Alcohol Problems in Intimate Relationships: Identification and Intervention

A Guide for Marriage and Family Therapists

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NIAAA
National Institute on Alcohol Abuse and Alcoholism

ALCOHOL PROBLEMS IN INTIMATE RELATIONSHIPS: IDENTIFICATION AND INTERVENTION

A Guide for Marriage and Family Therapists

February 2003

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We would like to acknowledge William F. Northey, Jr., Ph.D., of the American Association for Marriage and Family Therapy (AAMFT) for acting as the catalyst for this partnership, and for his wisdom in sharing with us the results of an AAMFT/CSAT survey that revealed 84%-88% of marriage and family therapists treat clients with primary or secondary alcohol problems.

NIAAA is deeply appreciative of our two principle authors, Linda Roberts (Alcohol Problems and Practice; Screening and Problem Assessment), and Barbara McCrady (Brief Interventions and Longer Term Approaches) for their careful attention to all aspects of this project. We must also recognize the team at Z-Tech Corporation - Jill Kooyman, Caspar Stuart, Cara McVeigh, M.P.H., Jeffrey Sorrells, Kellie Thompson, and Karen Vasquez - for their editing and design perspective and their good humor throughout this project; as well as Claudia Montana, Michael Bowers, M.A., and Karen Gautney, M.S., of AAMFT, who provided their support and expertise.

Special recognition must also be extended to NIAAA staff members Peggy Murray, M.S.W., for her expertise and never letting us forget the importance of this project; Maureen Gardner and Diane Miller, M.P.A., for their ongoing guidance; Mary C. Dufour, M.D., M.P.H., Deborah Dawson, Ph.D., Thomas Gentry, Ph.D., Kenneth R. Warren, Ph.D.; Gregory Bloss, M.A.; and Susan Farrell, Ph.D., who lent their scientific expertise at various points in this project; and Kathy Grady for her program support, particularly in managing the information flow.

We would also like to acknowledge the external and internal reviewers who provided their invaluable feedback and knowledge: Sharon G. Barnes, Ph.D.; Elizabeth Park, Ph.D.; Laura A. Mohr, Ph.D.; Meri L. Shadley, Ph.D.; Ann W. Lawson, Ph.D.; Joseph Worth, M.A., LPC, NCC; Captain Ann G. Mahony, M.P.H., and Herman I. Diesenhaus, Ph.D., of SAMHSA; as well as Cherry Lowman, Ph.D., Geoffrey Laredo, M.P.A., and Fred Donodeo, M.P.A., of NIAAA.

Finally, NIAAA acknowledges the tireless efforts of Kelly Green Kahn, M.P.A., for encouraging the Institute to address this topic with AAMFT, and for her dedication and perseverance in the overall management of this project to its fruition.

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This Guide was developed as a project under the National Institute on Alcohol Abuse and Alcoholism (NIAAA), Alcohol Research to Practice Network, which underscores NIAAA's focus on the crucial link between research and practice, and the interdependence between the research and services communities. The goal of the Network is to foster the application of alcohol research as an important part of the solution for solving human problems by encouraging the adoption of research advances into the prevention and treatment of alcohol abuse and alcoholism.

Table of Contents

PURPOSE OF THE GUIDE

As a marriage and family therapist, you are likely to see many individuals, couples, and families in your practice who are experiencing or are at risk of experiencing significant alcohol-related problems. This Guide will:

- Introduce you to an "alcohol problems framework" and its implications for alcohol treatment and intervention.
- Provide you with background information on defining characteristics and prevalence of a range of alcohol problems.
- Describe the significance of alcohol problems in the couple and family context.
- Encourage you to adopt a universal screening procedure in your practice for quick and efficient identification of undetected alcohol problems.
- Provide you with a "Clinical Toolbox" to conduct effective screenings and assessments of alcohol problems.
- Help you to decide whether to treat, when to treat, and how to select an appropriate intervention.
- Teach you the essentials of providing brief interventions for alcohol problems.
- Examine a range of treatment alternatives and discuss the factors to consider in choosing a treatment strategy or making a referral.
- Provide you with a number of resources that will help you utilize the various treatment strategies available or make a referral to specialty treatment alternatives when appropriate.

An Alcohol Problems Framework

Since the 1930s, "alcoholics" have been the primary focus of alcohol-related intervention efforts in the United States. While a focus on severe problems is typical of an initial societal response to a health problem,[1] alcohol dependence represents only a small portion of the entire range of alcohol-related problems.[2] Most drinking problems are of mild to moderate severity[3] and are amenable to relatively brief interventions.

In a report to the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the Institute of Medicine (IOM)[4] called for a "broadening of the base for treatment" and widespread adoption of an alcohol problems framework. This framework casts a wide net for treatment efforts, explicitly targeting individuals (or families) who currently are experiencing or are at risk for experiencing alcohol problems. Thus, therapists and health care professionals are asked to direct interventions not only to drinkers with alcohol use disorders, but also to problem drinkers and "at-risk" drinkers.

Alcohol Use Disorders

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition[5] (DSM-IV) recognizes two alcohol use disorders: alcohol dependence and alcohol abuse.

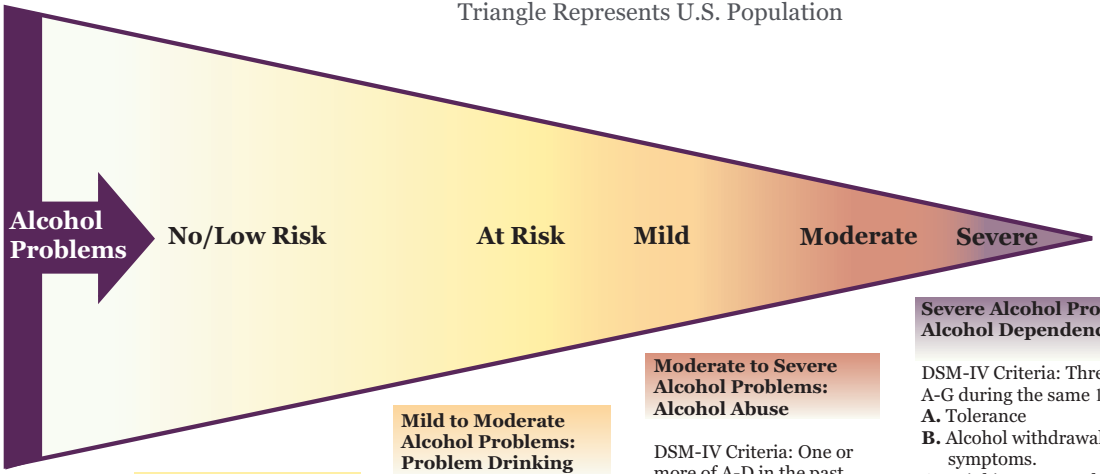
- Alcohol dependence is characterized by multiple symptoms, including tolerance, signs of withdrawal, diminished control over drinking, as well as cognitive, behavioral, and/or physiological symptoms that suggest the individual continues to drink despite experiencing significant alcohol-related problems.
- Alcohol abuse, on the other hand, is a maladaptive pattern of drinking that leads to clinically significant impairment or distress. An individual diagnosed with alcohol abuse drinks despite alcohol-related physical, social, psychological, or occupational problems. Alcohol abuse does not necessarily entail a consistent pattern of heavy drinking, but is defined by the adverse consequences associated with the drinking pattern.

Problem Drinking and Risky Drinking

As it is commonly used, "problem drinking" often is synonymous with "alcoholism." Among professionals, however, increasingly it is used to describe nondependent drinking that results in adverse consequences for the drinker.[6] In contrast to the dependent drinker, the problem drinker's alcohol problems do not stem from compulsive alcohol seeking, but often are the direct result of intoxication. Problem drinking

Figure 1. A Continuum of Alcohol Problems

Triangle Represents U.S. Population



At Risk for Alcohol Problems: Risky Drinking

A. Current drinking patterns (amount or situation of drinking) place drinker at risk for adverse consequences.
B. Is not already experiencing consequences due to drinking behavior.
C. Does not meet criteria for Alcohol Dependence.

Mild to Moderate Alcohol Problems: Problem Drinking

A. Experiencing adverse consequences due to drinking behavior.
B. Does not meet criteria for Alcohol Dependence.

Moderate to Severe Alcohol Problems: Alcohol Abuse

DSM-IV Criteria: One or more of A-D in the past 12 months *and* E.
A. Role impairment.
B. Hazardous use.
C. Recurrent legal problems related to alcohol.
D. Social or interpersonal problems due to alcohol.
E. Does not meet criteria for Alcohol Dependence.

Severe Alcohol Problems: Alcohol Dependence

DSM-IV Criteria: Three or more of A-G during the same 12-month period.
A. Tolerance
B. Alcohol withdrawal signs or symptoms.
C. Drinking more or longer than intended.
D. Persistent desire or unsuccessful attempts to control use.
E. Excessive time related to alcohol.
F. Reduction in social, recreational, or work activities due to alcohol.
G. Use despite knowledge of physical or psychological consequences.

represents a broader category than alcohol abuse disorder. The problem drinker may or may not have a problem severe enough to meet criteria for alcohol abuse disorder.

Even small amounts of alcohol consumed during pregnancy or in combination with certain medications may result in significant adverse consequences and therefore constitute risky drinking.

While problem drinkers are currently experiencing adverse consequences as a result of drinking, risky drinkers consume alcohol in a pattern that puts them at risk for these adverse consequences. Risky drinking patterns include high-volume drinking, high-quantity consumption on any given day, and even any consumption, if various medical or situational factors are present. Consumption is quantified in terms of standard drinks, which contain approximately 14 grams, or .6 fluid ounces, of pure alcohol (*See Appendix B for a graphic portraying standard drink equivalencies for popular alcoholic beverages*). Risky drinking can be determined by identifying one or more of the patterns below:

- High-volume drinking: 14 or more standard drinks per week on average for males, and 7 or more standard drinks for females.
- High-quantity consumption: Consumption on any given day of 5 or more standard drinks for males, and 4 or more standard drinks for females.
- Any consumption within certain contexts: Even when small quantities of alcohol are ingested, drinking is risky if it occurs within contexts that pose a particular danger, for example, during pregnancy, when certain health conditions are present, when certain medications are taken, etc.

The Continuum of Alcohol Problems

Alcohol problems can range in severity from mild, negative consequences in a single life situation to severe alcohol dependence with significant medical, employment, and interpersonal consequences. As shown in Figure 1, alcohol use and its associated problems can be viewed on a continuum—ranging from no alcohol problems following modest consumption, to severe problems often associated with heavy consumption.

The Prevalence of Problems

Alcohol abuse and alcohol dependence are among the most prevalent mental disorders in the United States.[7] In 1992, 7.4% of U.S. adults aged 18 years and older—roughly 14 million Americans—were found to have an alcohol use disorder (alcohol dependence or abuse).[8] (*See Table 1.*)

Table 1. 12-Month Prevalence Rates for Alcohol Problems in the United States

Alcohol Problem	Men	Women	Black[a]	White[a]	Hispanic	Total
Alcohol Dependence [b]	6.3	2.6	3.8	4.3	5.8	4.4
Alcohol Abuse and Dependence combined [b]	11.3	4.1	5.3	7.7	8.3	7.4
At least one alcohol problem indicator [c]	27.0	14.8	16.3	21.7	20.0	20.7
Risky consumption levels [d]	40.6	23.9	22.3	34.1	29.7	31.9

Notes:
Rates are for percentages of U.S. adult population and are based on data from the 1992 National Longitudinal Alcohol Epidemiologic Survey (NLAES); a nationwide household survey of 42,862 adults age 18 years and older conducted in conjunction with the 1992 census and sponsored by the National Institute on Alcohol Abuse and Alcoholism.

a. *These categories include non-hispanic blacks and whites.*
b. *Based on DSM-IV criteria.*
c. *Defined as those who reported experiencing any of the 31 symptoms or consequence indicators for alcohol use disorders in the NLAES interview.*
d. *For men, defined as exceeding weekly or daily limits by drinking more than 14 drinks per week on average, or drinking 5+ drinks on any given day at least once in the past 12 months; for women, defined as exceeding weekly or daily limits by drinking more than 7 drinks per week on average, or drinking 4+ drinks on any given day at least once in the past 12 months.*

Population estimates for alcohol use disorders do not include the millions of adults who experience less severe alcohol-related problems or who engage in risky drinking patterns that could potentially lead to problems. Criteria for alcohol use disorders are relatively clear, but establishing a "cut-off point" to separate problem drinkers from non-problem drinkers is difficult, making population estimates more problematic.[9] Although a pattern of recurrent trouble related to alcohol may indicate a more serious alcohol problem, experiencing any alcohol-related problem is cause for concern.[10] As shown in Table 1, a recent national study found that approximately 21% of Americans experienced at least one alcohol-related problem in the prior year, and roughly 1 in 3 Americans engaged in risky drinking patterns.

These base rates for alcohol problems and risky drinking are high in the general population, but they are considerably higher in clinical populations. Given the high rates of co-morbidity between alcohol use disorders and other psychiatric disorders, and the strong association that exists between drinking behavior and mood regulation, stress, and interpersonal and family problems, a high proportion of individuals, couples, and families who present for therapy may be experiencing or may be at risk for alcohol problems.

Alcohol Problems: The Couple and Family Context

When someone experiences alcohol problems, the negative effects of drinking exert a toll, not only on the drinker, but also on their partner and other family members.[11] Recent data suggest that approximately one child in every four (28.6%) in the United States is exposed to alcohol abuse or dependence in the family.[12]

One of the clearest demonstrations of how alcohol use negatively impacts the family is the widely documented association between alcohol use and interpersonal violence.[13] Family problems that are likely to co-occur with alcohol problems include:[14]

- Violence
- Marital conflict
- Infidelity
- Jealousy
- Economic insecurity
- Divorce
- Fetal alcohol effects

Epidemiological data confirm the well-known discrepancy in rates of alcohol problems for men and women. Men are nearly three times more likely than women to have alcohol use disorders and about twice as likely to experience mild to moderate alcohol problems and to engage in risky drinking. However, women have higher rates of morbidity and mortality from alcoholism than men.

