3 Assessing Drinking and Related Behaviors

OVERVIEW OF THE CHAPTER

Assessment is the first step in programs tailored to the individual.[1] We noted in Chapter 1 that there is considerable drinking variability among college students. In this chapter, we suggest ways to evaluate an individual's drinking and related issues and make decisions based on this information. There are several reasons it is important to understand an individual student's drinking:

- Information about drinking allows us to refer or match students to appropriate services. We want to know *what*, *why*, and *how* a student drinks so that we can direct him or her to services that are most likely to be helpful.
- Information about drinking allows us to tailor what we or someone else says or does. Information about alcohol use and consequences, as well as attitudes and beliefs, can be used as the content or focus of prevention or treatment programs.
- Sincere and candid questions let a student know that we are interested in him or her. If conducted with good interviewing skills, questions can also communicate concern and empathy. They allow us to speak directly to the individual's experiences.

Assessment is not difficult, but getting ready to assess can be. It requires that we select certain questions from myriad options. This chapter presents options for assessment and, where possible, notes benefits and limitations of the different approaches. The context of the interaction—how we come into contact with students and how much time we have—will naturally affect options and choices. A 5-minute assessment in a student health center will look different from a 2-hour assessment in a psychology clinic, even though their purposes might overlap. In this chapter, we briefly review some of places where

[1]A prevention program targeted to an entire population typically would not include individual assessment.

assessment is used and make suggestions for best practices given different goals and settings. In Chapters 5 and 6, we provide additional suggestions for when and where different assessments might make sense when paired with different interventions. Finally, in Appendices A–E, we provide copies of several measures we have found especially helpful. Those who have only very brief interactions with students might want to concentrate on the Alcohol Consumption (p. 27) and Alcohol Screening (p. 35) sections of this chapter, which suggest ways to assess briefly how much a student is drinking and to determine whether to refer him or her for more specialized services.

This chapter is not intended as a complete review of drinking assessment, especially assessment related to research and program evaluation. Assessment for these purposes is explored in a large and complex literature; fortunately, the NIAAA (2004) has produced an excellent volume, *Assessing Alcohol Problems*, that discusses and reproduces many of the tests. In this chapter, we choose measures selectively based on their clinical use with college students. Research on college assessments is unfortunately limited, so in many cases we have had to take our best guess in making recommendations.

Our discussion is divided into three sections. We begin by reviewing assessments of *alcohol involvement*, including drinking rate, drinking-related negative consequences, and alcohol dependence. Next, we review *screening measures* that tap aspects of these dimensions. We finish by briefly noting options for *related areas*—problem recognition, beliefs in alcohol effects, drinking contexts, and family history of alcohol problems. In each section we give our preferences, and at the end of the chapter we provide a table that summarizes our recommendations.

A final note before we begin: Nearly all college alcohol assessments are self-report. In the past, individual self-reports about drinking have often been assumed to be biased. This is perhaps due to the historical notions that alcoholics are in denial and chronically lie to conceal their condition or that people won't admit to embarrassing things. However, considerable research suggests that self-reports can be reliable and valid indicators of drinking if the individual believes that he or she has nothing to lose based on the report, is sober when reporting, and is given assurances of confidentiality (Babor, Brown, & Del Boca, 1990; Maisto & Connors, 1990; Sobell & Sobell, 2004). In fact, in comparing self-reports to the reports of others, we find that college students are as likely to overestimate (brag) as they are to underestimate (minimize) their drinking (e.g., Marlatt et al., 1998). The greater problems, described below, are that students may not pay enough attention to what they are drinking or that the assessments themselves may be so vaguely worded that students have difficulty answering them accurately.

WHEN AND WHERE TO ASSESS DRINKING

University staff can use assessments in a variety of interactions. Formal appointments occur in medical, counseling, administrative, and academic settings. Sometimes appointments are brief—5 to 10 minutes for consultation on a particular topic. Informally, stu-

dents also interact with faculty before and after class, talk with resident advisors in the halls, and seek information from administrative staff. Sometimes appointments are more extended, as can be the case with voluntary counseling or referrals for violations of university policy. Alcohol assessments can also be used as part of routine or specialized screenings, such as check-ins at health center visits, new student orientations, or health and wellness classes. Of course, in many of these contexts, alcohol use may have nothing to do with the reason for the appointment. In fact, our experience suggests that, more often than not, alcohol is *not* the initial or stated purpose of the meeting, even when it ultimately becomes a topic of conversation.

