The Effect of Alcohol Expectancies on Coping, Mental Health and Help Seeking

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Table of Contents

Acknowledgements ................................................................. 4
Abstract ................................................................................. 5
Chapter 1 .............................................................................. 6
Introduction ............................................................................ 6
1.1 Overview ......................................................................... 6
1.2 Alcohol and mental health ................................................ 9
1.3 Alcohol and coping .......................................................... 10
1.4 Help-seeking for mental health issues ................................. 12
1.5 Alcohol and help-seeking .................................................. 14
1.6 The current study ............................................................. 14
1.7 Hypotheses ...................................................................... 16
Chapter 2 .............................................................................. 17
Methodology .......................................................................... 17
2.1 Participants ..................................................................... 17
2.2 Sampling technique .......................................................... 17
2.3 Design ............................................................................ 17
2.4 Materials ......................................................................... 18
2.4.1 Drinking Expectancy Questionnaire- Revised ............... 18
2.4.2 Attitudes toward seeking professional psychological help 19
2.4.3 Cope Brief .................................................................... 21
2.4.4 General Health Questionnaire- 12 item ......................... 22
2.5 Procedure ........................................................................ 23
Chapter 3 .............................................................................. 25
Results ................................................................. 25
3.1 Overview of results .............................................. 25
3.2 Descriptive statistics ............................................. 25
3.3 Distribution of data ............................................... 26
3.4 Inferential statistics .............................................. 28
3.4.1 Alcohol expectancies and help-seeking attitudes .... 28
3.4.2 Alcohol expectancies and coping ........................ 28
3.4.3 Alcohol expectancies and mental health ............... 31
3.4.4 Gender differences in alcohol expectancies, attitudes to help-seeking and levels of mental health ............ 32
3.4.5 Alcohol expectancies and help-seeking ................. 33
3.4.6 Coping .......................................................... 33
3.5 Non-significant results ........................................... 34
3.5.1 Alcohol expectancies and help-seeking ................. 34
3.5.2 Alcohol expectancies and coping ........................ 35
3.5.3 Alcohol expectancies and mental health ............... 37
3.5.4 Gender differences ........................................... 38
3.5.5 Gender differences in alcohol expectancies .......... 38
3.5.6 Gender and help-seeking .................................. 38
3.5.7 Gender and coping ........................................... 40

Chapter 4
Discussion ............................................................... 42
4.1 Research Aims .................................................... 42
4.2 Support for the hypotheses .................................... 42
4.3 Expectancies of increased confidence, help-seeking,
<table>
<thead>
<tr>
<th>Section Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>coping and mental health</td>
<td>43</td>
</tr>
<tr>
<td>4.4 Expectancies of cognitive enhancement, help-seeking,</td>
<td>45</td>
</tr>
<tr>
<td>coping and mental health</td>
<td>47</td>
</tr>
<tr>
<td>4.5 Expectancies of tension reduction, help-seeking,</td>
<td>48</td>
</tr>
<tr>
<td>coping and mental health</td>
<td>50</td>
</tr>
<tr>
<td>4.6 Expectancies of negative consequences, help-seeking,</td>
<td>50</td>
</tr>
<tr>
<td>coping and mental health</td>
<td>51</td>
</tr>
<tr>
<td>4.7 Expectancies of increased sexual interest, help-seeking,</td>
<td>53</td>
</tr>
<tr>
<td>coping and mental health</td>
<td>54</td>
</tr>
<tr>
<td>4.8 Further gender differences</td>
<td>55</td>
</tr>
<tr>
<td>4.9 Limitations and strengths of the current study</td>
<td>60</td>
</tr>
<tr>
<td>4.10 Future research and application of findings</td>
<td>98</td>
</tr>
<tr>
<td>4.11 Conclusion</td>
<td>100</td>
</tr>
<tr>
<td>References</td>
<td>102</td>
</tr>
<tr>
<td>Appendices</td>
<td>103</td>
</tr>
</tbody>
</table>
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Abstract

Alcohol abuse is a major risk factor for suicide and mental health and coping difficulties. It is estimated that less than half of those experiencing mental health problems seek professional help. This study examined the relationship between alcohol expectancies and help-seeking, coping and levels of mental health, additionally exploring gender differences within these variables. One hundred and seventy six participants, with 117 eligible for analyses, were recruited using a snowball sampling method and completed online self-report questionnaires measuring attitudes to seeking professional psychological help, coping, levels of mental health and alcohol expectancies. Significant associations were found between attitudes to help seeking and two of the alcohol expectancies. Additionally, significant relationships were found between alcohol expectancies, coping and levels of mental health. Gender differences were also observed across these variables. Results of this study could be useful in explaining alcohol use related to key concerns underpinning rates of mental health issues.
Chapter 1: Introduction

1.1 Overview

A key finding of the Second Report of the Suicide Support and Information System (SSIS) was that alcohol abuse is a major risk factor for suicide across all subgroups identified (Arensman et al., 2013, pp. 6-7). While the recommendations of the SSIS (2013) in relation to alcohol proposed the development of national strategies highlighting the harmful effects of alcohol, education from childhood onwards, and restricted access to alcohol, emphasis was placed on the effects of alcohol abuse on mental health (Arensman et al., 2013, p. 7) rather than on a broader investigation of the effects of alcohol use on mental health. Some researchers have stressed the importance of the relationship between alcohol use, as well as abuse and dependence, and mental health (e.g. Borges, Walter & Kessler, 2000, p. 781; Gonzalez, Bradizza & Collins, 2009, pp. 443-444; Gonzales, Reynolds, Skewes, 2011, p. 303). Substance use has been shown to peak during transition to adulthood, 15 to 24 years (Gayman, Cuddeback & Morrissey, 2011, p. 464; Patrick et al., 2011, p. 330; Shaver, Veilleux & Ham, 2013, p. 1019), a time period showing considerable overlap with a period for increased risk of suicide for young men, 15 to 39 years, identified by the SSIS report (Arensman et al., 2013, p. 10). However, for females, the age group of 45 to 55 years demonstrated an increased risk of suicide (Arensman et al., 2013, p. 10) underlining the importance of research across the life span. Establishing reasons for alcohol use may therefore be particularly important in understanding these trends.

Gruen, Folkman and Lazarus (1998) emphasised the relationship between the experience of stress and a person’s coping resources, asserting that central stresses are likely to recur due to the particular coping ineptitudes of the person (Gruen, Folkman and
Lazarus, 1998, p. 744). From this perspective, it is reasonable to propose that use of alcohol to cope could become a recurring behaviour in response to central stresses and indeed much research has investigated coping alcohol use (e.g. Cooper, Frone, Russell & Mudar, 1995; Todd, Armeli, Tennen, Carney & Affleck, 2003; Piasecki et al., 2013). It has been suggested that the use of alcohol in relieving distress caused by negative affective states may result in stress or negative affect becoming a trigger for alcohol use (Veenstra et al., 2007, p. 1890; Gonzales et al., 2009). Coping-related alcohol use has been regularly demonstrated to predict higher levels of alcohol consumption (e.g. Todd et al., 2003; Armeli et al., 2005, p. 20-21; Hasking and Oei, 2004, p. 483). However, the nature of coping is complex, with individuals often using combinations of coping strategies in response to a stressful event (Folkman & Lazarus, 1985) and over-emphasis on drinking to cope as a link between negative affect and alcohol use (Todd et al., 2003, p.310) should be avoided. Additionally, alcohol expectancy theory posits that an individual’s belief about the expected outcome of drinking alcohol influences alcohol use. Alcohol expectancy theory has been usefully applied to investigations of the interactions, and influence, of expectancies and coping in predicting alcohol use in both community and alcohol dependent samples (e.g., Hasking and Oei, 2002, 2004). In the context of the SSIS (2013) report, delineation of interactions between alcohol expectancies and coping in relation to mental health in Ireland may be important.

Help-seeking for mental health issues has been emphasised as an area of concern as, despite the prevalence of mental health problems, it is estimated that less than half of those experiencing mental health difficulties seek professional help (Swami, 2012; Tedstone Doherty and Kartalova-O’Doherty, 2010; Gulliver et al., 2012, p. 1). Rickwood and Thomas (2012, p. 174) note that the age group where there is greatest discrepancy between those seeking professional help and experiencing mental disorder is between 16
and 24 years. However, at all ages, prevalence of mental disorder exceeds help-seeking (Gulliver et al., 2010, pp. 1-2; Rickwood & Thomas, 2012, p. 174). In young adults, a preference for self-reliance (Gulliver et al., 2010, p. 7), self-stigma (Yap, Wright & Jorm, 2011, p. 1260; Vogel, Wade & Hake, 2006, p. 333), lack of knowledge regarding mental health services (Gulliver, 2010, p. 6; Yap et al., 2011, p. 1263) and poor ability to identify problems as mental health disorder, have been identified as significant barriers to help-seeking. Additionally, past experience with mental health services was shown to encourage later help-seeking (Gulliver, 2010, p. 7; Vogel et al., 2006, p. 334), indicating that elements affecting help-seeking in early adulthood are likely to have influence across the life-span.

Gender has emerged in the SSIS (2013) report as a strong predictor of suicide, with men accounting for 80.1% of 307 cases studied (Arensman et al., 2013, p. 5). Additionally, gender differences in relationships between alcohol use and coping have been reported (e.g. Cooper et al., 1995, p. 998; Armeli et al., 2005), however, mixed results have characterised these observations (Veenstra et al., 2009). Help-seeking has also been reported to be influenced by gender, for example, self-stigma in professional help seeking has been demonstrated to be higher in men than women (Vogel et al., 2006, p. 334; Tedstone Doherty & Kartalova-O’Doherty, 2010, p. 224). In an Irish study on help-seeking from general practitioners, women were found to be more likely than men to report mental health problems and showed higher levels of current psychological distress (Tedstone et al., 2010, p. 224). It has been suggested that gender specific treatment strategies be devised in consideration of the different factors that influence help-seeking in males and females (Tedstone et al., 2010, p. 226-227). In the context of the SSIS (2013) findings, exploration of gender differences may yield important information about
alcohol use, coping and help-seeking to support targeted interventions and national information strategies.

1.2 Alcohol and mental health

Borges, Walter and Kessler (2000, p. 781) note that while much research on the relationship of alcohol and mental health focuses on the effect of substance abuse, substance users rather abusers or dependents, may share an elevated risk for suicide. While their research demonstrated that comorbid mental disorders could partially explain the association of substance use and suicidal behaviours, significant relationships remained when mental disorder was controlled for, giving support to the idea of a direct association between suicide and substance use (Borges et al., 2000, p. 781). Furthermore, Borges et al. (2000) stressed that current substance use, even without abuse or dependence, represents a significant risk for “unplanned suicide attempts among ideators” (Borges et al., 2000, p. 788). Gonzalez et al. (2009) have noted that much of the literature exploring the relationship of suicide and alcohol use has focused on linking completed suicides with a history of alcohol dependence; with social problems arising from alcohol abuse; or with pharmacological influence of alcohol intoxication on mental functioning and affect (Gonzales et al., 2009, pp. 443-444). These concerns also feature prominently in the SSIS report (Arensman et al., 2013, pp. 6-7). Furthermore, Gonzalez et al. (2009, p. 449) found that while depression and suicidal behaviour were strongly associated, even when controlling for depression, drinking to cope was a significant intervening variable in the association between suicidal ideation and alcohol consumption. In this context, they have argued for the need to explore the functional relationship between alcohol use and suicidal behaviour (Gonzalez et al., 2009, pp. 443). While suicide has not been explored in this study, in the context of the recommendations of the SSIS (2013) and the identified relationship between alcohol use and suicide (Arensman et al., 2013, pp. 7, 29), it was felt
that investigation of the relationship of alcohol use and mental health in Ireland was pertinent.

1.3 Alcohol and coping

The role of coping in alcohol use has received much research attention focused on the relationship of drinking to cope with levels of consumption or alcohol dependency (e.g. Cooper et al., 1995; Hasking and Oei, 2002, 2004; Armeli et al., 2005). While exploration of this relationship is wholly appropriate to understanding problem drinking or alcohol dependency, the use of alcohol in coping has broader implications for mental health, and levels of consumption or dependence may not always be the appropriate focus. It has been suggested that in those suffering from negative affective states, alcohol use may become an effective coping strategy (Gonzales et al., 2009, p. 449; Shaver, Veilleux, & Ham, 2013, p. 1023). Alcohol use in coping has been associated with alcohol misuse (e.g. Armeli et al., 2005; Shaver et al., 2013) a relationship that has been shown to stay true even when frequency and quantity of drinking are held constant (Shaver et al., 2013, p. 1019), suggesting that investigations that go beyond measurement and frequency of consumption may offer further insights.