Drinking problems may negatively alter marital and family functioning, but there also is evidence that they can increase as a consequence of marital and family problems.[15] Thus, drinking and family functioning are strongly and reciprocally linked.[16] Not surprisingly, alcohol problems are common in couples that present for marital therapy,[17] and marital problems are common in drinkers who present for alcohol treatment.[18]

Implications for Intervention

The alcohol problems framework explicitly recognizes tremendous heterogeneity in the severity, duration, progression, etiology, consequences, and manifestations of alcohol problems. If you wish to address alcohol problems in your individual, marital, or family practice, this heterogeneity requires that you are equipped with:

- A means to identify individuals with alcohol problems or those at risk for problems.
- Procedures for further assessment to determine the nature and severity of the problem, and to guide treatment decisions.
- Knowledge of a range of educational and clinical interventions that can be matched to the nature and severity of the problem.

The next sections of this Guide (and the Appendices) will supply you with these requisite tools and information.

SCREENING AND PROBLEM ASSESSMENT

Given the prevalence of drinking problems and the serious consequences that can result, brief screening procedures should be used routinely in your clinical practice to identify individuals who are experiencing or are at risk for experiencing alcohol problems. Before making any treatment decisions, a multi-dimensional problem assessment, which covers alcohol use patterns, dependence signs and symptoms, and alcohol consequences should be performed.

The tools we recommend for screening and assessment are flexible enough to be used with adults in individual, couple, or family therapy contexts. At times, you will be required to screen and assess alcohol use in adolescents, but such assessments are beyond the scope of this Guide. *For information on the assessment and diagnosis of alcohol use disorders in adolescents, see www.niaaa.nih.gov/publications/arh22-2/95-106.pdf.*

Appendix A features copies of exemplary instruments for both screening and problem assessment, creating a complete "Clinical Toolbox" for you to use in your practice.

SCREENING FOR ALCOHOL PROBLEMS

The objectives of a brief screen are to:

- Identify individuals or families experiencing alcohol-related problems.
- Identify individuals or families at risk for developing alcohol-related problems.
- Determine the need for further assessment and intervention.

Given the relative ease of conducting a screen, the high rates of alcohol problems in those presenting for treatment, and the availability of effective interventions, **all adult family members who present for therapy should be screened routinely for alcohol-related problems.** Since recurrent psychological, relationship, or family problems often are secondary to alcohol problems, screening for alcohol problems in settings where these problems typically are treated is especially important.

If an individual presents for therapy with a self-identified alcohol problem, it is prudent to skip the screening step and move directly to further assessment of the alcohol problem. However, screening should be conducted routinely with other presenting adult family members (e.g., the spouse). Even in the context of individual therapy, it is useful to routinely gather information from the client about the alcohol use of their spouse or other adult family members who are not present to determine whether a family member's drinking may be contributing to the client's problems.

Screening Instruments

A number of standardized screening instruments are available to help you quickly identify current and potential alcohol problems. These brief screening tools are designed to identify as many potential cases as possible, while at the same time minimizing false positives. Recommended tools include:

- The 10-item Alcohol Use Disorders Identification Test (AUDIT).[19]
- The 4-item CAGE.[20]
- The 25-item Michigan Alcoholism Screening Test (MAST),[21] or one of its derivatives: SMAST,[22] BMAST,[23] or VAST.[24]

Each of these instruments has been empirically validated and is quick and easy to administer. Screening generally takes less than 5 minutes. Screening questions should be addressed to each adult family member, with collateral reports used when necessary, or in addition to self-reports. *Further details on these and other screening tools are available at the NIAAA Web site under Alcoholism Treatment Assessment Instruments at www.niaaa.nih.gov/publications/instable.htm.*

The instruments can be either self-administered, for clients who have sufficient reading ability, or used in a face-to-face structured interview format. Based on the presenting problem, time constraints, family constellation, and other factors, you will need to determine whether the screening protocol is most effectively delivered in an interview format during the session, or whether it would be more effective to have individual family members complete paper or computer-assisted assessments. The interview format allows you to probe further and reconcile inconsistencies, but it may not be an efficient use of limited session time—especially when multiple family members need to be assessed.

Alcohol Problem Assessment

Screening for alcohol problems should be considered only a first step. Screening alone does not provide enough information to make either a diagnosis or an informed treatment decision. If an individual or family screens positive, i.e. there are indications of risk, further assessment is required to confirm the problem and to determine its nature, extent, and severity.

Since screening instruments are designed to err on the side of inclusion, (i.e., to maximize *sensitivity* rather than *specificity*), the initial goal of a more intensive problem assessment is to confirm or rule out the presence of an alcohol problem.

Primary goals of the problem assessment are to:

- Determine whether the drinking is related to the presenting problem—either directly or indirectly.
- Determine the severity of the alcohol problem, and in some cases, provide a diagnosis.
- Obtain a detailed picture of the cognitive, affective, and motivational aspects of the drinking behavior.
- Collect information that will form the basis of feedback to the drinker and/or the drinker's family.
- Determine which of the available treatment options is most appropriate.
- Guide decision-making related to the treatment plan.

Three essential domains that any alcohol assessment should cover are: (1) level and pattern of alcohol use; (2) dependence symptoms and the severity of the problem; and (3) consequences of alcohol use.

Although our overview is limited to a review of assessment strategies and instruments related specifically to alcohol problems, a broader assessment that covers other areas of psychological and interpersonal functioning is recommended prior to clinical intervention. Clinician skill and preference, as well as client literacy, will determine whether self-report instruments or interviews are selected.

Level and Pattern of Alcohol Use

Self-reports of the frequency and quantity of recent alcohol use remain the most reliable indicators of alcohol consumption patterns available. However, if the person is intoxicated at the time of assessment or has a severe drinking problem, consumption measures may not be accurate[25] and should be corroborated with other markers of drinking behavior, such as biomedical markers or collateral (e.g., a spouse) reports.[26] There are three major types of methods for assessing consumption, each of which has particular strengths and weaknesses:

- **Quantity-Frequency (Q-F) Methods**. Standard questions about how much and how often someone drinks yield typical frequency (number of days drinking), typical quantity (amount consumed), and derived from these, a quantity-frequency index representing the average amount of alcohol consumed in a specified time period. One advantage of this type of assessment is its brevity.

- **Drinking Self-Monitoring Logs**. Daily diary records tend to eliminate much of the bias associated with retrospective recall. However, they are often kept during a narrow window of time (e.g., 2 weeks) because of practical limitations, and therefore may not be representative of the drinker's typical drinking behavior. A major strength of diary reporting is that it may be used simultaneously to assess contextual information related to the respondent's drinking occasions (e.g., time, place, mood, interpersonal context), which can be useful in treatment planning.
- **Prompted Daily Recall and Timeline Methods**. These methods use prompts, calendars, or charts to collect recalled drinking behavior on specific dates or days of the week. The drinker generally is asked to estimate the number of drinking hours, which can provide critical information for accurately estimating highest Blood Alcohol Levels (BALs) achieved. Although more time-consuming than Q-F methods, timeline methods have been shown to yield more reliable estimates of drinking behavior.

Dependence Symptoms and Severity of the Problem

Assessing dependence symptoms is critical to determining the appropriate treatment option (*See Figure 2 - Decision Flowchart: From Screening to Intervention*). Two validated self-report instruments are:

- The 25-item Alcohol Dependence Scale (ADS),[27] and
- The 20-item Severity of Alcohol Dependence Questionnaire (SADQ).[28]

If you wish to make a formal diagnosis, or if you want detailed data related to a differential diagnosis (e.g., alcohol abuse vs. alcohol dependence), structured and semi-structured diagnostic interviews are recommended. Even if your goal is not to make a formal diagnosis, diagnostic instruments such as the two listed below, provide excellent questions to guide your assessment interview:

- The Alcohol Use Disorders and Associated Disabilities Interview Schedule (AUDADIS).[29]
- The Structured Clinical Interview for DSM-IV (SCID).[30]

Consequences of Alcohol Use

Drinking consequences represent a domain independent of dependence symptoms and should be measured separately. While many screening instruments and diagnostic clinical interviews contain

interview questions designed to identify negative consequences, having your clients complete a self-administered questionnaire will provide a detailed picture of negative consequences across a variety of life domains, and in the case of marital or family assessment, from different family member perspectives.

A thorough assessment of consequences also can be useful when evaluating treatment effects, since these measures have been shown to be sensitive to changes in drinking-related problems over time.[31] Communicating these assessment results often is useful in helping the drinker appreciate the connection between drinking and negative consequences across life domains.

The Drinker Inventory of Consequences[32] (DrInC) is a 50-item checklist of potentially adverse drinking consequences that provides summary scores in five areas:

- Interpersonal
- Physical
- Social
- Impulsive
- Intrapersonal

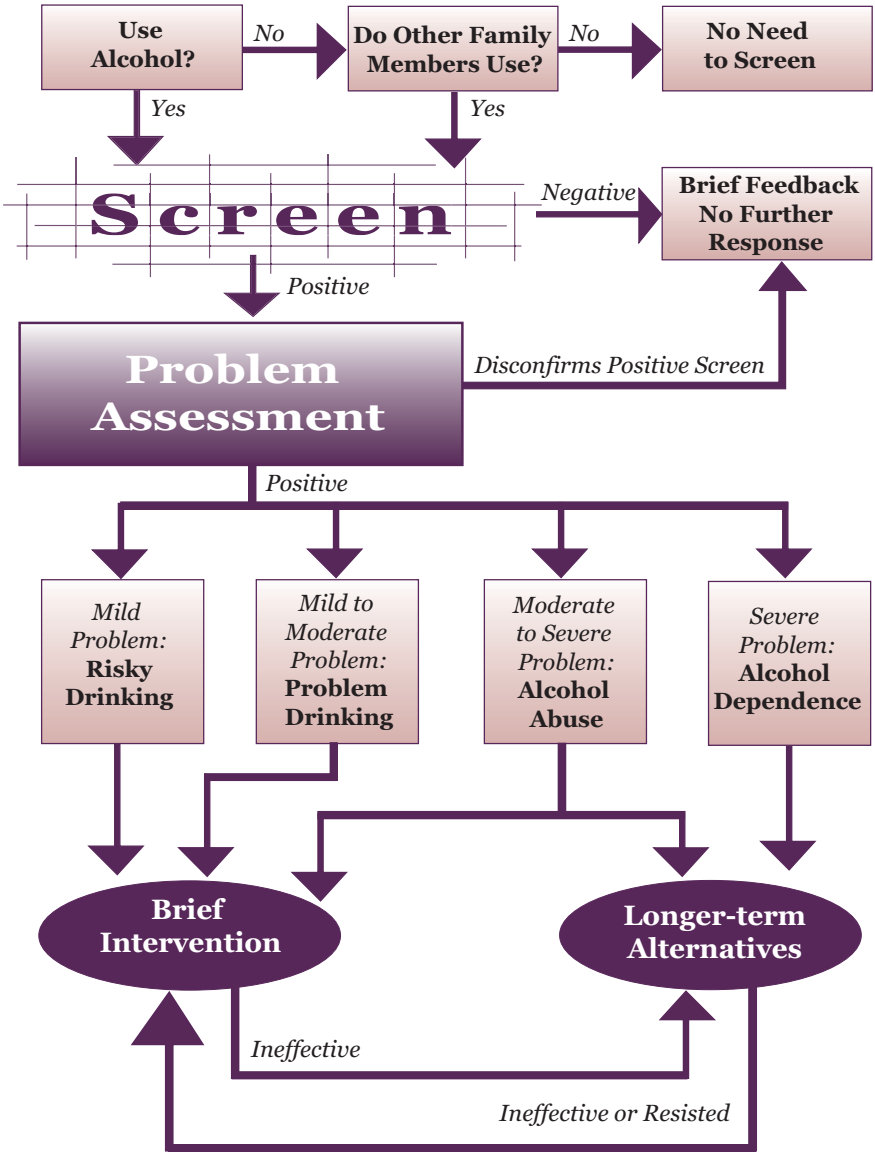
The full DrInC generally takes clients less than 10 minutes to complete, but a brief version of the DrInC, known as the Short Index of Problems (SIP), also is available. Collateral report forms are available as well.

From Screening and Assessment to Decisions and Action

Figure 2 summarizes the process of screening and problem assessment that we have described thus far. The next step in the process is to choose an intervention strategy that matches the nature of the identified problem.

By broadening the target population for alcohol-related interventions to include people with risky drinking patterns and mild to moderate alcohol problems, you will address a wider range of concerns that families may have about drinking. The goal of treatment also is necessarily broadened. From an alcohol problems framework, the overall goal of treatment is ***"To reduce or eliminate the use of alcohol as a contributing factor to physical, psychological, and social dysfunction and to arrest, retard, or reverse the progress of associated problems."*** [33]

Figure 2. Decision Flowchart: From Screening to Intervention



To achieve this treatment goal and effectively reach the large numbers of individuals and families manifesting mild or moderate alcohol problems, brief interventions are recommended. Brief interventions are time-limited strategies that focus on reducing alcohol use and thereby minimize the risks associated with drinking. Several studies have substantiated the effectiveness of brief interventions for non-dependent problem drinkers.[34] They also are used for more serious alcohol problems, either as the sole intervention, or as the initial step toward longer or more intensive treatment. Although most brief interventions use a cognitive-behavioral approach, you can integrate these interventions into your overall treatment model, regardless of your theoretical orientation.

Once you have identified an alcohol problem and have determined that a brief intervention approach would be appropriate, you are faced with a series of clinical decisions. The next sections of this Guide will walk you through the steps required to achieve a successful response from an individual, couple, or family client with an identified alcohol problem.

