction lines for High, Medium and Low RE scores.

Relationship Between Alcohol Use and Positive Alcohol Metacognitions, Split by Restricted Emotionality category.

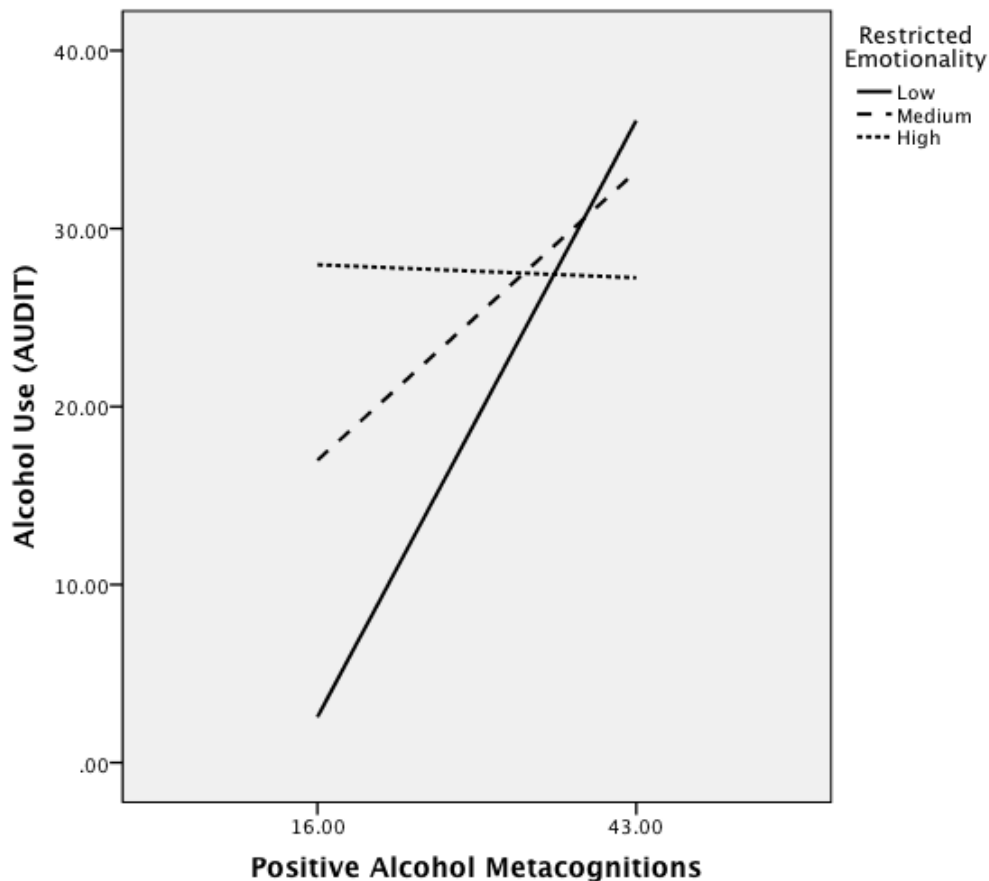


Figure 2. Males: Plot of alcohol use (AUDIT) as a function of positive alcohol metacognitions (PAM) for different levels of restricted emotionality (RE).

Untransformed data are used for ease of interpretation.

To assess whether the slopes for each of the individual RE group are statistically significant further analyses were conducted. Regressions were run to predict alcohol use from positive alcohol metacognitions separately within each RE group.

Three values of RE (12, 0 and -12) were selected as representative of high, medium and low groups in this subsample. Scores of 1.7 and -1.7 were chosen as representative values for PAM. Based on an examination of the frequency distribution, RE scores were divided into three groups. The lowest 33% of the subsample had RE scores lower than -4.39, the middle 33% had RE scores between -4.38 and 3.61, and the highest 33% had GRC scores above 3.62. The mid points of these groups corresponded to the values of RE for which the line graph above was calculated. This distribution split gave the largest number of participants in each group. Within the Low RE group the PAM variable was statistically significant as a predictor of alcohol use, $t(22) = 4.319, p < .001$. Within the Medium RE group the PAM variable was statistically significant as a predictor of alcohol use, $t(24) = 3.876, p < .001$. Within the High RE group the PAM variable did not reach statistical significance, $t(19) = -1.078, p = .295$.

Again caution is required for data that is correlational in basis when inferring causality, however, results appear to indicate that the higher an individual's restricted emotionality, the less likely a reduction in alcohol use if treatment were to focus on reducing positive alcohol metacognitions.

6. Analysis.

1. Correlations.

Chronbach Alpha is high for both male (.84) and female (.94) GRC implying the scale has good internal consistency. However, visual inspection of the pattern of intercorrelation for GRC subscales differs between males and females: five out of six intercorrelations display significant Pearson product moment correlation for the female subsample whereas, for males there are only two. Furthermore, the strength of correlation is different between male and female coefficients. The implication is that the GRC scale might display internal consistency but not uni-dimensionality. This possibility would mean different patterns of shared variance between subscales, hence different factors constituting the main GRC scale for male and female subsamples.

Differences in correlation coefficients, however, do not meet statistical significance. For example, the intercorrelations for SPC – RE ($r = .14$ male, $p > .05$ and $r = .39$, $p < .05$ female) on first inspection appear reasonably different. However, significance testing by converting the Pearson product moment correlations (r) into standard scores (z scores), then using these values to calculate the test statistic Z_{obs} , reveals a clearer picture. The above intercorrelations, for example:

$$Z_{obs} = \frac{Z_1 - Z_2}{\sqrt{\frac{1}{N_1} - 3 + \frac{1}{N_2} - 3}} = -1.16 \quad (Z_1, N_1 = \text{male}, Z_2, N_2 = \text{female})$$

As Z_{obs} lies between -1.96 and 1.96 differences between male and female correlation coefficients are not statistically significant. This example result, plus others not reported here, indicates that despite visual differences in the pattern of correlation coefficients, such differences are not significant so the GRC scale displays both internal consistency and uni-dimensionality. Furthermore, results also indicate that the same set of factors underpins both the male and female subsample.

Of greater concern is the high intercorrelation between the restricted emotionality (RE) and Restricted Affectionate Behaviour (RAB) subscales for both males (.56, $p = < .001$) and females (.81, $p = < .001$). Such a correlation suggests a high degree of

overlap between subscales thus calling into doubt whether they really sample discreet areas of the GRC domain. Inflated correlations can also ensue because of problems caused by content overlap, which in turn, has implications for reliability and validity. Inspecting items in the RE subscale reveals such a possible overlap. For example, three of the ten items included in this subscale (“Talking (about my feelings) during sexual relations is difficult for me” [item 13], “Telling others of my strong feelings is not part of my sexual behaviour” [item 22], and “Telling my partner my feelings about him/her during sex is difficult for me” [item 30]) appear to measure similar components of restricted emotionality in relation to sexual behaviour. Similarly, two other items (“I have difficulty expressing my tender feelings” [item 19], and “I often have trouble finding words that describe how I am feeling” [item 25]) both appear to describe overlapping notions about an inability to express emotion.

The strength of correlation between negative alcohol metacognitions (NAM) and AUDIT was stronger than previously reported (Spada & Wells, 2009). This latter difference could have resulted from different sampling frames. The previous study used a community sample (mean AUDIT = 11.2) whereas this study sampled a clinical population (mean AUDIT = 24.6, untransformed). Scores above 20 indicate alcohol dependence.

2. Hypothesis 1: *Scores of positive and negative alcohol metacognitions will differ by sex.*

Neither means nor regression analysis revealed any significant difference between males and female scores of either positive or negative alcohol metacognitions. Previous studies have presented contradictory evidence with regards to alcohol metacognition and sex differences. For example, on the one hand, Clarke et al. (2012, p. 573) report “... that being male, low on conscientiousness and high on positive alcohol metacognitions about cognitive self-regulation raises the risk for increased weekly levels of alcohol use in binge drinking university students”. In contrast, other studies (e.g. Spada et al., 2013) have not reported any significant differences between male and female scores on tests of positive and

negative metacognition. Such lack of difference, however, remains perplexing because alcohol metacognitions, can be regarded as a subset of alcohol expectancies generally, for which a number of studies have reported sex differences in both younger and older adults (e.g. Satre & Knight, 2001; Madson et al. 2013).

One factor that might explain these results is the commonly reported finding that sex differences in alcohol expectancies are confounded by the level of alcohol use (Wilson, 1988). High alcohol use tends to endorse positive (e.g., Brown et al., 1980; Mooney et al., 1987) and negative (Hittner, 1995; Rohsenow, 1983) alcohol expectancies more than low use across a broad age range of adults. Similar positive and negative metacognition scores in this study for males and females, therefore, might simply reflect similar levels of alcohol use; AUDIT scores showed no significant difference between male and females. Further research is required to disentangle this possible confound.

Another factor that might contribute towards an explanation about why results did not support the hypothesis is the difference in mean age between this study and previous ones. Many previous studies have relied on undergraduates as convenience samples or have deliberately targeted young adults. Hence, previously reported mean ages are considerably younger than participants in this research. For example, Clarke et al. (2012) report a mean age of 21.2 years and Madson et al. (2013) 20.2 years, compared with 41.03 years for males and 38.74 years for females in this study. It is possible therefore, that attitudes towards alcohol metacognitions and alcohol expectancies show greater differences between sexes at younger ages, then converge as age and alcohol experience increases. Evidence for age differentials has been demonstrated by Pabst et al. (2014) who report, that for age groups 18-24, 25-44 and 45-64 years, a range of alcohol expectancies have significantly different mean scores. Furthermore, an investigation conducted among a community sample Leigh and Stacy (2004) reported that positive expectancy predicted drinking better than negative expectancy only among respondents under 35, while negative expectancy was a better predictor of drinking status in most respondents over 35 years. These age related differences might result from past experiences with alcohol which, it is hypothesised, influence individuals' implicit alcohol-related expectancies (i.e., expectancies that are outside

conscious awareness and influence behaviours automatically) (Cox, Fadardi, & Klinger, 2006). It is possible that the shared experiences of heavy alcohol users over considerable periods of time might result in a convergence of attitudes towards alcohol expectancies generally and alcohol metacognitions particularly. Further research, of a prospective nature, is required to indicate if such a convergence occurs over time for alcohol dependent individuals.

3. Hypothesis 2: *GRC scores will predict alcohol use in men but not in women.*

Results of the regression analyses supported the hypothesis that gender role conflict predicts alcohol use in men but not women. This simple statement, however, belies a more complex picture. On the one hand, previous studies suggest that gender role conflict predicts both alcohol consumption and drinking problems in students as well as clinical populations (Blazina & Watkins, 1996; Isenhardt, 1993; Korcuska & Thombs, 2003), and that for similar age cohorts GRC is significantly higher in men than women (O'Neil, 2014) thus supporting the hypothesis. On the other hand, mean GRC and AUDIT scores in this study show little difference between men and women, suggesting that support for the hypothesis is surprising. One possible reason why results in this study, of mean scores compared with correlation and regression investigations, appear to oppose one another is that GRC might be related to other behaviours in men and women, and it is those consequent behaviours that create a differential in the propensity for alcohol use.

A number of alcohol related behaviours are associated with sex differences, e.g. impulsivity, normative amount and coping strategies. However, only the relationship between coping strategies, gender role conflict and alcohol consumption has been investigated. Uy, Massouth and Gottdiener (2014) report that, in an investigation of a clinical sample of men, coping strategies mediated the relationship between gender role conflict and alcohol consumption as well as drinking-related problems. Coping strategies were the only predictor of increased alcohol use as well as the most robust predictor of drinking-related problems. They note that alcohol might be used as a coping mechanism to deal with negative states (Khantzian, 1999), suggesting that men who restrict their emotions more frequently than others could experience a

greater desire to drink to cope with their emotions. Thus leading to greater alcohol consumption. This suggestion is consistent with results of this study that indicate the GRC subscale 'restricted emotionality' (RE) is significantly associated with alcohol use in men but not women. They hypothesize, that men with lower levels of gender role conflict, recognize and use more adaptive coping strategies such as obtaining support from others.

Furthermore, a prospective eight year study of alcohol coping strategy sex differences among untreated problem drinkers found that from baseline to year eight, both women and men increased their reliance on approach (adaptive) coping and decreased reliance on avoidance (maladaptive) coping and drinking to cope. Importantly, however, these improvements in coping over time were significantly more apparent for women than for men (Timko et al., 2005).

It is also possible, however, that the sex difference reported could have arisen if males and females were to hold differing conceptions of gender role conflict which, in turn, would be reflected in the GRC scale's lack of dimensionality generally and across males and females particularly. A recent confirmatory factor analysis of the GRC scale, with two independent male samples consisting of European and African American men, revealed that factorial invariance across both models was the same (Nowalk et al., 2011). Thus, suggesting that the GRC scale's dimensionality was the same across both samples. Further, analysis of this study's correlation matrix did not produce evidence of a lack of dimensionality across the male – female samples. While internal consistency is a form of reliability, dimensionality is associated with construct validity, hence it can be argued that the GRC scale represents conceptually identical domains for both men and women.

4. Hypothesis 3: *Scores on the GRC subscale 'Restricted Emotionality' will predict scores of positive alcohol metacognitions.*

Restricted emotionality (RE) predicted positive alcohol metacognition (PAM) in the total sample as well as the male and female subsamples despite a reduction in power

for the latter two. However, when RE was regressed on the emotional component of the PAM scale, 'emotional self regulation' (ESR), only male RE scores predicted ESR. These findings are consistent with a gendered social learning model (Addis et al., 2010; Smiler, 2004), which offers a theoretical framework for explaining relationships among masculine norms, alcohol expectancies and alcohol-related problems. This model hypothesizes that traditional masculine norms influence an individual's (male or female) perception of their environment so influencing the development of learning across a variety of social processes such as the development of positive alcohol expectancies (Addis & Cohane, 2005; Courtenay, 2000; Levant, 1996; Mahalik et al., 2003). Men, it is claimed, receive positive reinforcement within social contexts when they endorse masculine norms but are also penalised if they display characteristics perceived as a feminine, for example by expressing their emotions (Addis & Mahalik, 2003). Support for this contention is suggested by the observation that men, predominantly white American students, appear to restrict their emotionality more than women by having significantly higher RE scores (Zamarripa et al., 2003). As a result, men who adhere to such masculine norms might be more likely to learn and develop positive alcohol expectancies centred on emotional self regulation.