A longitudinal study of Dutch people between the ages of 45 and 70 years found that the relationship of responses to negative life events and alcohol use was mediated by coping style (Veenstra et al., 2007, p. 1897). While it was demonstrated that alcohol use can change following life events, the nature of the change depended on the coping style of the individual (Veenstra et al., 2007, p. 1898). A diary study undertaken by Armeli et al. (2005) found that although a combination of positive alcohol expectancies and avoidant coping style, as measured by the mental disengagement and denial scales of the COPE inventory (Carver, Scheier & Weintraub, 1989), predicted higher rates of alcohol
consumption generally, increased consumption was not higher on days where more stressful, positive or negative, events were experienced (Armeli et al., 2005, p. 11). They concluded that while avoidant coping styles may have considerable influence in adaptation to major life stresses, these effects may not necessarily be felt on a daily level. Daily expectancy levels however, were strong predictors of use of alcohol on that day (Armeli et al, 2005, p. 21). The current study does not address issues of volume or frequency of alcohol consumption, but seeks to examine the associations of alcohol use and coping from a dispositional perspective.

Recent research has measured alcohol outcome expectancies (using the Drinking Expectancies Questionnaire –Revised) on five dimensions; four of which are positive expectancies of increased confidence, increased sexual interest, cognitive enhancement and tension reduction, and one of which concerns negative consequences (Lee, Oei, Greeley & Baglioni, 2003). Expectancy theory has contributed much to understanding the relationship of coping and alcohol use. However the recent research of Hasking and Oei (2002, 2004) and Armeli et al. (2005) have employed an approach using a mean figure for positive alcohol expectancies in the examination of their relationship to coping. Hasking and Oei (2004, p. 484) have noted this approach as a limitation of their research, as combining these variables may mask their individual contributions, and recommended that further studies investigate the relationships of each of the positive alcohol expectancies separately. Similarly, reliance on total scores for coping in the 2002 study was noted as a limitation (Hasking & Oei, 2002, p. 490). The current study has sought to extend research on alcohol expectancies and coping using the same measures employed by Hasking and Oei, (2002, 2004) but measuring the independent correlations of each alcohol expectancy with each subscale total of the Brief COPE (Carver, 1997). In accordance with research supporting the idea of coping as a process involving multiple
coping approaches (Folkman & Lazarus, 1985) it was deemed appropriate to consider correlations with each subscale independently. Furthermore, a review of the literature has found that no studies of this nature have been undertaken in an Irish population.

1.4 Help-seeking for mental health issues

While help-seeking has been the subject of a surge in interest since 2005, poor consistency in the manner in which it has been studied has hindered the progress of research (Rickwood & Thomas, 2012, p. 176). Among the primary concerns in help-seeking research have been a lack of clarity around the definition of help-seeking, with many studies not providing any definition, and use of non-standardised measures, making comparisons with past and future research impossible (Rickwood & Thomas, 2012, p. 176). To address this difficulty, it is proposed that researchers follow a framework for measurement of help-seeking that addresses the part of the process the researcher is interested in; the timeframe of reference for the measurement (i.e. past, or during the next week); the source of help-seeking under investigation (e.g. formal, informal); the type of treatment sought; and the specific concern (e.g. psychological distress) (Rickwood & Thomas, 2012, p. 181). The current study has used the Attitudes Toward Seeking Professional Psychological Help Scale – short form (Fischer & Farina, 1995) as this was the most commonly used standardised measure and was identified in 55% of the studies reviewed (Rickwood & Thomas, 2012, p. 177). Additionally, the aspects of the framework outlined are addressed in the methodology.

Help-seeking is a complex process precipitated by problems challenging the competencies of the individual and is characterised by planned, problem-focused interaction with a healthcare professional (Cornally & McCarthy, 2011, p. 280). Successful interventions require analysis of barriers and facilitators to mental health while
considering all aspects of the help-seeking process. Failure to consider the help-seeking process in the design of an intervention has often resulted in interventions that only have moderate effect (Cornally & McCarthy, 2011, p. 286). However, successful interventions aimed at increasing help-seeking behaviours have been shown to reduce numbers of suicides (Calloway, Kelly & Ward Smith, 2012, p. 3) and therefore have considerable value when properly implemented. Young adults show a preference for self-reliance and have been observed to remain strongly resistant to seeking professional help even when they have developed a mental disorder (Gulliver et al., 2010, p. 1). It has been estimated that only 18 to 34% of young adults with high levels of depression will seek professional help and this effect may continue, only to a slightly lesser level, across the life-span (Gulliver et al., 2010, p. 1). As the prevalence of mental disorder peaks between the ages of 16 to 24 years (Gonzales et al., 2009, p. 443; Calloway et al., 2012, p. 3; Gulliver et al., 2010, p. 1) and previous experience of help-seeking has been shown to increase the likelihood of later help-seeking (Gulliver et al., 2010, p. 7), it may be that interventions designed to target younger adults could increase help-seeking in general.

Interesting barriers to help-seeking that have been identified were a difficulty in identifying symptoms (Gulliver et al., 2009, p. 6; Rickwood & Thomas, 2012; p. 182) and a process of accommodation whereby the meaning (in particular, whether the feelings were “normal” or not) attached to distress was altered to allow greater accommodation of stress (Gulliver et al., 2010, p. 7). The former could be addressed by well-designed interventions and mental health literature, whereas the latter would seem to be indicative of maladaptive coping strategies. The results of the current study could find application in both of these situations.
1.5 Alcohol and Help seeking

The convergence of increased rates of substance abuse (e.g. Gayman et al., 2011, p. 464), mental health difficulties (e.g. Gonzales et al., 2009, p. 443), and suicide (e.g. Calloway et al., 2012, p. 3; Arensman et al., 2013, pp. 5-6), as well as higher reluctance to seek professional help (Rickwood & Thomas, 2012, p. 174; Gayman et al., 2011, p.472) in early adulthood is an interesting phenomenon. These interactions, together with the observed relationships between alcohol use and coping (e.g. Hasking & Oei, 2002, 2004; Armeli et al., 2005; Gonzales et al., 2009) could suggest that the use of alcohol to cope represents a barrier to help-seeking for psychological distress, where “self-medicating” supresses or replaces more adaptive problem-solving. However, much of the literature focusing on a relationship between help-seeking and alcohol use does so within the specific context of help-seeking for alcohol related problems (e.g. Jordan and Oei, 1989; Gayman et al., 2011). One notable exception was a study by Groeschel, Wester, and Sedivy (2010) which sought to investigate the role of gender role conflict in mediating the relationship of drinking motivations and attitudes to help-seeking in a sample of male college students. The current study investigated the relationship of alcohol expectancies and help-seeking, coping and mental health in a non-college student sample.

1.6 The Current study

The current study explored the effect of alcohol expectancies on coping, mental health and help-seeking in an Irish sample. Examination of these variables was thought to have potential in addressing some key concerns regarding alcohol outlined by the SSIS (2013) report (Arensman et al., 2013, p. 7-8) underpinning the rates of suicide in Ireland and, by extension, to have implications for mental health generally.
Much of the available literature concerning the interaction of mental health, coping, alcohol use (e.g. Gonzales et al., 2009) and help-seeking variables (e.g. Gulliver et al., 2010; Calloway et al., 2012), focuses on the period of transition to young adulthood, often using student samples. While a convergence of prevalence rates for mental health disorder and suicidal behaviour, alcohol and substance use and abuse, and a resistance to help-seeking behaviour mark this age group as clearly of interest, the present study will extend beyond this to take in an adult sample of those 18 years or older. Subgroups identified by the SSIS report (Arensman et al., 2013, p. 6-7) also exhibit suicidal activity outside of the young adult age range suggesting that interactions of the identified variables may be important and interesting across the life span.

It was envisaged that findings of this study could be applied to devising structured, specific, early interventions for individuals, complimentary to those suggested by the SSIS (Arensman et al., 2013, p. 29). Additionally, it was felt that this study could extend research into the effect of alcohol expectancies on alcohol use and coping by, first, examining positive alcohol expectancies individually, rather than as a composite, with the other variables; and second exploring any potential relationship with help-seeking attitudes. Alcohol expectancy theory has typically been applied investigations of the relationship of alcohol use and coping (e.g. Armeli et al., 2005; Hasking & Oei, 2002, 2004) as well as to self-efficacy of alcohol refusal in relation to problem drinking (Hasking & Oei, 2004). While Groeschel et al. (2010) examined drinking motives and attitudes to help-seeking, no previous research was identified addressing the relationship between individual alcohol expectancies and help-seeking. It was felt that this could potentially extend this body of research.
1.7 Hypotheses

The hypotheses under study were, first, that there would be a relationship between alcohol expectancies and help-seeking behaviour; second, that there would be a relationship between alcohol expectancies and coping; third, that there would be a relationship between alcohol expectancies and levels of mental health; and fourth, that there would be gender differences in alcohol expectancies, help-seeking, coping and levels of mental health.
Chapter 2: Methodology

2.1 Participants

Participants (n = 117) were adults of Irish nationality, currently resident in Ireland, who drink alcohol. Of the responses received (n = 176), cases that met the criteria for exclusion (n = 59) i.e. those who were not of Irish nationality, not currently resident in Ireland, or did not drink alcohol, were not analysed. The sample consisted of 26 males (22.2%) and 91 females (77.8%), of ages ranging between 21 and 67 years (M = 36.15, SD = 9.456). All respondents were asked to complete all questions with the exception of the Drinking Expectancies Questionnaire – Revised (DEQ-R) (Lee, Oei, Greeley & Baglioni, 2003), where responses were limited to those who responded positively to the question “Do you drink alcohol?” All respondents participated voluntarily and without compensation. Participants (n = 117) were recruited through social media (Facebook) and email, using a snowball sampling method. Those identified to disseminate the survey agreed not to participate themselves to avoid sampling bias, but to share the study using electronic communication (i.e. email, Facebook).

2.3 Design

A quantitative correlational design was used to investigate correlations between participants’ scores on the variables of drinking expectancies, measured by the DEQ-R (Lee, Oei, Greeley & Baglioni, 2003); attitudes to help-seeking, measured by the Attitudes toward seeking professional psychological help scale – short form (ATSPPH-S) (Fischer & Farina, 1995); coping, measured by the COPE brief (COPE) (Carver, 1997); and levels of mental health, measured by the General Health Questionnaire-12 (GHQ-12) (Golberg & Williams, 1988). Additionally, between-groups analysis was conducted to examine gender differences across the same variables.
For correlations, alcohol expectancies was identified as the predictor variable, in line with the hypotheses under study, and attitudes to help-seeking, coping and levels of mental health were identified as the criterion variables. Between-groups analysis was conducted to examine gender differences across the same variables. Demographic information was collected for age, gender, nationality, Irish residency status, environment (i.e. rural or urban), employment status and student status.

2.4 Materials

Materials included a Google documents electronic questionnaire (see appendix A) pack comprising an information and consent form, a brief demographic questionnaire and four self-report questionnaires measuring the identified variables. The information for participants provided details of the purpose of the study, ensured that participants were aware of any potential risk, and gave a summary of the topics on which to expect questions. Participants were asked to respond to all questions and assured of anonymity and confidentiality. Debriefing information was supplied to participants automatically following electronic submission. The questionnaire pack was shared via a link and participant responses were collected automatically on submission.

2.4.1 Drinking Expectancy Questionnaire- Revised.

Participants’ alcohol expectancies were measured using the Drinking Expectancy Questionnaire – Revised (DEQ-R) (Lee, Oei, Greeley & Baglioni, 2003) (see appendix E), a 37 item questionnaire that measures individuals’ expected outcomes of drinking alcohol. The DEQ-R is shortened form of the Drinking Expectancy Questionnaire (DEQ: Young & Oei, 1996) which originally comprised 43 items from which six factors were computed to develop a profile of participants’ expectations of the outcome of drinking alcohol. Recent research examining the validity of the DEQ-R has demonstrated that this
shortened form, consisting of 37 items and five factors, to be more reliable (Lee et al., 2003 as cited in Hasking & Oei, 2004, pp. 473-474).

