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Metacognitive beliefs about alcohol use: Development and validation of two self-report scales

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Abstract

The goal of this research was to develop clinical assessment tools of positive and negative metacognitive beliefs about alcohol use. In Study 1 we constructed two scales and conducted preliminary factor analyses. Studies 2 and 3 investigated the predictive validity and temporal stability of the scales. Study 4 examined the factor structure, predictive validity and classification accuracy of the scales in a clinical sample. The Positive Alcohol Metacognitions Scale (PAMS) and the Negative Alcohol Metacognitions Scale (NAMS) were shown to possess good psychometric properties, as well as predictive validity and classification accuracy, in both clinical and community populations. The scales may aid future research into problem drinking and facilitate clinical assessment and case formulation.
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1. Introduction

Metacognition refers to the psychological structures, beliefs, events and processes that are involved in the control, modification and interpretation of thinking (Flavell, 1979; Moses & Baird, 1999; Wells, 2000). The great majority of theorists would agree in drawing a distinction between two basic aspects of metacognition (Flavell, 1979; Wells, 2000; Yussen, 1985): metacognitive regulation and metacognitive

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knowledge (or metacognitive beliefs). Metacognitive regulation refers to a broad spectrum of executive functions, such as monitoring, planning, checking, attention and detection of errors in performance (Wells, 2000). Metacognitive knowledge refers to the information individuals hold about their internal states and about coping strategies that impact on them (Wells, 2000). Examples of metacognitive knowledge may include beliefs concerning the significance of particular types of thoughts (e.g. "Having thought X means I am weak") and emotions (e.g. "I need to control my anxiety at all times"), and beliefs about cognitive competence (e.g. "I do not trust my problem-solving capabilities"). Examples of information individuals hold about their own coping strategies that impact on internal states may include both positive ("Ruminating will help me find a solution") and negative ("My checking behaviour is making me lose my mind") beliefs. In the metacognitive conceptualization of psychological dysfunction (Wells & Matthews, 1994; Wells, 2000) all the above constructs interact in maintaining maladaptive behavior.

The Self-Regulatory Executive function (S-REF: Wells & Matthews, 1994, 1996) theory was the first to conceptualise the role of metacognition in the etiology and maintenance of psychological disturbance. In this theory Wells and Matthews (1994, 1996) argue that a common style of thinking across psychological disorders leads to dysfunction. They propose that psychological disturbance is maintained by a combination of perseverative thinking styles, maladaptive attentional routines, and dysfunctional behaviors. This array of factors constitutes a cognitive-attentional syndrome (CAS; Wells, 2000). The CAS is derived from the individual's metacognitive knowledge (or metacognitive beliefs), which is activated in problematic situations and drivers coping (such as alcohol use) (Wells & Matthews, 1994, 1996; Wells, 2000).

The S-REF theory has led to the development of disorder-specific models of depression (Papageorgiou & Wells, 2003), generalised anxiety disorder (Wells & Matthews, 1994; Wells, 2000), obsessive–compulsive disorder (Wells & Matthews, 1994; Wells, 2000), post-traumatic stress disorder (Wells, 2000) and social phobia (Clark & Wells, 1995). Metacognitive beliefs have been found to be positively associated with depression (Papageorgiou & Wells, 2003), hypochondriasis (Bouman & Meijer, 1999), obsessive–compulsive symptoms (Emmelkamp & Aardema, 1999; Hermans, Martens, De Cort, Pieters, & Eelen, 2003; Myers & Wells, 2005; Wells & Papageorgiou, 1998), pathological procrastination (Spada, Hiou, & Nikčević, 2006), pathological worry (Wells & Papageorgiou, 1998), post-traumatic stress disorder (Roussis & Wells, 2006), predisposition to auditory hallucinations (Baker & Morrison, 1998; Morrison, Wells, & Nothard, 2000), psychosis (Morrison, French, & Wells, 2007), smoking dependence (Spada, Nikčević, Moneta, & Wells, 2007) and test-anxiety (Matthews, Hillyard, & Campbell, 1999; Spada, Nikčević, Moneta, & Ireson, 2006).

Whilst the S-REF theory was initially intended to account for emotional disorders, recent work has examined its application in predicting alcohol use. In a series of preliminary investigations (Spada & Wells, 2005; Spada, Zandvoort, & Wells, 2007) evidence was found of: (1) a positive association between a general dimension of metacognition (beliefs about the need to control thoughts) and alcohol use that is independent of negative emotions; and (2) an independent contribution (over negative emotions) of general dimensions of metacognition (beliefs about the need to control thoughts and low cognitive confidence) towards category membership as a problem drinker.

Further research undertaken by Spada and Wells (2006) has identified the existence of specific positive and negative metacognitive beliefs about alcohol use in problem drinkers. Positive metacognitive beliefs about alcohol use can be conceptualised as a specific form of outcome expectancy relating to the use of alcohol as a means of controlling cognition and emotion. From a metacognitive standpoint such beliefs

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