Comprehensive Drinker Profile

Manual Supplement

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for use with

- **Brief Drinker Profile**
- **Follow-up Drinker Profile**
- **Collateral Interview Form**

MANUAL SUPPLEMENT FOR THE

• Brief Drinker Profile

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• Collateral Interview Form

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CONTENTS

Introduction

All three of the instruments described in this manual supplement were derived from the Comprehensive Drinker Profile (CDP), which was first developed in 1971 as a structured intake interview procedure for assessing alcoholism in male inpatients. A revised version of this original instrument was published five years later (Marlatt, 1976). The CDP underwent extensive revision through several progressive forms developed for clinical and research applications and was published as a standardized interview by Psychological Assessment Resources in 1984 (Miller & Marlatt, 1984). This manual supplement describes three adjunct instruments that have been developed for clinical and research uses.

All three instruments, which are designed to be used as structured interviews, can be administered by a broad range of professional and paraprofessional personnel including psychologists, psychiatrists, social workers, nurses, counselors, and psychometric technicians. The interviews are complex, however, and the administration and scoring procedures must be studied carefully. Role-played practice interviews are highly recommended before client interviews are begun.

Purpose of the Instruments

The Brief Drinker Profile (BDP) is an abbreviated version of the CDP which can be administered as a 50-minute intake interview. The BDP covers a broad range of information including basic demographics, family and employment status, history of problem

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The CDP is adapted from G. Alan Marlatt, "The Drinking Profile: A Questionnaire for the Behavioral Assessment of Alcoholism". In E. J. Mash and L. G. Terdal, eds., *Behavior Therapy Assessment*, pp. 121-137. Copyright ©1976 by Springer Publishing Company, Inc., New York. Adapted by permission.

development, current drinking pattern, alcohol-related problems, severity of dependence, other drug use, additional life problems, and motivation for treatment. The BDP incorporates the widely used Michigan Alcoholism Screening Test (Selzer, 1971) as part of the interview, providing a survey of current drinking problems as well as a summary score of problem severity. The BDP also produces *quantitative* indices of other dimensions, including family history of alcoholism, problem duration, alcohol consumption, alcohol dependence, and life problems other than drinking. Quantitative indices are indicated on the BDP form by asterisks(*) (see page 31 in the CDP manual).

The Follow-up Drinker Profile (FDP) provides parallel outcome measures for evaluating client progress, relative to intake, at various intervals after treatment. It is intended to be used in conjunction with either the Comprehensive Drinker Profile (CDP) or the Brief Drinker Profile (BDP). The FDP is a brief structured interview that parallels the content of the CDP and BDP intake protocols. Administration of the FDP normally requires 30-50 minutes, depending upon the complexity of the client's current drinking pattern. The FDP provides both quantitative and qualitative information regarding client status at follow-up points. The interview is designed to inquire about the *3-month* period immediately preceding follow-up, although alternative retrospective time-frames can be adopted (e.g., past 6 months; 3 months preceding the most recent drink). The FDP is designed to supply clinically relevant information to be used in aftercare and evaluation, as well as numerical indices of outcome suitable for quantitative analyses in program evaluation research. Quantitative indices are indicated on the FDP interview form by asterisks (*). Like the CDP and BDP, the FDP is appropriate for use in either inpatient or outpatient settings.

Because self-report data are sometimes unreliable, and because it can be useful to have the perspectives of "significant others" who are close to the client, a Collateral Interview Form (CIF) has also been developed for interviewing friends and family. The CIF is designed to produce quantitative data that can be compared directly with client self-reports obtained from either intake (BDP or CDP) or follow-up (FDP) measures (Miller, Crawford, & Taylor, 1979). Collateral information can serve a variety of purposes including (1) verifying the accuracy of client self-report, (2) obtaining information and perspectives not available from the client, (3) increasing the accuracy of client self-report through awareness that information will be checked, and (4) involving significant others (SOs) in the change process.