BRIEF INTERVENTIONS: INITIAL DECISION-MAKING

Once you become aware that drinking is a problem for a family, you must ask yourself a series of questions:

- What type of drinking problem does this family have and how severe and acute is it?
- Should I address the drinking problem at all? If so, when should I do so?
- If I address the drinking, to what degree will I be able to help the family?
- Should I involve the drinker or other family members in alcohol-specific specialty services instead of, or in addition to, the treatment that I provide?
- If I take some of the responsibility for addressing the drinking, should I work only with the drinker for a while, or should I also continue working with other family members?
- If I do continue working with the family, to what extent should the children be involved?

Figure 3 provides an outline of the initial decisions you will need to make before proceeding with any intervention.

Determine the Type and Severity of the Alcohol Problem

Family alcohol problems can range in severity from conflicts about what is considered acceptable drinking behavior to severe alcohol dependence with resulting physical dependence or medical problems.[35] More severe problems will require immediate, specialized attention; those that are less severe can be addressed in the context of the overall treatment plan.

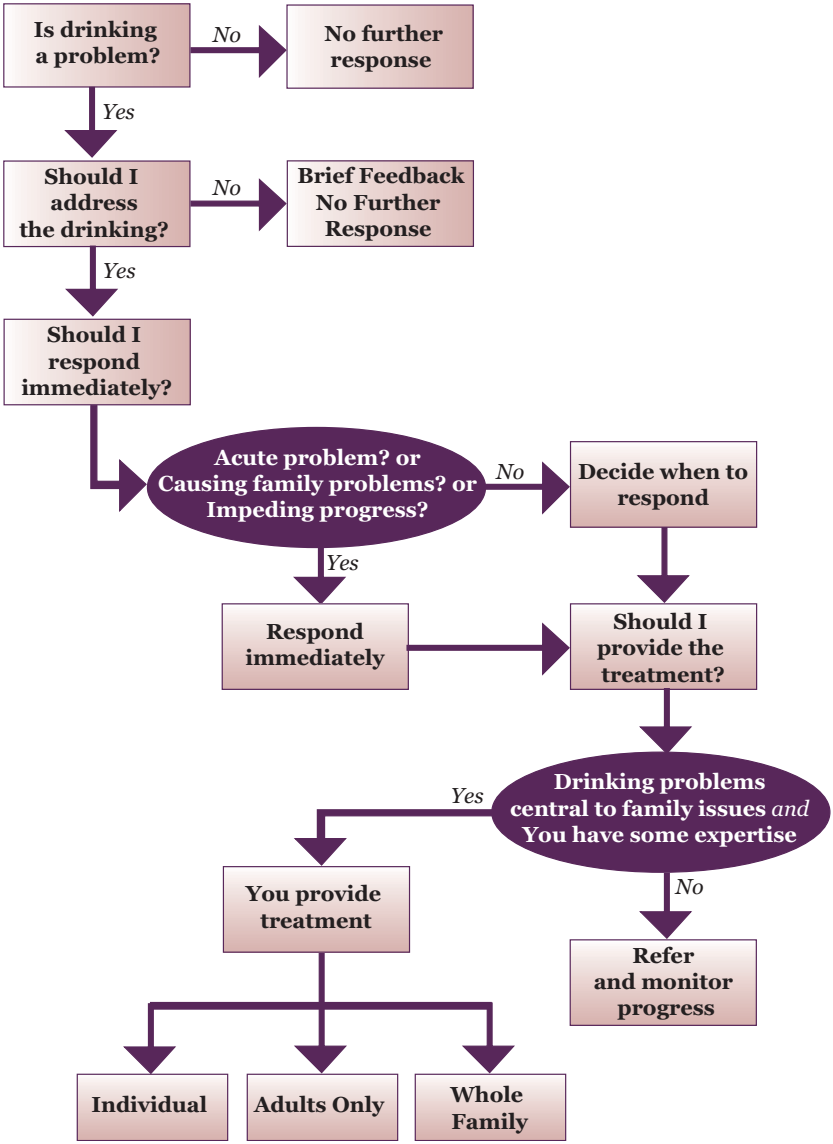
Decide Whether Identified Drinking Problems Should Be Addressed

Although it might seem counter-intuitive to ignore an important problem, there may be reasons for doing so:

- Treatment may be directed to another severe or acute problem, such as child abuse or the terminal illness of a family member.
- You may have a limited number of sessions or limited time during which the family is available for treatment.
- You may be concerned that any discussion of drinking problems will result in the termination of treatment. Although this outcome is uncommon when drinking issues are raised in a

respectful, client-centered manner (as described later in this Guide), you may choose to postpone a direct discussion of drinking if you are convinced that it would cause the family to leave treatment.

Figure 3. Decision Making About Treating Drinking Problems



Decide on the Timing of Your Response

- Respond immediately if drinking is causing acute medical, psychological, or interpersonal problems and refer for acute services.
- With less acute problems, consider the goals set and progress made within treatment and how a discussion of drinking may influence the achievement of those goals:
  - If the therapeutic alliance is tenuous, a direct discussion of drinking problems might strengthen the alliance by bringing a major hidden issue into the open. Conversely, addressing the drinking habits of one family member may undermine an already tenuous alliance.
  - Drinking may underpin the presenting problems, such as a couple's concerns with finances, sexual functioning, or allocation of time. Child or spousal abuse also may be linked directly to one family member's drinking. When drinking is closely tied to presenting problems, you should address the drinking early in the treatment.
  - Drinking may be addressed directly and more immediately if it is interfering with achieving treatment goals, such as lack of follow-through on homework assignments, erratic attendance, or other types of interference.
  - If drinking appears to be more marginally related to presenting problems and treatment is progressing smoothly, it can be addressed later in treatment.

Decide Whether to Treat Alcohol Problems Within Family Treatment or Through Referral

At least two elements will contribute to this decision:

- ***The centrality of drinking to presenting family problems.*** If drinking is linked directly to presenting problems, you probably cannot proceed successfully with treatment unless drinking issues are incorporated into the treatment plan.
- ***Your own expertise and comfort level in managing drinking-related problems.*** If you have some level of knowledge and expertise, integrating drinking issues into the larger treatment plan may be effective. If you have less expertise, you may feel more comfortable with adjunctive treatment that directly addresses the drinking and that allows you to facilitate and support the adjunctive treatment.

Decide Whether to See the Entire Family or Just the Drinker

If drinking is central to a family's problems, and you decide to intervene, it may be necessary to put aside other aspects of the family therapy until the drinking problem is stabilized and changes have been initiated. You may see the individual family member with the identified drinking problem alone for a period of time, and then bring other family members back into treatment.

Decide Whether to Involve the Children

There are several positive reasons for involving the children:

- Children typically are acutely aware if a parent is drinking heavily. Discussing the drinking with the children present brings what may have been a taboo topic out into the open.
- Even young children are aware that alcohol is a unique, special beverage and can link parental drinking to changes in behavior.
- The children's presence during treatment may give you opportunities to educate them about drinking, and to reassure them that a problem previously hidden in the family can now be discussed.

Involving children in treatment sessions may also present drawbacks:

- Boundary issues between parents and children may be violated in destructive ways by a full discussion of drinking issues with the children present. For example, it is common for intimate partners to be sharply divided and to have strong negative affect around drinking. Opportunities to learn to discuss, resolve, or manage these negative emotions may be provided more effectively without the children present.
- Any extensive discussion of drinking problems will involve addressing other personal problems and intimate couples issues that may be inappropriate for children to hear.
- If there is violence in the family, it might not be safe to ask children to discuss their parent's drinking.

Raising Drinking Issues in the Context of Family Therapy

There are no simple answers to the clinical decisions outlined above. If you decide to bring drinking problems into the therapeutic agenda, the next challenge is to determine how you can raise drinking issues and facilitate the family's acceptance of drinking as a legitimate part of the therapeutic agenda.

This section provides two vehicles for broaching the initial discussion of alcohol problems—linking drinking to presenting family concerns or

linking drinking problems to problems encountered in progressing toward therapeutic goals.

The use of three major therapeutic principles—empathy, motivation through attention to client goals, and choice—can facilitate the successful introduction of drinking issues into therapy. Figures 4a and 4b identify the key principles and pitfalls to consider when addressing drinking as an issue in family treatment.

Some General Therapeutic Principles

Accurate Empathy is Strongly Associated With a Positive Response to Treatment for Drinking Problems

Traditional approaches to alcohol treatment have taken a more confrontational style in which attempts are made to "break through" client denial to facilitate awareness of the extent and severity of their drinking. Research, however, does not support this approach. Instead, it finds that clinicians who can understand the complex emotions clients experience concerning his/her drinking and who can communicate this understanding in an empathic and supportive manner are more likely to achieve success in enabling clients to: (1) discuss their drinking, (2) realize the problems associated with it, and (3) prepare to change. From the first moment that you address drinking, utilizing an empathic approach is crucial.

Enhance Motivation by Focusing on Client Goals

Traditional views of change in drinking habits held that motivation was a trait that a client either did or did not have. Life experience, not clinician or family action, was the vehicle by which motivation would lead to change. However, contemporary research contradicts this traditional view. It offers substantial evidence that you can enhance your clients' motivation to change by using specific therapeutic behaviors, and by providing family members with interventions to change their behavior as well. (*See Elements of Brief Interventions: When the Drinker is Not Present, page 35*).

You can enhance client motivation by linking the client's drinking to their own positive goals. In particular, if there is a discrepancy between the client's current life circumstance and the specific goals that he/she has articulated, drinking may be contributing to this discrepancy between goals and desires. Helping the client make this linkage can provide a powerful source of motivation to change.

Give Client Choices

Providing clients who have drinking problems with choices about how to select treatment options and how to articulate treatment goals will result in better treatment retention and more positive outcomes.

Figure 4a. Raising Drinking as an Issue

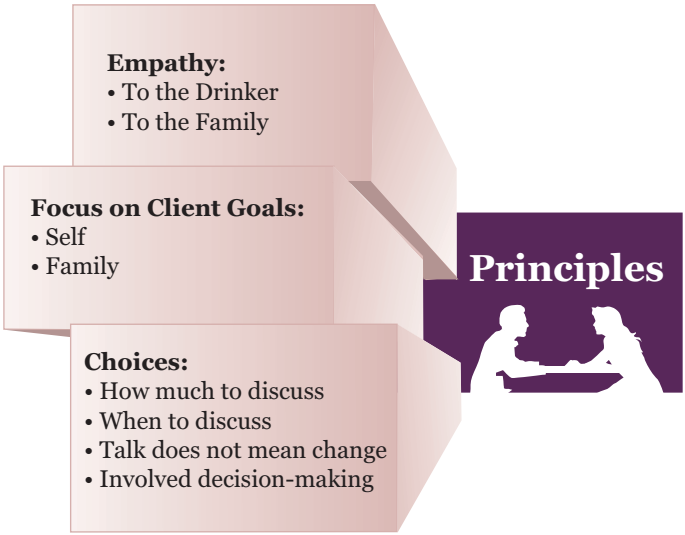
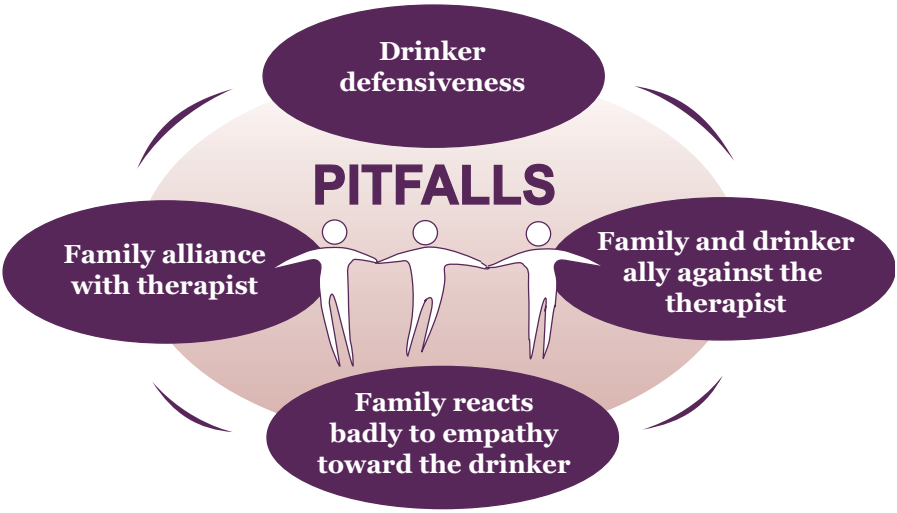


Figure 4b. Raising Drinking as an Issue



Instead of assuming an authoritative stance that directs the drinker to one course of action, you can provide choices that help the drinker to become knowledgeable about these options. You also can provide guidance about the advantages and disadvantages of various options without trying to force the client to select a specific choice.

Applying the General Principles

How can you use the three principles to successfully introduce drinking issues into family therapy?

Any Discussion of Drinking Should Be Approached With An Empathic and Respectful Demeanor

You might introduce the topic by saying:

- "I'd like to bring up a topic that we haven't talked about too much," or
- "I've been thinking about another issue that might be contributing to the difficulties that you've been having," or
- "It might be important to talk a bit more about how alcohol fits into the problems you've been experiencing. I've gotten the sense that this might be an uncomfortable topic."