The DEQ-R (Lee et al., 2003) requires participants to rate their agreement with statements (e.g. item 20, drinking increases my aggressiveness; item 22, drinking helps me be more mentally alert) on a 5-point Likert like scale ranging from ‘strongly disagree’ to ‘strongly agree’. Corresponding values for responses range from 1 to 5. Six of the 37 items are reverse-coded (e.g. item 1, I do not drink alcohol to help me to unwind after a hard day or week’s work; item 19, drinking does not help to relieve any tension I feel about recent concerns and interests) due to the negative factor loading of the items (see appendix E). In the current study one of the statements was excluded from the questionnaire pack (item 25, I am addicted to alcohol) due to the sensitive nature of the statement and as its diagnostic implication is beyond the scope of this study. The subsequent items were renumbered accordingly. Responses are summated to compute a total score for each of the five factors of: negative consequences, increased confidence, increased sexual interest, cognitive enhancement and tension reduction (see table 10, appendix E). Reliability analysis was conducted to confirm internal consistency of the subscales for each factor for this study (see Table 1).

2.4.2 Attitudes towards seeking professional psychological help.

The Attitudes toward Seeking Professional Psychological Help Scale: Short Form (Fischer & Farina, 1995) (appendix D) is a 10 item, uni-dimensional, shortened version of the original 29 item scale (Fischer & Turner, 1970). The scale measures an individual’s attitude towards seeking professional help across a number of situations. Participants
Table 1: Cronbach’s Alpha for the five factors of the DEQ-R

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<th>Factor</th>
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<tr>
<td>Negative consequences</td>
<td>.877</td>
</tr>
<tr>
<td>Increased confidence</td>
<td>.829</td>
</tr>
<tr>
<td>Increased sexual interest</td>
<td>.787</td>
</tr>
<tr>
<td>Cognitive enhancement</td>
<td>.590</td>
</tr>
<tr>
<td>Tension reduction</td>
<td>.692</td>
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were asked to rate their agreement with statements (e.g. item 1, “If I believed I was having a mental breakdown my first inclination would be to get professional attention”) on a 4 point scale ranging from “disagree” to “agree” (Fischer & Farina, 1995) to indicate how they would feel about seeking professional help. Corresponding values for responses range from 1 to 4. Five of the items (e.g. Item 2, “the idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts”) are reverse scored. Lower scores (10 to 25) are considered to indicate more positive attitudes, whereas higher scores (26 to 40) are considered to indicate more negative attitudes towards help-seeking. (Fischer & Farina, 1995). Fischer and Farina (1995) reported a strong correlation (.87) with the original scale, a one month test-retest value of (.80) with an internal consistency measure of (α = .84) (Vogel, Wade & Haake, 2006, p. 328). Similarly, Vogel, Wade and Haake (2006, p. 328) reported an alpha value of .84 and found that the scale correlated with previous use of professional help for a problem, suggesting that the measure is both reliable and valid. Reliability analysis conducted in this study gave a similar result (α = .83).
In accordance with the framework suggested by Rickwood and Thomas (2012, p. 181), it is important to note how the current study employed the ATSPPH-S. Responses were used as a measure of orientation towards help-seeking and to give a dispositional, rather than time frame dependent, value. The type of help-seeking under study was for emotional support concerning mental health difficulties, from a formal source.

### 2.4.3 Cope Brief

The Brief COPE is a 28 item questionnaire which is computed into 14 subscales, (active coping, planning, positive reframing, acceptance, humour, religion, using emotional support, using instrumental support, self-distraction, denial, venting, substance use, behavioural disengagement, self-blame – Table #) each consisting of two items (Carver, 1997, p. 94) (see appendix B). There are no reversals of scoring and the questionnaire does not result in an overall total score for coping. The measure was developed by Carver from the original COPE inventory in 1997, in response to an observed need for a shorter scale. Participants were asked to indicate how much they do what the item (e.g. item 2, “I concentrate my efforts on doing something about the situation I’m in”) says on a scale ranging from “I haven’t been doing this at all” to “I’ve been doing this a lot” (Carver, 1997). Corresponding values for responses range from 1 to 4.

Exploratory factor analysis using an oblique rotation and reliability analysis, consisting of the averaged scores over three test periods in samples of 168, 124, 126 persons respectively, supported the reliability of the subscales (Carver, 1997, p. 97). The Brief COPE has also been demonstrated to be sufficiently consistent with the original measure to support its validity (Carver, 1997, p. 98). Reliability analysis in this study was largely consistent but was contradictory for some of the subscales (Carver, 1997, p. 96) (see Table 2).
Table 2: Cronbach’s Alpha for the 14 subscales of the COPE Brief

<table>
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<tr>
<th>Subscale</th>
<th>Cronbach’s alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Coping</td>
<td>.75</td>
</tr>
<tr>
<td>Planning</td>
<td>.83</td>
</tr>
<tr>
<td>Positive reframing</td>
<td>.78</td>
</tr>
<tr>
<td>Acceptance</td>
<td>.52</td>
</tr>
<tr>
<td>Humour</td>
<td>.84</td>
</tr>
<tr>
<td>Religion</td>
<td>.79</td>
</tr>
<tr>
<td>Use of emotional support</td>
<td>.77</td>
</tr>
<tr>
<td>Use of instrumental support</td>
<td>.87</td>
</tr>
<tr>
<td>Self-distraction</td>
<td>.48</td>
</tr>
<tr>
<td>Denial</td>
<td>.55</td>
</tr>
<tr>
<td>Venting</td>
<td>.42</td>
</tr>
<tr>
<td>Behavioural disengagement</td>
<td>.65</td>
</tr>
<tr>
<td>Substance use</td>
<td>.90</td>
</tr>
<tr>
<td>Self-Blame</td>
<td>.76</td>
</tr>
</tbody>
</table>

2.4.4 General health questionnaire, 12 items.

The 12 item General Health Questionnaire (GHQ-12) (Goldberg & Williams, 1972) (see appendix C) was derived from the original 60 item version to focus on the area between “normal function and psychiatric upset” (Hardy, Shapiro, Haynes & Rick, 1999, pp. 160–161). Participants were asked to indicate on a 4 point scale whether they have experienced a particular behaviour or symptom recently. Available responses differ
according to whether the item being measured is considered positive (e.g. “felt that you are playing a useful part in things”) or negative (e.g. “lost much sleep over worry”), with responses for positive items ranging from “more so than usual” to “much less than usual”, and for negative items, from “not at all” to “much more than usual” (Goldberg & Williams, 1972; Hardy, Shapiro, Haynes & Rick, 1999, pp. 160–161). Corresponding scores range from 0 to 3. Participants in this study were asked to select the appropriate response to each item in comparison with how they normally felt and their attention was drawn to the fact that answers vary. A total score for the 12 items from a range of 0 to 36 was computed with higher scores indicating a higher level of psychological distress. Previous research has reported an internal consistency reliability value of .89 (Hardy, Shapiro, Haynes & Rick, 1999, pp. 160–161). Reliability analysis in this study concurred ($\alpha = .89$).

2.5 Procedure

A cover page gave brief details of the purpose of the study and indicated the topics that participants could expect to answer questions on. Participants were assured of the anonymity and confidentiality of his or her responses. Before proceeding to the questionnaires participants were asked to indicate that they were over 18 years of age; that his or her participation was voluntary; and that informed consent was being given. Additionally, applicants were made aware of the potential of the questions asked to cause mild distress and directed to appropriate support services in the event of experiencing distress. Contact details of the researcher were supplied. Each questionnaire gave instructions for its completion and it was required that all questions were answered, with the exception of the DEQ-R, in order for the participant to proceed. Participants who answered positively to the question “Do you drink alcohol?” were linked to the DEQ-R. Participants who responded negatively to this question were linked directly to the final
page where responses could be submitted. Participants were informed of their right to withdraw from the study up to the point of submitting their responses and informed that submitted responses would be analysed. On submission of responses, participants were linked to a debriefing page reiterating the appropriate support services available in the event of distress and giving contact details for the researcher.
3.1 Overview of results

Parametric and non-parametric analyses were used to investigate both the relationships between the variables and gender effects. For the first hypothesis, that there would be a relationship between alcohol expectancies and help seeking, a statistically significant relationship was found between alcohol expectancies of increased confidence and negative attitudes towards seeking professional psychological help. Additionally, a statistically significant association was found between alcohol expectancies of cognitive enhancement and help-seeking for males. No further significant relationships were observed for either males or females between alcohol expectancies and help-seeking when analyses were run by positive or negative attitudes to help-seeking, by gender, or for the undivided sample. In relation to the second hypothesis, that there would be a relationship between alcohol expectancies and coping factors, many statistically significant associations were noted ranging in strength from moderate to weak. Two statistically significant relationships were observed between alcohol expectancies and levels of mental health, giving some support to the third hypothesis. Further significant differences were observed between males and females in both alcohol expectancies and coping factors also giving some support to the fourth hypothesis.

3.2 Descriptive Statistics

Participants (n = 117) were 26 males (22.2%) with a mean age of 36.96 years, and 91 (77.8%) females with a mean age of 35.91 years, who met the inclusion criteria of Irish nationality, resident in Ireland and drink alcohol. A further 59 respondents were excluded from analyses as they did not meet all of these criteria. Of those analysed, 82.05 % lived in an urban environment, 81.2% were employed and 21.37% were students, of which
17.09% were part-time and 4.27% were full-time. Of the males in the sample, 80.77% lived in an urban environment, 80.77% were employed, and 7.69% were part-time students. Of the females in the sample, 82.42% lived in an urban environment, 81.32% were employed and 25.27% were students, of which 19.78% were part-time students.

3.3 **Distribution of data**

Normality tests revealed skewed and kurtotic distribution in many variables. Non-parametric analyses were used for alcohol expectancies of negative consequences, with skewness of .792 (SE = .224) and kurtosis of .672 (SE = .444); attitudes to help-seeking, with skewness of -.662 (SE = .224) and kurtosis of .103 (SE = .444); levels of mental health, with skewness of .862 (SE = .224) and kurtosis of .857 (SE = .444); and coping factors of denial, with skewness of 1.541 (SE = .224) and kurtosis of 2.372 (SE = .444); substance use, with skewness of 1.818 (SE = .224) and kurtosis of 2.985 (SE = .444); use of instrumental support, with skewness of -.064 (SE = .224) and kurtosis of -.937 (SE = .444); behavioural disengagement, with skewness of 1.881 (SE = .224) and kurtosis of 3.919 (SE = .444); planning, with skewness of -.468 (SE = .224) and kurtosis of -.494 (SE = .444); humour with skewness of .481 (SE = .224) and kurtosis of -.674 (SE = .444); and religion, with skewness of 1.088 (SE = .224) and kurtosis of .544 (SE = .444). Normal distribution was observed for alcohol expectancies of increased confidence, increased sexual interest, cognitive enhancement, tension reduction; and coping through self-distraction, active coping, use of emotional support, venting, positive reframing, acceptance and self-blame. Parametric analyses were used in these instances. Table 3 summarises the means and standard deviations of all psychological variables.
<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Std. deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEQ-R Negative consequences</td>
<td>28.30</td>
<td>8.02</td>
</tr>
<tr>
<td>DEQ-R Increased confidence</td>
<td>36.84</td>
<td>6.95</td>
</tr>
<tr>
<td>DEQ-R Increased sexual interest</td>
<td>11.44</td>
<td>1.91</td>
</tr>
<tr>
<td>DEQ-R Cognitive enhancement</td>
<td>5.46</td>
<td>1.56</td>
</tr>
<tr>
<td>DEQ-R Tension Reduction</td>
<td>8.25</td>
<td>2.57</td>
</tr>
<tr>
<td>ATSPPH</td>
<td>31.12</td>
<td>5.41</td>
</tr>
<tr>
<td>GHQ-12</td>
<td>25.09</td>
<td>6.20</td>
</tr>
<tr>
<td>COPE Self-distraction</td>
<td>5.13</td>
<td>1.64</td>
</tr>
<tr>
<td>COPE Active coping</td>
<td>5.87</td>
<td>1.46</td>
</tr>
<tr>
<td>COPE Denial</td>
<td>2.69</td>
<td>1.02</td>
</tr>
<tr>
<td>COPE Substance use</td>
<td>2.98</td>
<td>1.50</td>
</tr>
<tr>
<td>COPE Use of emotional support</td>
<td>5.42</td>
<td>1.63</td>
</tr>
<tr>
<td>COPE Use of instrumental support</td>
<td>5.21</td>
<td>1.77</td>
</tr>
<tr>
<td>COPE Behavioural disengagement</td>
<td>2.73</td>
<td>1.06</td>
</tr>
<tr>
<td>COPE Venting</td>
<td>4.82</td>
<td>1.42</td>
</tr>
<tr>
<td>COPE Positive reframing</td>
<td>5.40</td>
<td>1.67</td>
</tr>
<tr>
<td>COPE Planning</td>
<td>5.83</td>
<td>1.60</td>
</tr>
</tbody>
</table>
3.4 Inferential statistics

3.4.1 Alcohol expectancies and help-seeking attitudes

The first hypothesis was that there would be a relationship between attitudes toward help-seeking and alcohol expectancies. Negative attitudes towards seeking professional psychological help (M = 31.12, SD = 5.41) weakly and positively correlated with alcohol expectancies of increased confidence (M = 36.84, SD = 6.95) to a statistically significant level (tau b(115) = .167, p = .019). Correlations run by gender (see table 4 for means and standard deviations) revealed that for males, alcohol expectancies of cognitive enhancement (M = 6.04, SD = 1.66) had a moderate inverse association with attitudes toward seeking professional help (M = 29.65, SD = 5.82) (tau b(24) = -.397, p = .10). In these instances, the alternative hypothesis was accepted.