Obviously, the nature of assessment will vary depending on the available time and purpose of the contact. Even in a very brief encounter, one or two questions about alcohol may be appropriate. With more time, an interview can provide information about other practices and risks. In Chapter 2, we described a rough grouping of different interactions based on available time, and in Chapters 5 and 6, we present specific exercises that can be used for brief advice, behavioral consultation, and longer motivational interventions. For purposes of our discussion of assessment, we use a parallel three-level system also based on available time: brief assessment (less than 5 minutes), moderate-length assessment (5–15 minutes), and extended-length assessment (more than 15 minutes). Brief assessments are appropriate during informal meetings and discussions when one only has time to ask a few questions and the use of questionnaires might be awkward. In fact, the information gained in such a short period is necessarily quite limited and typically can only be used to support brief advice (see Chapter 5). Moderate-length assessments may allow for the use of a brief structured interview or questionnaire, in addition to other informal questions. With more than about 15 minutes for assessment, there are many more options for gathering a variety of drinking-related information.

ALCOHOL CONSUMPTION

When considering alcohol *consumption*, three dimensions are typically assessed: drinking rate or pattern, drinking-related negative consequences, and alcohol abuse or dependence diagnoses.

Drinking Rate

As noted in Chapter 1, drinking rate can be looked at in terms of frequency (i.e., how often), quantity (i.e., how much), and specific episodes of heavy drinking. Although this seems like a simple procedure, it can be much more complicated in practice. For example, at a meeting in April 2000, researchers from 12 countries met to develop standards for assessing alcohol consumption. What resulted were 12 different academic papers and a summary paper that detailed 34 recommendations (Dawson & Room, 2000). For our discussion of drinking rate, we use a simple grouping of methods suggested by Sobell and

Sobell (2004): (1) *quantity–frequency (QF)* methods, which ask the individual to give an estimate of average quantity, frequency, or peak consumption over a period of time; and (2) *daily drinking (DD)* methods, which ask the individual to estimate how much he or she drank each day during an interval.

QF methods are commonly used in survey research. As described in Chapter 1, college students might be asked a question like:

How frequently have you consumed alcoholic beverages (beer, wine, spirits) over the past 90 days?

____ *Not at all*
____ *Less than once a month*
____ *One to two times a month*
____ *One to two times a week*
____ *Three to four times a week*
____ *Daily or almost daily*

A student's answer gives an estimate of the total number of times he or she consumed alcohol in a typical day, week, or month during this 90-day window. Of course, in a more informal setting, the student could be asked the same question without the categories.

Drinking *quantity* is slightly more complicated. As we mentioned in Chapter 1, different types of alcohol are made comparable by defining a "standard drink," typically described as 12 ounces of beer, 4 ounces of wine, or 1¼ ounces of 80-proof spirits. For instance:

When consuming beverages containing alcohol, on average, how many drinks do you have in one sitting? (A "drink" is defined as 12 ounces of beer, 4 ounces of wine, or 1¼ ounces of 80-proof spirits):

____ *One drink*
____ *Two to three drinks*
____ *Four to five drinks*
____ *Six to seven drinks*
____ *Seven to eight drinks*
____ *More than 8 drinks*

Again, this question can be asked in an open-ended format, without the categories. Note that the drinking categories and threshold for the highest category (e.g., "more than eight drinks") are essentially arbitrary. Some surveys use different categories that extend well into the teens.

Despite the attempt to standardize amounts, there are still many limitations to quantity measures like these. First, since beverages vary in size and alcohol content, most students are only vaguely aware of how much they are consuming or how much alcohol is in the drink. This may be particularly true at parties where students consume alcohol without

knowing exactly what is in the drink (e.g., "jungle punch"). Second, keg and tap beer is usually served in cups that are bigger than the 10- to 12-ounce standard drink size, which means that students may underreport drinking. Third, despite the assumption that mixed drinks contain a consistent one shot of 80-proof liquor, restaurants routinely serve drinks that contain much more or less alcohol than this. Likewise, those who self-mix might add well beyond one shot per drink. Even within a single establishment, alcohol content can vary with time of day. For instance, an inexpensive happy hour drink may be much weaker than the same drink at other times of the day. Finally, most college students (and other adults) simply don't count how many drinks they are having. To address some of these difficulties, assessments sometimes ask separate questions for each beverage type (e.g., how many beers, how many glasses of wine, how many shots/mixed drinks?). It can also be helpful to have pictures or examples of different sizes of glasses, pitchers, and bottles to help students more accurately estimate the amount they consumed. Pitchers of beer in the United States, for example, may hold 48 or 60 ounces.