Each of these introductions is intended to be low-key, gentle, and non-accusatory in tone, reflecting your awareness that the drinker and other family members might find the topic difficult to address. After an initial introduction, you may respond to each client with reflective listening comments. In this example, the therapist expresses empathy without taking sides:

> ***Therapist:*** *"It might be important to talk a bit more about how alcohol fits into the problems you've been experiencing. I've gotten the sense that this might be an uncomfortable topic."*
>
> ***Husband:*** *"I knew it would come to this. My wife has been blaming everything on my drinking for years, and she promised she wouldn't bring it up here. I wouldn't have come to see you if I thought we'd be back on that old train again."*
>
> ***Therapist:*** *"So you're feeling set up now, and kind of angry that I'm bringing up the same topic?"*

Link Drinking to Client Goals and Aspirations

In family therapy, applying this principle is relatively easy. Clients seeking family therapy typically have a set of concerns that motivated them to seek assistance:

- Communication
- Decision-making
- Intimacy
- Finances
- Sexual incompatibility
- Management of family responsibilities
- Child behavior problems
- Parenting

If one person is drinking heavily, that drinking is likely to be contributing to the family's presenting problems. Your challenge is to understand how the drinking may be playing a role in the presenting problems, and to articulate this understanding to the family. For example:

> ***Therapist:*** "Although I am hearing, loud and clear, that you don't want to talk about your drinking, I am concerned that it may somehow be connected with the concerns the two of you came in with. You both said that you wanted help in becoming better parents, and that you were having too many arguments about discipline and rules. From what you've been telling me, I have a hunch that the different feelings you each have about John's drinking and his time away from the house may be affecting your ability to come to agreement about rules for your kids."

Even if drinking is not centrally related to the problems that brought a family into treatment, one family member's drinking might be creating barriers to successful progress in treatment. You may explain that you are raising drinking as an issue because of problems encountered in progressing in treatment.

Noncompliance with homework assignments, observing that specific types of assignments fall apart (e.g., having a couple go out together, or discuss a problem during the evening), or feeling bewildered about aspects of a family's functioning, are all clues that the drinking might be a contributing factor. Feedback about the linkages between drinking and lack of progress in treatment also can be used to introduce the topic of alcohol into therapy.

Applying Principles of Choice

The principle of "choice" becomes prominent as alcohol issues are explored more fully, but even in the initial discussion, you must keep this principle in mind. After first discussing drinking, you can give the family a choice about the degree to which the topic is pursued in any one session. You also can be clear that discussing drinking is not

equivalent to requiring that anyone change their behavior, and that the family will be involved actively in decision-making about how to proceed.

Some Common Pitfalls

Although this Guide assumes that it ultimately will be constructive and valuable to address drinking in the context of marital or family therapy, you must be prepared for pitfalls that are unique to the marital/family therapy context:

Defensiveness On the Part of the Drinker

Expect to hear assertions that the drinking is not a problem, is under control, can be controlled whenever the drinker desires, or that others are "making too big a deal about a few drinks." The three therapeutic principles that guide this section—empathy, motivation through goals, and choices—are all intended to attenuate the drinker's defensive reactions.

Reactions of Other Family Members During Any Discussion of Drinking

Family members may experience relief that the topic is being addressed, and may make strong efforts to ally with you against the family member with the problem drinking.

Such comments as, "I've been concerned about that too," or "She's right, we have to face this," are hints that a family member is trying to become your ally against the drinker. You must make efforts to neutralize the alliance, i.e., maintain an alliance with the family as a unit, rather than with specific family members.

Negative Reactions by Family Members to Your Empathic Responses to the Drinker

Family members, who often have experienced anger, frustration, fear, and sadness in response to years of problem drinking, may be impatient to see change occur once the topic of drinking is introduced into therapy. They may hope that you will "straighten out" the drinker, providing definitive instructions to stop the drinking behavior and to seek a specific form of treatment. When you do not respond accordingly, family members may react negatively. They may become angry with you for expressing empathy about how difficult it is to face and change a drinking problem, or for trying to help the client make decisions about how, when, and how much to change. You must walk a careful line, not sacrificing the needs or desires of any family member to those of others in the family. A balanced, empathic, and respectful response to the reactions of each family member can neutralize some of the intense emotions that surround this topic.

Family Members May Develop Alliance Against You

As a reflection of their desire to avoid discussing the role of alcohol in their family or the problems it has caused, the family may develop an alliance against you. Different factors may lead to a family alliance to avoid any discussion of drinking, including:

- Family lack of understanding about, or prejudice towards, alcohol use disorders.
- Family embarrassment or shame.
- Family members' concern that their own drinking behavior might also be challenged or affected.
- Family homeostatic balance that is threatened by any discussion of drinking.

Your response to family level resistance will be determined, at least in part, by your understanding of why the family is resisting the need to address drinking. However, this Guide is not advocating a dogged pursuit of drinking to the extent that the family drops out of treatment. It is a measured approach that integrates drinking issues into a larger case formulation and treatment plan for the entire family.

ELEMENTS OF BRIEF INTERVENTIONS: WHEN THE DRINKER IS PRESENT

The success of brief interventions for drinking problems is well supported by research conducted over the past 25 years.[36] The approach described below, best characterized as adapted motivational interviewing, can be an effective treatment for some alcohol use disorders without the need for further clinical intervention.[37] It also may resolve mild to moderate alcohol problems, enhance the client's readiness to address more severe drinking problems, and result in acceptance of a treatment referral.

Major elements of the brief intervention include:

- Careful assessment of the drinking and its consequences
- Feedback
- Drinker choices
- Emphasis on personal responsibility
- Involvement of the family
- Follow-up

You should deliver all six elements of the brief intervention using a motivational interviewing style. The six principles and techniques that guide brief interventions are summarized in Figure 5.

General Therapeutic Approach—Use of Motivational Interviewing Style

Motivational interviewing is an empathetic, client-centered, therapeutic style and should be used when conducting brief interventions. Three major principles underpin motivational interviewing:[38]

Express Empathy

Empathy implies an acceptance of each family member's experience, perspectives, and emotions, and requires the ability to express this acceptance in a warm, compassionate manner. The use of active reflective listening is key.

Roll With Resistance

Drinkers often attempt to persuade others that their drinking is not problematic. Such an argument tends to solidify the drinker's viewpoint. If you avoid arguments, empathically accept that the drinker is ambivalent, and encourage the drinker to merely consider an alternative viewpoint, resistance is likely to decrease.

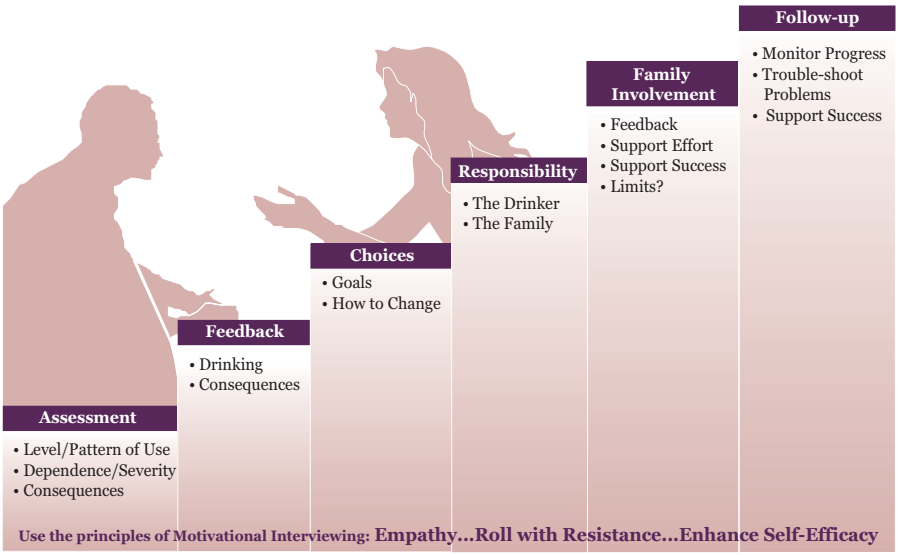
Enhance and Support Self-efficacy

You should view the drinker as capable of changing and communicate that perspective in a number of ways:

- Note the drinker's strengths (e.g., commitment to family, success in the work place);
- Communicate respect for the serious manner in which the drinker is responding to the brief intervention;
- Provide general information about the success drinkers tend to have in changing their behavior over time;[39]
- Help the drinker to envision himself/herself as a person who can change and to realize the importance of making the decision to change.[40]

The three basic principles of motivational interviewing should be used to implement the brief intervention described in the sections that follow.

Figure 5. Brief Interventions With the Drinker Present



Assessment

For the brief intervention, you should obtain information that will help the drinker and other family members understand why and in what ways their drinking is problematic. Several types of information, which can be obtained using questionnaires and interview questions, are helpful in achieving this understanding (*See Alcohol Problem Assessment, page 8*).

Feedback

A key element in brief interventions is the feedback provided to the drinker. A major purpose of feedback is to help the drinker recognize discrepancies that exist between his/her current circumstances and personal and family goals and aspirations. Feedback should be conveyed in a warm, empathic tone, and should be descriptive rather than evaluative. The clinician may introduce the feedback by saying:

> **[To the drinker]:** *"We've been spending a bit of time discussing your drinking, and you also spent some time filling out questionnaires that I gave you. I'd like to offer some feedback on what I've learned about your drinking, and what I think it suggests. Please feel free to ask questions as I go along. Then we can talk about your reactions and thoughts."*

> **[To the family]:** *"You'll probably find this interesting as well, and you may want to comment. Feel free to ask questions, but I suggest that you hold other comments until we've had some time to go through all the feedback."*

Feedback can be organized on a feedback sheet for the family to review. A sample feedback form provided in Figure 6 includes:

Feedback About Drinking

- **Average number of standard drinks consumed each week.** A standard drink is equal to one 12-ounce beer, one 5-ounce glass of table wine, one 3-ounce glass of fortified wine, or a 1.5-ounce shot of hard liquor.
- **Average number of drinks ingested on each drinking day.** Calculate this number by adding together the total number of drinks consumed, and divide by the number of days the client drank.
- **Highest consumption.** Look at all the drinking information and write in the largest amount the client drank on any given day.

Figure 6. Sample Feedback Sheet

Sample Feedback Sheet

1. Based on the information I obtained during the assessment, I calculated the number of "standard drinks" you consumed each day and have summarized three important indicators of your drinking:

   Total number of standard drinks per week _____

   Average number of standard drinks per drinking day _____

   Highest consumption in a day _____

2. When we look at everyone who drinks in the United States, *you have been drinking more than approximately* _____ *percent of the population* of women/men in the country.

3. I also estimated your highest and average blood alcohol level (BAL) in the past month. Your BAL is based on how many standard drinks you consume, the length of time over which you drink that much, whether you are a man or a woman, and how much you weigh. So,

   Your estimated peak BAL in an average week was _____

   Your estimated average BAL in an average week was _____

   This is a measure of how intoxicated you typically become. In the U.S. the legal intoxication limit is .08 or .10 (you may want to confirm the BAL limit for your specific state).

4. You have experienced negative consequences from drinking. Here are some of the most important:

   _____ _____

   _____ _____

   _____ _____

- **Comparison of drinking to national norms.**[41] To make this comparison, you can refer to a standard chart (*See Table 2.*) to determine where your client's drinking falls. For example, a man who drinks 28 drinks per week is at the 90th percentile—90% of men in the U.S. drink less than he does. Such feedback is valuable because many heavy drinkers associate with other heavy drinkers and believe that their own drinking pattern is "normal" rather than heavy.
- **Blood alcohol level (BAL).** To determine BAL, the clinician weighs four factors: amount consumed; time over which alcohol is consumed; client body weight; and client sex. Use of standard BAL charts (*See Figure 7.)* yields information on usual BAL as well as the BAL achieved on the heaviest drinking days. Comparing the BAL calculated to the legally defined limit for intoxicated driving in the client's state of residence (typically .08 or .10) provides a context in which to understand the client's BAL.

Feedback About Negative Consequences of Drinking

Information about negative consequences has been provided already by the drinker and other family members, but summarizing negative consequences often has a notable impact. The clinician can organize this section into:

- Subjective negative consequences.
- Objective negative consequences.
- Concerns of the family not necessarily shared by the drinker.
- Links between the drinking and either presenting family problems, or problems with progressing in therapy.

After the Feedback

At the conclusion of the feedback session, client and family reactions will vary widely:

- They may be moved emotionally, reacting to the feedback with sadness or shame.
- They may objectify the information and ask factually oriented questions.
- They may react neutrally, disagree, or minimize the significance of the information.
- They may interpret it as a signal to take action.
- Family members may become angry with the drinker and attempt to chastise, lecture, or express long-held negative feelings.

Table 2. Alcohol Consumption Norms for U.S. Adults (%)

Note: The numbers in this table are cumulative percentages—i.e. the percentage of the population that drinks at or below each drinking level.

Drinks per week	Men	Women	Total
0	29	41	35
1	46	68	58
2	54	77	66
3	57	78	68
4	61	82	71
5	67	86	77
6	68	87	78
7	70	89	80
8	71	89	81
9	73	90	82
10	75	91	83
11	75	91	84
12	77	92	85
13	77	93	86
14	79	94	87
15	80	94	87
16	81	94	88
17	82	95	89
18	84	96	90
19	85	96	91
20	86	96	91
21	88	96	92
22	88	97	92
23-24	88	97	93
25	89	98	93
26-27	89	98	94
28	90	98	94
29	91	98	95
30-33	92	98	95
34-35	93	98	95
36	93	98	96
37-39	94	98	96
40	94	99	96
41-46	95	99	97
47-48	96	99	97
49-50	97	99	98
51-62	97	99	98
63-64	97	>99.5	99
65-84	98	>99.6	99
85-101	99	>99.9	99
102-159	99	>99.9	>99.5
160+	>99.5	>99.9	>99.8

Source: 1990 National Alcohol Survey, Alcohol Research Group, Berkeley.

Keep in mind that the goal of feedback is to enhance the drinker's willingness to make changes in his/her drinking. Continue using the skills of motivational interviewing by:

- Taking an empathic stance;
- Avoiding the urge to confront resistance;
- Eliciting reactions from the drinker and family members;
- Acknowledging and respecting the complex reactions all members of the family might have; and
- Supporting statements that suggest the drinker is considering change.

Choice

After discussing reactions of the drinker and family members to the feedback, the conversation should move to determining possible next steps. Here, it is important to ensure that the drinker has choices and does not feel forced to select one option. Any movement toward change should be considered a positive outcome of the brief intervention. Although total abstinence from alcohol is always a safe, desirable outcome, reductions in drinking can lead to improved health and social functioning. Reductions in drinking also may serve as a way station to abstinence, whereby the drinker attempts to cut down, and ultimately decides that abstinence is either an easier choice or a necessary one. Although some drinkers may ask for specific advice and information about available treatments, many may respond by stating that they accept the need for change but want to try to change on their own. Both treatment and self-change can lead to positive results, so you can support either plan.