3.4.2 Alcohol expectancies and coping

The second hypothesis, that there would be a relationship between alcohol expectancies and coping was partially supported. Parametric and non-parametric analyses were undertaken to determine the strength of associations between alcohol expectancies and coping subscales. Statistically significant results for both Kendall’s tau b and Pearson’s correlation coefficients are summarised in tables 5 and 6, respectively.
Moderate relationships were observed between coping-related substance use (M = 2.98, SD = 1.5) and alcohol expectancies of tension reduction (M = 8.25, SD = 2.56), (τb(115) = .411, p < .01), and increased confidence (M = 36.84, SD = 6.95), (τb(115) = 0.325, p < .01), accounting for 16.98% and 10.56% of the variation in scores respectively.

Table 4: Means and standard deviations by gender for ATSPPH-S and Alcohol Expectancies

<table>
<thead>
<tr>
<th>Gender</th>
<th>Variable</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>ATTSPH-S</td>
<td>29.65</td>
<td>5.82</td>
</tr>
<tr>
<td>(n = 26)</td>
<td>Negative consequences</td>
<td>30.19</td>
<td>7.42</td>
</tr>
<tr>
<td></td>
<td>Increased confidence</td>
<td>38.23</td>
<td>6.40</td>
</tr>
<tr>
<td></td>
<td>Increased sexual interest</td>
<td>11.38</td>
<td>1.75</td>
</tr>
<tr>
<td></td>
<td>Cognitive enhancement</td>
<td>6.04</td>
<td>1.66</td>
</tr>
<tr>
<td></td>
<td>Tension reduction</td>
<td>8.85</td>
<td>2.51</td>
</tr>
<tr>
<td>Female</td>
<td>ATTSPH-S</td>
<td>31.54</td>
<td>5.25</td>
</tr>
<tr>
<td>(n = 91)</td>
<td>Negative consequences</td>
<td>27.76</td>
<td>8.14</td>
</tr>
<tr>
<td></td>
<td>Increased confidence</td>
<td>36.44</td>
<td>7.08</td>
</tr>
<tr>
<td></td>
<td>Increased sexual interest</td>
<td>11.46</td>
<td>1.97</td>
</tr>
<tr>
<td></td>
<td>Cognitive enhancement</td>
<td>5.30</td>
<td>1.49</td>
</tr>
<tr>
<td></td>
<td>Tension reduction</td>
<td>8.08</td>
<td>2.57</td>
</tr>
</tbody>
</table>
Expectancies of negative consequences (M = 28.30, SD = 8.02) were weakly and positively related to both coping-related substance use (M = 2.98, SD = 1.5), (tau b (115) = 0.249, p = .001) and self-blame (M = 4.86, SD = 1.81) (r(115) = .250, p = .006), each accounting for 6.2% of the variation in scores. Expectancies of increased confidence (M = 36.84, SD = 6.95) were weakly and positively associated with coping through humour (M = 4.45, SD = 1.84), (tau b (115) = .201, p = .003), denial (M = 2.69, SD = 1.02), (tau b (115) = .243, p = .001), behavioural disengagement (M = 2.73, SD = 1.06), (tau b (115) = .172, p = .019), self-distraction (M = 5.13, SD = 1.64) (r (115) = .206, p = .026) and self-blame (M = 4.86, SD = 1.81) (r (115) = .286, p = .002). Expectancies of cognitive enhancement (M = 5.46, SD = 1.56) had a weak positive relationship with both coping-related substance use (M = 2.98, SD = 1.5) (tau b (115) = .176, p = .022) and acceptance (M = 5.79, SD = 1.41) (r (115) = .276, p = .003), and a weak negative association with use of instrumental support (M = 5.21, SD = 1.77) (tau b (115) = -.169, p = .020). Finally, alcohol expectancies of increased sexual interest (M = 11.44, SD = 1.91) correlated weakly and positively with both coping through use of emotional support (M = 5.42, SD = 1.63) (r (115) = .183, p = .048) and venting (M = 4.82, SD = 1.42) (r (115) = .216, p = .019).

3.4.3 Alcohol expectancies and mental health

Thirdly, it was hypothesised that mental health and alcohol expectancies would have a statistically significant relationship. Levels of mental health (M = 25.09, SD = 6.17) correlated weakly and positively with both alcohol expectancies of negative consequences (M = 28.30, SD = 8.02), (tau b (115) = 0.14, p = .027) and increased confidence (M = 36.84, SD = 6.95), (tau b (115) = .232, p < .01), accounting for 2.2% and 5.38% of the variance in scores respectively. Therefore there was also partial support for the third hypothesis and in each of these instances, the alternative hypothesis was accepted.
Table 5: *Kendall’s Tau b Correlations - alcohol expectancies and coping*

<table>
<thead>
<tr>
<th></th>
<th>Negative consequences</th>
<th>Increased confidence</th>
<th>Increased sexual interest</th>
<th>Cognitive Enhancement</th>
<th>Tension reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denial</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance use</td>
<td>.249**</td>
<td>.325**</td>
<td>.176*</td>
<td>.411**</td>
<td></td>
</tr>
<tr>
<td>Instrumental support</td>
<td></td>
<td></td>
<td></td>
<td>.169*</td>
<td></td>
</tr>
<tr>
<td>Self-Blame</td>
<td></td>
<td></td>
<td></td>
<td>.176**</td>
<td></td>
</tr>
<tr>
<td>Behavioural disengagement</td>
<td></td>
<td></td>
<td>.172*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Humour</td>
<td></td>
<td></td>
<td>.201**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.01 level (2-tailed)  
* Correlation is significant at the 0.05 level (2-tailed).
Table 6: Pearson’s correlations for alcohol expectancies and coping

<table>
<thead>
<tr>
<th>Variables</th>
<th>Increased confidence</th>
<th>Increased sexual interest</th>
<th>Cognitive enhancement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-distraction</td>
<td>.206**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-blame</td>
<td>.286**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of emotional support</td>
<td></td>
<td>.183*</td>
<td></td>
</tr>
<tr>
<td>Venting</td>
<td></td>
<td>.216*</td>
<td></td>
</tr>
<tr>
<td>Acceptance</td>
<td></td>
<td></td>
<td>.276**</td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.01 level (2-tailed)
* Correlation is significant at the 0.05 level (2-tailed).

3.4.4 Gender differences in alcohol expectancies, attitudes to help seeking and levels of mental health

The fourth hypothesis, that there would be gender differences in relation to alcohol expectancies, help-seeking, coping and levels of mental health found partial support. Kendall’s tau b correlations were conducted separately by gender, and comparison of means analyses were undertaken to determine if there were statistically significant differences between males and females across these variables. Both parametric and non-parametric analyses were used.
3.4.5 Alcohol expectancies and help-seeking

For males, alcohol expectancies of cognitive enhancement (M = 6.04, SD = 1.66) had a moderate inverse association with attitudes toward seeking professional help (M = 29.65, SD = 5.82) (tau b(24) = -.397, p = .10) providing some support for the fourth hypothesis. Additionally, a statistically significant difference (t(37.348) = 2.05, p = .047) in the mean scores of males (M = 6.04, SD = 1.66) and females (M = 5.30, SD = 1.494) was found for alcohol expectancies of cognitive enhancement. The 95% confidence limits showed that the population mean difference of the variables lay between .010 and 1.47. Therefore the null hypothesis was rejected in this instance.

3.4.6 Coping.

The mean scores of males (M = 6.35, SD = 1.23) and females were (M = 5.64, SD = 1.42) found to differ to a statistically significant degree (t(45.731) = 2.5, p = .016) for coping through acceptance, with males showing a higher propensity for this coping strategy. The 95% confidence limits showed that the population mean difference of the variables lay between .138 and 1.28.

Females (M = 44.17) had a higher mean rank than males (M = 63.24) in coping through use of instrumental support, which was found to be statistically significant (z = -2.564, p = .010). Finally, the mean rank of females (M = 62.07) was higher than that of males (M = 48.27) for coping through religion and differed to a statistically significant level (z = -1.961, p = .050). In each of these cases the null hypothesis was rejected.
3.5 Non-significant results

3.5.1 Alcohol expectancies and help-seeking

The first hypothesis was that there would be a relationship between attitudes toward help-seeking and alcohol expectancies. Correlational analyses between attitudes towards seeking professional psychological help (M = 31.12, SD = 5.413) and the five drinking expectancy factors of negative consequences (M = 28.30, SD = 8.022), (tau b (115) = -0.13, p = .844); increased confidence (M = 36.84, SD = 6.952), (tau b (115) = .092, p = .160); increased sexual interest (M = 36.84, SD = 6.952), (tau b (115) = .109, p = .116); cognitive enhancement (M = 31.12, SD = 5.413), (tau b (115) = -.063, p =.368); and tension reduction (M = 8.25, SD = 2.569), (tau b (115) = .109, p = .106) revealed no statistically significant relationships. In all instances, the null hypothesis could not be rejected.

When separated by the strength of attitude to help-seeking, (i.e. positive or negative), correlational analyses revealed no further statistically significant associations. Positive attitudes towards help-seeking did not relate alcohol expectancies of negative consequences (M = 28.30, SD = 8.02) (tau b(115) = .128, p = .499); increased confidence (M = 36.84, SD = 6.95) (tau b(115) = .055, p = .768); increased sexual interest (M = 11.44, SD = 1.91) (tau b (115) = .360, p = .071); cognitive enhancement (M = 5.46, SD = 1.56) (tau b(115) = -.101, p = .604); and tension reduction (M = 8.25, SD = 2.57) (tau b(115) = .158, p = .415). Negative attitudes towards help-seeking professional did not relate to alcohol expectancies of negative consequences (M = 28.30, SD = 8.02) (tau b(115) = .051, p = .478); increased sexual interest (M = 11.44, SD = 1.91) (tau b (115) = .099, p = .190); cognitive enhancement (M = 5.46, SD = 1.56) (tau b(115) = .011, p = .890); and tension reduction (M = 8.25, SD = 2.57) (tau b(115) = .089, p = .224).
When separated by gender, no statistically significant relationships were observed for males between attitudes towards seeking professional psychological help ($M = 29.65$, $SD = 5.82$) and alcohol expectancies of negative consequences ($M = 30.19$, $SD = 7.42$) ($\tau b(115) = .145$, $p = .317$); increased confidence ($M = 38.23$, $SD = 6.4$) ($\tau b(115) = .119$, $p = .410$); increased sexual interest ($M = 11.38$, $SD = 1.75$) ($\tau b(115) = .179$, $p = .239$); and tension reduction ($M = 8.85$, $SD = 2.51$) ($\tau b(115) = .033$, $p = .823$). Additionally, for females, no statistically significant relationships were observed between attitudes towards seeking professional psychological help ($M = 31.54$, $SD = 5.25$) and alcohol expectancies of negative consequences ($M = 27.76$, $SD = 8.14$) ($\tau b(115) = -.025$, $p = .738$); increased confidence ($M = 36.44$, $SD = 7.08$) ($\tau b(115) = .141$, $p = .058$); increased sexual interest ($M = 11.46$, $SD = 1.97$) ($\tau b(115) = .100$, $p = .206$); cognitive enhancement ($M = 5.30$, $SD = 1.49$) ($\tau b(115) = .044$, $p = .581$); and tension reduction ($M = 8.08$, $SD = 2.57$) ($\tau b(115) = .146$, $p = .057$). In these instances the null hypothesis was retained.