More formal research-based QF measures sometimes assess quantity and frequency of different beverage types separately (Cahalan, Cisin, & Crossley, 1969) to compute a "volume–variability" index that puts drinkers into categories. These categories can be used to identify people who tend to bunch their drinks together. Complicated QF indices lose their simplicity, however. A common alternative used in studies of college students is to define a heavy-drinking episode, and then assess its frequency. For example, in the CAS surveys, students are asked:

- [For men] *How many times have you consumed five or more drinks in a row over the last 2 weeks?*
- [For women] *How many times have you consumed four or more drinks in a row over the last 2 weeks?*

The Daily Drinking Questionnaire (DDQ) is another attempt to measure episodic drinking in a QF format (Collins, Parks, & Marlatt, 1985; Dimeff, Baer, Kivlahan, & Marlott, 1999). In this measure, students are given a weeklong calendar and are asked to write in the number of drinks typically consumed on each day. The assessment portion of the Check-Up to Go (CHUG, Appendix G) uses a similar format, with spaces on each day for different types of beverages—beer, wine, and liquor. The advantage of this format is that it allows students to differentiate between moderate drinking on some days and heavy episodes on others, although, of course, they are still averaging to create a "regular" week that may not exist. As we mentioned in Chapter 1, students tend to be opportunistic drinkers, drinking around events rather than days of the week. To account for this partially, some measures provide a separate space to describe a particularly heavy episode during the past month.

The advantage of QF measures is their brevity and simplicity. Unfortunately, QF measures don't do as good a job measuring sporadic heavy drinking, which can be especially risky. QF measures also ask for mathematical averages, which most people are not

very good at estimating. As a result, QF measures tend to give lower estimates of drinking than do other kinds of measures (Sobell & Sobell, 1992).

The alternative, *daily drinking (DD) measures*, are more accurate than QF measures. DD measures, such as the Time Line Follow-Back (TLFB; Sobell, Toneatto, & Sobell, 1994) and the Form 90 (Tonigan, Miller, & Brown, 1997), use a calendar for specific period of time (e.g., the previous 90 days). Using "anchor" events, such as holidays, birthdays, and social events, individuals are asked to report how many and what kinds of alcoholic beverages they consumed on each day. Although at first blush this seems like an overwhelming task, the process actually works pretty well. Abstinent days are noted first, then regular patterns, and finally, specific instances of heavy drinking. The time it takes to complete a DD assessment varies with the length of the window (e.g., 30, 60, 90 days) and the amount of drinking the individual reports. From this assessment, any number of summary measures can be derived—frequency of drinking, average quantity, average quantity on weekends, heaviest day, etc. But the chief benefit of the DD format is the ability to capture drinking patterns without summarizing.

On the whole, DD measures generate more accurate information than do QF measures. In addition, DD methods minimize averaging and are thus more likely to reveal extreme or dangerous incidents. On the other hand, DD methods take more time to administer and require an interviewer trained in the method. These technical requirements cause most people to shy away from DD techniques, which is unfortunate. It takes time to gather accurate information about drinking.

Estimating Blood Alcohol Concentration

The most important factor in determining risk is blood alcohol concentration (BAC). This is partially because blood alcohol levels take into account the individual's gender, weight, and drinking rate.[2] Intuitively we know that five or more drinks in a row might be dangerous for a 100-pound female who drinks them all at once, but would mean little for a 200-pound male who drinks them over the course of a day. Thus, when used to make clinical decisions, assessments of drinking quantity should be adjusted based on weight, gender, and time. In Appendix J we include summary BAC cards that can help a student to estimate his or her own BAC. For a more personalized card, BAC Zone sells laminated cards that are customized based on gender and weight.[3]

To estimate peak BAC, we need gender, weight, and drinking rate. Gender and weight are usually straightforward. Those sensitive about their weight can be told that it will be helpful in calculating the amount of alcohol in their body. We also recommend asking students how long they spent drinking during a specific drinking episode. For instance, to inquire about drinking on a given evening, ask:

[2]BAC can also vary with food intake and hormonal fluctuations, but these differences are relatively small compared to the three main factors of gender, weight, and rate of consumption.

[3]For ordering information, see www.baczone.biz.

- *About what time did you begin drinking?*
- *About what time did you stop drinking?*

The difference between the answers is the length of the drinking episode. To calculate BAC, use the cards in Appendix J. Subtract 0.016 for each hour of drinking to arrive at the estimated peak BAC for the episode. DD techniques work well for collecting this type of information.

Some paper assessments collect information that can be used to calculate BAC. For example, the CHUG assessment (Appendix G; see also the DDQ used in Dimeff et al., 1999) asks students to write in the number of drinks they consumed on each day for different types of beverages, as well as the number of hours they spent drinking. The CHUG scoring sheet lists give websites that can automatically calculate BAC given this information. The CHUG feedback (Appendix G) also lists common experiences at different BAC levels.