Providing a drinker with choices is more than passive acceptance of the individual's goals and preferred route to change. You can play an active role by providing specific information about different goals and different treatment options. Lay out your view of the advantages and disadvantages of each option, and even suggest a preferred course of action. Having an educational discussion and clearly stating the importance of choosing a route to change that is acceptable will enhance the likelihood of success.

Although the main target of this discussion is the drinker, the other family members should be encouraged to express their views about advantages and disadvantages of different approaches. By the end of the discussion, the ideal outcome invokes a specific change plan. Referral for specialty treatment; involvement with self-help; continued work on the drinking in the family therapy; or an initial attempt at self-change are all acceptable change plans. If the drinker is not willing to commit to

Figure 7. Blood Alcohol Level Estimation Charts

Men

Approximate Blood Alcohol Percentage

Drinks	Body Weight in Pounds								Sample Behavioral Effects
	100	120	140	160	180	200	220	240	
0	.00	.00	.00	.00	.00	.00	.00	.00	Only Completely Safe Limit
1	.04	.03	.03	.02	.02	.02	.02	.02	Impairment Begins
2	.08	.06	.05	.05	.04	.04	.03	.03	Driving Skills Significantly Affected; Information Processing Altered
3	.11	.09	.08	.07	.06	.06	.05	.05	
4	.15	.12	.11	.09	.08	.08	.07	.06	
5	.19	.16	.13	.12	.11	.09	.09	.08	
6	.23	.19	.16	.14	.13	.11	.10	.09	**Legally Intoxicated; Criminal Penalties; Reaction Time Slowed; Loss of Balance; Impaired Movement; Slurred Speech**
7	.26	.22	.19	.16	.15	.13	.12	.11	
8	.30	.25	.21	.19	.17	.15	.14	.13	
9	.34	.28	.24	.21	.19	.17	.15	.14	
10	.38	.31	.27	.23	.21	.19	.17	.16	

One drink is 1.5 oz. shot of hard liquor, 12 oz. of beer, or 5 oz. of table wine.

Women

Approximate Blood Alcohol Percentage

Drinks	Body Weight in Pounds								Sample Behavioral Effects
	90	100	120	140	160	180	200	220	240	
0	.00	.00	.00	.00	.00	.00	.00	.00	.00	Only Completely Safe Limit
1	.05	.05	.04	.03	.03	.03	.02	.02	.02	Impairment Begins
2	.10	.09	.08	.07	.06	.05	.05	.04	.04	Driving Skills Significantly Affected; Information Processing Altered
3	.15	.14	.11	.10	.09	.08	.07	.06	.06	
4	.20	.18	.15	.13	.11	.10	.09	.08	.08	
5	.25	.23	.19	.16	.14	.13	.11	.10	.09	
6	.30	.27	.23	.19	.17	.15	.14	.12	.11	**Legally Intoxicated; Criminal Penalties; Reaction Time Slowed; Loss of Balance; Impaired Movement; Slurred Speech**
7	.35	.32	.27	.23	.20	.18	.16	.14	.13	
8	.40	.36	.30	.26	.23	.20	.18	.17	.15	
9	.45	.41	.34	.29	.26	.23	.20	.19	.17	
10	.51	.45	.38	.32	.28	.25	.23	.21	.19	

One drink is 1.5 oz. shot of hard liquor, 12 oz. of beer, or 5 oz. of table wine.

Subtract .015 for each hour that you take to consume the number of drinks listed in the table. For example, if you are a 160 pound woman, and have two drinks in two hours, your BAC would be .06 - (2 x .015) = .03

NOTE: Blood Alcohol Level (BAL) charts do not take into consideration a wide range of additional variables that contribute to the determination of BAL's achieved and the behavioral effects experienced at a given BAL. These additional variables include: age, water to body mass ratio, ethanol metabolism, tolerance level, drugs or medications taken, amount and type of food in the stomach during consumption, speed of consumption, and general physical condition. ***Thus, BAL charts only provide extremely rough estimates and should never be used alone to determine any individual's safe level of drinking.***

Adapted from BAC Charts produced by the National Clearinghouse for Alcohol and Drug Information.

any plan, you should respect that choice, but indicate that you will return to a discussion of drinking in future sessions after the entire family has had the opportunity to think about the feedback.

Personal Responsibility

Whether an individual chooses to initiate change in their own behavior ultimately is their responsibility. During the brief intervention, you should communicate this principle clearly to the drinker and to the family members. Families can help and support a person in their change efforts, and may serve as a source of motivation for change, but the ultimate decision is an individual one. You can communicate this principle through comments such as:

> *"It is your decision to do what you want to do,"*
>
> *"I appreciate that this is a lot of information and that you might want to think about it more before reacting,"* or
>
> **[To the family]:** *"I know that you're eager for John to stop drinking, but he has to feel comfortable with that kind of decision and know that it's the right thing for him to do."*

At the same time, family members have the right to make choices for which they will be responsible. A spouse may decide that living in a relationship with someone who is drinking daily or heavily is not acceptable, and may choose to separate from the drinker who continues to drink. Such a decision requires an acceptance of responsibility, rather than focusing on the drinker's responsibility (e.g., "I choose to leave you if you keep drinking," versus "You made me leave because you wouldn't stop drinking.")

Family Involvement

The preceding sections have guided you in managing the family's reactions during the brief intervention. Additional roles the family may play include:[42]

Providing Additional Feedback to the Drinker

This may include feedback about negative consequences resulting from drinking, or objectionable behaviors observed when drinking; the results of previous change attempts; or family members' subjective reactions to the drinking or to the clinician's feedback. Encouraging the use of constructive communication skills is key to successful family feedback. Suggest that they use "I" statements rather than attacks, and expressions of care and concern rather than expressions of blame or contempt.

Supporting the Drinker's Attempts to Change

This is a topic that may continue through future sessions, but which

can be introduced during the brief intervention. As the drinker decides upon a course of action, you may ask the family to consider ways to support these actions.

Finding Ways to Support and Reinforce Positive Change

Families might spend more time with the drinker when abstinent, express positive reactions to changes in drinking (e.g., "I really enjoyed today), or provide positive feedback through concrete actions (e.g., a heartfelt hug.)

Stating Specific Limits

Family members may have decided on limits about what they will tolerate, and what they plan to do should the drinking continue unchanged. Knowledge about such limits might have an important influence on the drinker's decision-making.

Follow-Up

Although most descriptions of brief interventions stop here, the family therapist who implements a brief drinking intervention usually has an on-going relationship with the family, and will have the opportunity to follow-up beyond the initial intervention.

If the drinker and family settle on a change strategy by the end of the brief intervention, you should continue to check in and monitor success and problems in future treatment sessions.

If the initial plan is not succeeding, you can discuss further options. A tone of collaboration and respect should characterize these later discussions as well. For example:

> *"Your initial plan was to try to cut down on your own. That seemed to go quite well for a while, but lately you've been telling me that you're struggling again. Maybe we could go back to that list of options and think about whether some other option might work better for you at this point. The fact that you're interested in change and trying hard is great. Now it's a matter of finding the strategies that work best for you."*

If the brief intervention does not immediately result in a change plan, you also will want to revisit the discussion in later sessions. The tone of the follow-up should continue to be respectful, and responsibility should remain with the drinker. For example:

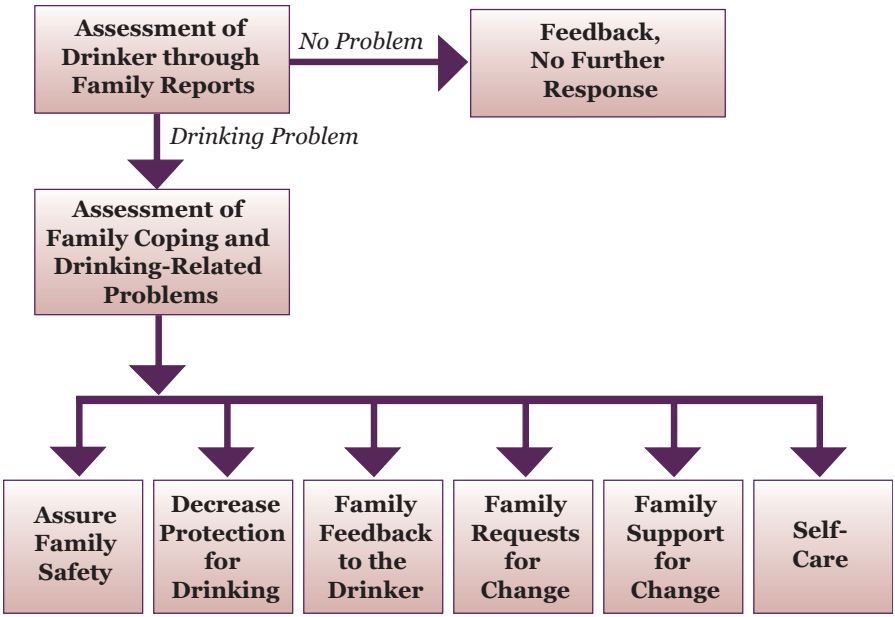
> *"Last week we talked quite a bit about your drinking, and you said you wanted to think about what we discussed. I'm curious to know what your thoughts have been during the week, and whether you have discussed them with your family?"*

ELEMENTS OF BRIEF INTERVENTIONS: WHEN THE DRINKER IS NOT PRESENT

The brief intervention described earlier is designed to work directly with the drinker. However, the drinker is not always part of the treatment and may be unwilling to get involved. A second set of therapeutic strategies can help the family respond constructively to a family member's alcohol problem and motivate the drinker to change or seek treatment.

It is a myth that family members cannot influence a drinker to change. Family members cannot make an individual stop drinking, but they can change their own behavior in ways that will help the drinker recognize that the drinking is problematic, and that change is desirable. In fact, study findings support the effectiveness of such interventions.[43]

Figure 8. Brief Interventions Without the Drinker Present



When family members are involved in treatment without the drinker, a careful assessment is required to determine whether the affected family members are dealing with a loved one who has a drinking problem. This initial assessment should be followed up with confirmatory feedback. Providing further assessment of family coping

strategies and offering guidance in specific responses form the core of such interventions. **Safety issues and other aspects of self-care must also be addressed, regardless of the drinker's behavior (*See Assuring Family Safety*).**

Several aspects of brief interventions with the drinker not present are similar to those described previously for brief interventions with the drinker present. Others are unique to the situation where the drinker is not available to the therapist. Key elements include:

Assessment and Feedback About the Drinker's Drinking

Family members often are uncertain about the seriousness of the drinking of another family member. You can conduct an assessment similar to that described for the drinker using the family member's report.

Ideally, you will be able to determine whether an alcohol problem is present or establish a diagnosis of alcohol abuse or dependence based on the family member's report, and also assess the quantity and frequency of drinking. After making this determination, you should give the family feedback, either to assure them that the drinking is not objectively a problem, or that it is problematic or a diagnosable disorder. If the drinking pattern is neither problematic nor diagnosable, then your intervention should focus on discussing the different attitudes and values about drinking in the family. If the drinking is problematic, a more detailed family intervention is needed.

Assessment of Family Coping Strategies

How families cope with the drinking is an important area of assessment. Families engage in a wide range of responses to drinking, including behaviors that support or tolerate the drinking, confront or control the drinking, or attempt to withdraw from the drinking or the drinker.

You can assess family coping through interviews as well as questionnaires. In an interview, ask questions such as:

> *"How have you responded to your family member's drinking?"*
> *"How have you tried to influence his/her drinking?"*
> *"How have you tried to help him/her to change?"*
> *"How has his/her drinking affected you?"*
> *"What have been some particularly difficult situations you've run into related to his/her drinking?How have you coped with these?"*

Your goal is to learn how the family members have reinforced drinking, protected the drinker from experiencing negative consequences from drinking, talked with the drinker about his/her drinking behavior, and how they have been affected themselves.

There are several good questionnaires to assess family coping, including The Coping Questionnaire,[44] the Significant-Other Behavior Questionnaire,[45] the Spouse Enabling Inventory,[46] and the Spouse Sobriety Influence Inventory.[47]

As with a drinker's assessment, an assessment of family coping should be approached in a spirit of inquiry by engaging the family in a discussion that reveals their perceptions about positive and negative actions, as well as their subjective feelings about interactions with the drinker. This assessment of family coping strategies sets the stage for suggested interventions.

Assuring Family Safety

Spouse and child abuse occur at elevated rates in families where one member has an alcohol problem. You should conduct a specific assessment for the presence of physical violence if there are drinking issues in the family. Assessment should target specific aggressive behaviors, rather than global questions such as, "*Is there any violence in your home?*" Specific questions should be asked about behaviors such as throwing objects, grabbing a family member roughly, slapping, pushing, hitting, or threatening harm. The Conflict Tactics Scale can be used to conduct a more formalized assessment of domestic violence. *For more information on the Conflict Tactics Scale, go to: www.unh.edu/frl/measure4.htm.*

Additional questions about actual injuries also should be included in the assessment. The presence of weapons in the home, particularly guns, also should be noted.

If there is evidence of physical violence in the family, you must take steps to assure the safety of the family. Since some families may view such behavior as normal, it is essential that you make a clear, unambiguous statement about the need for safety and the unacceptability of being hit or otherwise hurt. Advising the family on other safety measures—such as keeping a bag packed, establishing a place to go should violence appear imminent, and understanding the role and limitations of restraining orders—also is appropriate. If there are guns or other weapons in the home, you should consider advising either their removal or a secure locking system to prevent a potentially violent family member from accessing the weapons.[48] *Further information about intimate partner violence and treatment can be found at: www.cdc.gov/health/violence.htm and www.ama-assn.org/ama/pub/category/4605.html.*

Changing Family Coping

Once you have assured the basic safety of the family, you can begin to address changes in family behavior that may help the drinker recognize his/her drinking as problematic.