### 3.5.2 Alcohol Expectancies and coping

No statistically significant associations were observed between alcohol expectancies of negative consequences ($M = 28.30$, $SD = 8.02$) and coping through self-distraction ($M = 5.13$, $SD = 1.64$) ($\tau b(115) = -.111$, $p = .106$); active coping ($M = 5.87$, $SD = 1.46$) ($\tau b(115) = -.130$, $p = .063$); use of emotional support ($M = 5.42$, $SD = 1.63$) ($\tau b(115) = -.119$, $p = .083$); venting ($M = 4.82$, $SD = 1.42$) ($\tau b(115) = .020$, $p = .770$); positive reframing ($M = 5.4$, $SD = 1.67$) ($\tau b(115) = -.005$, $p = .942$); acceptance ($M = 5.79$, $SD = 1.98$) ($\tau b(155) = .070$, $p = .314$); denial ($M = 2.69$, $SD = 1.02$) ($\tau b(115) = .082$, $p = .261$); instrumental support ($M = 5.21$, $SD = 1.77$) ($\tau b(115) = -.074$, $p = .279$); behavioural disengagement ($M = 2.73$, $SD = 1.06$) ($\tau b(115) = .062$, $p = .396$); planning
(M = 5.83, SD = 1.60) (tau b(115) = .044, p = .522); humour (M = 4.45, SD = 1.84) (tau b (115) = .132, p = .054); and religion (M = 3.33, SD = 1.60) (tau b(115) = .134, p = .060).

Alcohol expectancies of increased confidence (M = 36.84, SD = 6.95) were not associated significantly with active coping (M = 5.87, SD = 1.46) (r(155) = -.063, p = .498); use of emotional support (M = 5.42, SD = 1.631) (r(115) = .135, p = .148); venting (M = 4.82, SD = 1.424) (r(115) = .081, p = .387); positive reframing (M = 5.4, SD = 1.67) (r(115) = -.020, p = .834); acceptance (M = 5.79, SD = 1.98) (r(115) = .006, p = .947); instrumental support (M = 5.21, SD = 1.77) (tau b(115) = .021, p = .754); planning (M = 5.83, SD = 1.60) (tau b(115) = .005, p = .942); and religion (M = 3.33, SD = 1.60) (tau b(115) = .072, p = .312). Additionally, expectancies of increased sexual interest (M = 11.44, SD = 1.91) and coping through self-distraction (M = 5.13, SD = 1.64) (r(115) = .100, p = .284); active coping (M = 5.87, SD = 1.46) (r(115) = .082, p = .378); positive reframing (M = 5.40, SD = 1.67) (r(115) = .068, p = .467); acceptance (M = 5.79, SD = 1.98) (r(115) = .015, p = .873); self-blame (M = 4.86, SD = 1.809) (r(115) = .005, p = .955); denial (M = 2.69, SD = 1.02) (tau b(115) = .027, p = .724); substance use (tau b(115) = -.121, p = .112); instrumental support (M = 5.21, SD = 1.77) (tau b(115) = .125, p = .083); behavioural disengagement (M = 2.73, SD = 1.06) (tau b(115) = .033, p = .674); planning (M = 5.83, SD = 1.60) (tau b(115) = -.050, p = .489); humour (M = 4.45, SD = 1.84) (tau b(115) = .000, p = 1.00) and religion (M = 3.33, SD = 1.60) (tau b(115) = -.131, p = .082) were found to be unrelated. Expectancies of cognitive enhancement (M = 5.46, SD = 1.58) were not associated with coping through self-distraction (M = 5.13, SD = 1.64) (r(115) = .081, p = .383); active coping (M = 5.87, SD = 1.46) (r(115) = -.023, p = .805); use of emotional support (M = 5.42, SD = 1.63) (r(115) = -.135, p = .148); venting (M = 4.82, SD = 1.42) (r(115) = -.102, p = .272); positive reframing (M = 5.4, SD = 1.67) (r(115) = .001, p = .991); self-blame (M = 4.86, SD = 1.81) (r(115) = .050, p = .591);
denial (M = 2.69, SD = 1.02) (tau b(115) = -.065, p = .403); behavioural disengagement (M = 2.73, SD = 1.06) (tau b(115) = .136, p = .083); planning (M = 5.83, SD = 1.60) (tau b(115) = .043, p = .563); and humour (M = 4.45, SD = 1.84) (tau b(115) = .037, p = .611).

Finally, expectancies of tension reduction were not associated with self-distraction (M = 5.13, SD = 1.64) (r(155) = .150, p = .106); active coping (M = 5.87, SD = 1.46) (r(115) = .055, p = .559); use of emotional support (M = 5.42, SD = 1.63) (r(115) = .031, p = .744); venting (M = 4.82, SD = 1.42) (r(115) = -.009, p = .924); positive reframing (M = 5.4, SD = 1.67) (r(115) = -.017, p = .852); acceptance (M = 5.79, SD = 1.98) (r(115) = .098, p = .294); self-blame (M = 4.86, SD = 1.81) (r(115) = -.033, p = .720); denial (M = 2.69, SD = 1.02) (tau b(115) = .008, p = .911); instrumental support (M = 5.21, SD = 1.77) (tau b(115) = .084, p = .229); behavioural disengagement (M = 2.73, SD = 1.06) (tau b(115) = -.009, p = .905); humour (M = 4.45, SD = 1.84) (tau b(115) = .046, p = .514); and planning (M = 5.83, SD = 1.60) (tau b(115) = .056, p = .431) to a statistically significant degree.

3.5.3 Alcohol expectancies and mental health

No significant relationships were observed between levels of mental health (M = 25.09, SD = 6.20) and alcohol expectancies of cognitive enhancement (M = 5.46, SD = 1.56), (tau b(115) = .001, p = .992), increased sexual interest (M = 11.44, SD = 1.91), (tau b(115) = .070, p = .311) and tension reduction (M = 8.25, SD = 2.57) (tau b(115) = .089, p = .182).
3.5.4 Gender differences

3.5.5 Gender differences in alcohol expectancies.

With the exception of a significant finding for males between alcohol expectancies of cognitive enhancement and attitudes towards seeking professional help, no statistically significant relationships were found between any of the alcohol expectancies and help-seeking. Comparison of means analyses were also used to test gender differences in alcohol expectancies. Males had a mean rank of 68.35, compared to the mean rank of 56.33 in females for alcohol expectancies of negative consequences. A Mann-Whitney U test revealed that there was no statistically significant difference between males and females for expectancies of negative consequences (z = -1.596, p = .111). For alcohol expectancies of increased confidence, males (M = 38.23, SD = 6.402) had a higher mean score than females (M = 36.44, SD = 7.08). However, an independent t-test found that this difference was not statistically significant (t(44.054) = 1.228, p = .226). Females (M = 11.46, SD = 1.97) had a slightly higher mean score than males (M = 11.38, SD = 1.75) for an alcohol expectancy of increased sexual interest, which was found to be insignificant (t(44.822) = -.192, p = .848). Finally, males (M = 8.85, SD = 2.51) had a higher mean score in alcohol expectancies of tension reduction (M = 8.08, SD = 2.57), which was also statistically insignificant (t(41.264) = 1.371, p = .178).

3.5.6 Gender and help-seeking

A Mann-Whitney U test determined that the difference in the mean scores of males (M = 50.58) and females (M = 61.41) on help-seeking was statistically insignificant (z = -1.439, p = .150).
Table 7: Independent t-test for gender differences in coping

<table>
<thead>
<tr>
<th>Variable</th>
<th>Groups</th>
<th>Mean</th>
<th>SD</th>
<th>T</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-distraction</td>
<td>Males</td>
<td>5.19</td>
<td>1.698</td>
<td>.220</td>
<td>39.139</td>
<td>.827</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>5.11</td>
<td>1.629</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Active coping</td>
<td>Males</td>
<td>6.00</td>
<td>1.442</td>
<td>.512</td>
<td>41.044</td>
<td>.612</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>5.84</td>
<td>1.470</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Use of emotional</td>
<td>Males</td>
<td>5.08</td>
<td>1.521</td>
<td>-1.274</td>
<td>43.408</td>
<td>.210</td>
</tr>
<tr>
<td>support</td>
<td>Females</td>
<td>5.52</td>
<td>1.656</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Males</td>
<td>4.54</td>
<td>1.174</td>
<td>-1.305</td>
<td>50.118</td>
<td>.198</td>
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<tr>
<td>Venting</td>
<td>Females</td>
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<td>1.484</td>
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<tr>
<td>Positive reframing</td>
<td>Males</td>
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<td>1.696</td>
<td>.864</td>
<td>39.744</td>
<td>.393</td>
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<tr>
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<td>Females</td>
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<tr>
<td>Self-blame</td>
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<td>1.470</td>
<td>.502</td>
<td>51.349</td>
<td>.618</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>4.82</td>
<td>1.901</td>
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</tr>
</tbody>
</table>
Table 8: Mann Whitney u tests for gender differences in coping

<table>
<thead>
<tr>
<th>Variable</th>
<th>Groups</th>
<th>Mean</th>
<th>z</th>
<th>p</th>
</tr>
</thead>
<tbody>
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<td>Denial</td>
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<tr>
<td></td>
<td>Females</td>
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<td></td>
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<td>Substance use</td>
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<td>.779</td>
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<td></td>
<td>Females</td>
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<td>Behavioural</td>
<td>disengagement</td>
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<td>-.917</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Females</td>
<td>57.62</td>
<td></td>
</tr>
<tr>
<td>Planning</td>
<td>Males</td>
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<td>.351</td>
</tr>
<tr>
<td></td>
<td>Females</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Humour</td>
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<td>.103</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>56.32</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3.5.7 Gender and mental health

Males (M = 58.35) exhibited a slightly lower mean score on levels of mental health than females (M = 59.19), however this difference was not statistically significant (z = - .112, p = .911).
3.5.8 Gender and coping.

Table 7 summarises non-significant independent t-test results for males and females on the variables of self-distraction \( (t(39.139) = .220, p = .827) \), active coping \( (t(41.044) = .512, p = .612) \), use of emotional support \( (t(43.408) = -1.274, p = .210) \), venting \( (t(50.118) = -1.305, p = .198) \), positive reframing \( (t(39.744) = .864, p = .393) \) and self-blame \( (t(51.349) = .502, p = .618) \). In these cases the null hypothesis was retained.

Table 8 summarises the non-significant findings for gender differences in denial \( (z = -1.602, p = .109) \); substance use \( (z = -.280, p = .779) \); behavioural disengagement \( (z = -.917, p = .359) \); planning \( (z = -.933, p = .351) \); and humour \( (z = -1.629, p = .103) \). The null hypothesis was retained in these cases.
Chapter 4: Discussion

4.1 Research Aims

The aim of this study was to investigate potential relationships between alcohol expectancies and help-seeking, coping and levels of mental health in Irish adults. The intention was to investigate alcohol expectancies in a normal population, rather than in a clinical sample and, in doing so, to focus on alcohol use rather than dependence. Given recent research findings (Arensman et al., 2013) concerning relationships between alcohol use and suicide, it was felt that investigation of relationships between alcohol and help-seeking was timely, as delineating any interaction between these variables could support the development of structured interventions. Similarly, relationships between alcohol use, coping and levels of mental health could yield important information in this context. Additionally, it was felt that this study could extend research into the effect of alcohol expectancies on alcohol use and coping by, firstly, examining positive alcohol expectancies individually, rather than as a composite, with the other variables; and secondly, exploring any potential relationship with help-seeking attitudes.

4.2 Support for the hypotheses

The hypotheses tested in the current study were: first, that there would be a relationship between alcohol expectancies and help-seeking behaviour; second, that there would be a relationship between alcohol expectancies and coping; third, that there would be a relationship between alcohol expectancies and levels of mental health; and fourth, that there would be gender differences in alcohol expectancies, help-seeking, coping and levels of mental health. Partial support was found for all hypotheses. Relationships were observed between two alcohol expectancy factors and attitudes to help-seeking, providing partial support for the first hypothesis. Additionally, many significant relationships between alcohol expectancies and coping factors were observed. Two alcohol
expectancies were associated with levels of mental health, giving partial support to the third hypothesis. Finally, gender differences were observed in relation to attitudes to help-seeking and coping, but not in relation to levels of mental health, giving partial support to the fourth hypothesis. Results for all hypotheses have been discussed in relation to each alcohol expectancy, and in order of the magnitude of their contribution to the current study, as this approach facilitated more meaningful discussion, and the remaining gender differences are discussed subsequently.