Recommendations for Assessing Drinking Rate

Based on this quick review of assessment options for drinking rate, we offer the following general recommendations.

- *Be specific*. Avoid vague or closed-ended questions like "Do you drink?" and "Do you drink a lot?" Far better to ask "How many drinks did you have last Saturday night?" or "How typical was last Saturday of your drinking in the past 3 months?"
- *Limit averaging and estimating*. "How much did you drink last Saturday?" is better than "How much do you typically drink?" Similarly, "How many times have you had alcohol in the past 2 weeks?" is better than "On average, how frequently do you drink?" If using QF questions that require averaging, make intervals small (e.g., past week, past month). Assess separately by beverage type if possible.
- *Assess gender, weight, and the number of hours spent drinking during a heavy episode*. Keep this information in mind when calculating BAC.

In terms of the available time for assessment, we recommend:

- For *brief* encounters, ask two QF questions and one that taps episodic heavy drinking.
  1. *About how many times per week do you have something to drink?*
  2. *When you drink, about how many drinks do you consume in a typical day?*
  3. *During the last month, what's the most you consumed on one occasion?*
- For *moderate*-length encounters, use as much DD information as possible. Ask the student to describe a typical drinking week and one heaviest episode over the past month.

1. *If you think over the last month, how many drinks did you usually consume on a typical Monday? typical Tuesday? typical Wednesday?, etc.*
2. *During the last month, what's the most you consumed on one occasion?*
3. *On that day, when did you start drinking? When did you stop?*

- In *extended* meetings, use a DD assessment, such as the TLFB or Form 90 (see Sobell et al., 1994, or Tonigan et al., 1997, for instructions).

Negative Consequences

So much attention is given to *rates* of drinking that the *results* of drinking are often overlooked. This is unfortunate because, as we have mentioned, the consequences of drinking directly capture the things we are most interested in. Alcohol-related consequences also speak directly to the experiences of students. Students may vehemently defend their right to drink but are less likely to argue with the consequences. In addition, as we discuss in Chapters 5, 6, and 7, by highlighting the consequences of an individual's drinking, we hope to raise awareness and (if appropriate) increase the likelihood of change.

Several scales have been developed to assess drinking-related negative consequences among young adults. Among them are the Young Adult Alcohol Problems Screening Test (YAAPST; Hurlbut & Sher, 1992; Kahler, Strong, Read, Palfai, & Wood, 2004), the College Alcohol Problems Scale (CAPS and CAPS-r; Maddock, Laforge, Rossi, & O'Hare, 2001; O'Hare, 1997a), and the Drinking Practices Questionnaire (DPQ; Williams & Morrice, 1992). In addition, one scale developed for use with adolescents has been widely used with college students: the Rutgers Alcohol Problem Index (RAPI; White & Labouvie, 1989).

These scales generally ask individuals what experiences have occurred as a result of drinking and to rate the frequency of those experiences over a period of time. Items may tap obvious problems related to drinking, such as blackouts and tolerance, but might also query other experiences common to college students. For example, the YAAPST asks students, "Have you driven a car when you knew you had too much to drink to drive safely?" "Have you ever gotten into trouble at work or school because of drinking?" and "Have you ever received a lower grade on an exam or paper than you should have because of your drinking?"

There are several good consequence measures that can be completed in 5–10 minutes. The YAAPST contains 27 items (although Kahler et al., 2004, suggest that a 20-item version is just as informative), while the RAPI contains 23 items. The CAPS-r (Maddock et al., 2001) is even briefer—only 8 items—and is designed to tap two dimensions of alcohol problems: social (i.e., sexuality and driving) and personal (i.e., depression, sleep, irritability). Bear in mind that the purpose of these questions is to identify problems, not to diagnose dependence. As such, they do not generally have "cut" scores that will identify students at special risk. Also, most drinkers will report some negative consequences, so the endorsement of a few items should not be alarming in and of itself. Rather, these tests are useful for understanding students' individual experiences with alcohol. They show the

interviewer *how* and *how often* alcohol has interfered with a student's life. Such information can also be included in personalized feedback, a motivational tool discussed in Chapter 5.