The cognitive component of the PAM scale 'cognitive self regulation' (CSR) is not predicted by male or female RE scores, however, as a combined sample (male + female) CSR is predicted by RE. The low power observed in the two subsamples indicates that, given the low to medium effect sizes for these regression results, the sample size was too small to accept the reliability of these results. Even so, other concerns about repetition in three of the four items of the CSR subscale might also affect the result. For example, item 3 '*Drinking makes me think more clearly*', item 5 '*Drinking helps me control my thoughts*' and item 11 '*Drinking helps me focus my mind*' appear undifferentiated in terms cognitive processes. This lack of differentiation suggests that the relationship between RE and CSR in the total (male + female) sample might be inflated, thus weakening the case for accepting the positive prediction observed.

5. Hypothesis 4: *Positive and negative metacognitive belief scores will not predict alcohol use independently of gender role conflict.*

Results from this study indicated that gender role conflict did not mediate the relationship between positive alcohol metacognitions and alcohol use, so mediation appears not to be a process that supports this hypothesis. In broad terms, results from a recent investigation among US students using similar variables supports the observed result (Iwamoto, Corbin, Lejuez & MacPherson, 2014). These researchers argue that a structural model showing that ‘alcohol expectancies’ mediate the relationship between ‘conformity to masculine norms’ and ‘alcohol use’ provides the best fit of their data. Hence, the hypothesis that gender role conflict (i.e. conformity to masculine norms) mediates the relationship between positive alcohol metacognition (i.e. alcohol expectancies) and alcohol use is unlikely to succeed. However, despite the general indication supporting the results of this study some significant differences of detail emerge between the two studies.

In the study by Iwamoto et al. (2014) the correlation between the independent variable (conformity to masculine norms) total score and the mediator variable (alcohol expectancy) total score is not reported. However, only 12 of the 36 subscale intercorrelations met statistical significance and none achieved a correlation above $r = .19$. Mediation, however, was rejected in this study by the author because it failed to meet one the first set of criteria set by Barron and Kenny (1986), namely, the independent variable (PAM) and the mediator variable (GRC) should demonstrate a statistically significant relationship. The implication is that statistical analysis based on Barron and Kenny’s (1986) procedures (correlation and regression) rather than structural equation modelling employed by Iwamoto et al. (2014) would not have yielded support for the alternative mediation route proposed by them. What this means is that evidence for a competing model of mediation has yet to be confirmed and that the lack of support from this study for the existence of mediation might be better explained by other factors such as low power.

A further difference of note relates to Iwamoto et al.'s conformity to masculine norms' subscale 'emotional control' and its relationship to the variables 'alcohol expectancy' and 'alcohol use'. In the development of the 'conformity to masculine norms' scale Mahalik et al. (2003) report a strong and significant positive correlation between the 'emotion control' subscale and the GRC subscale 'restricted emotionality' of $r = .66, p < .001$ among Caucasian US students. It is surprising, therefore, to note the disparity between Iwamoto et al.'s results and those of this study with regards to these subscales. For example, Iwamoto et al. report a weak but significant negative correlation between 'emotion control' and 'alcohol use'. Such a claim lies in contrast to the results of this study and results reported elsewhere among predominately US students (e.g. Levant et al., 2009; Groeschel et al., 2010).

It is difficult to explain this divergence, however, one possible reason might lie in the use of similar but different measures, which necessarily employ different use of language. It has been suggested, at least among largely white US students, that the language used in the GRC scale, and others similar, might prime individuals in a way that directs scores in a particular direction (Jones & Heesacker, 2012). Furthermore, in that study, scores on the 'restricted emotionality' subscale showed the greatest sensitivity to priming.

Although results of mediation studies did not support the hypothesis, findings from the moderation analysis did lend weight to the contention that positive metacognitions would not predict alcohol use independently of gender role conflict. Caution, however, in drawing conclusions from correlational methods is necessary. Bearing such caution in mind, results appear to indicate that gender role conflict in men moderates the relationship between positive alcohol metacognition and alcohol use. Results for men showed a large effect ($f^2 = .50$) and a high level of power (.99, $\alpha = .05$), whereas results for women showed a large effect ($f^2 = .32$) but a low level of power (.47, $\alpha = .05$). The large effect size noted in each group indicate that despite the small subsample size for women the difference between the groups can be regarded as reliable indicators of differences in the underlying populations.

When split by severity of GRC, findings for men indicate that reducing alcohol use through a reduction in positive alcohol metacognition deteriorates as GRC increases.

The implication of this result is that alcohol abuse treatment based on reducing such metacognitive beliefs, or more generally, what are described as ‘expectancy challenges’ are less likely to be successful for individuals with high GRC.

To date no studies have investigated the moderating effects of GRC with regards to alcohol consumption. However, some evidence consistent with these results is indicated in a recent review of expectancy challenge studies. Labbe and Maisto (2011) report that expectancy challenge treatment was more effective, reducing positive alcohol expectancy and alcohol consumption, in male only groups of US students compared with mixed sex groups. One explanation for this difference is that men might be less likely to enact traditional masculine norms when the priming presence of women is absent. It could be that in the presence of women, men feel a greater need to display their masculinity thus leading to increased internal distress in the form of gender role conflict and, as a result, fail to reduce confirmatory masculine behaviours such as alcohol use.

For women, there was no difference in outcome whether or not they attended mixed or single sex groups, which is consistent with the findings of this study indicating there was no statistically significant interaction of GRC and PAM on alcohol use.

Further analysis of the GRC subscale ‘restricted emotionality’ (RE) yielded a similar pattern of results to the total GRC scale. However, inspection of change in the F ratio between the full GRC scale and RE revealed an absolute increase in the ratio from $F(3, 70) = 11.574, p < .001$ to $F(3, 70) = 14.724, p < .001$. What this change indicates is that the RE subscale gives a better model fit than the full GRC scale. The implication of this observation is twofold. Firstly, the change identifies component of GRC that is most salient to individuals who suffer from, or are recovering from, alcohol dependence. Secondly, the use of the RE subscale opens increased possibility of clinical utility. This is because, rather than asking clients to complete the full GRC scale during their assessment the narrower topic range covered by the 10 RE subscale items could possibly be covered through conversational means. The implication of this possibility is covered more fully in the discussion section.

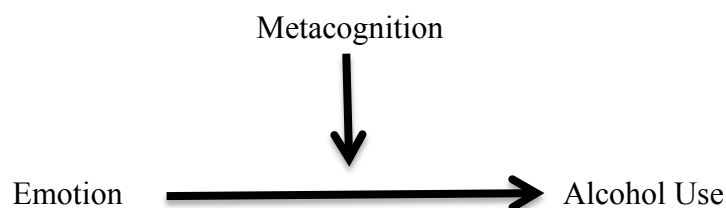
7. Discussion.

This present study examined a number of possible sex differences on measures of gender role conflict, alcohol positive and negative metacognitions and alcohol use. Findings suggest that gender role conflict does predict alcohol use in men but not women. Positive and negative alcohol metacognition mean scores, however, do not differ significantly according to sex. Interestingly, gender role conflict was found to moderate the relationship between positive alcohol metacognitions in men but not in women. Negative alcohol metacognitions did not moderate that relationship in either men or women. No evidence of mediation was found for that relationship in either men or women. The ‘restricted emotionality’ (RE) subscale of the GRCS was found to moderate the relationship between positive alcohol metacognitions and alcohol use in men but only marginally failed to do so in women.

Moneta (2011) also observed that the direct relationship between metacognition and alcohol use was not straightforward. In particular, that metacognition moderated the relationship between emotion (anxiety and depression) and alcohol use. Sex differences in alcohol use were also reported. However, the findings of this present study compared with Moneta (2011) differ in a number of significant areas.

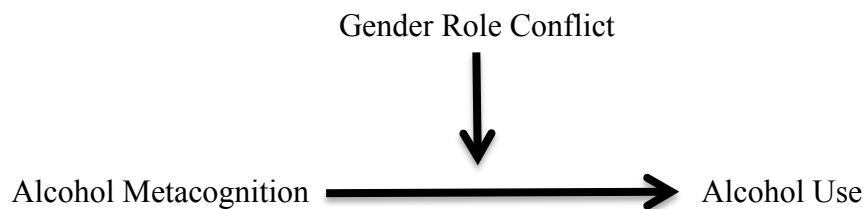
Firstly, the theoretical premise on which the Moneta (2011) hypotheses is based is predicated on the notion that individuals displaying high maladaptive metacognition scores tend to engage in maladaptive coping strategies, such as alcohol consumption, to alleviate the symptoms of distress. Hence the hypothesised moderation model can be considered as:

Moderation of the relationship between Emotion and Alcohol Use by Metacognition.



In simple terms, metacognition is the valve that controls the effect of emotion on alcohol use. The theoretical premise of this present study is that self-evaluation conflict (e.g. gender role conflict) reduces an individual's attention allocation capacity thereby disrupting metacognitive monitoring of internal states, which in turn leads to dysregulated alcohol use. Hence the hypothesised moderation model can be considered as:

Moderation of the Relationship Between Alcohol Metacognition and Alcohol Use by Gender Role Conflict.



In this model gender role conflict is the valve that controls the effect of alcohol metacognition on alcohol use.

Secondly, this present study uses the Positive Alcohol Metacognitions Scale (PAMS) and the Negative Alcohol Metacognitions Scale (NAMS) while the Moneta (2011) study used the general Metacognitions Questionnaire (MCQ). The upshot of this difference is that this present study was able to differentiate the effects of positive and negative metacognition and was able to report that the above model held for positive alcohol metacognitions but not for negative alcohol metacognitions. Moneta (2011) did not differentiate between positive and negative metacognitions hence did not report the circumstances in which its hypothesised model held.

Thirdly, the internal state variable used in Moneta (2011) was emotion, defined as scores on the Hospital Anxiety and Depression Scale (HADS). The internal state variable in this present study is gender role conflict (GRC). These internal states are not the same nor equivalent. GRC is a construct defined as a psychological state in which the socialized gender role has negative consequences for the individual and others (O'Neil, 2008). Whereas anxiety is a feeling of worry, nervousness, or unease about something with an uncertain outcome; while depression is a low mood accompanied by loss of interest and enjoyment in usual activities together with

reduced energy and decreased endeavour (American Psychiatric Association, 2013). While it might be argued that GRC could lead to feelings of anxiety or depression psychometric measures of each are not equivalent.

Fourthly, and most importantly, the hypothesis and observations outlined in Moneta (2011) do not account for the sex differences reported. Female alcohol use scores were reportedly lower than those for males but no sex difference was reported for metacognition scores. As the incidence of anxiety and depression is generally greater among females than males (The NHS Information Centre for health and social care, 2009), so higher emotion scores ought to be associated with higher female alcohol use. However, the reverse is reported with no explanation. This present study attempts to account for sex differences of observed scores (e.g. see below).

7.1. Gender Role Conflict – Cause or Consequence?

An interesting inference to be drawn from the theoretical positions outlined in this study is that the causal relationship between alcohol consumption and gender role conflict might not be so straightforward. While current research tends to the view that gender role conflict might lead to increased alcohol consumption in men (O’Neil, 2008), the situation might be the reverse in women. So, if women who drink excessively do experience increased gender role conflict then the sample of women in this thesis research, who are members of an alcohol treatment and recovery programme, should demonstrate higher mean gender role conflict scores than women who are generally not in such a programme. However, mean gender role conflict scores of women in this study do not differ significantly from the normative female scores reported by O’Neil (2008), (124.8 vs. 119.4 respectively) nor do they differ significantly from the male sample in this study. One explanation for the lack of difference between group results is that the impact of gender role conflict on women could be bidirectional and additive. As a result, women’s gender role conflict might comprise pre and post drinking components. So women’s total GRC could represent a summation of pre drinking and post drinking scores and simply be coincidentally similar to male scores. This possibility, however, does not explain the similarity to the normative scores for women. Although the actual pre-morbid female GRC scores from the study’s participants is not known. This complexity of female drinking-

related cognitions has been noted in previous studies. For example, a wider range of drinking-related cognitions differentiated female problematic drinkers from male problematic drinkers among US young adults and students (Thombs, 1993; Williams et al., 1998). Some studies, however, suggest that the bidirectional nature of GRC is not necessarily restricted to women alone. Smith (1998) used a hermeneutic phenomenological design to examine how six individuals (three men; three women) with drinking problems described the lived experience of the distress caused by excessive alcohol use. Participants reported experiencing a wide range of negative feelings about the self and drinking to overcome how they felt. This behaviour led to feelings of guilt, shame and perceived stigma that in turn led to further drinking. Smith (1998, p. 20) concluded, “people with drinking problems described their lived experience of suffering as a spiraling vicious vortex, which involved the physical, psychological, social and spiritual aspects of the individual’s being”.

Despite the similarity of mean male and female GRC scores noted in this research, regression analysis demonstrated that male GRC scores were predictive of alcohol consumption while female scores were not. One explanation for the greater predictive power of gender role conflict in male problematic drinkers is that GRC might be a more salient factor in men’s self-evaluation and subsequent alcohol consumption than it is for women. Indeed, the salience masculine self-evaluation in men is a powerful discourse in alcohol literature. Alcohol consumption is viewed as “a primary symbol of manliness” (Lemle & Miishkind, 1989, p.213). Furthermore, drunkenness in men continues to be tolerated across various societies since it is seen as being consistent with masculine traits such as risk taking, personal prowess and physical stamina (Herd, 1997). The effect of this discourse, it can be argued, has been to legitimise its assumptions so that they rarely challenged. As a result, research and explanatory models have grown out of this viewpoint that, in turn, appear to strengthen the claim that the salience of gender role conflict as a precursor to alcohol use is greater for men than women. For example, Williams and Ricciardelli (1999) have coined the terms *confirmatory* and *compensatory* drinking, to account for the interaction of culturally bound gender roles and alcohol consumption in men. Confirmatory drinking refers to alcohol consumption that reinforces, or confirms, a perceived view of masculine gender role drinking behaviour.