Parallel Content

The BDP, FDP, and CIF proceed in a logically structured order, with information organized into major sections. The numbering of items within the BDP corresponds to item designations on the CDP. For this reason, item numbering within the BDP is

Table 1
Parallel Content of the CDP, BDP, FDP, and CIF

CONTENT SECTION	CDP ITEMS	BDP ITEMS	FDP ITEMS	CIF ITEMS
Demographic Information				
Age and Residence	A1-5	A1-5	1-4	I
Family Status	A6-11	A6-8	5	
Employment and Income Information	A12-20	A12-14	6	
Educational History	A21-23	A21-23	—	
Drinking History				
Development of Drinking Problem	B24-29	B24-28	—	
Present Drinking Pattern	B30-37	B30-34, B37	7-13	II
Pattern History	B38-44	B38, B41	—	
Alcohol-Related Life Problems	B45	B45	14	III
Drinking Settings	B46-47	—	—	
Associated Behaviors	B48-55	B48-51	15-18	
Beverage Preferences	B56-57	—	—	
Relevant Medical History	B58-65	B58	—	
Motivational Information				
Reasons for Drinking	C66-72	—	—	
Effects of Drinking	C73-74	—	—	
Other Life Problems	C75	C75	19	
Motivation for Treatment	C76-87	C76-79, C82, C87		
Drinker Type Ratings	C88	C88		
Follow-up Status				
Change Ratings			20-21	IV
Self-Efficacy Ratings			22-24	
Program Perceptions			25-30	

discontinuous at points where CDP items have been omitted. For the FDP and CIF, independent and sequential item numbering has been used. Table 1 reflects parallel sections for the four instruments.

The Brief Drinker Profile

Administration

Comments on Interview Style

The BDP is a structured interview, and is intended to be administered in one session and in the order presented. If necessary, however, the interview can be completed over more than one session. Order of information collection can also be modified, although the BDP is arranged in a carefully designed and tested sequence.

The best style for administering the BDP is a comfortable, conversational one. An empathetic approach, reflecting the client's meaning and emotion, is appropriate and is likely to elicit more honest information than will a skeptical, distrustful, or confrontational interview style. It is important that the interviewer be thoroughly familiar with the BDP format in order to avoid unnecessary reliance on the form or manuals. An interviewer who must read questions from the form necessarily maintains less eye contact with the client and may give the appearance of an impersonal pollster. The interviewer should avoid referring constantly to the BDP form or manuals and focus on the client instead.

The question of reliability of alcoholics' self-reports is often raised, with the implication that problem drinkers are prone to lying, deceit, and denial regarding their drinking. Although such incidents certainly occur, it has been the authors' experience that interviewer style is a much more powerful determinant of client honesty than "alcoholic personality" traits inherent in the clients themselves (Miller, 1976, 1983, 1985). A distrustful, argumentative, and overtly confrontational style during the interview is likely to elicit client responses that are evasive and less than truthful. On the other hand, honest and accurate information is more likely to be elicited by asking clear and specific questions in a respectful and

empathetic manner, and by responding to answers in a reflective fashion rather than with shock, disapproval, accusation, or judgment. The majority of studies evaluating the accuracy of alcoholics' self-reports have found reasonably good correspondence with other information sources when questions have been asked of clients in a specific and nonthreatening manner (Midanik, 1982; Miller, Crawford, & Taylor, 1979; Sobell, Maisto, Sobell, & Cooper, 1979). An informational interview conducted in empathetic fashion may also benefit the treatment process by increasing client motivation (Miller, 1983, 1985). If desired, significant others can be interviewed for corroborating data by using the structured CIF described later in this manual.

Some General Rules

A few general rules apply throughout the BDP. Following these suggestions will increase the interpretability of interview results and the usefulness of data to other staff.