Recommendations for Assessing Consequences

In brief encounters, questionnaires may take too much time. For a brief assessment of consequences, we suggest asking a few questions about the student's personal experiences that are most relevant to the goals of the conversation. For example, a worker in a student health center might choose questions about physical risks:

1. *How often in the past month have you driven a car shortly after drinking three or more drinks?*
2. *How often in the past month have you had a physical injury when you were drinking?*

In an academic counseling center, you might select experiences associated with academic performance:

1. *How often in the past month have you missed class because of drinking?*
2. *How often in the past month have you performed poorly on a test because of drinking?*

For moderate-length interactions, use the eight-item CAPS-r (see Appendix C). For extended interactions, use the YAAPST (see Appendix B).

Alcohol Dependence

We recommend assessing alcohol abuse and dependence only when there is time to explore symptoms carefully and when such information is clearly warranted. An assessment of alcohol dependence makes sense when students have repeatedly come to the attention of administrators, when previous interventions have been unsuccessful, or when placement in more intensive programs requires a diagnosis. The assessment of dependence symptoms can also be useful in other applications. For example, in providing personalized feedback, some students are shocked to learn that they already meet two criteria for alcohol dependence, even though they have only been drinking for a short period of time. In addition, group discussions of the nature of dependence can sometimes be informative and motivating.

As we discussed in Chapter 1, alcohol dependence is less common among college students than among older drinkers. As such, a diagnosis is usually not necessary to gain access to most college counseling programs. Furthermore, a diagnosis of alcohol dependence can take as long as 30–45 minutes. Table 3.1 summarizes the DSM-IV criteria for

TABLE 3.1. DSM-IV Substance Dependence Criteria

Tolerance
Needs increased amounts of alcohol to achieve the same effect, or has a reduced effect given the same amount of alcohol.
Withdrawal
Either a physical withdrawal when alcohol is removed, or alcohol (or a closely related substance) is used to avoid withdrawal.
Impaired control
Persistent desire or unsuccessful attempts to cut down or control drinking.
Increased consumption
Drinking in larger amounts or over a longer period than intended.
Neglect of activities
Important social, occupational, or recreational activities are given up or reduced because of drinking.
Time spent drinking
A great deal of time is spent obtaining alcohol, using it, or recovering from its effects.
Use despite problems
Continued use despite knowledge of physical or psychological problems caused or exacerbated by alcohol.

alcohol dependence. To receive a formal diagnosis of alcohol dependence, an individual must meet three of these criteria during a 12-month period and their presence must cause "clinically significant impairment or distress" (American Psychiatric Association, 1994).

For alcohol abuse, a less severe diagnosis, only one of the following criteria must be met during a 12-month period, and its presence must again cause "clinically significant impairment or distress":

- Failure to fulfill major role obligations
- Use in hazardous situations
- Legal problems
- Use despite interpersonal problems

Recommendations for Assessing Alcohol Dependence

Alcohol dependence can only be assessed in extended meetings. We recommend a standardized interview based on DSM-IV criteria, such as a checklist (see Hudziak et al., 1993 for a DSM-III-R version), the Structured Clinical Interview for DSM-IV (First, Spitzer, Gibbon, & Williams, 1995), or the Composite International Diagnostic Interview (Robins et al., 1989). Each of these interviews systematically queries abuse and dependence criteria, using specifically worded questions. Though comprehensive, there are also a number of trade-offs to using structured interviews, and the interested reader is referred to Maisto, McKay, and Tiffany (2004) for a thorough discussion. In most college treatment contexts, we prefer brevity. A checklist modified for DSM-IV from earlier versions (Hudziak et al.,

1993; see also Forman, Svikis, Montoya, & Blaine, 2004) takes the least amount of time and is preferred for that reason.

The Alcohol Dependence Scale (Skinner & Horn, 1984) offers a questionnaire-based option to the clinical interview. This 25-item questionnaire covers a range of cognitive, physiological, and behavioral aspects of alcohol dependence. Although not specially based on DSM criteria, the scale has good validity when compared against diagnostic interviews. A score of 9 or higher suggests high probability of some alcohol dependence (Ross, Gavin, & Skinner, 1990).

ALCOHOL SCREENING

In recent years, there has been considerable interest in developing brief and reliable measures to screen for *potential* alcohol-related problems. Alcohol screening measures are often used in primary care settings, where large groups of people present with health concerns. In our opinion, if campus medical practitioners regularly screened students in this way, the number of problem drinkers who slip through the cracks would be greatly reduced. Alcohol screening may also be appropriate in campus health centers, health classes, and other administrative and counseling offices.