Compensatory drinking, on the other hand, represents an attempt to surmount the internal conflict experienced through a perceived failure to meet notions of the masculine ideal. Confirmatory drinking, they report, is characterised by high levels of *negative masculinity* and low levels of *positive femininity* and predicts increased levels of alcohol consumption. Individuals who exhibit this pattern of self-perception drink to “enhance their expressivity but are doing so in a masculine context” (p. 329). In contrast, compensatory drinking is exhibited by individuals reporting low scores on both *positive masculinity* and *positive femininity* and again predicts levels of alcohol consumption. Clearly, both types of drinking represent ways to enhance an individual’s notion of manliness. The presentation, however, of these findings leaves the implicit assumption that information about gender stereotypes must be of greater salience to men than women. Whereas other studies have demonstrated that women whose alcohol consumption defined them as ‘high risk’ drinkers were found to score significantly lower on the same measure of *positive femininity* than women rated as ‘moderate risk’ drinkers (Ricciardelli, Connor, Williams, & Young, 2001). What this suggests is that salience of self-evaluation of gender stereotypes leading to alcohol use is just as great for women as men but possibly for different reasons. Indeed, these authors suggest that their findings can be accounted for because of the incompatibility of heavy drinking and stereotypical attitudes with the behaviour expected of women. In other words heavy alcohol consumption in women might predict gender role conflict.

7.2. Reducing Gender Role Conflict.

It is possible that results from this present research could call into question the efficacy of the approaches suggested for the metacognitive of treatment of problematic drinkers. This is because each phase of treatment in the triphasic formulation is predicated on the notion that modifying metacognitive beliefs, evidenced by reducing scores on the positive and negative alcohol metacognitions scale, will reduce alcohol consumption. Whereas, findings from this research have suggested that, for men, the rate of reduction of positive alcohol metacognition scores is a function gender role conflict scores. Results showed that that the greatest rate of decline in positive alcohol metacognitions was among men within the lowest band of scores for gender role conflict. In contrast, men in the highest band of GRC scores

showed almost no reduction in alcohol metacognition scores. Similar results were obtained for the RE subscale. The implication of these findings is that treatment based on the triphasic metacognitive formulation of problem drinkers might help certain clients by taking into account expectancies surrounding gender stereotypes in men especially.

While results from this study indicated that that the relationship between positive alcohol metacognitions and alcohol use in women was not moderated by gender role conflict the statistical non-significance was marginal. Furthermore, the 'restricted emotionality' (RE) subscale did predict such a relationship in both men and women. An important question that needs to be addressed is whether treatment needs to be adapted depending on the client's sex? This is because it is easy to envisage a situation where male and female response to items in the positive alcohol metacognition scale (PAM) might differ depending on the sex of the respondent. For example, the items: 'Drinking makes my negative thoughts more bearable', 'Drinking reduces my anxious feelings', 'Drinking reduces my self-consciousness' and 'Drinking makes me feel happy' are unlikely to receive as positive response from women who experience negative gender stereotyping by what Lillie (2002) describes as 'Being in Society's Spotlight' as a result of drinking compared with men. Comparisons between male and female item sub-groups was not undertaken in this research, however, mean scores of positive alcohol cognitions in this research did not differ significantly between men and women. It would be interesting, therefore, to examine potential sex differences in sub-groups of items. Furthermore, from an anecdotal perspective it was noted that many women participants in post survey feedback sessions raised topics of concern mentioned by Lillie (2002) relating to the gender stereotyping of women with alcohol problems. The stigma experienced by these women as a result of their drinking, it appeared to the researcher, was especially acute among those women whose children had been removed by social services.

A further factor that might impact on women's recovery progress is the concentration on mental processes rather than content in metacognitive therapy. With such an orientation there is a danger that therapy is perceived as being directed at some abstract inner mental machine rather than the individual. Indeed, Lillie (2002, p. 106) observed that women "felt stigmatized by society and often judged, unheard and

unseen by those from whom they sought help. Potential helpers saw the problem and not the person”. All eight women interviewed in that study believed that treatment from professionals had had a negative effect on them, and at best, had resulted in a failure to reduce alcohol use or even increase it. The reasons given for this counterproductive behaviour included not being listened to or consulted about their needs, and not having either the severity or the complexity of their alcohol dependence recognised or accepted. Frequently, participants reported that the expectation of immediate and permanent abstinence from professionals led to diminishing self-esteem and motivation and a return to drinking when they failed to meet such demands. Women, the study concluded, believed that they were often met on a superficial level, and not offered the opportunity to talk in depth. Given the experiences outlined in this study, a focus on mental processes alone as a treatment approach seems likely to alienate female clients with consequent detrimental effects on their recovery.

Men, in contrast, might benefit from the processes orientated approach of metacognitive therapy. Owen-Pugh & Allen (2012) conducting a qualitative study of the male experience of alcohol dependency contrasted their findings with Lillie’s (2002) study of female drinkers. Male drinkers they noted tended to take personal responsibility for their drinking and the need to change, whereas female drinkers stressed the roles of others such as their experience of professional. Men, they concluded, “portrayed themselves as active, solution orientated and in control” Owen-Pugh & Allen (2012, p. 272). The implication is that practicalities, if successful, might outweigh personalities.

Men’s emotional behaviour might also impact on the responses to metacognitive treatment. Results of this study that indicate the GRC subscale ‘restricted emotionality’ (RE) is significantly associated with alcohol use in men but not women. Restricted emotionality also predicted positive alcohol metacognition (PAM) in the total sample as well as the male and female subsamples. When, however, RE was regressed on to the PAM sub-scale, ‘emotional self regulation’ (ESR), only male RE scores predicted ESR. What these findings imply is that for some men the ability to recognise, display and cope with their emotions is less well developed than for women and contributes to their problematic behaviour. Two theoretical positions help account for men’s attitude towards their emotional state and its relation to their

drinking behaviour. Pleck's (1995) concept of gender role strain argues that the male socialisation process can be traumatic as they attempt to comply with male gender stereotype expectations. The result is suppression of emotional display, the development of aggression and, for those who find themselves falling short of male norms, to low self-esteem. As a consequence of such behaviours, Levant (1998) argues the male socialisation process leaves men comparatively unaware of their emotions and lacking the vocabulary to describe them. It is possible, therefore, that the metacognitive therapy focus on mental processes rather than the meaning of affect laden cognitions could fit better with a male perspective of therapy.

7.3. Reducing Gender Role Conflict – No Right Approach.

While the above argument sets out the case why treatment might differ between sexes it is equally the case that there are reasons why it might differ within sexes. One client's treatment preferences are not necessarily the same as another hence a flexible approach to therapy seems required. This is especially the case since therapist flexibility has been linked with improved therapeutic relationships (Perren, Godfrey & Rowland, 2009). Indeed, Cooper and McCloud's (2007, 2011) advocacy of a pluralistic approach to therapy is centred on the notion that different clients could benefit from different treatment methods and strategies. Therapists and clients are expected to collaborate to identify which approach that best aligns with clients' therapeutic goals and preferences. So addressing alcohol related beliefs through metacognitive therapy alone might result in little improvement if such treatment fails to match client preferences. For example, the key difference between the Marlatt model in its original form, compared with the metacognitive approach is that the former is content orientated while the latter process orientated. The difference for individuals in treatment is that the focus shifts from what they are thinking to how they are thinking. Using the Marlatt model, an individual in treatment might identify that walking past a pub triggers thoughts about how much better they would feel if they had a drink and the cravings that ensue. Such a train of thought would be broken down into a 'high-risk situation' (walking past pubs) and an 'alcohol outcome expectancy' (drinking makes me feel like one of the boys). Treatment would then focus on practical strategies to avoid high-risk situations and challenging the expectancy that alcohol always makes you feel 'like one of the boys' or that alcohol

is the only way you can engage with male friends. In contrast, a metacognitive approach in, say, the pre-alcohol use phase would attempt to interrupt extended thinking and associated metacognitive beliefs. So, the therapist would recognise the triggering effect of walking past a pub but then employ techniques such as detached mindfulness to encourage the client to observe their cravings, images and thoughts without attempting to control them (Spada, Caselli, & Wells, 2012).

Deciding which of these two approaches best suits a particular client can be addressed through meta-therapeutic dialogue (Cooper & McCloud, 2012) or through more formal means such as *The Therapy Personalisation Form* (Bowen and Cooper, 2012). This process is important because recent studies suggest that therapist-client agreement on the goals and methods employed in therapy are significant predictors of treatment outcomes (Horvath, Del Re, Fluckinger & Symonds, 2012; Tyron & Winograd, 2011). Furthermore, evidence indicates that clients who received their preferred manner of treatment were up to 50 per cent less likely to exit their course of therapy early compared with those not receiving their preferred choice (Swift, Callahan & Vollmer, 2011).

7.4. The Impact of Context.

A problem for all measures is that the assumption that the underlying domain it claims to reflect is invariant across different situations. There is reason to believe that such an assumption is questionable with regard to alcohol metacognition beliefs. Where, when and with whom individuals drink has been shown to affect the pattern, frequency and quantity of alcohol consumption among US and Canadian students (e.g. Wechsler & Nelson, 2008; Demers et., 2002; Lo Monaco, Piermatteo Guimelli, & Ernst-Vintilla, 2011). The *situational-specificity hypothesis* advanced by Wall, Mckee and Hinson (2000) contends that context mediates alcohol expectancies with regards to consumption. For example, Canadian students' scores of positive alcohol expectancies increased when measured in a drinking context (e.g. a bar) compared with a neutral context (e.g. a meeting room) (Wall, Hinson, Mckee, & Goldstein, 2001; Wall, Mckee, & Hinson, 2000). However, use of the term *context* can mask the components from which it derives. Context, it can be argued, can comprise

location, people and stimuli such as cues; each of which contributes in varying degrees as well as interacting with each other. In a recent review, for example, Monk and Heim (2013) have reported that both social factors (being among peers) and alcohol related cues (video scenes of bars) both contribute to increases in positive alcohol expectancies. In turn, positive alcohol expectancies have been associated with increased alcohol consumption in experimental bar environments accompanied by peers or friends when measured among Dutch students (Larsen et al., 2012). In this study group effects such as the presence of peers or friends accounted for 70 per cent of alcohol consumption variance.

Despite the plethora of research aimed at investigating the influence of context on alcohol expectations such research has been criticised for its failure to access participants' *in vivo* cognitions (Monk & Heim, 2013). Typically, they argue, participants do not report cognitions when actually in a particular context but are required to respond as if they were. This observation suggests that the full extent of contextual influence on alcohol expectations might not only be underestimated but also that much research lacks the ability to unpack the differing dimensions of expectation such as tension reduction or sexual enhancement in addition to consumption.

Furthermore, the well-known effects of priming on participants' alcohol consumption ought to be taken into consideration. For example, US female undergraduates primed with video images from a pub consumed significantly more alcohol than those primed with video images from a neutral environment (Roehrich & Goldman, 1995). Similarly, male US undergraduates primed in a mock bar reported both greater alcohol related memories as well alcohol consumption compared with those primed in a neutral location (Barraco & Dunn, 2009). Indeed, Reich et al. (2005) noted that more alcohol expectancy words were recalled when a memory word list began with an alcohol related word (e.g. beer) compared with a non-alcohol related word (e.g. water) when investigating US 18-19 year olds.

Perhaps the most obvious observation is that the confounding effect of context on alcohol metacognition was not 'controlled for' in the present study. It is possible, therefore, that the wording and setting of both alcohol expectancy and metacognitive

research has an impact on the outcomes reported. This present study was carried out in similar but not identical settings. Surveys were completed in mixed sex groups during time made available in a group alcohol recovery programme. Although participants completed the survey privately with little interruption from other group members, how individuals might think, feel and behave in one to one therapy sessions might not overlap wholly with their experience in a group setting. More importantly, responses given in the context of an alcohol recovery programme might not translate completely to life events experienced outside therapeutic settings. What this observation implies is that therapists' expectations of client behaviour in naturalistic settings needs to be tempered with the understanding that clients themselves might not fully appreciate the effect that context can have. This suggests that the progress of alcohol metacognitive therapy might not be as straightforward as the theoretical claims made for such an approach.

Furthermore, gender role conflict is not immune to criticism concerning context invariance. Jones and Heesacker (2012) examined whether gender role conflict might be altered by contextual circumstances. For example, if certain notions of masculinity are made more salient would gender role conflict scores change as a result? Participants, mainly white male US students, were primed using a video clips, chosen by a group of counselling psychology graduates, depicting comedians satirising what were considered to be normative masculine ideologies (e.g. 'men don't cry'). Findings demonstrated that gender role conflict scores were significantly lower for primed participants compared with non-primed participants. What these results suggest is that at least part of the manifestation of gender role is transient or context dependent. Consonant, with findings from this present study scores on the 'Restricted Emotionality' subscale of the GRCS were most affected by priming reinforcing the case of its utility in a clinical setting.

Overall, these observations indicate that the more therapy is removed from what clients experience in naturalistic settings the more likely their responses will diverge. The implication is that metacognitive therapy that relies on process changes alone, in the absence content meaning, might falsely inform the therapist about their client's internal world and slow progress. Equally, such a situation could leave clients less prepared to cope with their difficulties than they otherwise believed.

7.5. Conclusion.

The findings of this research might prove useful for clinical practice. These findings indicate that traits related to male gendered expectations could form part of the assessment and treatment process in the Marlatt model of relapse prevention, specifically where metacognitive alcohol interventions might be employed. Procedures could be initiated that help to educate men about the negative consequences of traditional masculine ideologies and resultant gender role conflict. Additionally, the relationship between gender role conflict and coping strategies could also be addressed.