Use a pencil rather than a pen. It is frequently necessary to change answers as further clarification is obtained, and this is much easier when responses have been recorded in pencil.

Print clearly. There is much detail in the BDP, and later deciphering of unclear handwriting can be difficult.

Fill every blank. When an item is not applicable to the client, print "NA" on the line. This makes it clear that the item was not overlooked, and helps to differentiate between missing data and zero values.

Check only one answer to multiple choice items, except where instructed otherwise. Note, however, that some items require *all applicable* alternatives to be checked. Follow instructions closely.

Record fully and carefully. The results of card sort items, for example, must be recorded in full before the cards are picked up. On open-ended questions, a client's additional or incidental comments may contain information essential to later understanding of the client's meaning or to content classification. *When in doubt, record.* If BDP responses are to be content coded or computer analyzed, keep the coder in mind while conducting the interview.

Follow wording of questions. Each question within the BDP has been worded carefully, and it is recommended that the same wording be used while conducting the interview. To do this

without sounding stilted or artificial requires a considerable familiarity with the instrument.

Do not read alternative responses. In multiple-choice items, it is not desirable to read alternative responses to the client. Rather, allow the client to answer the question, then select the appropriate alternative to match the answer given, or ask for further clarification as needed.

Perform calculations immediately after the interview. At several points in the BDP, calculations are required. These should not be done during the interview, but it is highly desirable to complete them immediately afterwards. This permits needed calculations to be done while the interview is still fresh in mind. In the event that insufficient information has been obtained for completion of the necessary calculations, the client should be recontacted for needed details.

Transition statements. Transition prose for use in the interview process is suggested in the guidelines that follow. Here the phrasing is not crucial, but rather is intended to promote a smooth interviewing style.

When To Interview

The best time to conduct the BDP will vary with client populations. For inpatients requiring detoxification, it certainly is best to wait a few days to a week, until the major agitation and disorientation of withdrawal have subsided.

In some cases the individual has a particular goal in presenting himself or herself; it may be admission to the program, mitigation of court penalties, disability or other financial benefits. To whatever extent possible, it is desirable to settle such questions before embarking on an extensive interview such as the BDP. Otherwise, the client's responses may be unduly influenced by his or her motivations to achieve a certain goal. This is not always possible, of course, and collateral confirmation of self-report may be particularly valuable in such cases.

With outpatients, the administration of a blood alcohol concentration (BAC) screening test prior to interviewing is recommended as a standard practice. The easiest way to accomplish this is through breath testing via an instrument designed for BAC analysis (e.g., Intoximeter, Intoxilyzer). It is quite difficult to judge intoxication from overt behavior alone. A BAC test eliminates doubt on this matter, and ensures that one is interviewing a sober

individual. As a general guideline, an interview should not proceed if the client's BAC exceeds 50 mg% (.050 g/100 ml).

Specific Administration Procedures

The complete BDP kit includes this manual supplement, the CDP manual (for details of scoring and interpretation), individual BDP interview forms, and the CDP reusable card sets, of which four are required for administration of the interview (Drinker Types: orange, cards A-1 through A-6; Other Drugs: grey, cards D-1 through D-9; Other Life Problems, tan, cards G-1 through G-18; and Treatment Goals, blue, cards H-1 through H-6). Note that the BDP omits items contained in the CDP, yet the CDP numbering system has been retained.

Introducing the BDP

It is helpful, before beginning the interview, to give the client a general picture of the nature and purpose of the session. A sample introduction follows:

"Today I'm going to be talking with you for about one hour in order to learn more about you and your present situation. I'll be asking you a number of specific questions, and I'll be following a general outline that we use here at the clinic. I'll try to make the questions as clear as I can, but if you aren't sure what I mean please ask. The most important thing is for you to give answers that are as honest and accurate as possible. This information will help us later in planning the best treatment for you. There is nothing for you to fill out — I'm going to do most of the work today, but I do want to emphasize how important it is for you to be as accurate as possible in your answers. Are you ready to start?"