Changing Consequences of Drinking

It is common for family members to try to protect the drinker from the naturally occurring negative consequences of drinking. They may assume the drinker's responsibilities; cover for the drinker at work; provide comfort and reassurance after a drinking binge; hide their feelings about the drinking; hide the drinker's problems from family or friends, etc. Each of these actions may be well intentioned, but the net effect is to shield the drinker from the consequences of absences from work, the full impact of a hangover, or the realization that a loved one is frightened or angry.

The drinker who has the opportunity to hear about such consequences gradually may realize that there is a large cost associated with drinking and may begin to consider change. You can help the family recognize the unintended adverse effects of protecting the drinker, guide them to reduce actions that protect the drinker, and help them recognize that there are certain actions that are necessary to preserve the family (such as paying bills), or the life of the drinker and others (such as not letting a person drive when intoxicated). Problem-solving, role-playing new responses during the treatment session, and giving specific homework assignments that involve practicing new behaviors are all excellent approaches to implementing these new behaviors.

Family Feedback to the Drinker

A second active intervention is providing direct feedback to the drinker. Families may communicate in unproductive ways about drinking, for example, with nagging, ridicule, and sarcasm. Your goal is to encourage them to use straightforward, constructive communication techniques when giving their feedback. Remember that feedback should be:

- Provided when the drinker is sober.
- Factual and objective, rather than evaluative or emotional.
- Delivered in a caring and compassionate tone, communicating that the family member is discussing drinking out of caring rather than from more negative motives.
- Associated with specific requests to change.

You can guide family members to develop specific feedback and role-play how to discuss their concerns with the drinking family member.

Family Requests for Change

Family members also can be guided to make specific, positive requests for change from the drinker. Requests may be directed toward changes in the drinking itself, toward behavior when drinking, or toward seeking assistance. You can guide family members in articulating the changes they want and help them practice how to make such requests. You should prepare the family by explaining that the drinker does not always respond to such discussions or requests with immediate acceptance. You should also help the family understand that requests for change are part of the larger set of behavior changes described in this section of the Guide.

Family Support for Change Efforts

Families also need to learn to support the drinker's efforts toward change. They may resist providing support and encouragement, feeling that the drinker is simply doing what he or she "should have done all along." Despite such feelings, support for efforts to change is likely to increase them, while ignoring such efforts or responding negatively likely will decrease attempts at change. Family members can support change through verbal encouragement, nonverbal gestures, or taking on family responsibilities to free up the drinker's time for treatment or self-help meetings. You can work closely with the family to identify supportive actions that are comfortable and acceptable to them.

Family Member Self-Care

Spouses with an actively drinking partner experience significant levels of anxiety, depression, and psychophysiological complaints.[49] Children may have behavior problems, anxiety or depression, or eventually develop alcohol or drug problems themselves. Thus, in addition to interventions to attempt to influence the drinker, you should help family members learn how to take care of their own needs.

Twelve-step organizations are one source of support that is specific for families of drinkers. Al-Anon is a self-help organization for adults affected by another's drinking; Alateen provides similar support for adolescents. Al-Anon and Alateen are widely available without cost to participants. The limited amount of research available on Al-Anon has demonstrated its effectiveness in helping to decrease distress among families affected by drinking.[50] Specifically, Al-Anon is most effective as a source of support for the affected family member, and is not designed as a resource for motivating the drinking family member to change. Therefore, you should use this resource primarily as a source of support for affected family members.

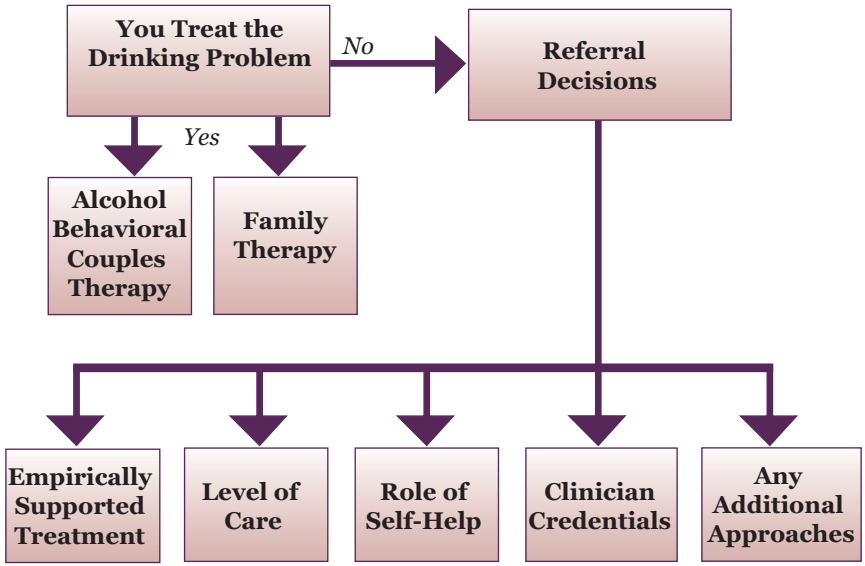
LONGER-TERM APPROACHES TO ALCOHOL PROBLEMS

The family therapist may choose to integrate continuing alcohol treatment into the couple or family therapy using an empirically supported approach. However, some clients benefit from longer or more focused treatment for their drinking that is separate from the family therapy. You may refer clients to the specialty system, by selecting a level of care and treatment model that best matches their specific needs and characteristics, and by identifying a program or practitioner with demonstrable credentials for treating clients with drinking problems.

Referral to a self-help group may serve as the only specialty referral in many locations, or it may be used to complement a formal treatment program. Several factors will guide the choice between these strategies:

- Your own competence and comfort with addressing alcohol-related issues in treatment.
- The drinker's willingness to seek additional services.
- The types of services that are available and accessible in your community.

Figure 9. Treatment Alternatives: Longer-Term Approaches to Changing Alcohol Problems



Change Through Family-Involved Treatment

Two major approaches to family-based treatment for alcohol problems have been developed and tested in controlled research—alcohol-focused behavioral couples therapy (ABCT), and family systems approaches. ABCT is a structured therapy based on cognitive-behavioral principles of behavior change.[51] Major components of ABCT include:

- Cognitive-behavioral strategies that will help the drinker stop drinking and acquire coping skills to respond to both drinking-specific and general life problems;
- Strategies that teach family members to support the drinker's change efforts, reduce protection for drinking-related consequences, develop better skills to cope with negative affect, and communicate around alcohol-related topics;
- Strategies to improve the couple's relationship by increasing positive exchanges and improving communication and problem-solving skills;
- Behavioral contracts between intimate partners to support the use of medication.[52]

Research suggests that ABCT results in greater marital happiness after treatment, fewer incidents of marital separation, and fewer incidents of domestic violence.[53] Many also report that ABCT leads to greater improvements in drinking behavior than comparison treatments, although study results are mixed.

One empirical study has tested the effectiveness of family systems therapy to treat alcohol problems in adults. Family systems therapy views drinking as one aspect of the marital/family relationship and focuses on altering couple interactions that might be sustaining the drinking, as well as each partner's views of the meaning of the drinking. You may not require abstinence from drinking, but rather may prefer to help couples select and pursue a drinking goal of their own choosing. Both strategic and structural-family therapy techniques can be used to manage clients' ambivalence about change. Preliminary results suggest that such approaches are more effective than cognitive-behavioral approaches in retaining resistant and angry clients in therapy.[54]

Change Through Referral

A second long-term strategy is to refer clients to community-based services for help with their drinking problems. Alcohol treatment services are provided at different levels of care—inpatient, residential rehabilitative, intensive outpatient, outpatient, or self-help.

There are two different approaches to selecting the level of care, and each has some support for its effectiveness. The first approach is stepped care, in which treatment is initiated at the least restrictive level possible for the client.[55] It is usually a brief, outpatient intervention, and the intensity of treatment is increased only if the client does not respond to the initial intervention. The second approach, patient-treatment matching, is most fully articulated by the American Society of Addiction Medicine (ASAM) through their patient placement criteria (PPC).[56]

The PPC specify six dimensions to consider when selecting an initial level of care:

- Severity of alcohol dependence and likelihood of withdrawal syndrome.
- Medical conditions and complications.
- Emotional/behavioral/cognitive conditions or complications.
- Motivation to change.
- Relapse/continued use potential.
- The nature of the recovery environment.

Although the PPC are quite specific in defining levels of care based on combinations of impairments in these six areas, the general principle underlying the criteria is to select more intensive, supervised treatment for more extensive problems.

To effect a referral to the alcohol treatment system, you can obtain information about local treatment resources through your state alcohol and drug agency. Many states provide online treatment directories and/or have toll-free hotlines that provide information about treatment services.

> *For more information, contact the Substance Abuse and Mental Health Services Administration (SAMHSA), National Drug and Alcohol Treatment Referral Routing Service at (800) 622-HELP or http://findtreatment.samhsa.gov.*

If you anticipate making regular referrals for alcohol treatment, you would do well to visit some of the treatment centers to become familiar with their programs, staff, and facilities. If you expect to effect referrals to individual practitioners, it is appropriate to verify the practitioner's credentials. Several professions provide specific certifications indicating competence or expertise in substance abuse treatment:

- Mental health providers, including marriage and family therapists, may receive national certification from the American Academy of Health Care Providers in the Addictive Disorders.
- Counselors may be certified at the state or national level as certified alcohol and drug (or substance abuse) counselors.
- Physicians may be certified through the American Society of Addiction Medicine.
- Psychiatrists have their own separate certification through the Academy of Addiction Psychiatry.
- Psychologists can obtain a Certificate of Proficiency in the Treatment of Substance Use Disorders through the College of Professional Psychology of the American Psychological Association.

Keep in mind that the absence of these certifications does not mean that the practitioner is not skilled in alcohol treatment, but certification does assure that there is a certain level of knowledge and experience.

In addition to knowledge about levels of care and credentials, you also should be aware of research knowledge about effective treatment approaches. Three treatment models have been studied extensively, and each has fairly consistent support for its effectiveness:[57]

- **Cognitive-Behavioral Therapy (CBT)** has been delivered in residential, intensive outpatient, and outpatient settings. CBT focuses on identifying high-risk situations for drinking, developing alternative coping strategies, and preventing relapse. CBT is particularly effective for clients who have less severe alcohol dependence.
- **Motivational Enhancement Therapy (MET)** is a brief, two- to four-session treatment that combines assessment, feedback, and principles of motivational interviewing (described in an earlier section of the Guide). MET is particularly effective for those clients who are angry and resistant at the onset of treatment.
- **Twelve-Step Facilitation (TSF)** treatments are active counseling approaches that draw upon the principles of Alcoholics Anonymous (AA). They help clients develop an affiliation with AA, and work with them through the initial steps. TSF has been provided in residential, intensive outpatient, and outpatient settings, and appears to be particularly effective with clients who have more severe drinking problems, few psychiatric complications, or social networks that

encourage them to drink. Treatment programs that draw upon the principles of AA are the most widely available.

Other treatment models and programs also are available, but they lack sufficient research support:

- Fairly extensive research literature supports the effectiveness of family systems approaches with adolescents, but limited research has addressed the use of family systems interventions for adults with alcohol use disorders.
- Treatment programs exist that are designed specifically for certain populations–women, gay and lesbian clients, people of color, adolescents, and older adults. Although there is compelling evidence of variability in the nature and patterning of drinking and problems in different populations, most population-specific treatment approaches are untested in controlled research studies.
- Some programs have incorporated treatment elements to address the unique needs and world views of subgroups of clients, such as spiritual or alternative healing practices, meditation, or nutritional interventions. Empirical bases for these approaches are lacking because they have not been tested in controlled research.

Self Help Groups

Clinicians also should be aware of and familiar with self-help groups. Alcoholics Anonymous (AA) provides a program of recovery based on twelve steps to recovery that stress acceptance of drinking as a problem, willingness to seek help, and personal and interpersonal change designed to enhance a spiritual approach to life. AA is widely available, free of charge, and requires a desire to stop drinking as the only "membership" requirement. Research studies have found a significant though modest correlation between attending more AA meetings and being abstinent, and an even stronger relationship between involvement with AA (e.g., working the steps, reading AA literature, having a sponsor, as well as going to meetings) and abstinence.

Other self-help groups are less widely available or researched, but provide alternative sources of self-help for clients who would like a self-help format but are unwilling to attend AA.[58] Groups include Women for Sobriety, SMART Recovery, Secular Organizations for Recovery/LifeRing, Moderation Management, and culturally specific self help groups, such as Red Road for the American Indian population. Little research is available about the effectiveness of any of these organizations.

SUMMARY

Alcohol problems are common, particularly among individuals and families seeking mental health services. Families may present other problems as their primary concerns, but drinking is often the primary cause of or corollary to their presenting problems.

Drinking problems may range in severity, from differences in values and preferences about drinking that create family conflicts, to severe alcohol dependence. As a result, marriage and family therapists should screen all clients for possible drinking problems and complete additional assessments where appropriate. When determining whether to intervene and how to intervene, it is important to first consider the overall goals of family therapy and any safety concerns that may be involved. Brief interventions, either directly with the drinker or with concerned family members, can have a positive impact on alcohol problems.

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CLINICAL TOOLBOX FOR SCREENING AND ASSESSMENT OF ALCOHOL PROBLEMS

The instruments and interview questions provided in this Clinical Toolbox will enable you to conduct screening and assessments of alcohol problems in your own practice. The figure below provides an overview of a few recommended tools in both interview and self-administered formats. Selection of self-report or interview formats will be determined by clinician skill and preference, as well as client literacy.

The tools in the shaded boxes represent a complete protocol for screening and problem assessment and are reproduced in this Appendix. The other instruments are available from the sources indicated.