Specific gender role conflict factors, such as restricted emotionality, could be addressed through the development of skills training programmes. For therapists working with men who acknowledge problems relating to emotional expression psychological education has been shown to be helpful (Kilmartin, 2005). Furthermore, as traits associated with traditional male stereotypes, such as competitiveness and aggression, are also associated with alcohol use more adaptive behaviours and could be explored that could provide alternative means of self-expression.

More generally, issues surrounding male gendered expectations and gender role conflict could be discussed more frequently in substance misuse treatment settings. For example, male clients, who report working long hours because they believe women are only attracted to successful men then feels the need to drink excessively as a way of coping with their self-imposed pressure, can be made aware of how their beliefs about masculinity affect their drinking behaviour. Therapists can use opportunities in sessions to normalise what might be considered proscriptive male behaviour such as showing fear or crying (Greif, 2009). So, by helping men acknowledge and recognise their emotional responses, as well as certain behaviours, these procedures might help reduce the pressure some feel to conform to gender norms. Finally, educating men that gender specific stressors are best addressed through a range of more adaptive coping strategies could be key to better treatment efficacy not just within the Marlatt model generally but alcohol metacognitive therapy specifically.

7.6. Limitations.

A key limitation in this study was its design. The data collected represented a cross-sectional view of the sampling frame therefore did not allow for the definitive establishment of causal effects. Future longitudinal studies are needed to establish the a priori understanding that gender role conflict, positive alcohol metacognitions and negative alcohol cognitions are antecedent to alcohol use in men. Longitudinal studies might also help elucidated the bidirectional relationship between gender role conflict and alcohol use in women. The study also employed retrospective self-report surveys, hence the data gathered could have been influenced by social desirability factors leading to inaccurate observations.

Additionally, a limitation of quantitative research is that the operational definitions of psychological constructs are predetermined by the researcher thus controlling the both the type and range of responses; for example the Likert style scales employed in the survey questionnaire. Hence a greater contribution of qualitative data in the study would have held open the possibility of including research where participants are actively involved in the process of defining and assessing the variables of interest to this study. Nelson and Quintana (2005) highlight how qualitative approaches also supplement quantitative research by enquiring about the socio-cultural context of the clients' experience. In this regard the voice of mothers in recovery whose children had been taken from them is absent from this research but was an active and important theme running through all the groups visited.

Furthermore, the counselling and therapy process can be regarded as culturally influenced. How the researcher/therapist defines the psychological problem is culturally mediated, as are the expected roles of client and therapist (Sue & Sue, 2003). The quantitative outcome studies examined in this research make no allowance for such mediated processes and assume any therapeutic treatment emerged from a homogenous therapeutic relationship. How clients and therapists experienced treatment more than likely has some to say about the outcomes described. Indeed, in the groups visited clients often regarded their journey to abstinence as aided recovery rather than therapy; in other words two compatible but distinct views.

In that regard it is interesting to note that a key area of qualitative research that could have aided this study surrounds the idea of recovery; for example Gubi and Marsden-Hughes (2013), White (2009), Jakobson, Hensing and Spak (2005). Another area of interest, as alluded to above, is client and therapist perception of each other's contribution and role; for example Laudet and White (2004). Finally, the notion of gender identity in relation to alcohol use is a recurrent and fluid theme e.g. Lyons & Willmott (2008).

Furthermore, the study did not take account of racial or ethnic factors associated with alcohol use (O'Neil, 2008). Given the diversity of cultural, ethnic and racial communities in the UK such information could inform therapists about differences in traditional gender stereotypes between groups. That said, data was collected from several different locations each of is known to be racially and culturally diverse, however, the participants in this study were observed to be almost exclusively white British.

The study did not differentiate participants in abstinent recovery or active drinkers. As the active use of alcohol has been associated with cognitive effects it is possible that those in abstinence, albeit recent, could have scored differently in the surveys.

Finally, the statistical power could have been increased with a larger sample size particularly for the female population.

Reflexive Statement 2.

In beginning a reflexive statement about this topic I feel compelled to honour a particular tradition of transparency in this field by announcing: *my name is, and I am not an alcoholic*. I do, however, have a relationship with alcohol, alcoholics and individuals who work with alcoholics.

Much of that relationship is defined by my role as therapist, on placement, at two drug and alcohol services; one statutory the other not. Also, prior to the course, I was a keyworker with homeless dual diagnosis individuals. During this time I have watched as clients have lost relationships, their health, jobs, children, homes, liberty and, occasionally, their lives. These were profound experiences that have evoked strong emotions and reactions within me. Consequently, I came to this topic with a number of preset ideas and prejudices that might affect the objectivity of this review. However, some of those biases only became apparent as I went through the process of completing the research and I discuss them below.

I noticed as I began to research the topic that perhaps I was, in fact, searching for a way to *save* all the clients I had been unable to stop drinking. This residual guilt, I feel, has to some extent framed the scope of the topic. As a result, it could be argued that I have sought to examine each the Marlatt model in a way that leaves no stone unturned. Thus resulting in a quest to discover something I had missed, misunderstood or ignored. To some extent this quest also explains why I chose the recent work on metacognitive therapy because it fulfills my fantasy that new must mean better.

Another effect of conducting research in an area in which I am a therapist was the realisation of how little I knew and how unstructured my thinking about the topic had been. Admitting this makes me feel uncomfortable as it implies that I was less effective as a therapist than might have been the case. Most notably, a view that has developed by working in this field is how ineffective alcohol treatment appears to be. The effect of this on the research has been, I believe, a kind of search for culprits. It could be argued that I have explored each model with an agenda to seek out failings. As a result, the tone of the research, while attempting to give balanced arguments, can seem negative at times.

It has also been interesting to observe the interaction between conducting this research and my practice. I found that current clients come to mind as wrote which then subtly alters the analysis. More especially, I noticed how a deeper knowledge and understanding began to affect my work with clients and with formulation particularly. Here, however, I felt that I had uncovered an ethical dilemma. Was my treatment approach changing as a result of being a more informed therapist or were clients becoming guinea pigs in a real time experiment? This problem is not easily resolved as it is impossible to leave behind experience as you enter the therapy room. However, a heightened awareness about intentions brought some checks and balances into this interaction.

One area of prejudice that I brought to the review was a concern about the motives of non-statutory organisations. Much of the daily talk of managers in these organisations, of which I have experience, concerns the winning and losing of contracts and the outcome statistics by which they are measured. Their concern for the client seemed limited. As a result I found that I was seeking evidence of economic drivers of service provision which did not really fit with the research aims and from which I had to retreat.

Perhaps the most striking effect has been the interaction of the research and my own attitudes. Heath (1995) argues that views about drinking alcohol vary from culture to culture but that indifference is rare, and feelings much stronger, than in connection with other topics. Indeed, completing this review has elicited a number of reactions within me. At one point, for example, the sheer scale of the harm that alcohol abuse causes left me feeling sympathetic towards those who wish to see increased controls on consumption. However, my attitudes softened as I explored this issue with clients who invariably would lay the cause of their alcoholism at their own feet. The effect on the research was that I deliberately avoided painting a bleak picture of individual and societal downfall often described by the statistics. However, my position as author has not been neutral; for me the topic matters. In some sense I have written this study as an expose on how little current alcohol treatment appears to be achieving. Of course, that is not its intention but Heath (1995) is correct, my feelings were, perhaps, stronger than might have been the case with a different topic.

Lastly, this research has meant I had to confront my own perceptions of masculinity

and how they might have influenced not just this study but my life choices, family, friends, colleagues and clients. I noticed, for example, that in choosing the, arguably, 'masculine' rationality of a quantitative study that I may have been playing out my own gendered perceptions of what feels comfortable as research. Perhaps this observation also explains the inclusion of various qualitative pieces of research about the male and female experience of alcohol dependence as a kind of compensatory activity.

In the end I have attempted to present a dispassionate account as possible of the topic under review while remaining committed to highlighting some of the limitations of current treatment models.

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Appendix 1.

Section 1.

Please complete the following questions.

Age: _____

Sex: Male Female

Instructions: In the space to the left of each sentence below, write the number that most closely represents the degree that you Agree or Disagree with the statement. There is no right or wrong answer to each statement; your own reaction is what is asked for.

_____	Strongly Agree					Strongly Disagree
	6	5	4	3	2	1

1. _____ Moving up the career ladder is important to me.
2. _____ I have difficulty telling others I care about them.
1. _____ Verbally expressing my love to another man is difficult for me.
4. _____ I feel torn between my hectic work schedule and caring for my health.
5. _____ Making money is part of my idea of being a successful man.
6. _____ Strong emotions are difficult for me to understand.
7. _____ Affection with other men makes me tense.
8. _____ I sometimes define my personal value by my career success.
9. _____ Expressing feelings makes me feel open to attack by other people.
10. _____ Expressing my emotions to other men is risky.
11. _____ My career, job, or school affects the quality of my leisure or family life.
12. _____ I evaluate other people's value by their level of achievement and success.

	Strongly Agree					Strongly Disagree
	6	5	4	3	2	1

13. ___ Talking about my feelings during sexual relations is difficult for me.
14. ___ I worry about failing and how it affects my doing well as a man.
15. ___ I have difficulty expressing my emotional needs to my partner.
16. ___ Men who touch other men make me uncomfortable.
17. ___ Finding time to relax is difficult for me.
18. ___ Doing well all the time is important to me.
19. ___ I have difficulty expressing my tender feelings.
20. ___ Hugging other men is difficult for me.
21. ___ I often feel that I need to be in charge of those around me.
22. ___ Telling others of my strong feelings is not part of my sexual behavior.
23. ___ Competing with others is the best way to succeed.
24. ___ Winning is a measure of my value and personal worth.
25. ___ I often have trouble finding words that describe how I am feeling.
26. ___ I am sometimes hesitant to show my affection to men because of how
others might perceive me.
27. ___ My needs to work or study keep me from my family or leisure more than
would like.
28. ___ I strive to be more successful than others.
29. ___ I do not like to show my emotions to other people.

30. ____ Telling my partner my feelings about him/her during sex is difficult for me.

Strongly
Agree
6

5

4

3

2

Strongly
Disagree
1

31. ____ My work or school often disrupts other parts of my life (home, family, health, leisure).

32. ____ I am often concerned about how others evaluate my performance at work or school.

33. ____ Being very personal with other men makes me feel uncomfortable.

34. ____ Being smarter or physically stronger than other men is important to me.

35. ____ Men who are overly friendly to me make me wonder about their sexual preference.

36. ____ Overwork and stress caused by a need to achieve on the job or in school, affects/hurts my life.

37. ____ I like to feel superior to other people.

Section 2.

People use alcohol for recreational and other purposes. Below are a number of beliefs about using alcohol given by people.

Thinking about your own usage of alcohol, please read each statement and indicate how much you agree with each one by circling a number on the right hand scales.

There are no right or wrong answers. Please try to be as honest as possible in your response.

PLEASE INDICATE HOW MUCH YOU AGREE WITH EACH OF THE FOLLOWING STATEMENTS AFTER YOU HAVE STOPPED A SESSION DRINKING:

	<i>Do not agree</i>	<i>Agree slightly</i>	<i>Agree moderately</i>	<i>Agree very much</i>
1. I have no control over my drinking	1	2	3	4
2. If I cannot control my drinking I will cease to function	1	2	3	4
3. Drinking will damage my mind	1	2	3	4
4. My drinking persists no matter how I try to control it	1	2	3	4
5. Drinking will make me lose control	1	2	3	4
6. Drinking controls my life	1	2	3	4

Section 3.

People use alcohol for recreational and other purposes. Below are a number of beliefs about using alcohol given by people.

Thinking about your own usage of alcohol, please read each statement and indicate how much you agree with each one by circling a number on the right hand scales.

There are no right or wrong answers. Please try to be as honest as possible in your response.

PLEASE INDICATE HOW MUCH YOU AGREE WITH EACH OF THE FOLLOWING STATEMENTS WHEN YOU BEGIN DRINKING:

	<i>Do not agree</i>	<i>Agree slightly</i>	<i>Agree moderately</i>	<i>Agree very much</i>
1. Drinking makes me more affectionate	1	2	3	4
2. Drinking makes me more confident	1	2	3	4
3. Drinking makes me think more clearly	1	2	3	4
4. Drinking makes me feel more relaxed	1	2	3	4
5. Drinking helps me to control my thoughts	1	2	3	4
6. Drinking makes my negative thoughts more bearable	1	2	3	4
7. Drinking reduces my anxious feelings	1	2	3	4
8. Drinking makes me more sociable	1	2	3	4
9. Drinking reduces my self-consciousness	1	2	3	4
10. Drinking makes me feel happy	1	2	3	4
11. Drinking helps me focus my mind	1	2	3	4
12. Drinking helps me fit in socially	1	2	3	4

Section 4.

Please circle your answer.

1. How often do you have a drink containing alcohol?

Never Monthly or less 2–4 times a month 2–3 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 to 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

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 Monthly Weekly Daily or almost daily

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

No Yes, but not in the last year Yes, during the last year

10. Has a relative or friend or a doctor or other 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

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE.

Participant Information Sheet.

Dear reader,

As a part of the Professional Doctorate in Counselling Psychology programme at London Metropolitan University carrying I am carrying out research into alcohol use.

The questions in this survey have been designed to help us understand how different people think about themselves when thinking about alcohol and in doing so make treatment for alcohol problems more effective.

The questionnaire should take about 15 minutes to complete. Your completed questionnaire is **completely anonymous** and will be destroyed at the end of the project using a confidential shredding service. To ensure your answers are confidential please put your completed questionnaire in the envelope marked: "Confidential, Research Project". Please seal the envelope and return it to the keyworker who gave it to you. No one, other than the researcher should be able to see your answers and **the researcher will not be able to identify you.**

You are at liberty to stop participating at any time.

If you believe you have been affected by this experience please speak to your therapist; alternatively a list of organisations offering help is attached.