A. Demographic Information

This first section of the BDP is straightforward. The exact wording of questions in this section is not crucial. A transition statement is appropriate to introduce this section; for example: *"First I want to ask you for some basic information."*

Age and Residence

A1. Ask for date of birth and age, and be sure that these two agree.

A2-3. Obtain present address and telephone, if any.

A4. Obtain the name and address of a stable individual, unlikely to move over the next five years, through whom the client could always be reached. This address is useful in locating a client for aftercare or follow-up, in the event that contact with the client has been lost.

A5. Ask how the client came to this program.

Family Status

A6. Ask, *"With whom are you living now?"* Check only one alternative.

A7. Ask whether the client is married. If YES, ask whether the client is currently living with his/her wife or husband. If NO, ask whether client has ever been married. Check only one alternative.

A8. Inquire as to how many times the client has been married. Include the present marriage (if applicable) in this number. Examples: Now married for the third time = 3. Currently divorced from the first marriage and not remarried = 1. Never married = 0. Do not leave blank.

Employment and Income Information

A12. Record the client's occupational skills (whether or not presently employed) and the spouse's occupation (if applicable).

A13. Check the one status that applies best. Attending school does not count as employment.

A14. Record title of present or most recent job. If the client currently engages in more than one type of work, record the job at which most hours are worked. If currently unemployed, note how long it has been since the client was employed.

Educational History

A21. Record all educational training that the client has had, including formal degrees earned and major area of study, where appropriate.

A22. Translate A21 to total years of formal education. Examples: High School graduation (not G.E.D.) = 12. B.A. = 16 (even if it took 8 years of part-time study to complete the 4 years of B.A. education). Include full-time equivalent years of technical and vocational training. Do not leave this item blank.

A23. Record current education status. Check only one.

B. Drinking History

A transition statement is in order at the beginning of this section. An example: *"Now I would like to ask you some questions about your drinking history."*

This is the largest section of the BDP, and it is designed to obtain specific information about past and present drinking patterns and problems.

Development of the Drinking Problem

B24-25. Ask these questions as written. Do not leave blank. Record a specific age in years for each item.

B26. The first card set is used here, although this set is not sorted in any way by the client. This is the Drinker Types set (orange, cards A-1 through A-6), which consists of six cards describing drinking styles ranging from "Non-drinker" through "Alcoholic." Place these six cards in front of the client *in order* (with card A-1 on the left and card A-6 on the right in a single horizontal row) and say:

"Here are six cards describing different kinds of drinkers. Which one of these best describes the drinking habits of your MOTHER? Which one best describes the drinking habits of your FATHER? Which one best describes the drinking habits of your HUSBAND/WIFE/PARTNER?"

If the client has no spouse or partner, omit the last sentence and record "NA" on the spouse/partner line. The "mother" and "father" questions apply to the individuals whom the client regards to have been his or her mother or father (usually those by whom the client was raised), whether or not they were the biological parents. If the client does not know, code 0. Do not code "NA" for parents. If one of the individuals in question was considered by the client to have been a problem drinker or alcoholic at *some* time in his or her life, code that response (5 or 6) even if the person later became an abstainer or nonproblem drinker. If the individual in question was *never* a problem drinker or alcoholic in the client's opinion, code the one pattern that best describes the person's drinking habits for most of his or her life. Use one code only, not multiple codes.

B27. Ask as written. Note that this item refers only to *blood* relatives of the client, not to adoptive family. In each case,

the number of known blood relatives believed by the client to be (or have been) problem drinkers *or* alcoholics is indicated in the left column. Note that male and female blood relatives are coded separately. Every line should be filled with either a whole number or 0. Finally, indicate whether or not the client was raised by his or her biological parents, and if not, by whom. (Instructions for scoring this and other scorable items are contained in the Scoring Procedures section of this manual.)