Screening questionnaires come in various lengths—from as little as 3 questions to as many as 30 (see Connors & Volk, 2004, for a review). One simple screen for alcohol problems is the CAGE (Ewing, 1984; Mayfield, McLeod, & Hall, 1974), an acronym for four questions related to the desire to *C*ut down, feeling *A*nnoyed by criticism, feeling *G*uilty about drinking, and needing alcohol in the morning (*E*ye-opener). Given how nonspecific and extreme these items are, it is surprising that the CAGE works at all. But surprisingly, this simple measure is often quite effective in detecting severe alcohol problems in some populations (see Kitchens, 1994, for a review). Unfortunately, the CAGE does a poor job identifying alcohol problems among younger or less severe drinkers (Heck & Lichtenberg, 1990; Smith, Collins, Kreisberg, Volpicelli, & Alterman, 1987). This is also true of another popular screening tool, the Michigan Alcoholism Screening Test (MAST; Selzer, 1971) and the Brief MAST (Pokorny, Miller, & Kaplan, 1972; see Clements, 1998, for a thoughtful review). A number of modifications to the CAGE, such as the TWEAK (Chan, Pristach, Welte, & Russell, 1993), have produced improvements for some subpopulations. One variation on the CAGE replaces the question about being "Annoyed" with a question about "often driving *U*nder the influence of alcohol," thus creating the CUGE acronym. A recent study by Aertgeerts and colleagues (2000) suggests that this acronym may do a better job of identifying problematic college drinkers than the CAGE.

We believe the best screening tool for college students is the Alcohol Use Disorders Identification Test (AUDIT; Saunders, Aasland, Babor, De La Fuente, & Grant, 1993; see Appendix A). The AUDIT was developed by the World Health Organization to detect harmful alcohol consumption (as opposed to alcoholism). The AUDIT has been evaluated in many different populations around the world, including college students. The AUDIT contains 10 questions scored from 0 to 4 points (maximum score = 40): three questions on

the amount and frequency of drinking, three questions regarding alcohol dependence, and four questions on alcohol-related problems. Among adults, a score of 8 or more indicates a high likelihood of an alcohol use disorder (Saunders et al., 1993).

Not surprisingly, the AUDIT typically outperforms other screening measures in college populations (Aertgeerts et al., 2000; Clements, 1998). Aertgeerts and colleagues (2000) found that a cut score of 6 provided the best discrimination for identifying problem drinking in a large group of European college students, and a similar result has been recently noted by Kokotailo and colleagues (2004) in an American sample. In an effort to make the process even briefer, researchers recently found that the first three items of the AUDIT (called the AUDIT-C), or in some cases just question #3 ("How often do you have six drinks or more on one occasion?"), identified alcohol problems among primary care patients in a Veterans Affairs hospital (Bradley et al., 2003). However, to our knowledge, this ultra-brief version of the AUDIT has not been tested with college populations.

Recommendations for Alcohol Screening

We recommend that college providers use the 10-question AUDIT to screen students for alcohol-related problems and use a score of 6 or more as an indicator of high-risk drinking and 8 or more as an indicator of a possible alcohol use disorder. (Further assessment, of course, would be necessary to confirm these indications.) The AUDIT is brief enough to be used in many contexts. In student health and counseling centers, we recommend that the AUDIT be included in the intake packet for all new patients.

If there is not time for the full 10-item AUDIT, we recommend asking the first three questions:

- *How often do you have a drink containing alcohol?*
- *How many drinks containing alcohol do you have on a typical day when you are drinking?*
- *How often do you have six drinks or more on one occasion?*

Decision rules for these three items in college students have not been tested to date. In the absence of data, we encourage the provider to use the student's answers to initiate a conversation about any alcohol-related difficulties and recommend at least brief advice if the student reports any episode of six or more drinks in the past month.

RELATED AREAS

Besides alcohol *involvement*, there are social and psychological factors that are often associated with alcohol use. For those interested in a more complete discussion of these areas, we suggest a review by Donovan (2004). Also, the BASICS manual (Dimeff et al., 1999)

describes a number of assessments that can be useful for providing feedback to students about alcohol. We note just a few options here.

In a brief interaction, it is impossible to assess all the psychological and social factors related to alcohol. Even in a moderate-length interaction, options can be limited. However, with more available time, additional assessments can provide a broader understanding of the individual and supply information for providing feedback (see Chapter 6). Here we describe four dimensions that may be helpful in understanding young adult drinking: motivation, beliefs about alcohol's effects, drinking contexts, and family history of alcohol problems.