Thank you for assistance.

Nicholas Cook,
Counselling Psychologist in Training / Volunteer Counsellor, CRI

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M.

Group Essay

Introduction.

This essay examines interventions in cognitive behavioural therapy (CBT) and psychodynamic therapy in the context of group psychotherapy. A brief outline of each model of therapy is given first followed by a rationale for the specific interventions chosen for comparison. The method of comparison draws heavily on the concept of complementarity as a framework capable of knitting together what are often quite diverse approaches. Next, the chosen interventions are compared. Firstly, more process orientated intervention then more content orientated. Finally, there is a discussion about my own learning when reflecting on this essay. Clinical examples come from the literature as unanimous client consent from the group with which I am involved could not be achieved.

Theoretical models of group therapy.

CBT.

Kazdin (1978, p.337) suggests that CBT comprises of treatments that “attempt to change overt behaviour by altering thoughts, interpretations, assumptions and strategies of responding”. This broad overview has been further elaborated as a cognitive model of psychopathology that asserts that the processing of external events is systematically biased and, therefore, distorts an individual’s construction of experience (Dobson & Dozois, 2010). A variety of cognitive errors such as: overgeneralisation, selective attention, polarisation etc. are then manifest. Underlying these distorted interpretations, often referred to as automatic negative thoughts, are dysfunctional assumptions and core beliefs that are embedded in relatively stable cognitive structures (schemata). When schemata are activated by external events or internal stimuli they tend to bias information processing and produce the typical cognitive content of a specific disorder (Beck, 2005). Therapy proceeds by changing maladaptive thoughts and processes leading to changes in affect and behaviour. Group CBT, however, has the ability to emphasise certain aspects of the range of CBT interventions that can be employed. Normalisation of difficulties, for example, can be achieved by the mere presence of other similar group members as well as through sharing subjective experiences. Improvements in interpersonal

functioning are made possible through interventions such as role play and modelling (Wyles, Hayward, Thomas, 2005).

Psychodynamic therapy.

Lemma (2003, p.xii) begins her introduction to psychoanalytic psychotherapy by saying “I draw on several psychoanalytic theories as I have yet to come across one model or theory that can satisfactorily account for all my analytic work”. With that caveat in mind Sundberg (2001) proposes that commonalities include:

- An emphasis on the centrality of intrapsychic and unconscious conflicts.
- Seeing defenses as developing in internal psychic structures in order to avoid unpleasant consequences of conflict.
- A belief that psychopathology develops especially from early childhood.
- A view that internal representations of experiences are organized around interpersonal relations.
- A conviction that life issues and dynamics will re-emerge in the context of the client-therapist relationship as transference and counter transference.
- Use of free association as a major method for exploration of internal conflicts and problems.
- Focusing on interpretations, transference, defense mechanisms and current symptoms.
- Insight as important for success in therapy.

Montgomery (2002) argues that three main traditions of group psychodynamic therapy are practised in the UK: Interpersonal, Tavistock and group analytical. He suggests that they share common ground but are also marked by differences in leadership style and underlying theoretical assumptions. He also asserts that group analytic therapy is now the principal form of psychodynamic therapy offered within the National Health Service (NHS). For that reason, group analytic therapy will be the major model of comparison in this essay.

Group Analysis was developed by S.H. Foulkes, who believed there were four main therapeutic processes at work within a group context: mirroring, exchange, social integration and activation (Roberts & Pines, 1992). Montgomery (2002) suggests

that the first three of these processes correspond with Yalom's (1970) *curative factors*, while activation aligns with Foulkes notion of the group matrix. Foulkes conceived groups as developing an unconscious network of interactions, or matrix. At one level this can be understood as the shared ground of the group, while at another level it represents a sense of belonging similar in concept to the secure base. Another important feature for Foulkes was communication, which is described as being at the root of mental disturbance (Foulkes & Anthony, 1957). Finally, the role of the group leader, or conductor as Foulkes describes them, is to point out unacknowledged sources of conflict and balance interpretations with supportive comments.

Points of comparison.

Based on a review of psychotherapy literature Blagys and Hilsenroth (2000) identified seven features of psychodynamic therapy that differentiated it from CBT: Focus on affect and expression of emotions ; Exploration of attempts to avoid topics; Exploration of patterns of thoughts, feeling and relationships; Exploration of past experiences; Focus on interpersonal experiences; Focus on therapeutic relationships; Exploration of wishes, dreams and fantasies. Additionally, Blagys and Hilsenroth (2002) argued that there six features of CBT that differentiated it from psychodynamic therapy: Use of homework; Direction of session activity; teaching of coping skills; Emphasis on future experiences; providing information about treatment and symptoms; A cognitive focus. Given these descriptions it could be expected that the interpersonal behaviours of group leaders might lead to different outcomes depending on the model of therapy and so forms the first area of comparison. As a framework for making such a comparison the notion of complementarity has been chosen. Complementarity in therapy interactions refers to the process of therapy rather than the content (Tracy, 1993). The second area of comparison concerns interventions that arguably represent core techniques that exemplify their theoretical origins from each modality; the challenging of cognitions in CBT and offering interpretation in psychodynamic therapy. Both of these interventions are viewed through a lens of complementarity as a method of drawing comparison. Finally, role play has been chosen as an intervention because it is common to both models of therapy but is enacted for different theoretical reasons. As a result, role play may

also be practiced differently in different modalities.

Complementarity.

Interpersonal theory (Kiesler, 1983) conceptualises interpersonal behaviour along two axes: *Interdependence*, (commonly understood as dominant-submissive) and *Affiliation* (friendly-hostile). Implicit within this theory is the notion of complementarity. Complementarity refers to interactions between individuals that demonstrate a sharing of role behaviours along these axes. Simply put, individuals take turns at displaying dominance followed by submission or friendliness followed by hostility. Kiesler (1983) suggests that interactions that maintain complementarity preserve individuals' views of the self. Interactions that reduce complementarity are considered to induce opposite effects. Importantly, reduced complementarity is thought to effect behaviour change in participants such that either complementary behaviour returns or stops. The implication of this assertion is that the outcome of reduced complementarity can be therapeutic change, but also conflict and resistance among group members.

Tracy (1993) suggests that complementarity supports a pan-theoretical three stage model of therapeutic outcomes. Successful outcomes are associated with high therapist-client complementarity in the initial stage, becoming lower in the middle before returning to high in the latter stage. High complementarity is considered necessary in the initial stage so that a strong therapeutic relationship is forged. Lower complementarity in the middle stage of therapy could, for example, be associated with interventions such as challenging cognitive distortions in CBT or offering interpretations from a psychodynamic perspective (Dietzel & Abeles, 1975; Tracy, Sherry & Albright, 1999). A return to high complementarity in the final stage can be regarded as a relationship repair following rupture in the middle stage (Safran, Murant, Samstag & Stevens, 2001). This high-low-high pattern of complementarity has been to be evident in successful outcomes for both individual psychodynamic and cognitive behavioural therapy (Tasca & McMullen, 1992; Tracy, Sherry & Albright, 1993). In group therapy, however, there is evidence of divergence between the two therapeutic modalities.

Interpersonal behaviour of group leaders – process orientated intervention.

Three of the six differentiating features outlined by Blagys & Hilsenroth (2002) (direction of session activity, teaching of coping skills and providing information about treatment or symptoms) accord with Westbrook, Kennerley & Kirk's (2012, p. 24) suggestion, that the problem-focused and structured nature of CBT requires the therapist to maintain structure in sessions "and then largely stick to it". As a result CBT therapists might talk more than in other therapies, possibly up to 50 per cent of the session in the early stages, and that some groups can be highly didactic and lacking interaction (Morrison, 2001). Such a description contrasts with Lemma's (2003) intersubjectivist view that in psychodynamic therapy, therapists form intense relationships with their clients. Here the notion of therapist as observer is replaced with the therapist as participant. It seems, therefore, that differences in complementarity can be expected between CBT and psychodynamic groups.

Indeed, Tasca, Foot, Leite Maxwell, Balfour & Bissada (2011) report lower levels of complementarity in the early stage of group therapy for binge eating disorder (BED) in a CBT group compared with a psychodynamic psychotherapy group (PP). Tasca et.al. note that Dr V (leader of the PP group) was *affirming and understanding* 74 per cent of the time compared with 57 per cent from Dr F the CBT group leader. What is more, when Dr V was affirming and understanding the PP group members responded with its complement *disclosing and expressing* 78 per cent of the time. By contrast 47 per cent of Dr F's interactions in the CBT group were coded as *controlling* compared with 39 per cent of Dr V's in the PP group. Significantly, more than 44 per cent of Dr F's controlling behaviours in the early stage of therapy were immediately followed by non complementary reactions from members of the CBT group. For example, Bette (a member of the CBT group) wanted to discuss rewarding herself after having successfully avoided binge eating (disclosing and expressing). Dr F acknowledged the item's interest to the group, however, intent on keeping to the session agenda told Bette that the topic would be discussed in a future session; a non complementary controlling behaviour.

Overall, Tasca et.al. (2011) report that 80 per cent of the PP group's interpersonal behaviours displayed complementarity compared with 61 per cent of the CBT group in the early stage of therapy. Tracy (1993) has argued that high complementarity is necessary at this stage so that a firm therapeutic alliance is established and from

which a productive middle stage ensues. The difference in complementarity observed between these two groups implies that CBT groups might encounter more problematic behaviours during the middle course of therapy and, as a result, worse outcomes. Indeed, Tasca et.al. (2011) note that CBT group members did demonstrate resistance to Dr F's treatment suggestions during the middle stage of therapy. On the face of it, the evidence appears to support the prediction that reduced complementarity leads to increased difficulties. However, the authors also report that both the CBT and PP groups "were equally effective in reducing days binged among patients with BED at post treatment" (Tasca et.al., 2011). An alternative conceptualisation, therefore, merits consideration.

Westbrook et.al. (2011) would understand Dr F's behaviour of acknowledging the relevance of Ellen's topic, but to be addressed at the jointly agreed time, in terms of the CBT notion of therapeutic collaboration. They suggest the collaborative nature of CBT means therapists should relate to clients in an adult-to-adult way. Thus therapists are open to ideas and give feedback on their relevance; precisely what Dr F did. However, although these same authors caution that CBT groups should not mimic the principles of psychodynamic groups it is still worth noting Foulkes' (1948) contention, that the activation of the collective unconscious is one of four key therapeutic processes in group work. He suggests that learning to understand the needs of others in the group occurs when members realise their own wishes (Ellen's wish to discuss herself) are not congruent with the wishes of the group (sticking to the topic on the agenda – verbalised by the leader). Foulkes & Anthony (1957) use the phrase *ego training in action* to emphasise the learning component of group therapy. *Insight*, the understanding of self is allied with *outsight*, the understanding of others. They propose that an essential element of therapeutic change lies in an individual's understanding of what they can do for others. In a group setting, therefore, it can be argued that upholding a jointly agreed contract of maintaining the agenda is the simplest manifestation of what individuals can do for others.

Challenging cognitions and offering interpretations – Content orientated interventions.

therapy when group leaders challenge cognitions in CBT settings or offer interpretations in a psychodynamic arena. Both of these techniques require the client to confront an alternative perspective. Jointly, they might be regarded as interventions based on confrontation and as such need care in their application. From a psychodynamic perspective Flores (1997, p. 340) warns that “Inappropriate confrontation may even strengthen the client’s resistance to change, thereby increasing the rigidity of defences”. Similarly, when it is necessary for CBT therapists to point out contradictions in client’s cognitions such confrontations should be specific and indisputably true. For example, Falkowski (1996) discusses a group member whose medical records demonstrated severe liver malfunction. When the participant maintained they did not have an alcohol problem the group leader suggested that he “convince his liver of that fact”. The leader’s reply created amusement in other group members and “the client immediately changed his attitude in the desired direction” (Falkowski, 1996, p.212).

Singer et.al. (1975) suggests that the therapy contract in psychodynamic groups is the vehicle from which leaders derive their authority to confront group members by making interpretations. Lemma (2003), however, notes that challenging the client’s perspective on a given issue is only one function of interpretation. Interpretations, she suggests, can be experienced as unwanted intrusions that threaten to disrupt a fragile psychic equilibrium and, as a result, a risky strategy. As a consequence, it seems likely that psychodynamic groups might experience a greater reduction in complementarity compared with CBT groups as leaders begin to exert their authority and confront clients with alternative perspectives in the middle stage of therapy. The evidence, however, points in the opposite direction. Tasca et. al. (2011) report that complementarity reduced by 7 per cent in the psychodynamic group compared with 21 per cent in the CBT group. A possible explanation for this contrary result might lay in differing leadership interventions that ameliorate the effects of confrontation.

Foulkes and Anthony (1957) suggest that the holding or containing function of the psychodynamic group leader is at least as important as any interpretations given. Foulkes (1998) promotes mirroring as one of the four main therapeutic processes responsible for creating change. In more psychodynamic orientated groups for alcohol misuse, for example, leaders use the knowledge that participants often are not

sure what they feel and have difficulty communicating their feelings to others. Group leaders, therefore, aid members to towards affect regulation by labelling and mirroring feelings as they arise; say, following interpretation. In that way participants begin to recognise and own their emotions (US Department of Health, 2005). In contrast, the US Department of Health (2005) suggests that in CBT groups leaders are frequently tempted to become the expert in how to think, how to express that thinking behaviourally and how to solve problems. In doing so CBT group leaders can ignore the emotional impact of confrontational interventions on clients. The net effect in such circumstances is to leave emotional disturbances unresolved.

A more useful way to think about confrontation in CBT group settings is to point out inconsistencies such as disconnects between behaviour and stated goals rather. Its purpose is to help clients see and accept reality so they can change accordingly (White & Miller, 2007). The linguistic roots of the verb *to confront*, they explain, means to come face to face. In this sense confrontation, they suggest, is a therapeutic goal rather than a counseling style: helping clients come face to face with their present situation, reflect on it and decide what to about it. The confusion of confrontation as a therapeutic *goal* versus a harsh counseling *method* continues to create confusion by mixing together quite diverse treatment approaches (Polcin, 2003).