4.3 Expectancies of increased confidence, help-seeking, coping and mental health

The finding that more negative attitudes to help-seeking relate to alcohol expectancies of increased confidence is exciting in that previous research has not examined relationships between these constructs. This finding somewhat contrasts with previous research on help-seeking and alcohol use, in that positive drinking motives were not found to have a relationship with help-seeking (Groeschel et al., 2010, p. 133). However, it should be noted that while drinking motives and alcohol expectancies are related, they are considered to be separate constructs (Piasecki et al., 2013, p.1; Hasking & Oei, 2004, p. 467-468). Nonetheless, this disparity and the lack of previous research examining this interaction, indicate that further research is needed to clarify this relationship. In addition to the association with attitudes to help-seeking, relationships between expectancies of increased confidence and the coping variables may mark this interaction as potentially interesting in consideration of the SSIS (2013) report. Alcohol expectancies of increased confidence were found to have a moderate positive association with coping-related substance use, as well as weak positive relationships with coping through humour, denial, behavioural-disengagement, self-distraction and self-blame. Denial, a refusal to acknowledge the existence of the stressor, and behavioural disengagement, a reduction of engagement in addressing the stressor (Carver et al., 1989, p. 269) are both considered to
be avoidant coping strategies (Cooper et al., 1995, p. 991). Insofar as these strategies attempt to minimise, redirect attention away from the stressor, or refuse to accept its existence (Cooper et al., 1995, p. 991), use of humour to cope could arguably be characterised as avoidant also. Previous research has provided evidence of relationships between avoidant coping strategies and both drinking to cope (Cooper et al., 1995, p. 991) and positive expectancies (Hasking & Oei, 2002, p. 490; Armeli et al., 2005, p. 9) which find support in the current study. In Armeli et al.’s (2005) study, avoidant coping was measured using the combined total of the mental disengagement and denial scales of the COPE inventory (Carver et al., 1989). The original mental disengagement subscale of the COPE Inventory is represented as self-distraction in the COPE Brief (Carver, 1997, p. 95). Thus, the finding in the current study of a relationship between expectancies of increased confidence and self-distraction was consistent also.

Drinking to cope has consistently been related to mental health issues (e.g. Gonzales et al., 2009; Gonzales et al., 2011) and is purportedly used as a means of negative affect regulation (e.g. Veenstra et al., 2007; Gonzales et al., 2009; Patrick et al., 2011). Piasecki et al. (2013, p. 2) argue that coping motives may be exclusively related to negative affect reduction, while enhancement motives may be exclusively related to positive affect enhancement. However, relationships between expectancies of increased confidence, which may be seen as a desire to enhance emotional affect, and coping-related substance use, which may be interpreted as a desire to reduce negative affect, appears to contradict this differentiation. Additionally, it is plausible that the use of alcohol for either outcome could reduce likelihood of help-seeking in preference of maladaptive coping strategies. The current study also found that expectancies of increased confidence related to higher levels of psychological distress, which in the context of the other findings, may also suggest a motivation of negative affect reduction. Further research should examine the
complex interplay of these variables, as further delineation of these relationships could have great potential in clarifying the nature of the interactions and may yield information to support the effective design of interventions aimed at identifying individuals at risk of alcohol related mental health issues and encouraging help-seeking.

Furthermore, recent research has suggested that coping-related alcohol use is related to more punishing effects (Piasecki et al., 2013, p. 5). A relationship between expectancies of increased confidence and self-blame might be seen to support this finding. Carver et al. (1997) observed that opposing forces such as self-blame (criticising one’s self for responsibility in the situation) and denial often appear together and has suggested that this phenomenon warrants further exploration (Carver, 1997, p. 98). The current study demonstrated this co-occurrence in that both self-blame and denial were positively related to expectancies of increased confidence. It is possible that alcohol consumption with expectancy of increased confidence somehow represents an avenue for counter-balancing a negative self-view likely to result from coping through self-blame. Alternatively, self-blame may arise from using alcohol to cope or enhance positive affect. This finding may represent one avenue through which the simultaneous appearance of apparently opposing forces might be explored. Consuming alcohol with a view to enhancing confidence suggests the use of maladaptive means of coping. That relationships were not observed between this expectancy and more functional approaches (e.g. active coping, positive reframing, acceptance) to coping is therefore unsurprising.

4.4 Expectancies of cognitive enhancement, help-seeking, coping and mental health

Correlations run by gender revealed that for males, an alcohol expectancy of cognitive enhancement had a moderate inverse association with attitudes toward seeking professional help. Again, in the context of limited research exploring help-seeking attitudes and alcohol expectancies, this finding is important. However, the inverse
relationship indicated that expectancies of cognitive enhancement related to more positive attitudes towards help-seeking, which is perhaps counterintuitive. Adding to the curious nature of this finding was the observed inverse relationship of cognitive enhancement expectancies with use of instrumental support. It might be expected that more positive attitudes to professional help-seeking would be somewhat consistent with the use of instrumental support. Further research is needed to clarify the nature of these relationships. Additionally, expectancies of cognitive enhancement were found to have weak positive relationships with both coping-related substance use and coping through acceptance. Somewhat consistent with the findings of Cooper et al. (1995, p. 998), who found that males were more likely drink for enhancement, males in the current study were more likely to hold expectancies of cognitive enhancement than females. The differentiation of coping and enhancement motives for drinking (Cooper et al., 1995; Piasecki et al., 2013), however, would again seem to contrast with the findings of the current study, given that cognitive enhancement expectancies were associated with coping-related substance use. Acceptance has been characterised as both a functional and dysfunctional means of coping, sometimes depending on the appraisal stage at which it is employed (Carver et al., 1989). However, acceptance has also been found to predict lower levels of distress (Carver, 1997, p. 94). Furthermore, expectancies of cognitive enhancement did not relate to levels of mental health. In the context of these mixed findings it is difficult to suppose why cognitive enhancement expectancies did not relate to some of the other coping variables also. Further research should explore these findings, which may be useful in understanding the complexities of coping and alcohol use and their relationship with help-seeking.
4.5 Expectancies of tension reduction and help-seeking, coping and mental health

The current study found a moderate positive relationship between expectancies of tension reduction and coping-related substance use. Drinking to cope has been consistently related to increased alcohol consumption (e.g. Cooper et al., 1995, p. 991; Todd et al., 2003, p. 309; Hasking & Oei, 2004, pp. 481, 483) and it has been suggested that the tension-reduction properties of alcohol may be used to ameliorate negative affect (Cooper, 1995, p. 1003; Hasking & Oei, 2004, p.484). Cooper et al. (1995, p. 998) found the effects of depression and maladaptive emotion focused coping on coping-related alcohol use were moderated by tension reduction expectancies. Patrick et al., (2011, p. 334) found that while many of the reasons given for using alcohol decrease reliably with age, one of the exceptions was drinking to relax, which increased significantly with age. However, it has been suggested that given the pervasiveness of drinking to cope and tension reduction as explanations for drinking, it is plausible that heavier drinkers would be inclined to propose these reasons in explanation of their drinking (Todd et. al., 2005, p. 304). Nonetheless, the current study’s finding of an association between tension reduction expectancies and coping-related substance use is consistent with much previous research and further exploration may be useful to the design of interventions and national information strategies in the context of the SSIS report. In the context of previous research demonstrating the relationship of coping-related alcohol use with negative affect (Gonzales et al., 2011; Patrick et al., 2001) and suicide (Borges et al., 2000; Gonzales et al., 2009), it is perhaps surprising that expectancies of tension reduction were not found to relate to levels of mental health in the current study. Similarly, demonstrated relationships between coping-related alcohol use and maladaptive coping strategies (Cooper et al., 1995; Armeli et al., 2005; Piasecki et al., 2013) would suggest that tension reduction expectancies would relate to more avoidant coping strategies. Surprisingly, this
study did not find evidence of such relationships. One possible explanation for this finding, particularly in the context of not finding a relationship between mental health and tension reduction expectancies, is that avoidant coping strategies have been suggested to be less pertinent to everyday tribulations and more likely to emerge in response to major life stressors (Armeli et al., 2005, p. 21). It is possible that the measurement of coping in a dispositional manner (i.e. participants were asked to respond according to what they usually did) may not have elicited responses indicating these other types of coping. Cooper et al. (1995, p. 991) has asserted that while drinking to cope has been associated with more avoidant, emotion focused coping, it has not been associated with deficits in problem focused coping. From this perspective, that the current study did not find associations between tension reduction expectancies and more active, approach focused coping is consistent. Gender differences were also not observed on expectancies of tension reduction. Previous research has drawn mixed conclusions on gender differences in tension reduction (e.g. Cooper et al., 1995; Patrick et al., 2011) and in this context, gender differences were not necessarily expected.

4.6 Expectancies of negative consequences, help-seeking, coping and levels of mental health

In contrast to the findings of Groeschel et al., (2010), no significant relationship was observed between alcohol expectancies of negative consequences and attitudes to help-seeking. The discrepancy in findings between Groeschel et al.’s (2010) and the current study may be due to the different measures used in each case. Further research should examine the relationship between expectancies of negative consequences and help-seeking, perhaps using multiple measures, to establish their effects on attitudes to help-seeking and the utility of measures of this construct. Hasking and Oei (2002, p.468) have noted that the tendency of researchers to focus only on positive expectancies when
conducting research on alcohol expectancies has resulted in understating the contribution of negative expectancies. As suggested by Hasking and Oei (2004, p. 481), this study has tested each expectancy separately, and so contributes to the furthering of expectancy research. Negative expectancies were found to relate weakly and positively to coping-related alcohol use and self-blame. Previous research has demonstrated that negative expectancies relate to both increased consumption (Lee et al., 1999, as cited in Hasking and Oei, 2004, p. 470) and problematic drinking patterns (Brown, 1985a, as cited in Hasking & Oei, 2002, p.468). A relationship with coping-related alcohol use may be consistent in this regard, however, mixed results have characterised the study of the independent contributions of negative expectancies (e.g. Hasking & Oei, 2004, p. 481) and further research should examine their relationship with coping variables. Self-blame has been found to predict poor adjustment in dealing with stress (Bolger, 1990, and McCrae & Costa, 1986 as cited in Carver, 1997, p. 95) indicating that negative expectancies may yield important information to alcohol use in coping, and thus supports their further examination in relation to help-seeking. Furthermore, a relationship between higher levels of psychological distress and negative expectancies was observed. In the context of the relationships with coping-related substance use and self-blame, this finding was unsurprising but indicates that further research is needed. Findings that negative expectancies were not associated with more adaptive forms of coping (e.g. active coping, positive reframing) are also unsurprising. Again, no gender differences were observed for negative expectancies. Gender differences observed in negative expectancies by Jones and McMahon (1993) were attributed to the differential responses of males and females to proximal and distal negative expectancies. However the measure used in the current study accounted did not account for this differentiation. Given that there was relatively
little research available on negative expectancies, there was no expectation of finding
gender differences in the current study.

4.7 Expectancies of increased sexual interest, help-seeking, coping and mental health

Finally, an expectancy of increased sexual interest was found to have a weak
relationship with venting. The subscale of venting measures the tendency toward release
of negative emotion related to a stressor and has been characterised as both functional and
dysfunctional. In the short-term, expression of negative emotion may be necessary,
allowing an individual to move on from stressful circumstances, whereas over a longer
period focusing on distress may impede more active coping (Carver et al., 1989, p. 269).
Perhaps the relationship of venting with an expectancy of increased sexual interest
represents potential for indirect expression of emotion. Previous research has found that
expectancies relating to sexual function were related to intentions to over-consume
alcohol (Wall et al., 1998 as cited in Hasking & Oei, 2002, p.469) which may be
consistent with coping-related venting. However, in the absence of other research
supporting this finding, this interpretation is mere conjecture. Similarly, that expectancies
of increased sexual interest did not relate to any of the other coping variables, may not be
surprising, but previous research has not given attention to similar findings. Future
research could examine this relationship, however, given that this expectancy did not
interact with levels of mental health, help-seeking or any of the other coping variables it
may not be particularly relevant research exploring these relationships. Additionally, no
gender differences were noted on either expectancies of increased sexual interest or
venting.