B28. Ask as written and record response. Code age of problem onset *or* place a check mark on the "denies" line. Do not record age *and* check the "denies" line. Calculate years of problem drinking (except for "denies" clients) by subtracting age at first problem from present age in years. Then ask the open-ended question as written, and record the client's response. (For optional content coding of this and other open-ended items consult Appendix A in the CDP manual.)

Present Drinking Pattern

Obtaining an accurate picture of an individual's alcohol consumption pattern is not an easy process. One is unlikely to obtain reliable data simply by asking, "How much do you drink?" The structured interview procedure in this section is designed to guide the client step by step through a careful description of his or her drinking pattern. Although a client who desires to falsify data can still easily do so within this format, self-report data obtained through this structured interview procedure have been found to correspond well with data derived from collateral interviews using a similar format (e.g., Miller, Crawford, & Taylor, 1979).

Throughout this section an empathic style should be maintained. Many clients find themselves alarmed or surprised at the amount of drinkng they are reporting, and some make comments to this effect. Such remarks should be reflected back (e.g., *"It seems like a lot to you."*) without making judgmental additions (*"You really are drinking too much."*) Some clients also grow impatient with the amount of detail required here. Empathic reflection of such impatience or frustration is again the best approach.

Some clients drink in a consistent fashion from week to week, whereas others are binge drinkers, and still others show both a steady and periodic drinking pattern. To deal with this complication, separate assessments of each client's steady drinking pattern and periodic drinking pattern are conducted. For some clients only

the steady pattern will apply (i.e., drinking does not fluctuate substantially from one week to the next). For true binge drinkers who abstain between episodes, only the periodic pattern will need to be assessed because there is no regular weekly (steady) pattern. For still other clients who have a steady weekly pattern combined with periodic heavier drinking episodes, both patterns will require quantification.

B30. The first step is to determine which of the three drinking patterns best fits the client. This classification is *not* based on the client's or interviewer's subjective opinion as to which label best fits, but rather on the research criteria provided in B30.

First determine whether or not the client is a regular drinker (e.g., drinks at least some alcohol in an average week). If the client reports *no* regular weekly drinking (i.e., does not drink at least once per week, but instead has only episodes occurring less often than once weekly), then classify the client as a PERIODIC DRINKER (P) and skip to B33. If the client *does* report a regular weekly consumption pattern, the correct classification will be either STEADY DRINKER (S) or COMBINATION PATTERN DRINKER (C). In order to determine which of these two categories is correct, it will be necessary to proceed to B31 and complete the STEADY Pattern Chart, which is used for both STEADY and COMBINATION PATTERN drinkers. The difference between these two latter categories is specific: after determining the steady drinking pattern, determine whether there are other drinking occasions when the client drinks *more* than that. Specifically, in the past 3 months have there been episodes in which drinking exceeded the steady pattern by five (5) or more drinks per day on one or more days? (A standardized unit is used throughout this Profile to define a "drink." Consult the Scoring Procedures section of the CDP manual.) To qualify as a COMBINATION PATTERN drinker the client must report one or more periodic drinking episodes in which alcohol consumption exceeded the steady pattern by at least five (5) drinks on at least one day. If such episodes have occurred the client is classified as a COMBINATION PATTERN DRINKER. If not, the correct classification is steady drinker. Note that these classifications are mutually exclusive categories, and that only one can be checked.