One exception to this approach is the use of paradoxical debate where the client plays the role of arguing for change while the therapist argues against. “This is an activity that works especially well for highly resistant groups or those low on motivation for change” (Walters, Ogle & Martin, 2002). Role play in therapeutic groups is discussed next.

Role Play.

Role play is often considered to be a key intervention that enables individuals to practice, receive feedback and develop skills (Miller & Rollnick, 2002). In a CBT group role play can encompass a range of cognitive-behavioural interventions such as assertion training, behavioural rehearsal and exposure training. The group provides members with the opportunity to take controlled risks then examine the outcome. Ellis (1977), however, has argued that role play is much more effective if it entails

cognitive restructuring of attitudes that contributed to the problem addressed. In contrast, role play in psychodynamic therapy is typically designed to allow participants to bring into consciousness aspects of themselves of which they were not previously aware (Corsini, 1966).

Edwards and Kannan (2002) describe the case of one participant, Vumile, a black African male, in a CBT group for social phobia. Vumile was asked to role play approaching a girl (a volunteer) at a party while being video taped. Vumile's activity conforms neatly with the goals of rehearsal and exposure. In addition, Vumile was asked to predict how he would look and feel during the interaction. The purpose of this request was an attempt at cognitive restructuring advocated by Ellis (1977) by testing the accuracy of Vumile's predictions against the video tape evidence. However, despite the evidence disputing Vumile's predictions, Edwards and Kannan (2002) report that Vumile discounted it as invalid because his felt sense of the volunteer's perception of him remained negative. It is also evident that despite being a group therapy project, no other member was involved. So, it is questionable whether or not group therapy was, in fact, being harnessed.

An interesting psychodynamic variation of role play might have addressed Vumile's concerns differently. "The protagonist stands back and watches a very live form of videotape play back" (Corey, 1990, p.) Role play here is where an *auxiliary ego*, a member of the group, mirrors the postures, gestures and words of another individual within the group. Through this method, it is suggested, clients develop a more accurate and objective self assessment. The technique, it is contended, helps sensitive individuals to the reality of how others perceive them. In doing so individual help clarify discrepancies between their self reports and what they communicate of themselves to others. On the other hand, Corey (1990) cautions that this type of role play can be a powerful confrontation technique and ought to be used with discretion; empathy, it is maintained, should be the objective not ridicule.

Discussion.

Perhaps the most telling reflection, as a counselling psychologist, on this essay is the importance of the quality of the therapeutic relationship. It is through this relationship that therapeutic change is perhaps best predicted. In group settings,

however, the quality of individual relationships is necessarily diluted and the temptation is to fill the gap created with technique. A measure of that gap is seen in the different scores of complementarity between the different interpersonal styles of the CBT and psychodynamic therapists investigated. Working in CBT groups implies that as a counselling psychologist I should perhaps more explicitly prepare the relational groundwork prior to applying interventions at the beginning of therapy. Equally, paying greater attention to quality of the therapeutic relationship with participants rather than relying on technique and content to achieve the goals set should be both beneficial as well as more congruent with my professional identity. This implies also that making efforts to repair the alliance with participants at the first sign of rupture is an integral part of that monitoring process.

Word Count: 3291

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Process Report.

Introduction.

This process report examines how the interface between different cultural views of mental health requires a more sensitively negotiated formulation and treatment plan than might otherwise be the case. The challenge in this case has been to integrate this idea with the theoretical notion proposed by Fiske et al. (1998) that two culturally patterned social systems, independent and interdependent, represent the 'psyches' of Western and East Asian societies respectively. These cultural level distinctions, I argue, can impact on the formulation and treatment of a South Asian Muslim asylum seeker who has been the victim of torture.

Ahmed, the pseudonym given to the client, is a 39 year-old male of Sri Lankan origin who arrived in the UK in 2009 seeking asylum. He was referred by his GP because of his low mood. Ahmed's referrer described him as suffering from depression and expected a course of cognitive behavioural therapy (CBT) to relieve this. The service is community health centre and GP practice where I am a trainee counselling psychologist.

I have chosen to examine this particular episode because it demonstrates how psychological knowledge together with an understanding of the development of the therapeutic relationship can enhance the outcome of therapy.

Assessment.

Ahmed said that he fled to the UK in 2009 from Sri Lanka following his detention by government officials who tortured him systematically over a four-day period and threatened the life of both him and his family. Ahmed reported feelings of intense sadness at the separation from his wife and two children, now aged ten and six, who remain in Sri Lanka and became quite distressed during this explanation. Ahmed also reported that his sleep was disturbed by nightmares concerning his torture. Poor sleep, he said, resulted in lethargy and little energy the following day.

Ahmed said that he suffered from intrusive memories of his torture that would induce intense feelings of fear and anxiety. To reduce triggering such thoughts Ahmed said he avoided watching the news on television as well as violent programmes and films.

Despite his deep love for his family, Ahmed reported frequent angry outbursts at his wife when they communicated via *Skype*.

Ahmed reported that he had continuous pain in his left leg that has resulted in paralysis on occasions. He said that he suffers from frequent back and neck pain for which he had been referred to a specialist pain clinic that had not been able to help. Ahmed said that when he felt stressed he suffered from severe headache and gastrointestinal problems. He also reported that he believed his penis was shrinking. Ahmed's medical record showed that he had presented at the surgery on more than 90 occasions during the preceding three years for the range of physical symptoms described above and that no organic cause could be identified. Latterly, and perhaps unsurprisingly, Ahmed's perception of lack of treatment progress coupled with his separation from family served to lower his mood and prompt a diagnosis of depression from his GP.

Key cognitions noticed during the assessment were centred on mistrust of others. As a result Ahmed said he had no close friends and distanced himself from co-workers. Ahmed said that he believed that his physical symptoms and his general predicament was the result of charm (spell) cast on him. Ahmed also said that he believed he could not recover without the help of others.

Ahmed did not report any suicidal ideation.

Formulation.

Fiske et al. (1998) have argued that values are tied to cultures. In particular, values associated with mental health have been observed to differ across cultures (Summerfield, 2004). For example, the view that depression can be socially disadvantageous and stigmatising leads to greater presentations of symptoms as somatic problems in South India (Raguram et al., 1996). Taking this perspective could explain why Ahmed continually reported symptoms of pain rather than mental distress to his GP who was also of South Asian origin. Only when the medical options were exhausted was Ahmed able to contemplate his psychological distress. However, the potential stigma might not be the only reason maintaining Ahmed's symptoms of distress.

Despite several attempts to persuade The Home Office to grant his family permanent residence in the UK, Ahmed says all have failed. As a result, Ahmed increasingly believes that perhaps the only way he will be reunited with his family will be by returning to Sri Lanka. It seems, therefore, that by holding open the idea of returning to Sri Lanka, Ahmed keeps alive the very reason why he fled originally. It is feasible that Ahmed's desire to be reunited triggers memories of torture thus maintaining his distressing symptoms and maladaptive coping strategies.

It can be argued that Ahmed's psychological problems are consistent with the DSM-IV criteria for post traumatic stress disorder (PTSD). If, however, return is a perceived as a real possibility then treatment models, based on distorted appraisals of risk and danger not being sufficiently processed (e.g. Ehlers & Clarke, 2000), appear to run counter to the reality that Ahmed experiences (Bowley, 2006). Intervention, therefore, might be better served by adopting an adjustment approach that helps clients to understand their experiences and identify adaptive coping strategies (Moorey, 1996). Adjustment in this sense can be regarded as a process of trying to gain mastery in circumstances that are perceived as unlikely to abate, which for Ahmed centre on separation from his family. Successful adjustment is indicated by minimal disruption to life roles, effective regulation of emotional distress and the capacity to remain actively involved with social relationships. In contrast, unsuccessful adjustment is indicated by disengagement, withdrawal and helplessness (Spencer, Carver & Price, 1998). Ahmed's lack of friends, distance from co-workers and his belief that progress could only take place with the help of others suggests, so far, a pattern of unsuccessful adjustment to his new circumstances.

In seeking to apply a model of adjustment, however, it is important to be cognisant of the culturally bound nature of Ahmed's beliefs and how these manifest in his symptomology. Markus and Kitayama (1991) proposed the notions of *independent self* and *interdependent self*. They contend that people in individualistic (Western) cultures generally display an independent self whereas those in collectivist (Eastern) cultures have an interdependent self. The independent self is an autonomous entity with clear boundaries between self and others whereas the interdependent self has diffuse boundaries between self and others. In this context of *oneness* Patel &

Sumathipala (2006) argue that Cartesian dualism, which became a strong influence on Western biomedical concepts during the 20th century, lies in contrast to the fusion of mind-body concepts that underlie the greater prevalence of somatic presentations in Asian cultures. Such an explanation is consistent with the lack of organic cause in relation to Ahmed's physical complaints. Indeed, it is argued that some somatic syndromes (for example Ahmed's belief that his penis is shrinking – the dhat syndrome – associated with anxious and dysphoric mood states) are now only found in non-Western cultures Sumathipala, Siribaddana & Bhugra (2004).

Therapy is designed to follow a two-stage model suggested by (Naeem, Phiri, Rathod & Kingdom, 2010). During the first stage the therapeutic relationship is the focus of attention. The first stage comprises elements of treatment delivered in a primary care setting in Sri Lanka to patients with somatic complaints (Sumathipala, Hewege & Hanwella, 2000). These elements are: recapitulation of the problem, acknowledging symptoms, distress and disability are genuine, explaining the treatment strategy and explaining the nature of somatic complaints. For example, the first element, recapitulation, is designed to reassure Ahmed that his distress has been appreciated as genuine and that the therapist can empathise with it. Such approach, it is contended, helps establish rapport that leads to a "strategic alliance" and a shift from what Ahmed might have experienced during his years of medical consultations. The second element, acknowledgement, demonstrates an understanding that any symptom, irrespective of its cause, can make clients worry. In this way, it is argued, Ahmed's beliefs are not threatened and his world view remains in tact.

Transcript and Commentary.

Overview of Therapy.

The second stage of therapy, of which this session is a part, attempts address elements of treatment that include returning to normal activities, diary keeping and monitoring progress. In this session coping strategies are addressed. So far Ahmed has discussed his experience of the previous week and the outcome of a behavioural experiment designed to improve mood and link to his experience of pain.

Therapist 1. And so do these thoughts Ahmed about your family...I saw a moment ago when you were talking about your son that your eyes got a little bit tearful.

My intention at this moment was two fold. Firstly, I was aware that validating the experience of minority group clients reduces the likelihood of dropping out of treatment (Hays & Iwamasa, 2006). I also had in mind Morley's (1996) observation that sadness and depression are entirely rational responses to objectively difficult circumstances so I should be wary of alienating Ahmed by diminishing his emotions as the result of over reaction or dysfunctional thinking. I was keen to maintain, therefore, what I believed was a good therapeutic relationship by acknowledging the obvious distress that separation from his son had caused Ahmed. Secondly, I wanted to begin exploring the meaning of separation and how Ahmed might begin the process of adjustment.

Client 1. I miss him very much.

T2. Yes, I can see.

C2. I promise myself I would never do this but this I can't control. This is life you know, this is life, what can I do?

T3. So when this image comes to your mind Ahmed you feel it very strongly.

C3. Yeah, very strongly. Believe me you don't know how much I miss my family. This is making me more weak. I can't tolerate. Only thing I encourage myself and XXX. Everyday but I am going just encouraging myself. But I wish, I really wish everything is finished. Sickness is always sickness. See I'm having gastritis...

T4. Mmm.

C4. I really just got it two times and then I recover but I can't it without tablet. If I don't take my tablets at night I can't have a cup of coffee. I will puke. It's burning and I have to go further on. Everyday I'm taking tablets. So life is like this, ok, no problem. As long as this breath is there for this body, for this name. I want to do something good. I want to repair myself.

Acknowledging Ahmed's distress allows him to expand on how separation affects him. Importantly, Ahmed quickly begins to conceive of his distress in physical terms.

While the prevalence of somatic responses in Asian cultures has been well documented (e.g. Kirmayer, 1984) it is perhaps worth considering Ahmed's description in the context of somatic symptoms as metaphors for experience (Kirmayer & Young, 1998). From this perspective Ahmed's complaints might represent not only the physical sensations in his gastro-intestinal tract but also the notion of 'disagreeableness'. In this sense it might be possible to interpret Ahmed's reaction to mean that separation is something that can't be digested, that is, coped with. In a similar vein Lock (1993) has suggested that somatic symptoms can represent a form of protest or contestation of social conditions. Compared with frank complaints, Kleinman (1986) argues, somatic symptoms are oblique so protect the powerless from counter attack that might follow from more direct criticism. In Ahmed's case it would be understandable that he appreciates his safety in the UK but is also upset by the UK authorities' refusal to allow his family to join him. Ahmed could easily find it difficult to voice his frustrations at me, an authority figure in a state run institution, so finds a more culturally acceptable form of expression.

T5. Mmm.

C5. Main benefit is for my family, bring them up. Make myself ok do something.

T6. So Ahmed, if the main medicine for you is your family... [Ahmed holds up his hand].

C6. I'm one hundred per cent ready just to go right now with the flight. Get down there.

T7. Ok.

C7. I will do that. I know myself, I'm doing the most miserable thing, which if I were destroying myself.

T8. Yes.

C8. The person who is funding for the family is gone but what will happen to my family? They will be depending on my mother and their mother. Everyday they will be shamed, why should I do this? This is the only thing that is stopping me, why should I do this? Friends are there only when you have money. You've got no money. Who are you? Oh I'm busy. This is life.