Figure A-1. Recommended Assessment Tools

Overview of Recommended Tools		
	Interview	**Self-Administered**
Screen	Q-F and CAGE	AUDIT
Problem Assessment		
Consumption	BDP	Q-F
Dependence	SCID	ADS
Consequences	SCID	DrInC

Descriptive Information on Recommended Tools			
Acronym	**Full Name**	**Source/Availability**	**Administration Time (minutes)**
CAGE	Stands for main word in each of four questions	Mayfield, McLeod and Hall, 1974; Ewing, 1984. Available on pages A-2 and A-4.	1
Q-F	Basic Quantity-Frequency Items	NIAAA, 1995. Available on pages A-2 and A-4.	1
AUDIT	Alcohol Use Disorders Identification Test	Babor, et al., 1992. www.niaaa.nih.gov/publications/insaudit.htm	2
BDP	Brief Drinker Profile	Miller and Marlatt, 1984. Available on pages A-6 through A-10.	3-10*
SCID	Structural Clinical Interview for DSM IV-TR	First, et al., 2001. Dependence questions available on pages A-11 and A-12, Alcohol Abuse questions available through www.scid4.org	2-5*
ADS	Alcohol Dependence Scale	Skinner and Horn, 1984. www.niaaa.nih.gov/publications/ads.pdf	5
DrInC	Drinker Inventory of Consequences	Miller, Tonigan and Longabaugh, 1995. Available on pages A-13 through A-18.	10

*Times are estimates for the adapted versions presented in this Guide.

Tools for Screening

Although we have selected the CAGE questions to use in the screening protocol that follows, any of the screening instruments described earlier may be substituted for the CAGE. If you plan to use self-administration rather than an interview format, we suggest you use the Alcohol Use Disorders Identification Test (AUDIT) rather than the CAGE, because it includes consumption questions with standardized response options. If you determine that an interview is the appropriate format for your screening protocol, we recommend the following set of screening questions:

Basic Quantity-Frequency Questions (Self Report)

- Do you drink alcohol, including beer, wine, or hard liquor?
  If "no," discontinue the screen.
- On average, how many days per week do you drink alcohol?
- On a typical day when you drink, how many (standard) drinks do you have?
  Explain that a "standard drink" is defined as: 1.5 oz. shot of hard liquor, 5 oz. of table wine, 3 oz. of fortified wine, or 12 oz. of regular beer. *You may also reproduce the graphic found in Appendix B and use it to prompt accurate responses to this question.*
- What is the maximum number of drinks you consumed on any given day during the last month?

CAGE Questions (Self Report)

- Have you ever felt you should **C**ut down on your drinking?
- Have people **A**nnoyed you by criticizing your drinking?
- Have you ever felt bad or **G**uilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)?

IF there is a positive response to any of the CAGE questions, ask whether the incident(s) happened during the past year.

Interpreting Risk from the Screening Questions

An individual may be at risk for alcohol-related problems if alcohol consumption is:

For adult males less than 65 years old:

- 14 or more drinks per week, or
- 5 or more drinks during any given day

For all adult females and males 65 years or older:

- 7 or more drinks per week, or
- 4 or more drinks during any given day

Or if:

One or more responses to the CAGE questions referring to the past year were positive.

TOOLS FOR COLLATERAL SCREENING

Gathering "collateral" reports (e.g., a spouse reports on their partner's drinking) may be useful in helping you identify potential alcohol problems in the family. Furthermore, it is important to determine whether family members who are not present for therapy may have an alcohol problem, particularly when the presenting problem involves couple or family issues. The following general questions about drinking and family life may be incorporated into any standard family intake:

Family/Relational Drinking Conflict Questions

(These questions, when asked, may be used to reference "anyone" in the family, or may be asked specifically about the spouse.)

- Have you felt worried or upset about the drinking habits of anyone in your family?
- Are there disagreements in your family about how, when, where, or why alcohol is used?
- Do the drinking habits of anyone in your family cause tension or conflict at home?

Alcohol problems may exist at a family or relational level if any of these questions is answered positively. Further screening information should be collected directly from the family member whose drinking is a concern, or if this is not possible, through further collateral reporting. Modified versions of the consumption and CAGE questions may be used to screen for alcohol problems in other family members. For example, to gather information on the spouse's drinking, the questions may be asked as follows:

Basic Quantity-Frequency Questions (Family Member Report)

- Does your partner drink alcohol, including beer, wine, or hard liquor?

  If "no," discontinue the screen.
- On average, how many days per week does your partner drink alcohol?
- On a typical day when your partner drinks, how many (standard) drinks would you say he/she has?
- What is the maximum number of drinks your partner consumed on any given day during the last month?

CAGE Questions (Family Member Report)

- Has your partner ever attempted to **C**ut down on his/her drinking?
- Has your partner ever become **A**ngry or upset when others comment on his/her drinking?
- Has your partner ever felt bad or **G**uilty about his/her drinking?
- Does your partner ever have a drink first thing in the morning (**E**ye opener)?

IF there is a positive response to any of the questions, ask whether the incident(s) happened during the past year.

See the box "Interpreting Risk from the Screening Questions" above to make decisions about further assessments.

Remember: Answers to the screening questions and these interpretive guidelines may be used initially to help you gauge the potential for alcohol problems in the family. **A diagnosis, however, should not be made based on these questions alone.** If an individual or family "screens positive," suggesting indications of risk, further assessment is required to confirm the risk and to determine the nature, extent, and severity of the problem.

Source: Adapted from,

(1) National Institute on Alcohol Abuse and Alcoholism. (1995). *The Physicians' Guide to Helping Patients with Alcohol Problems*. U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, Pub No. 95-3769. Bethesda, MD.

(2) Mayfield, D., McLeod, G., and Hall, P. (1974). The CAGE questionnaire: Validation of a new alcoholism screening instrument. *American Journal of Psychiatry*,13,1121-1123.

(3) Ewing, J.A.(1984). Detecting alcoholism: The CAGE questionnaire. *Journal of the American Medical Association*, 252 (14), 1905-1907.

A Tool for Assessing Alcohol Consumption: The Brief Drinker Profile (Modified)

Brief Quantity-Frequency (Q-F) questions, such as those described earlier (*See Basic Quantity-Frequency Questions on pages A-2 and A-4*), may be used to assess consumption patterns. However, the consumption section of the Brief Drinker Profile is recommended because it yields more information on drinking patterns, including information that will allow you to calculate peak BAL levels. The information derived from the BDP should not only give you a more accurate assessment of the client's consumption pattern, but also provide a range of summary indices that can be used in your brief intervention feedback session (*See Feedback, page 27*).

The modified version of the BDP presented here assesses:

- Typical pattern of use (quantity and frequency)
- Episodic occasions of use
- Time span of consumption, allowing estimates of peak and typical BAL's achieved

The forms provided on the following pages should be used during the interview to record the respondent's information. Summary indices, however, should be calculated after the interview, based on the information provided by the respondent. To complete summary indices related to BAL, you should consult the charts found earlier in this Guide (*See Figure 7. Blood Alcohol Level Estimation Charts, p. 32*).

This consumption assessment uses the metric of standard drinks. Prior to conducting the BDP interview, you should familiarize yourself with the definition and equivalencies for a standard drink. A graphic portrayal of standard drink equivalencies is available in Appendix B. It is recommended that you reproduce this graphic and use it in consultation with the respondent during the interview to arrive at accurate standard drink estimates. To arrive at standard drink estimates, you should probe for the number of drinks consumed as well as the type of beverage and size of the drink, and then work with the respondent to arrive at the number of standard drinks consumed.

Although this interview protocol may also be conducted using a 30-day time frame, we use a 90-day (3-month) time frame in the protocol and attached forms to capture less frequent incidents of heavy drinking. To help the respondent accurately remember drinking occasions during the specified time frame, it is helpful to have a calendar available marked with holidays and other events that may provide "anchors" for the time frame.

You can introduce the assessment as follows:

> *I'd like to get a sense of how and when you use alcohol. I'm going to ask you about your drinking patterns and I'd like you to think about the past 90 days as your frame of reference. It's often helpful to "anchor" the time frame by thinking of specific events in your life that occurred approximately 90 days ago. (Use calendar to help "anchor" the time frame).*

If the respondent drinks less than once a week, you should skip the Steady Pattern Chart and complete the Episodic Occasions Chart. You will also need to complete the Episodic Occasions Chart if the client indicates occasions of drinking that were heavier than his/her typical pattern. You can explain the transition as follows:

> *We've gone over your typical pattern of drinking, but now I'd like to go back and record occasions when you had more to drink than your typical pattern. This would include both times that you drank more than your typical amount or times that you drank on a special day or occasion when you typically would not be drinking.*

Reproducible forms with further instructions on administration and scoring appear on the pages that follow.

Source: Adapted from Miller, W.R., and Marlatt, G.A. (1984). *Brief Drinker Profile*. Odessa, FL: Psychological Assessment Resources.

Brief Drinker Profile Consumption Section (Modified)

During the last 90 days, did respondent typically drink at least once a week?

IF YES: Complete Steady Pattern Chart

IF NO: Skip to Episodic Occasions Chart

Name: _____

Gender: Male Female

Age: _____

Weight: _____

For each time period, enter the number of standard drinks consumed *AND* approximate time span during which it was consumed (in hours).

Steady Pattern Chart				Calculate Daily Standard Drink Totals
	Morning	Afternoon	Evening	
Monday	+	+		= _____
Tuesday	+	+		= _____
Wednesday	+	+		= _____
Thursday	+	+		= _____
Friday	+	+		= _____
Saturday	+	+		= _____
Sunday	+	+		= _____

Steady Pattern Summary Indices

A. Total drinking (non-abstinent) days in a typical week _____

B. Total standard drinks in typical week _____

C. Average number of standard drinks consumed per drinking day (B divided by A) _____

D. Maximum number of standard drinks consumed in a day during a typical week _____
(Choose highest daily standard drink total from above)

E. Estimated Peak BAL for heaviest drinking day in a typical week _____
(To estimate peak BAL, you will need to refer to a standard BAL chart and take into account the respondent's gender, weight, number of drinks consumed, and number of hours over which the drinks were consumed. For number of drinks and hours, refer to the heaviest drinking day in the Steady Pattern chart. If more than one drinking occasion is listed for that day, e.g., the respondent drank one drink in the morning in .5 hours and six drinks in the evening over 2 hours, use only the highest consumption occasion, i.e., in this example, six drinks over 2 hours).

Complete Episodic Occasions Chart if, in past 90 days, respondent:

1) **Did not meet criteria for Steady Pattern Chart, or**
2) **Reports episodic occasions of higher consumption than the typical amounts reported in the Steady Pattern Chart.**

Complete a box below for each episodic drinking amount respondent reports.
For example, if respondent has no typical weekly drinking pattern, but reports on occasion having one drink with lunch and on occasion drinking six drinks with friends on the weekend, fill out one box for the one-drink episodes and another box for the six-drink episodes. For respondents who have completed the Steady Chart, fill in boxes only for episodes not already represented on that chart. For example, a respondent who typically has 6 drinks on Friday nights, but who occasionally has 8, other times 15, and sometimes 20 drinks, should have boxes completed for each of the episodic drinking amounts (8,15, 20). *Use additional copies of this form if additional boxes are required.*

Episodic Occasions Chart	Summary Calculations
_____ Number of standard drinks consumed x _____ Number of these episodes in past 3 months Approximate time span of consumption (hours) _____	= _____
_____ Number of standard drinks consumed x _____ Number of these episodes in past 3 months Approximate time span of consumption (hours) _____	= _____
_____ Number of standard drinks consumed x _____ Number of these episodes in past 3 months Approximate time span of consumption (hours) _____	= _____
_____ Number of standard drinks consumed x _____ Number of these episodes in past 3 months Approximate time span of consumption (hours) _____	= _____
_____ Number of standard drinks consumed x _____ Number of these episodes in past 3 months Approximate time span of consumption (hours) _____	= _____

Episodic Occasions Summary Indices

Calculate A-C only if Steady Pattern Chart was not completed for respondent.

A. Total number of drinking episodes during past 3 months _____

B. Average number of standard drinks per week over the past 3 months _____
(Total standard drinks from all episodic drinking divided by 13 weeks)

C. Average number of standard drinks consumed per episode _____
(Total standard drinks from all episodic drinking divided by B)

D. Maximum number of standard drinks consumed episodically _____

E. Estimated Peak BAL for highest consumption drinking episode _____
(To estimate peak BAL you will need to refer to standard BAL charts and take into account the respondent's gender, weight, number of drinks consumed and number of hours over which the drinks were consumed. For number of drinks and hours, refer to the episode in which the highest number of standard drinks were consumed in the Episodic Occasions Chart).

If respondent completed the Steady Pattern Chart, compare the summary indices for D. and E. on the Episodic and Steady forms and choose the highest of the two for feedback to the respondent.

A Tool for Assessing Dependence: The SCID Alcohol Dependence Questions

The questions below are taken from the alcohol dependence section of the Structured Clinical Interview for DSM-IV-TR Patient Edition (SCID-I/P). SCID questions for use in the diagnosis of alcohol abuse, as well as a full version of the SCID designed for clinical assessment of all Axis I disorders, are also available (*See www.scid4.org*).

The SCID questions are designed to allow clinicians and researchers to systematically evaluate each of the seven indicators of dependence specified in the DSM-IV-TR diagnostic criteria. As noted in Figure 1 on page 2 of this Guide, the DSM-IV-TR Criteria for Alcohol Dependence involve finding three or more of the following in a 12-month period:

A. Tolerance
B. Alcohol withdrawal signs or symptoms
C. Drinking more or longer than intended
D. Persistent desire or unsuccessful attempts to control use
E. Excessive time related to alcohol
F. Reduction in social, recreational, or work activities due to alcohol
G. Use despite knowledge of physical or psychological consequences

Note: *These are brief summaries of the indicators. You should refer to DSM-IV for a complete description of each of these indicators.*

Since the SCID questions do not follow the ordering of the indicators in DSM-IV, we have indicated the relevant indicator for each question in the interview protocol below.