4.8 Further gender differences

One statistically significant gender difference not discussed earlier is that of a higher
use of religion in relation to coping in females. As religion has not interacted with the
other variables to any significant degree, it was felt that perhaps this finding was of less relevance in the current study. However, religion has been noted in previous research to be an important means of coping (Carver et al., 1989) and future research should not discount its potential contribution. Most important to the current study was the finding that there were no gender differences in coping-related substance use. However, observations in relation to this aspect have been discussed earlier in the context of other findings. Similarly, no gender differences were observed on many of the other coping variables, but previous research had led to the expectation of differences across some, but not all, of these variables. Therefore these findings were unsurprising.

4.9 Limitations and strengths of the current study

While the sampling method in the current study sought to address a need to move beyond a student sample, the comparatively small number of males in the final sample may affect the generalisation of findings to the population. Also, the design of the questionnaire allowed inclusion of responses from non-drinkers, which were later excluded from analysis.

Findings in relation to the variables of attitudes to help-seeking and mental health were limited. Perhaps multiple measures of help-seeking, for example, measures of previous help-seeking and help-seeking from informal sources, might have been usefully combined with the measure of attitudes towards seeking professional psychological help to yield a more complete picture of help-seeking behaviour and its relationship with alcohol expectancies. Regarding measurement of mental health, it might be argued that perceived levels of mental health may be maintained by complex interactions of coping variables with alcohol expectancies to obscure possible associations with alcohol expectancies. For example, Hasking and Oei found that while positive alcohol expectancies and drinking to cope were related to higher consumption, participants for whom these interactions were
reported did not report a lower level of self-efficacy in refusal of alcohol. This finding was understood to indicate that these participants did not perceive drinking to cope as a maladaptive coping strategy requiring control and therefore their self-efficacy for refusing alcohol was not affected (Hasking & Oei, 2004, p. 484). A similar mechanism may have been in operation here and perhaps, the measure used was not sufficiently sensitive to capture the complexity of these relationships. The addition of a qualitative aspect to the study might have helped to support findings with a level of detail not possible in a purely quantitative approach.

While this study sought to address limitations of previous research, it should be noted that many of the studies cited (e.g. Cooper et al., 1995; Armeli et al., 2003; Hasking & Oei, 2002, 2004; Todd et al., 2005) employed more sophisticated designs and complex analyses in arriving at their conclusions. While the current study attempted to build on this work in investigating the relationships of alcohol expectancies to help-seeking and coping, the methodology employed was less sophisticated. However, the current study has supported the independent investigation of alcohol expectancies and coping variables, and has extended alcohol expectancy research to include the outcome of attitudes to help-seeking. Furthermore, the sampling method employed was used to gain access to a non-student sample, which is particularly important in psychological research generally, but also in relation to the aims of the current study. Much of the relevant research on help-seeking (e.g. Groeschel et al., 2010; Gayman et al., 2011) and alcohol use (e.g. Armeli et al., 2005; Gonzales et al., 2011) employed student samples. Lastly, a literature review found that research of this nature had not previously been conducted in an Irish sample and the findings of the SSIS (Arensman et al., 2013) make a case for the relevance of the current study.
4.10 Future research and application of findings

Observed relationships between both suicide and depression, and alcohol use (e.g. Arensman et al., 2013; Borges et al., 2000; Gonzales, et al., 2009, 2011) make a strong case for further research in this area. Future research should further examine the relationships of independent alcohol expectancies and help-seeking, perhaps including drinking motives. As previous research has usefully focused on the interaction of alcohol expectancies and coping in predicting alcohol consumption (e.g. Armeli et al., 2005; Todd et al., 2003, Hasking & Oei, 2004) a similar design (i.e. a mediational model) could be applied to this research, but testing the interactions of each independent expectancy and coping subscale, in predicting help-seeking. Additionally, incorporating several measures of help-seeking may provide more detailed understanding of circumstances affecting the use of support for mental health issues from either formal or informal sources. This understanding will be crucial to the design of successful interventions. As previously mentioned, it is thought that inclusion of a qualitative aspect in future research might provide a worthwhile dimension. More targeted sampling, in consideration of the findings of the SSIS report (Arensman et al., 2013), could greatly assist the practical application of potential findings. Recommendations of the SSIS (Arensman et al., 2013) include intensification of national strategies to increase awareness of the harmful effects of alcohol misuse and to reduce access to alcohol (Arensman et al., 2013, p. 29). Well-designed interventions to increase levels of help-seeking have been shown to reduce numbers of suicides (Calloway et al., 2012, p. 3). The findings of the current study are therefore envisaged to have practical value in generating further research into the relationship of alcohol use and help-seeking, and in highlighting key concerns in the design and implementation of targeted mental health and suicide interventions. From a clinical perspective, the recommendation of the SSIS report was to encourage
collaboration between addiction treatment services and mental health services in the identification of those at risk (Arensman et al., 2013, p. 29). Better characterisation of the effects of alcohol use on help-seeking, coping and mental health could allow for earlier detection of those at risk who are not currently in treatment for either mental health difficulties or addiction and encourage help-seeking at an earlier stage. The findings of current study, with further research, could provide a basis for earlier intervention.

4.11 Conclusion

The most important findings of the current study were that alcohol expectancies of increased confidence and cognitive enhancement were associated with attitudes towards seeking professional psychological help. In particular, the association between expectancies of increased confidence with coping-related substance use and higher levels of psychological distress may be important to interventions designed to target areas of concern identified by the SSIS report (Arensman et al., 2013). While less clear, the findings surrounding expectancies of cognitive enhancement may be usefully delineated by future research for the same purpose. The relationship of negative expectancies to coping-related alcohol use and higher psychological distress was also important and may be a fruitful avenue of exploration. The many interactions observed between the coping variables and alcohol expectancies support the use of subscales rather than composite measures of these constructs and as such the current study has built on previous research in this area. It is expected that the findings of this study may be important to further research directed at increasing help-seeking, and designing interventions targeting those at risk of mental health issues related to alcohol use.
References


Appendices

Appendix A: Questionnaire Pack

Information and informed consent

The purpose of this study is to explore ways of coping and attitudes towards professional help-seeking, mental health and alcohol use in adults resident in Ireland. This study is being conducted as part of a post-graduate higher diploma in psychology thesis and will be subject to examination. Findings may be published in the Dublin Business School library, or presented at student congress.

Participation is anonymous and confidential; responses cannot be attributed to any one participant. For this reason, it is not possible to withdraw your information from the survey once it has been submitted. However, before you click 'submit', you may choose to end your participation and none of the information you have provided up to that point will be recorded. Participation is voluntary.

Before answering any questions, you will be asked to indicate that you are consenting to the use of any information you supply as outlined above, and that you have been informed as to the purpose of the study. You must be 18 years old or older to participate. This questionnaire contains questions about you, the way you cope, your general mental health, your attitudes towards seeking professional help, and attitudes towards alcohol use/drinking. Although widely used in research, some of the questions could cause you some minor negative feelings. Should this happen to you, contact information for useful support services is included on the final page.

All data collected will be stored in electronic format on a password protected computer.
It should take no more than 15 - 20 minutes to complete this questionnaire. The bar at the bottom of each page will show your progress. Please answer all questions. Should you have any questions about this study, please contact me at

Thank you for taking the time to complete this survey.

Kate O'Donnell

Please click the box below to indicate your consent to use the information you supply as part of the study outlined above, that your participation is voluntary, and that you have been made aware of the purpose of the study.*Required

●
Demographic questions

1. How old are you? *Required

Please enter your age in years

2. Are you male or female? *Required

- Male
- Female

3. Please indicate your nationality. *Required

Please click in the circle next to the answer most appropriate to you

- Irish
- Other

4. Are you currently resident in Ireland? *Required

Please click in the circle next to the answer most appropriate to you

- Yes
- No
5. Do you live in a rural or urban environment? *Required

Please click in the circle next to the answer most appropriate to you

- Rural
- Urban

6. Are you currently employed? *Required

Please click in the circle next to the answer most appropriate to you

- Employed
- Unemployed

7. Are you a student? *Required

Please click in the circle next to the answer most appropriate to you

- Yes - full time student
- Yes - part time student
- No
Coping

The items in this section are about the ways that you cope with stress in your life. There are many ways to deal with problems. These items ask what you do to cope with the problems in your life. Each item says something about a particular way of coping. I would like to know to what extent you do what the item says - how much or how frequently. Please select your answer on the basis of whether or not you do what the item says, not whether or not it works for you. Try to rate each item separately in your mind from the others. Make sure your answers are as true FOR YOU as you can. Answers range from "I haven't been doing this at all" to "I've been doing this a lot".

1. I turn to work or other activities to take my mind off things*Required

Please click the circle next to the statement most appropriate to you

- I haven't been doing this at all
- I've been doing this a little bit
- I've been doing this a medium amount
- I've been doing this a lot

2. I concentrate my efforts on doing something about the situation I'm in*Required

Please click the circle next to the statement most appropriate to you

- I haven't been doing this at all
- I've been doing this a little bit
3. I say to myself "this isn't real"*Required

Please click the circle next to the statement most appropriate to you

- I haven't been doing this at all
- I've been doing this a little bit
- I've been doing this a medium amount
- I've been doing this a lot

4. I use alcohol or other drugs to make myself feel better*Required

Please click the circle next to the statement most appropriate to you

- I haven't been doing this at all
- I've been doing this a little bit
- I've been doing this a medium amount
- I've been doing this a lot

5. I get emotional support from others*Required

Please click the circle next to the statement most appropriate to you

- I haven't been doing this at all
- I've been doing this a little bit
- I've been doing this a medium amount
6. I give up trying to deal with it*Required

Please click the circle next to the statement most appropriate to you

● I haven't been doing this at all
● I've been doing this a little bit
● I've been doing this a medium amount
● I've been doing this a lot

7. I take action to try to make the situation better*Required

Please click the circle next to the statement most appropriate to you

● I haven't been doing this at all
● I've been doing this a little bit
● I've been doing this a medium amount
● I've been doing this a lot

8. I refuse to believe what is happening*Required

Please click the circle next to the statement most appropriate to you

● I haven't been doing this at all
● I've been doing this a little bit
● I've been doing this a medium amount
- I've been doing this a lot

9. I say things to let my unpleasant feelings escape*Required

Please click the circle next to the statement most appropriate to you

- I haven't been doing this at all
- I've been doing this a little bit
- I've been doing this a medium amount
- I've been doing this a lot

10. I get help and advice from other people*Required

Please click the circle next to the statement most appropriate to you

- I haven't been doing this at all
- I've been doing this a little bit
- I've been doing this a medium amount
- I've been doing this a lot

11. I use alcohol or other drugs to help me get through it*Required

Please click the circle next to the statement most appropriate to you

- I haven't been doing this at all
- I've been doing this a little bit
- I've been doing this a medium amount
- I've been doing this a lot
12. I try to see the situation in a different light, to make it seem more positive*Required

Please click the circle next to the statement most appropriate to you

- I haven't been doing this at all
- I've been doing this a little bit
- I've been doing this a medium amount
- I've been doing this a lot

13. I criticise myself*Required

Please click the circle next to the statement most appropriate to you

- I haven't been doing this at all
- I've been doing this a little bit
- I've been doing this a medium amount
- I've been doing this a lot

14. I try to come up with a strategy about what to do*Required

Please click the circle next to the statement most appropriate to you

- I haven't been doing this at all
- I've been doing this a little bit
- I've been doing this a medium amount
- I've been doing this a lot
15. I get comfort and understanding from someone.*Required

Please click the circle next to the statement most appropriate to you

- I haven't been doing this at all
- I've been doing this a little bit
- I've been doing this a medium amount
- I've been doing this a lot

16. I give up the attempt to cope.*Required

Please click the circle next to the statement most appropriate to you

- I haven't been doing this at all
- I've been doing this a little bit
- I've been doing this a medium amount
- I've been doing this a lot

17. I look for something good in what is happening.*Required

Please click the circle next to the statement most appropriate to you

- I haven't been doing this at all
- I've been doing this a little bit
- I've been doing this a medium amount
- I've been doing this a lot
18. I make jokes about it*Required

Please click the circle next to the statement most appropriate to you

- I haven't been doing this at all
- I've been doing this a little bit
- I've been doing this a medium amount
- I've been doing this a lot