At C6 Ahmed states his willingness to return to Sri Lanka, which he has spoken about in previous sessions. This willingness to return, as mentioned in the formulation, keeps alive the fears that initiated his problems. So, if as Bessel van der Kolk (1994) puts it “the body keeps the score in trauma”. It is perhaps unsurprising that Ahmed’s gastritis and range of other physical complaints, mentioned elsewhere in the session, become evident. Also significant is Ahmed’s identification of the shame of not being able to support his family as a reason with sufficient power to overcome his desire for reunification. Although shame is an emotion frequently mentioned by those who have suffered traumatic experiences (Wills, 2006), some theorists have proposed that this emotion can represent East-West cultural differences. Shame orientated Eastern cultures, it is argued, rely on external sanctions for good behaviour whereas guilt orientated Western cultures rely on internalised notions of sin (You, 1997). The perspective of the interdependent-self might, therefore, account for the weight Ahmed places on the prospect of the opprobrium of others, thus leading him to control his personal desires.

T9. So Ahmed, if your family are a part of your recovery, an intimate part of your recovery. And I know that you are separated by distance and geography at the moment, but is there a connection between you and your family that still aids your recovery do you think?

Having acknowledged the importance of Ahmed’s family my intention was to identify aspects of his current relationship that still held positive meaning despite the distance between Ahmed and his family and then build on that idea for therapeutic effect. This intervention, I believed, was congruent with the adjustment approach (Morley, 1996) to Ahmed’s problems identified in the formulation.

C9. No. What I mean by recovery in the sense, at least, the way I’m trusting you.

T10. Yes.

C10. But my, I mean some things which I can’t talk to my wife. At least I’ve got somebody to look after me.

T11. Mmm.

C11. At the moment I've got nobody. If I pay I can get somebody but that's not total commitment, that is for what you get paid.

T12. Mmm.

C12. That service.

T13. Yeah.

C13. But when you have somebody who you love next to you. I suppose one hundred per cent there'll be problems, issues will come. But with this way I'm going on I think that is nothing.

Ahmed's response left me feeling disappointed. I had hoped for a simple answer to my question and thereby progress to my objective. On reflection I can see that I was on the border of what Sanders and Wills (2005) describe as being 'hooked' into an interaction with Ahmed where the therapist gets sucked into dysfunctional cognitive-interpersonal cycle (Safran & Muran, 2003). I constructed a question (at T14 below) that was partly related to Ahmed's previous statements and partly providing an answer to relieve my frustration. A better approach might have been to repeat in simple terms the request for positive aspects of his current family relationship.

T14. Let me ask you Ahmed, do you still love your wife?

C14. No doubt. If I did not I'll be bearing towards this day.

T15. I can understand that, and do you believe your wife still loves you?

C15. No doubt.

T16. Ok. So this love between you and your wife exists and you have no doubt about it. But the. And so if you had that love between yourselves when you were in Sri Lanka – if you went from the house to the city, to Colombo, what sort of distance is that?

C16. From city to Colombo? My wife is there, I'm here in Colombo?

T17. No, say, say.

C17 Both of us together you mean.

T18. Say you went from your house in Sri Lanka and your wife stayed in the house what kind of distance would that be?

C18. That's about three and half hour distance.

T19. Ok about three and a half hours. Ok, and your wife still loves you and you still love her. How would you feel? Would you feel ok or would you feel sad and depressed because you were in Colombo?

Despite the difficulties I believed that I had at last framed a question that would elicit how Ahmed felt when separated from his wife that would quickly provide a spring board to identify previously successful coping strategies.

C19. Ah, when we got married, yeah.

T20. Yeah.

C20. Er and when she was pregnant. My father in law is a well influential person with hospital, lawyers, doctors. So he said I want, I want my daughter to be in my area. Where he can look after. So I thought ok that's good but my father did not like. She also prefer together. And if I be adamant one day she, she got a chance to tell me both my parents was ready but you was only so adamant you. I did not want to make her a slave.

I said mum dad see this hesitation. They also, their only daughter no? You also have a daughter how do you feel? But it's not good son you here and she's there. For little time no? I went and talked to her in my family house. I was in Colombo. Everyday she takes the phone, she says listen I have to go. I will look after you. You said you want a family also. All together is not possible but I'll come and see you, at the weekend. I left her. She pinpoints and always tells me about this. So you left me I my mother's house and you're staying with your parents. Well I gave her option. If I keep you you're going to say this to me; end of the day you will bind with your parents and blame it on me. Now your parents are happy and I have made my parents to understand. They are not objecting. Only thing we're apart, but I'm still coming. And suddenly, suddenly when I go she will never let me to go and talk to anybody. I have to give it her because she missed me that day.

T21. Yes.

C21. You can't take that entire gap. I have to share with everybody. Even though you were apart.

As Ahmed spoke my attention was drawn to his interweaving of family members into his reply. His narrative, I noted, fitted my perception of the interdependent self outlined in the formulation. However, as I reflect again on the passage I also recognise my growing frustration with how little I understood of what Ahmed was attempting to communicate. The impact of this frustration was to fall back on previous ways of thinking (wondering about Ahmed's mentalisation) to relieve my own tensions. Relating psychological skills to intercultural adjustment, Matsumo, Hirayama & Le Roux (2005) argue that if negative emotional reactions overwhelm individuals they cannot engage in critical thinking about those skills nor the differences between cultures. Instead, they contend, individuals regress to pre-existing modes of thought rather than create rival hypotheses outside of previous social experience. For them, emotion regulation is the gatekeeper to dealing with cultural difference, "because, if we cannot put inevitable negative emotions in check, it is impossible to engage in what is clearly higher order thinking about cultural difference" (Matsumo et al., 2005, p.387). This analysis implies that I should have paid greater attention to my own emotional process and questioned its meaning during this interaction rather than creating a question designed to bring Ahmed into my frame of reference.

T22. [Talking over] But did you both cope with the separation?

C22. I told you we had some bombs, but we coped on.

T23. Mmm.

C23. We had some bombs, we coped on.

T24. So what I was trying to get at Ahmed...

C24. [Interrupting] When there is too much love.

T25. Yes.

C25. There is pain.

T26. Ok.

C26. When there's less love there's too much doubt.

T27. Mmm.

C27. When there's no love you lose a lot. Either she's for something, I for something.

T28. Mmm.

C28. But the matter in us there's too much love.

Listening to Ahmed's response I can see that our frames of reference were different and that the intention behind my interventions was being interpreted quite differently. In particular the use of Socratic dialogue did not seem to elicit the kind of response given by European clients. Naeem, Phiri, Rathod & Kingdom (2010) make the point that South Asian Muslim clients often expect the therapist to be a 'master' or 'teacher' who will advise rather than use long Socratic dialogue to help them achieve insights. Indeed, Socratic dialogue, they argue, can make clients feel uncomfortable as they interpret such a technique as criticism of their thinking. My own response was to notice the sadness in that seemed to come across Ahmed's demeanour as he gave his philosophical reply. His body language suggested someone who felt dejected. Wanting to acknowledge this change in mood I pursued that observation.

T29. But when that...when you were separated physically in Sri Lanka did the pain, I know you had some upsets there, but was it anything like the upset the upset and distress you feel here?

C29. This is totally different. That was nothing.

T30. Mmm.

C30. Everyday both of us like dying. But only thing I wind her up, I encourage her up. I'm calling everyday because she has to ready to look after the children. I have to encourage her and give her strength. Listen to me..

T31. Mmm.

C31. You know the situation, this is. I'm not just sleeping I'm trying to do my maximum level, this. But when you come here it's a different life for you. There you're like a queen, when you come here you have to do each and every thing. I'm ready for it.

But don't hurt your parents because they're old. When you come to elderly age every small thing ... when they are shouting that means they are trying to protect you.

T32. Mmm.

C32. Respect it. But once you've come here even their headache or their fever you can't go to see them so balance your time, appreciate what you have at the moment. Once you come here it's a different total world.

T33. Mmm.

C33. There's nobody to cook for you everything is us. So I made every thing understanding. I wonder...ok. She's very capable.

T34. Mmm.

C34. She's very capable.

On hearing Ahmed's reply again I recognise that my response was driven by the continuing gulf between us. It appeared to me that much of Ahmed's response was irrelevant; I had not considered the possibility, however, that much of my intervention was irrelevant to him. Reflecting on this mismatch now, a better way forward might have been aided by greater cognisance of my own internal processes (frustration and confusion) as a springboard for questioning the validity of my intervention. Patel and Sumathipala (2006) argue that a key element of intercultural psychological treatment relies on an appreciation of the client's explanatory model, which can offer an alternative approach for understanding their distress. Clues for revealing the client's model, they suggest, include: client assumptions, beliefs, thoughts about their problems and causes, associated fears, impact of their symptoms and expectations of treatment. While this ground had been covered in earlier session the opportunity was lost to revisit it and address specifically what Ahmed expected of therapy and me as therapist. A better approach might have been to express my confusion and ask

Ahmed if he held any similar feelings. In doing so, holding open the possibility of a constructive dialogue about the differences that appeared to be present.

T35. So the... pain you feel here, of separation, is much greater than you felt...

C35. At that time.

T36. At that time. But you were still three hours apart.

C36. Three hours apart. For how many days did she give birth. After she gave birth I took leave for about a week.

T37. Mmm.

C37. I was with her then my daughter was born sick. Doctor, what they said there. Colour's changing. They put her in incubator, things like that, oh.

T38. Mmm. How did you cope Ahmed when you were apart in Sri Lanka? How did you cope with the separation?

C38. I made myself busy as possible.

When Ahmed said this I felt some degree of relief that we had got to a coping strategy that he had identified. However, as I soon realised that relief was based on my interpretation of what this statement would mean to Ahmed. In fact, his reply was more like a crossing of paths rather than a confluence of ideas.

Remainder of session.

The session continues to elicit Ahmed's thoughts about possible positive coping strategies. At the end of the session Ahmed reports a positive shift in mood.

Evaluation.

Naeem et al. (2010) make the point that South Asian Muslim clients frequently seek additional sources of help (spiritual, religious etc.) that can create competing therapeutic frameworks. Without a strong therapeutic alliance, they argue, such

clients are likely to disengage from treatment. The emphasis, therefore, on listening to clients and validating their subjective experience as a necessary condition to treatment cannot be overstated. Indeed, for some, raising psychological factors at this stage should be avoided (Patel & Sumathipala, 2006). It can, perhaps, be argued that this initial stage represents the first step towards adjustment for Ahmed as he learns to accept a novel individual, in terms of both culture and situation, into his life routine. Indeed, Price (2000) noted that assessment for psychological therapy, for those presenting with somatoform disorders, might of itself have therapeutic effects. In the round, therefore, Ahmed's attendance at every session over a six month period coupled with no GP appointments might indicate a degree of success with this approach. From a cultural context, such an approach to adjustment serves to minimise threats to Ahmed's world view enabling him to engage in therapy from a secure and equal base.

Moving on from this initial stage, however, the process of adjustment, particularly with regards to emotion regulation, is less certain. On the one hand, increasing evidence has shown acknowledgement and appropriate expression of emotion can promote adjustment (e.g. Austenfield & Stanton, 2004). On the other, in Asian cultures, expressive emotion regulation styles have been shown to be disadvantageous for psychological well being (Nagata & Shimizu, 2004). This implies an individual's style of emotion regulation compared with their culturally sanctioned style can determine whether such behaviour is adaptive or maladaptive. It is feasible that in this session my interpretation of Ahmed's responses to questions about coping with sadness as irrelevant or tangential could have represented a culturally congruent non-expressive style of emotional coping. In other words, when asked, Ahmed demonstrated his coping response. The validity of this analysis, however, was not pursued in the session because of my failure to engage Ahmed in a dialogue about his expectations of the process of therapy and my part in it. As mentioned in the commentary, I didn't pause to reflect on the meaning of my frustration and confusion that, in retrospect, seem to be valid indicators of cross cultural discrepancies. The impact of this lack of dialogue was that probably both client and therapist didn't know how, if at all, therapy was proceeding at that moment. For me, as the therapist, this implies that my understanding of treatment, its effects and possible interventions were not grounded in Ahmed's needs. During supervision it was advised that I *enter the*

client's world to reduce the difference between us. It is, however, more apparent now that greater consideration is given as to how that objective is achieved. In that regard Matsumoto et al. (2005) advise that in addition to “openness and flexibility to call to mind and to consider alternatives that might have been inappropriate in previous social experience. A further necessity in adjusting to a new culture must be the monitoring of the behaviours and reactions of one’s self” seems pertinent. The object lesson in Ahmed’s case, therefore, is that if adjustment is to be helpful as a therapeutic intervention the therapist is the subject of adjustment also.

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Reflexive Essay.

Learning and the Therapist

Introduction.

In writing this essay I have attempted to trace my development as a therapist in a chronological manner that elicits how it has fashioned my emerging philosophy of practice. For the most part my practice has centred on clients' struggles with drug and alcohol dependency, and their attendant problems. Consequently, the clients I have chosen to illustrate my development reflect this fact. More importantly, it was these clients who invariably represented key points of insight along the way. The essay begins with an examination of my motives to become a therapist in the cognitive tradition. It moves on to describe my early experiences of therapy then explores how I incorporated new perspectives into my practice. Finally, the essay attempts to draw together these experiences as an emerging philosophy of practice.

Motivation.

I would like to set the ground of some early experiences and their influence on my decision to pursue psychology. During my 40s, following the take over of the financial institution for which I worked, I found myself in an environment where the the business model of the new organisation was of questionable ethics. The internal tension created by the clash between personal and corporate ethics became irresistible and I resigned in search of something more worthwhile. I concede that my high-minded principles were bolstered by the fact that, financially, I didn't need to earn a living any more. I began working as a volunteer at a charity for the homeless, assessing clients and helping them find accommodation. One client, however, transformed the situation from worthwhile to something more personal. David (a pseudonym) presented for assessment; he was crying, hallucinating and vomiting as he withdrew from heroin. Generally, David would have been asked to leave, instead I cleaned up, asked if he would like some tea and just sat with him. We chatted about his hallucinations. After an hour or so David's hallucinations abated, his demeanour was calmer and his withdrawal symptoms less acute. We agreed to go to A& E at the local hospital and as walked over together I apologised for not finding any accommodation. He cried as he thanked me for the relief he now felt. That evening as I reflected on the fact that I hadn't found David some accommodation but suddenly

felt, in an intense way, I had really helped someone. My response was twofold. Firstly, I became less procedural with clients and spent more time simply listening. Secondly, I needed to understand what had happened between David and me. I recognise that as a person that I am attracted to things in the abstract, a detached curiosity, (perhaps why I am resubmitting) and enrolled, part time, on a psychology course at the Institute of Education (IOE) in the belief that I might learn something about human behaviour. I learned I didn't know much about human behaviour.