Dependence Assessment Interview Protocol

I'd like to ask you some questions about your drinking habits **IN THE PAST 12 MONTHS**.

1. *Drinking more or longer than intended*: Have you often found that when you started drinking you ended up drinking much more than you were planning to?

   IF NO: What about drinking for a much longer period of time than you were planning to?

2. *Persistent desire or unsuccessful attempts to control use*: Have you tried to cut down or stop drinking alcohol?

   IF YES: Did you ever actually stop drinking altogether? How many times did you try to cut down or stop altogether?

   IF NO: Did you want to stop or cut down? Is this something you kept worrying about?

3. *Excessive time related to alcohol*: Have you spent a lot of time drinking, being high, or hung over?
4. *Reduction in social, recreational, or work activities due to alcohol*: Have you had times when you would drink so often that you started to drink instead of working or spending time at hobbies or with family or friends?
5. *Use despite knowledge of physical or psychological consequences*: Has your drinking caused any psychological problems, like making you depressed or anxious, making it difficult to sleep, or causing "blackouts"?

   Has your drinking ever caused significant physical problems or made a physical problem worse?

   IF YES TO EITHER OF THE ABOVE:

   Did you keep drinking anyway?
6. *Tolerance*: Have you found that you needed to drink a lot more in order to get the feeling you wanted than you did when you first started drinking?

   IF YES: How much more?

   IF NO: What about finding that, when you drank the same amount, it had much less effect than before?
7. *Alcohol withdrawal signs or symptoms*: Have you ever had any withdrawal symptoms when you cut down or stopped drinking like....

   ....sweating or racing heart?
   ....hand shakes?
   ....trouble sleeping?
   ....feeling nauseated or vomiting?
   ....feeling agitated?
   ....or feeling anxious?

   How about having a seizure or seeing, feeling, or hearing things that weren't really there?

   IF NO: Have you started the day with a drink, or did you often drink to keep yourself from getting the shakes or becoming sick?

Source: Adapted with permission of Michael B. First, M.D.
First, M.B., M.D., Spitzer, R.L., Gibbon, M., and Williams, J.B.W. (2001). *Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Patient Edition*. (SCID-I/P) New York: Biometrics Research, New York State Psychiatric Institute.

A Tool for Assessing Consequences: Drinker Inventory of Consequences

The Drinker Inventory of Consequences is a self-administered 50-item questionnaire designed to measure adverse consequences of alcohol abuse in five areas: Interpersonal, Physical, Social, Impulsive, and Intrapersonal. This scale has been adapted to provide a 12-month measure of adverse consequences (Other versions of the DrInC are available at http://casaa-0031.unm.edu/inst/inst.html).

Reproducible forms for self administration of the DrInC appear on the pages that follow.

Source: Adapted from Miller, W. R., Tonigan, J. S., and Longabaugh, R. (1995). The Drinker Inventory of Consequences (DrInC): An instrument for assessing adverse consequences of alcohol abuse. *NIAAA Project MATCH Monograph Series*, Vol. 4, U.S. Department of Health and Human Services, Bethesda, MD.

DrInC Scoring Sheet

Physical	Interpersonal	Intrapersonal	Impulse Control	Social Responsibility	Control Scale
1. _____		2. _____		3. _____	
	4. _____				5. _____
				6. _____	
	7. _____				
8. _____			9. _____		
			10. _____		
11. _____		12. _____			
13. _____				14. _____	15. _____
		16. _____			
	17. _____	18. _____	19. _____	20. _____	
	21. _____		22. _____		
			23. _____		
24. _____					25. _____
				26. _____	
	27. _____		28. _____		
29. _____	30. _____				
	31. _____		32. _____		
33. _____		34. _____			35. _____
		36. _____			
		37. _____			
		38. _____			
	39. _____			40. _____	
			41. _____		
			42. _____		
	43. _____			44. _____	45. _____
	46. _____		47. _____		
48. _____			49. _____		
			50. _____		
_____ +	_____ +	_____ +	_____ +	_____ –	_____ _____
Physical	**Interpersonal**	**Intrapersonal**	**Impulse Control**	**Social Responsibility**	**Total DrInC Score** **Control Scale**

Instructions: For each item, copy the circled number from the answer sheet next to the item number above. Then sum each column to calculate scale totals. Sum these totals to calculate the total DrInC score.

*Zero scores on control scale items may indicate careless or dishonest responses. On version 2R (recent drinking), totals of 5 or less are suspect.

Drinker Inventory of Consequences (DrInC-2R)

INSTRUCTIONS:
Here are a number of events that drinkers sometimes experience.
Read each one carefully, and indicate how often each one has happened to you DURING THE PAST 12 MONTHS by circling the appropriate number (0=Never, 1=Once or a few times, etc.).
If an item does not apply to you, circle zero (0).

DURING THE PAST 12 MONTHS, has this happened to you? Circle one answer for each item:	**Never**	**Once or a few times**	**Once or twice a week**	**Daily or almost daily**
1. I have had a hangover or felt bad after drinking.	0	1	2	3
2. I have felt bad about myself because of my drinking.	0	1	2	3
3. I have missed days of work or school because of my drinking.	0	1	2	3
4. My family or friends have worried or complained about my drinking.	0	1	2	3
5. I have enjoyed the taste of beer, wine, or hard liquor.	0	1	2	3
6. The quality of my work has suffered because of my drinking.	0	1	2	3
7. My ability to be a good parent has been harmed by my drinking.	0	1	2	3
8. After drinking, I have had trouble with sleeping, staying asleep, or nightmares.	0	1	2	3
9. I have driven a motor vehicle after having three or more drinks.	0	1	2	3
10. My drinking has caused me to use other drugs more.	0	1	2	3

Please continue on the next page

DURING THE PAST 12 MONTHS, has this happened to you? Circle one answer for each item:	Never	Once or a few times	Once or twice a week	Daily or almost daily
11. I have been sick and vomited after drinking.	0	1	2	3
12. I have been unhappy because of my drinking.	0	1	2	3
13. I have not eaten properly because of my drinking.	0	1	2	3
14. I have failed to do what is expected of me because of my drinking.	0	1	2	3
15. Drinking has helped me to relax.	0	1	2	3
16. I have felt guilty or ashamed because of my drinking.	0	1	2	3
17. While drinking, I have said or done some embarrassing things.	0	1	2	3
18. When drinking, my personality has changed for the worse.	0	1	2	3
19. I have taken foolish risks when I have been drinking.	0	1	2	3
20. I have gotten into trouble because of drinking.	0	1	2	3
21. While drinking, I have said harsh or cruel things to someone.	0	1	2	3
22. When drinking, I have done impulsive things that I regretted later.	0	1	2	3
23. I have gotten into a physical fight while drinking.	0	1	2	3

Please continue on the next page

Now answer these questions about things that may have happened to you.

DURING THE PAST 12 MONTHS, how much has this happened? Circle one answer for each item:	**Not at All**	**A Little**	**Some-what**	**Very Much**
24. My physical health has been harmed by my drinking.	0	1	2	3
25. Drinking has helped me to have a more positive outlook on life.	0	1	2	3
26. I have had money problems because of my drinking.	0	1	2	3
27. My marriage or love relationship has been harmed by my drinking.	0	1	2	3
28. I have smoked tobacco more when I am drinking.	0	1	2	3
29. My physical appearance has been harmed by my drinking.	0	1	2	3
30. My family has been hurt by my drinking.	0	1	2	3
31. A friendship or close relationship has been damaged by my drinking.	0	1	2	3
32. I have been overweight because of my drinking.	0	1	2	3
33. My sex life has suffered because of my drinking.	0	1	2	3
34. I have lost interest in activities and hobbies because of my drinking.	0	1	2	3
35. When drinking, my social life has been more enjoyable.	0	1	2	3
36. My spiritual or moral life has been harmed by my drinking.	0	1	2	3
37. Because of my drinking, I have not had the kind of life that I want.	0	1	2	3
38. My drinking has gotten in the way of my growth as a person.	0	1	2	3
39. My drinking has damaged my social life, popularity, or reputation.	0	1	2	3
40. I have spent too much or lost a lot of money because of my drinking.	0	1	2	3

Please continue on the next page

DURING THE PAST 12 MONTHS, has this happened to you? Circle one answer for each item:	**No**	**Almost**	**Yes, Once**	**Yes, More than Once**
41. I have been arrested for driving under the influence of alcohol.	0	1	2	3
42. I have had trouble with the law (other than driving while intoxicated) because of my drinking.	0	1	2	3
43. I have lost a marriage or a close love relationship because of my drinking.	0	1	2	3
44. I have been suspended/fired from or left a job or school because of my drinking.	0	1	2	3
45. I drank alcohol normally, without any problems.	0	1	2	3
46. I have lost a friend because of my drinking.	0	1	2	3
47. I have had an accident while drinking or intoxicated.	0	1	2	3
48. While drinking or intoxicated, I have been physically hurt, injured, or burned.	0	1	2	3
49. While drinking or intoxicated, I have injured someone else.	0	1	2	3
50. I have broken things while drinking or intoxicated.	0	1	2	3

Figure B-1. Standard Drinks Chart

WHAT IS A STANDARD DRINK?

A standard drink contains about 14 grams (about .6 fluid ounces) of pure alcohol. Below are approximate standard drink equivalents.

12 **oz. of beer or cooler**	8-9 **oz. of malt liquor** 8.5 oz. shown in a 12-oz glass that, if full, would hold about 1.5 standard drinks of malt liquor	5 **oz. of table wine**	3-4 **oz. of fortified or dessert wine** 3.5 oz. shown	2-3 **oz. of cordial, liqueur, or aperitif** 2.5 oz. shown	1.5 **oz. of brandy** (a single jigger)	1.5 **oz. of spirits (a single jigger of gin, vodka, whiskey, etc.)** Shown straight and in a highball glass with ice to show level before adding mixer
						
12 oz.	**8.5 oz.**	**5 oz.**	**3.5 oz.**	**2.5 oz.**	**1.5 oz.**	**1.5 oz.**

Note: Some of these drinks are sold in containers holding multiple standard drinks. For example, malt liquor is often sold in 16-, 22-, and 40-oz. bottles that contain between two and five standard drinks.

NIAAA RECOMMENDED RESOURCES

Materials from NIAAA

Assessing Alcohol Problems: A Guide for Clinicians and Researchers — This handbook reviews and recommends instruments and scales for assessing alcohol problems to enable even those new to the field to understand the critical issues involved in formal evaluation of alcoholism and alcohol treatment, and to compare alternative measures. Handbook Series 5 due for release in 2003.

Frequently Asked Questions Concerning Alcohol Abuse and Alcoholism — English version: NIH Publication No. 01-4735; Spanish version: NIH Publication No. 02-4735-S.

Alcoholism: Getting the Facts — A booklet that describes alcoholism and alcohol abuse and offers useful information on when and where to seek help. English version: NIH Publication No. 96-4153; Spanish version: NIH Publication No. 99-4153-S.

Alcohol: A Women's Health Issue — This 12-minute video describes the effects of alcohol on women's health at different life stages and includes first-person accounts of women of various ages and ethnic groups who are in recovery, with on-screen information on the prevalence and effects of alcohol problems. NIH Publication No. 02-5152.

Alcohol: What You Don't Know Can Harm You — A pamphlet that provides information on drinking and driving, alcohol-medication interactions, interpersonal problems, alcohol-related birth defects, long-term health problems, and current research issues. English version: NIH Publication No. 99-4323; Spanish version: NIH Publication No. 99-4323-S.

Drinking and Your Pregnancy — This booklet briefly conveys the lifelong medical and behavioral problems associated with Fetal Alcohol Syndrome and advises women not to drink during pregnancy. Revised 2001. English version: NIH Publication No. 96-4101; Spanish version: NIH Publication No. 97-4102.

How To Cut Down on Your Drinking — A pamphlet that presents tips for those who are acting on medical advice to reduce their alcohol consumption. English version: NIH Publication No. 96-3770; Spanish version: NIH Publication No. 96-3770-S.

Helping Patients with Alcohol Problems: A Health Practitioner's Guide — A guide on screening and brief interventions for primary care practitioners, physicians, physician's assistants, nurse practitioners and others who see patients for general health care. Second Edition due for release Spring 2003.

Alcohol Alerts — These 4-page bulletins provide timely information on alcohol research, prevention and treatment issues including: patient treatment matching, women, the workplace, alcohol and minorities, AIDS, co-occurring disorders, fetal alcohol exposure and the brain, aging, sleep, and more.

Alcohol Research & Health — Each issue of this quarterly, peer-reviewed journal contains review articles on a central topic related to alcohol research including issues such as violence, children of alcoholics, preventing alcohol problems, and alcohol and stress, to name just a few.

Interactions Between Alcohol and Various Classes of Medications — A laminated 8-1/2- by 11-inch desk chart listing drug classes, generic names, brand names, and types of interactions between alcohol and medications.

These publications are available in full text on NIAAA's Web site at: www.niaaa.nih.gov.

Print copies are available from:

NIAAA Publications Distribution Center
P.O. Box 10686, Rockville, MD 20849-0686
Phone: (301) 443-3860 or Fax: (301) 480-1726

Resources from AAMFT

Family Therapy Resources — This online resource provides information on alcohol dependence and a wide range of other marriage and family therapy topics. AAMFT members can view and print out complete magazine and journal articles for free at: *www.familytherapyresources.net*.

Alcohol Problems Consumer Update — Consumers can find information about alcohol problems and a variety of other issues addressed by marriage and family therapists. Online versions can be found at: *www.therapistlocator.net*.

Print copies are available from:

American Association for Marriage and Family Therapy
112 South Alfred Street, Alexandria VA, 22314-3061
Phone: (703) 838-9808 or Fax: (703) 838-9805

NIH Publication Number 03-5284
Printed February 2003

National Institute on Alcohol Abuse and Alcoholism
National Institutes of Health
U.S. Department of Health and Human Services