19. I do something to think about it less, such as going to the movies, watching TV, reading, daydreaming, sleeping or shopping*Required

Please click the circle next to the statement most appropriate to you

- I haven't been doing this at all
- I've been doing this a little bit
- I've been doing this a medium amount
- I've been doing this a lot

20. I accept the reality of the fact that it is happening*Required

Please click the circle next to the statement most appropriate to you

- I haven't been doing this at all
- I've been doing this a little bit
- I've been doing this a medium amount
- I've been doing this a lot
21. I express my negative feelings*Required

Please click the circle next to the statement most appropriate to you

- I haven't been doing this at all
- I've been doing this a little bit
- I've been doing this a medium amount
- I've been doing this a lot

22. I try to find comfort in my religion or spiritual beliefs*Required

Please click the circle next to the statement most appropriate to you

- I haven't been doing this at all
- I've been doing this a little bit
- I've been doing this a medium amount
- I've been doing this a lot

23. I try to get advice or help from other people about what to do*Required

Please click the circle next to the statement most appropriate to you

- I haven't been doing this at all
- I've been doing this a little bit
- I've been doing this a medium amount
- I've been doing this a lot
24. I learn to live with it*Required

Please click the circle next to the statement most appropriate to you

● I haven't been doing this at all
● I've been doing this a little bit
● I've been doing this a medium amount
● I've been doing this a lot

25. I think hard about what steps to take*Required

Please click the circle next to the statement most appropriate to you

● I haven't been doing this at all
● I've been doing this a little bit
● I've been doing this a medium amount
● I've been doing this a lot

26. I blame myself for things that are happening*Required

Please click the circle next to the statement most appropriate to you

● I haven't been doing this at all
● I've been doing this a little bit
● I've been doing this a medium amount
● I've been doing this a lot
27. I pray or meditate*Required

Please click the circle next to the statement most appropriate to you

- I haven't been doing this at all
- I've been doing this a little bit
- I've been doing this a medium amount
- I've been doing this a lot

28. I make fun of the situation*Required

Please click the circle next to the statement most appropriate to you

- I haven't been doing this at all
- I've been doing this a little bit
- I've been doing this a medium amount
- I've been doing this a lot
Mental Health (See Appendix C for coding and scoring)

I would like to know how your mental health has been over the last few weeks. The following items ask how you have been recently compared with how you are usually.

Please read the questions below and select one of the four possible answers. The answers vary, so please read them carefully. Have you recently:

1. been able to concentrate on what you're doing? *Required

Please click in the circle next to the answer most appropriate to how you have been in the past few weeks

- better than usual
- same as usual
- less than usual
- much less than usual

2. lost much sleep over worry? *Required

Please click in the circle next to the answer most appropriate to how you have been in the past few weeks

- not at all
- no more than usual
- rather more than usual
- much more than usual

3. felt that you are playing a useful part in things? *Required

Please click in the circle next to the answer most appropriate to how you have been in the past few weeks
4. felt capable of making decisions about things?*Required

Please click in the circle next to the answer most appropriate to how you have been in the past few weeks

- more so than usual
- same as usual
- less so than usual
- much less than usual

5. felt constantly under strain?*Required

Please click in the circle next to the answer most appropriate to how you have been in the past few weeks

- not at all
- no more than usual
- rather more than usual
- much more than usual
6. felt you couldn't overcome your difficulties? *Required

Please click in the circle next to the answer most appropriate to how you have been in the past few weeks

- not at all
- no more than usual
- rather more than usual
- much more than usual

7. been able to enjoy your normal day to day activities? *Required

Please click in the circle next to the answer most appropriate to how you have been in the past few weeks

- more so than usual
- same as usual
- less so than usual
- much less than usual

8. been able to face up to your problems? *Required

Please click in the circle next to the answer most appropriate to how you have been in the past few weeks

- more so than usual
- same as usual
- less so than usual
9. been feeling unhappy or depressed? *Required

Please click in the circle next to the answer most appropriate to how you have been in the past few weeks

- not at all
- no more than usual
- rather more than usual
- much more than usual

10. been losing confidence in yourself? *Required

Please click in the circle next to the answer most appropriate to how you have been in the past few weeks

- not at all
- no more than usual
- rather more than usual
- much more than usual

11. been thinking of yourself as a worthless person? *Required

Please click in the circle next to the answer most appropriate to how you have been in the past few weeks

- not at all
- no more than usual
• rather more than usual
• much more than usual

12. been feeling reasonably happy, all things considered? *Required

Please click in the circle next to the answer most appropriate to how you have been in the past few weeks

• more so than usual
• same as usual
• less so than usual
• much less than usual
Seeking professional help (See Appendix D for coding and scoring)

I would like to know how you would feel about seeking professional help. The following 10 items measure a person's attitude towards seeking professional help. The possible responses to each of the statements below range from "Disagree" to "Agree". To what extent do you agree with the statements below:

1. If I believed I was having a mental breakdown my first inclination would be to get professional attention.*Required

Please click in the circle next to the answer most appropriate to you

- Disagree
- Somewhat disagree
- Somewhat agree
- Agree

2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.*Required

Please click in the circle next to the answer most appropriate to you

- Disagree
- Somewhat disagree
- Somewhat agree
- Agree
3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy. *Required

Please click in the circle next to the answer most appropriate to you

- Disagree
- Somewhat disagree
- Somewhat agree
- Agree

4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help. *Required

Please click in the circle next to the answer most appropriate to you

- Disagree
- Somewhat disagree
- Somewhat agree
- Agree

5. I would want to get psychological help if I were worried or upset for a long period of time. *Required

Please click in the circle next to the answer most appropriate to you

- Disagree
- Somewhat disagree
6. I might want to have psychological counselling in the future.*Required

Please click in the circle next to the answer most appropriate to you

- Disagree
- Somewhat disagree
- Somewhat agree
- Agree

7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.*Required

Please click in the circle next to the answer most appropriate to you

- Disagree
- Somewhat disagree
- Somewhat agree
- Agree

8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.*Required

Please click in the circle next to the answer most appropriate to you

- Disagree
- Somewhat disagree
9. A person should work out his or her own problems. Getting psychological counselling would be a last resort. *Required

Please click in the circle next to the answer most appropriate to you

- Disagree
- Somewhat disagree
- Somewhat agree
- Agree

10. Personal and emotional troubles, like many things, tend to work out by themselves. *Required

Please click in the circle next to the answer most appropriate to you

- Disagree
- Somewhat disagree
- Somewhat agree
- Agree
Alcohol

Do you drink alcohol? *Required

Please indicate whether you drink alcohol or not by clicking in the appropriate circle below.

- Yes, I drink alcohol
- No, I don't drink alcohol.

The Effects of Drinking Alcohol

I would like to know about your thoughts and feelings about drinking alcohol. Below are 36 statements describing the effects that drinking alcohol may have on you. I would like to know how much or how little you agree with each statement - there are no right or wrong answers. The possible responses for each of the statements range from 'Strongly disagree' to 'Strongly agree'. To what extent do you agree with the statements below:

1. I do not drink alcohol to help me unwind after a hard day or week's work *Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

2. Little things annoy me less when I'm drinking *Required

Please click in the circle beside the answer most appropriate to you
3. Drinking makes me feel outgoing and friendly*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

4. Drinking alcohol makes me tense*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

5. I have more self-confidence when drinking*Required
Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

6. Drinking makes me more sexually responsive*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

7. When I am anxious or tense I do not feel a need for alcohol*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree
8. Drinking makes the future brighter*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

9. I drink alcohol because it's a habit*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

10. Drinking makes me bad tempered*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree
11. I am more aware of what I say and do if I'm drinking alcohol*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

12. I feel that drinking hinders me in getting along with other people*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

13. I feel restless when drinking alcohol*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree
14. I am more sullen and depressed when I'm drinking alcohol * Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

15. I cannot always control my drinking * Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

16. I am less concerned about my actions when I'm drinking * Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
17. If I'm drinking it's easier to express my feelings*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

18. I often feel sexier after I've been drinking*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

19. Drinking does not help to relieve any tension I feel about recent concerns and interests*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
20. Drinking increases my aggressiveness*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

21. Drinking makes me feel like a failure*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree
22. Drinking helps me to be more mentally alert*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

23. Drinking alcohol removes most thoughts of sex from my mind*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

24. I tend to adopt a "who cares" attitude when drinking*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
25. Drinking brings out the worst in me*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

26. I feel less shy when drinking*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

27. Drinking makes me feel more violent*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

28. I am less discrete if I drink alcohol*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

29. When I am drinking it's easier to open up and express my feelings*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

30. I am powerless in the face of alcohol*Required

Please click in the circle beside the answer most appropriate to you
• Strongly disagree
• Disagree
• Neither agree nor disagree
• Agree
• Strongly agree

31. When I am drinking I avoid people or situations for fear of embarrassment*Required

Please click in the circle beside the answer most appropriate to you

• Strongly disagree
• Disagree
• Neither agree nor disagree
• Agree
• Strongly agree

32. Drinking alcohol sharpens my mind*Required

Please click in the circle beside the answer most appropriate to you

• Strongly disagree
• Disagree
• Neither agree nor disagree
• Agree
• Strongly agree
33. I feel disappointed in myself when drinking*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

34. I tend to avoid sex if I've been drinking*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

35. I lose most feelings of sexual interest after I've been drinking*Required

Please click in the circle beside the answer most appropriate to you

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
● Strongly agree

36. I am clumsier when drinking alcohol*Required

Please click in the circle beside the answer most appropriate to you

● Strongly disagree
● Disagree
● Neither agree nor disagree
● Agree
● Strongly agree
Confirmation Page

Thank you for answering all of the questions. In case the content of this questionnaire has been upsetting or distressing for you I have included a number of links to support agencies below which may be useful: http://www.aware.ie/ http://www.samaritans.org/ http://www.alcoholicsanonymous.ie/ http://www.drinkaware.ie/ http://www.psihq.ie/ If you have specific comments or questions please feel free to contact me at . Thank you again for your participation. Kate O'Donnell
Appendix B

COPE Brief (Carver, 1997)

Key

1 = I haven't been doing this at all

2 = I've been doing this a little bit

3 = I've been doing this a medium amount

4 = I've been doing this a lot

Scoring

Scales are computed as shown in Table 9 with no reversal of coding. A total score was computed for each subscale.

Table 9: Computation of the 14 COPE Brief subscales

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-distraction</td>
<td>1 + 19</td>
</tr>
<tr>
<td>Active Coping</td>
<td>2 + 7</td>
</tr>
<tr>
<td>Denial</td>
<td>3 + 8</td>
</tr>
<tr>
<td>Substance use</td>
<td>4 + 11</td>
</tr>
<tr>
<td>Use of emotional support</td>
<td>5 + 15</td>
</tr>
<tr>
<td>Use of instrumental support</td>
<td>10 + 23</td>
</tr>
<tr>
<td>Behavioural disengagement</td>
<td>6 + 16</td>
</tr>
<tr>
<td>Topic</td>
<td>Count</td>
</tr>
<tr>
<td>------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Venting</td>
<td>9 + 21</td>
</tr>
<tr>
<td>Positive reframing</td>
<td>12 + 17</td>
</tr>
<tr>
<td>Planning</td>
<td>14 + 25</td>
</tr>
<tr>
<td>Humour</td>
<td>18 + 28</td>
</tr>
<tr>
<td>Acceptance</td>
<td>20 + 24</td>
</tr>
<tr>
<td>Religion</td>
<td>22 + 27</td>
</tr>
<tr>
<td>Self-Blame</td>
<td>13 + 26</td>
</tr>
</tbody>
</table>
Appendix C

General Health Questionnaire-12 (GHQ-12) (Goldberg)

There are three groups of responses used in the questionnaire.

Question 1:

better than usual (0)

same as usual (1)

less than usual (2)

much less than usual (3)

Questions 2, 5, 6, 9 and 10:

not at all (0)

no more than usual (1)

rather more than usual (2)

much more than usual (3)

Questions 3, 4, 7, and 8:

more so than usual (0)

same as usual (1)

less so than usual (2)

much less than usual (3)
Scoring

All question were scored on a likert like scale from 0, 1, 2, 3, with no reversals of coding. A total score, within the range of 0 to 36 was computed for each participant. The original scoring system was adapted to avoid a diagnostic dimension. Scores were considered on a continuum of 0 to 36, with higher scores indicating higher levels of distress.