My work with the homeless continued and involved working with those with mental health and substance misuse problems. During that time I began to see my self differently, less judgemental, less materialistic more empathetic towards clients and the causes of their plight. Indeed, in reviewing trainee psychotherapist's motivations Rizq (2009) concludes that these are often accompanied by the desire for some kind of self-transformation. However, I was concerned that I lacked any formal training in therapy and that I would be more effective if I trained professionally.

My proficiency as a practitioner, I believed, would be best served by building on the psychology studied at IOE. Miller (2003) cites the likes of Piaget, Bruner and Bartlett among those at the forefront of what he, and others, describe as the *cognitive revolution* in psychology. These figures, along with other notable cognitive psychologists such as Vygotsky, feature as central theorists in IOE psychology courses (IOE, 2008). My contention, therefore, is that the IOE is firmly rooted in the cognitive tradition and, in turn, shaped my view of how psychology proceeds. As a consequence, I recognise that my desire to become a practitioner was predicated on assumptions that my use of psychology would be congruent with the cognitive paradigm from which I emerged. The advantage of this view, as I saw it then, was that cognitive behavioural therapy (CBT) would mesh readily with the formidable body of experimental and theoretical work that supported the cognitive approach.

First Encounters.

My early experience of practice mirrored the first phase of development for new professionals. It is suggested that trainees in this phase rely on external authority figures for both theoretical and experiential learning (Auxier et.al., 2003; Brott & Myers, 1999). In my case (at a NHS drug and alcohol service) Marlatt & Gordon

(1985) provided a cognitive theoretical framework, Beck, Wright, Newman and Lise (1993) a CBT treatment protocol, finally supervision from a clinical psychologist strongly allied with a cognitive therapeutic stance. Combined, these elements provided a smooth transition from theory to practice. They also reinforced my assumptions about the benefits of utilising the cognitive paradigm within clinical practice.

However, as my experience grew, particularly with alcohol dependent clients, I began to question if CBT alone could best address the problems of this group. For example, a number of my clients expressed positive views about Alcoholic Anonymous (AA). Indeed, a number of studies have demonstrated superior rates of recovery when traditional CBT is combined with active participation in AA and, for some individuals, the AA programme alone has been sufficient to bring about abstinence (e.g. Oulmette, Finney & Moos, 1997). The point here is not that additional resources might have aided recovery rates but that the AA programme is predicated on spiritual beliefs, not any psychological theory. The evidence pointed to the fact that two wholly different theoretical paradigms could produce the same results and what's more, when combined, results that were superior to either individually. Reflecting on this observation I can see that I had encountered, in a practical way, the debate about common factors and pluralism within therapeutic practice (Wampold, 2001).

I also noticed that in my desire to become more professional than the amateur I believed I was at the homeless charity that I tended to follow a fairly rigid CBT protocol with clients. My so called professionalism, however, seemed to rebound clients' homework wasn't completed, behavioural experiments abandoned, goals changed and DNAs increased. The client progress I had experienced previously as an amateur appeared to evaporate as a professional. I needed to adapt.

Clients had been sufficiently motivated to come to therapy in the first place but then disappointed by it. Clearly, their expectations of how therapy proceeds was a key factor and, when asked, more often than not simply meant doing what they believed worked for them not what a text book treatment plan had devised. One approach for clients who regarded self help models as their primary route to recovery was utilising

the approach of an American organisation, SMART Recovery (SMART Recovery, 2013). SMART is a self-help organisation that offers an alternative four point programme to AA's 12 step facilitation and eschews any notion of spirituality. By reorganising my work using SMART's four point programme (motivation, coping with cravings, managing thoughts feelings behaviour, living a balanced life) I was able to support clients by recognising their needs and preferences while still incorporating CBT principles. For example, following assessment I would ask clients about their likes and dislikes generally. Most would find this engaging and would suggest topics that provided the basis for a motivating agenda. For example, many clients would list music among things they enjoy which allowed me to introduce the Rolling Stones track *Angie*. *Angie* is code for Keith Richards' love affair with heroin, his desire and craving – information from Richards' autobiography often new and interesting to clients. Listening to the track or reading the lyrics provides an opportunity to ask how clients feel, what goes through their mind and how they cope; three of the four SMART steps. Feeling motivated, clients would often lead their own SMART/AA group with an identical session. The impact was that homework was completed, DNAs reduced and clients actively created sessions. Once motivated, new perspectives, new learning appeared to be of real benefit to clients.

As a result I began to feel more confident but, as a novice, still paid close attention to the limits of my ability. In one such case Jane, a pseudonym, displayed extreme mood swings both in and out of session. Of particular concern were Jane's active self-harming and suicide attempts, which had resulted in a number of recent hospital admissions. After three assessment sessions with Jane it was apparent that her high-risk behaviours ought to be the focus of care. I referred Jane to the Community Mental Health Team (CMHT) with a view to her being accepted into its Dialectical Behaviour Therapy (DBT) programme as it offered 24 hour telephone support and, in the initial stages, a structured day programme.

Puzzles and Contradictions.

Numerous studies over many years have consistently shown that up to 50 per cent of post treatment alcohol dependent individuals relapse (e.g. Neto, Lambaz & Tavares,

2007). Despite this knowledge, when working with such clients on relapse prevention, I noticed a greater than expected degree of personal anxiety in sessions. I was not only concerned but also puzzled why so many clients who had suffered so much and struggled so hard to achieve abstinence then behaved in this goal incongruent way. It seemed to me that the dominant CBT theory of Marlatt & Gordon (1985) failed to explain adequately the self-defeating nature of such behaviour. Reflecting on my anxiety, I recognised that it was in large part due to my sense of confusion when attempting to understand the clients' world, as they perceived it.

At this stage of my training I was able to draw on the psychodynamic concept of projective identification. Using this notion opened the possibility that the anxiety and confusion I experienced, in fact, represented latent feelings within clients that had been split off as a means of self-protection. If this was the case, what was provoking such confusion and anxiety within clients? Discussing these ideas of confusion, anxiety and self-defeating behaviour in supervision I was pointed towards Kelly's Personal Construct Theory (Kelly, 1955).

Kelly proposed that humans act as scientists in an attempt to make sense of the world. The sense making media are personal constructs (bipolar discriminations) acquired developmentally from infancy onwards and which allow individuals to anticipate events by engaging in experiments (i.e. their behaviour with others) (Bannister & Fransella, 1971). Although Kelly believed there to be a reality individuals did not have direct access to it. Kelly maintained that one individual's interpretation of their world is as valid as any other. Importantly, Kelly (1955) proposed that individuals choose alternatives from their construct poles that are more meaningful and coherent within their construct system, so protecting their identity from invalidation. What this means is that individuals tend to act in idiosyncratic ways to make their world more predictable and less confusing, even if it runs counter to what others might believe is in their best interests. From this Kellian perspective I was better able to account for abstinent clients' confusion and anxiety, and their apparent self-defeating behaviour. With this new perspective I better understood a comment from one client, who had been alcohol dependent for more than 20 years and was suffering from life threatening alcohol related pancreatitis, that seemed to sum up this experience; he said

“The problem is that now I’m sober I just don’t get it, everything feels alien, it’s just not me”. He relapsed.

I began to think at this stage that some clients were so wedded to a construction of the world that their freedom of action was constrained. Somehow, I believed these clients needed to learn that they could construct alternatives. In the back of my mind I remembered an early experiment in the study of cognitive dissonance where participants’ attitudes changed as a result of being required to act out certain roles (Brehm & Cohen 1962). I began, therefore, to incorporate role play into my work in the expectation that it would facilitate new learning. In truth I am unable to say if this technique loosened clients’ constructs of the world, however, on a number of occasions clients did report more tolerant attitudes and behaviour in what otherwise might have volatile circumstances. I was beginning to form the view that learning was an important element in my practice of therapy. Perhaps, from a psychodynamic perspective, this notion might be regarded as insight.

Incorporating New Perspectives.

I was able to incorporate Kelly’s ideas into my practice as a way of making sense of apparently contradictory behaviour. I also made greater use of clients’ early childhood experience in creating a formulation than perhaps I had done previously. More recently, Kelly’s influence on Ryle’s development of Cognitive Analytic Therapy (CAT)(Ryle & Kerr, 2002) has opened up a new area of interest and connections in my practice. Ryle intentionally drew on Kelly’s theory and notion of the individual as scientist actively construing the world. Indeed it has been noted that this idea chimes well with CBT’s use of behavioural experiments (Marzillier & Butler, 1995). As a consequence I have been able to conceptualise such interventions in practice from an additional perspective thereby giving a richer meaning to client reports of their results. With one client, for example, who suffered from severe social anxiety a simple exercise compared his cognitions about how he believed he was perceived by other patients in the health centre waiting room of my placement with recordings I made of their actual reactions. There was a significant disparity between the client’s negative view and his almost total invisibility noted in the recorded reactions. Later in the session, however, I asked the client to imagine that the waiting room was a theatre populated by actors and to ascribe roles to the

individuals. I then asked him what role he took, weakling, he replied. This additional perspective enabled the most fluid conversation we had had so far discussing the believability of his 'performance', how he would know and what he had learned of his role.

Marzillier and Butler (1995) also note similarities between CAT and schema focused CBT (e.g. Young et. al. 2003). In fact they find few differences between these two models other than ones of emphasis. On the other hand, given the analytic influence on CAT, this cognitivist endorsement of CAT seems a little biased. Indeed, Ryle (1998) has indicated that CAT is different from CBT in that the former lays greater emphasises on social interaction as the major component of therapeutic interest. In taking on Kelly's ideas it seems that Ryle, and by implication CAT, places greater weight on how personal constructs interact with the world rather than on their intrapsychic qualities. Allison & Denman (2001) suggest that social interaction in CAT is represented by the notion of *reciprocal roles* as a unit of procedural knowledge that enables individuals to 'do' a certain kind of relationship, and know what to anticipate from it.

Ryle (1994) suggests that reciprocal roles are internalised templates of our early experience of the social world. They consist of a role for the self, a role for the other and a paradigm for their relationship. More often than not reciprocal roles are shared templates so when an individual adopts one pole the person to whom they are relating feels the need to take up the congruent pole. In normal social situations, Ryle suggests, this reciprocation is generally appropriate and unnoticed. In a therapeutic setting, however, there are fewer environmental cues to guide choices and if the client's reciprocal roles are characteristically dysfunctional the therapist can feel a strong pressure to reciprocate. Ryle argues that although this phenomenon has been recognised as counter-transference and projective identification in psychodynamic theory these concepts are unduly opaque. In contrast, he argues, the notion of reciprocal roles is a less mystifying and more transparent explanation of the process issues involved. Importantly, for me as a cognitive therapist, the CAT notion of reciprocal roles offers the opportunity for me to integrate psychodynamic concepts into my practice rather than simply them to run in parallel.

A Learning Process.

In drawing together my experiences and influences from studying the psychology of education at IOE through my initial experiences with clients explaining the CBT *hot cross bun* to my introduction to Vygotsky's influence on CAT, it seems to me that I conceive and value therapy as a learning process. CBT acknowledges the role of psychoeducation particularly in the early stages of treatment when we are exhorted to *socialise clients to the model* (Sanders & Wills, 2005). Giving clients a rationale for understanding their problems and consequently the treatment offered is considered to enhance the likelihood of a positive outcome (Wells, 2009). However, I think it is important to conceive of therapy in its self as a process of learning. To some extent this notion is recognised by Westbrook, Kennerley and Kirk (2011) when they call on the adult learning theory models of Lewin (1946) and Kolb (1984) to aid therapeutic change. These models emphasise the value of a cycle reflection for clients, especially when helping them to "become their own therapists" (Westbrook et.al. 1984, p121). Indeed, this idea resonates with me when I think of my own experiences supporting clients who valued AA's model of self-help. Similarly, Young conceives learning as a central plank of schema therapy. "We assign *Reinventing Your Life* ...to patients to help them learn about their schemas" (Young, Klosko & Weishaar, 2003, p 76). The work of Vygotsky has been important in the development of CAT (Ryle & Kerr, 2002). Vygotsky proposed the notion of *scaffolding*, a process by the teacher provides just sufficient support to enable the student to do what they are not yet able to do by themselves. Scaffolding proceeds by the provision of theoretical knowledge, which the client assimilates. In CAT the shared tools for self-reflection that both client and therapist create represent the process of scaffolding.

However, here lie the seeds of problems, perhaps, especially from a counselling psychology perspective. The notion of therapy as a learning process, as CAT's use of scaffolding might imply, can reduce the therapeutic relationship to one of teacher and student together with the power imbalances that can accompany such relationships. Therapy is inevitably characterised by differences in expertise and authority (Marecek & Hare-Mustin, 2009). These authors argue that psychotherapists are by definition members of a professional class and as such often

unreflectively incorporate values and norms representative of one cultural milieu. This leads them to assume that ideas about certain experiences, emotions, behaviour and relationships are sanctioned according to their world view. Such a notion has led some to call the therapy session *the power hour* (Green, 1995). Therapists who are sensitive to such power distortions have sought ways to share power with clients as a means to check the unwitting control of one over another (e.g. Guilfoyle, 2003). I believe my training via counselling psychology has heightened my awareness of these pitfalls. Equally, I contend that education of the client has a role to play in counteracting the forces of power by adopting the position of clients as informed consumers, rather than “patients who submit to the doctor’s orders” (Marecek & Hare-Mustin, 2009, p87).

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