Motivation

Motivation or *readiness to change* describes a student's degree of interest in changing. As noted in Chapter 2, most college drinkers are either *precontemplators* or *contemplators*. Precontemplators do not see their alcohol use as a problem and rarely request help in changing behavior. Contemplators are wondering about or considering their options, but are not yet engaged in making changes. Therefore, a reasonable goal of an interaction may only be to raise concerns about drinking or to stimulate thoughts about change. Carey, Purnine, Maisto, and Carey (1999) have provided a thorough review of assessments related to assessment of readiness to change (see also Donovan, 2004). The key limitation for our purpose is that most scales designed to assess readiness, such as the University of Rhode Island Change Assessment (URICA; McConnaughy, Prochaska, & Velicer, 1983, 1989) and the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES; Miller & Tonigan, 1996), were developed with individuals either seeking or already in treatment for alcohol problems. Wording in these measures often refers to a recognition of problems related to alcohol and a desire to abstain from drinking. Because of this, these assessments can seem odd to many college students. They appear most useful for those students in formal counseling for alcohol problems or who have been referred for significant infractions (e.g., DUI).

A better scale to use with college students is the Readiness to Change Questionnaire (RTCQ; Rollnick, Heather, Gold, & Hall, 1992; see Appendix D). The RTCQ was developed for use in medical settings with individuals not seeking help for alcohol problems. It is brief (12 items), and the questions are more subtle—for instance, the word "problem" is avoided. Items include "My drinking is okay as it is," and "I am at the stage where I should think about drinking less alcohol."

For very brief interactions, the RTCQ is probably too lengthy. An alternative is the "Importance and Confidence Rulers" discussed in Chapter 5, which consists of two scaled questions about the importance and confidence of change.

- *On a scale of 1–10, how important is it for you to make a change in your drinking?*
- *On a scale of 1–10, how confident are you that you could change your drinking if you wanted to?*

The student's responses to these two questions give a quick indicator of two areas related to motivation—importance and confidence. The questions can also be worded differently, depending on what the clinician wants to assess. For instance, "How important is it for you to be safe when you drink?" is another alternative. In addition to gathering information about motivation, these questions can be part of the brief motivational exchange discussed in Chapter 5.

Alcohol Expectancies

Beliefs in alcohol effects describe people's expectations of what will happen when they drink. For instance, young adults commonly expect that alcohol will relieve anxiety, make parties more fun, and make them more attractive. Whether accurate or not, these beliefs are related to drinking. Knowing what a student expects from alcohol can also help the clinician understand reasons why he or she drinks and can reveal areas where students might feel less competent if they chose to make a change.

There are several options for assessing alcohol expectancies. We recommend the Comprehensive Effects of Alcohol scale (CEOA; Fromme, Stroot, and Kaplan, 1993; see Appendix E), which queries both positive and negative expectations about drinking. The CEOA asks students to identify ways they expect to feel after drinking—sexy, clumsy, sociable, and so on. We like the CEOA because it asks students to rate each effect in two ways: the likelihood that the effect will occur and how good or bad the student believes the effect will be. This combination allows the interviewer to tell whether the effects rated more likely to occur are also the ones rated most positively.

Drinking Context

Drinking context describes the social and psychological environments where drinking takes place (Thombs, Wolcott, & Farkash, 1997). Contexts vary depending on age, gender, living situation, and the function that alcohol serves at different times and places. There is some overlap here with the concept of alcohol expectancies, but drinking context scales can provide additional information about the things that surround drinking. For example, an individual may expect anxiety reduction from alcohol but drink only in social situations. A person like this is probably drinking for a different purpose than someone else who expects anxiety reduction but drinks alone.

Two different measures have been developed to assess drinking contexts. Using a group of high school students, Thombs and Beck (1994) developed a Social Context of Drinking Scale, with subscales assessing social facilitation, emotional pain, peer acceptance, family, sex seeking, and motor vehicle. O'Hare (1997b) offers a less comprehensive but more focused 23-item Drinking Context Scale, with three subfactors assessing convivial drinking, private intimate drinking, and negative coping. The O'Hare scale was developed with college students and appears to be the better option.

Family History

Family history of alcohol problems describes the extent to which a student has blood relatives who have had problems related to alcohol. Although family history of alcoholism is not a strong predictor of drinking during the college years (see Chapter 2), it can be a risk factor for alcohol problems later in life. The risk increases if the relatives are numerous, the same gender, and/or more closely related to the student. For this reason, we find that many students privately worry about their personal risk based on what they know about their families. Students want to know if they are at higher risk for developing alcohol problems not only currently, but over the next 10 or 20 years.

There are two brief techniques for assessing alcohol problems among relatives. One option is the Family Tree Questionnaire (FTQ; Mann, Sobell, Sobell, & Pavan, 1985), where students are presented with a picture of a family tree. After placing first- and second-degree relatives on the tree, a set of questions is asked about each person, indicating whether he or she experienced alcohol-related problems. If desired, the FTQ also provides a flexible method for assessing broader family trees and selected parts of families.

For briefer encounters, the student can be asked to give the number of blood relatives who are now, or have been in the past, problem drinkers or alcoholics:

> *Think about the number of your **blood relatives** who are now, or have been in the past, problem drinkers or alcoholics.*
>
> *Number of parents?* ____
> *Number of brothers and sisters?* ____
> *Number of grandparents?* ____
> *Number of uncles and aunts?* ____
> *Number of first cousins?* ____

The student receives two points for each first-degree relative (parent, brother, sister) and one point for each second-degree relative (grandparents, aunts, uncles, cousins). Using categories developed by the NIAAA (Miller, Zweben, DiClemente, & Rychtarik, 1995), the total number of points gives the student an estimated risk of low, medium, high, or very high (see Appendix G, Feedback Form, Section 3). Of course, even without an aggregate score, these assessments may provide interesting talking points about a student's family history.

CONCLUSION

In this chapter, we presented options for assessing drinking and related areas. Table 3.2 gives a summary of our recommendations. Given the central role of alcohol on campus, we strongly urge practitioners to regularly screen students who might be at risk. Almost any question about alcohol is better than nothing! A few key screening or consumption ques-

TABLE 3.2. Summary of Recommended Assessment Measures

	Time required		
Dimension	Brief (1–5 minutes)	Moderate (5–15 minutes)	Lengthy (15 minutes)
Consumption	Quantity–frequency Questions[a]	Daily Drinking Calendar[a]	Time Line Follow-Back (TLFB; Sobell et al., 1994)
Consequences	College Alcohol Problems Scale—Revised (CAPS-r; Maddock et al., 2001)[a]	Young Adult Alcohol Problems Screening Test (20-item YAAPST; Hurlbut & Sher, 1992)[a]	Same
Dependence			DSM Checklist (Forman et al., 2004; Hudziak et al., 1993)
Screening	Alcohol Use Disorders Identification Test (AUDIT-C; first three questions from the AUDIT; Bradley et al., 2003)[a]	AUDIT (Saunders et al., 1993)[a]	Same
Motivation	Importance and Confidence Rulers (Rollnick et al., 1999)[a]	Readiness to Change Questionnaire (RTCQ; Rollnick et al., 1992)[a]	Same
Expectations		Comprehensive Effects of Alcohol Scale (CEOA; Fromme et al., 1993)[a]	Comprehensive Effects of Alcohol Scale—Full Version
Context		Drinking Context Scale (DCS; O'Hare, 1997b)	Same
Family history	"Number of blood relatives" question (Miller et al., 1995)[a]	Same	Family Tree Questionnaire (FTQ; Mann et al., 1985)

[a]Measure reproduced in this book.

tions can be asked in less than three minutes. Unfortunately, our sense is that very few college providers ever ask students about their alcohol use. We suspect that many omit this important step not from a lack of awareness, but from a lack of time and knowledge of what to ask and perhaps from a fear about asking questions that might seem intrusive or rude. With all the important health issues vying for attention, we recognize that student service and health personnel are in a bind: too many questions about too many things in too little time. While we can't solve the larger problem of multiple demands on health services, we

have tried to offer a few ways to quickly assess alcohol-related difficulties, as a prelude to a referral or brief intervention. Alcohol use can and should be discussed without judgment or embarrassment. Thus, we suggest an open, honest, and calm assessment style. The strategies we present in the next chapters can be helpful in setting a respectful tone for conversations about alcohol.

KEY POINTS

- Assessment helps us to better understand why a student drinks and tailor our approach to his or her needs. The assessment process need not take a long time—you can accomplish a lot with just a few basic questions.
- Planning assessments is important. Consider the purpose of the assessment and consider how much time you can realistically take.
- Limit questions that ask a student to report consistent patterns or average drinks over days, weeks, or months. As much as possible, ask about specific episodes of heavy drinking.
- When assessing drinking amount, be specific about the time frame. To estimate a peak BAC, ask about gender, weight, and time spent drinking.
- A detailed assessment of alcohol dependence or abuse is probably not necessary for working with most students, unless the student is showing other signs of risk. Rather, assessing alcohol-related consequences can be helpful in understanding the difficulties a student might be having related to alcohol.
- Brief screening tools, such as the AUDIT, can be useful for identifying students at special risk and for initiating a conversation about alcohol.
- Areas related to drinking, such as motivation, expectancies, drinking context, and family history are helpful in understanding why a student drinks, what reasons he or she might have to change, and what difficulties he or she might encounter in the future.

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