B31. Steady Pattern Chart. If the Steady Pattern Chart is to be completed (STEADY and COMBINATION PATTERN DRINKERS only), begin with these instructions. Adhere closely to the phrasing provided:

> *"Now I want to ask you about your regular drinking pattern. First I'd like to get a picture of a typical week of drinking. I realize that drinking will vary from day to day and from week to week, but I want to get an idea of your drinking during a typical week. If there are other special occasions, we will get to those later."*

Note that the Steady Pattern Chart divides a regular drinking week into 21 parts: morning, afternoon, and evening for each of the seven days. Fill in each of the 21 boxes by recording the type and amount of alcohol typically consumed (including the proof or percentage strength of alcohol content whenever possible), and the approximate time span (e.g., beginning and ending hours) over which it is consumed. Begin with weekdays, working through mornings, then afternoons, then evenings. Use these instructions to start:

> *"In a typical week – let's start with weekdays, Monday through Friday – what would you normally drink in the morning, from the time you get up until about lunchtime?"*

The latter phrasing is intended to provide permission for reporting morning drinking. Alternative phrasings such as *"Do you ever drink in the morning?"* may encourage falsification or minimization of morning drinking information. Ask about "weekdays" together, rather than inquiring separately about Mondays, Tuesdays, etc. This expedites completion of this section for the typical client.

The interviewer can help the client to be more specific by first asking *which* beverages are consumed, then how much of each. It helps to know ordinary drink sizes, e.g., standard bar draft of beer = 10 oz.; ordinary wine glass = 4 oz. (refer to Scoring Procedures section of the CDP manual). The interviewer should be careful *not* to assume drink sizes. "One drink" of whiskey may mean an 8 oz. tumbler for one client, but a 1 oz. shot for another. *Ask for details.* After each reported type of drink for a given time block, ask: "*...and what else?*" Remember to ask about the time period over which the alcohol is usually consumed.

Clients should not be permitted to avoid answering by claiming that their drinking is too variable to estimate. One method to help clients specify an average amount is *bracketing.* This is accomplished by choosing an amount that is almost certainly too high (*"More than two cases of beer?"*), then one that is

probably too low (*"More than two beers?"*), and continuing to narrow these upper and lower limits until a tighter range is achieved. When this range cannot be further contracted, the midpoint of the final range can be used.

Clients frequently volunteer a range, such as "three or four beers." In such cases it is useful to ask, *"Closer to three, or closer to four?"* By specific behavioral interviewing of this kind, better specification of the typical drinking pattern can be achieved.

After covering weekday mornings, proceed thus:

"Now how about weekday afternoons, including what you drink with lunch up through the afternoon until dinner time. What would you normally drink on weekday afternoons?"

Frequently afternoon drinking varies from day to day, and there may be a regular pattern such that certain days of the week are characterized by heavier drinking. In other cases the pattern may not be attached to particular days, but the client may be able to specify one pattern "on two days a week" and another for the remainder, etc.

The grid is then continued by inquiring about evenings:

"And now how about weekday evenings? What would you normally drink with dinner, up through the rest of the evening until the time you go to sleep?"

Finally the grid is completed by repeating this entire process for weekend days. Separate inquiries are recommended for weekdays and weekends because drinking patterns on these days often differ widely. Repeat the query regarding morning drinking even if the client, when asked about morning drinking on weekdays, reported never drinking in the morning.

For any time block where no drinking is reported, enter a zero (0). *Do not leave any blank boxes.* An entry should be made in all 21 boxes of the grid. This prevents errors through omission of time periods. Be careful not to make restrictive assumptions (for example, that a client does not drink while driving or during working hours).

These procedures must be modified to accommodate clients with certain lifestyles or schedules (e.g., working night shifts, European meal patterns, etc.). Remember that the purpose of this grid is to obtain a well-specified estimate of drinking over the course of an average week.

B32. Quantity/frequency summary data are calculated from

the Steady Pattern Chart according to instructions contained in the Scoring Procedures section of this manual. If the client does not drink at least once per week but instead drinks only in episodes occurring less often than weekly, the entire Steady Pattern Chart is bypassed and items B31-32 are left blank.

B33. Episodic Pattern Chart. The Episodic Pattern Chart is designed to quantify alcohol consumption not included in the Steady Pattern Chart (B31). It is to be completed for all clients classified as either PERIODIC or COMBINATION PATTERN drinkers. For clients classified as STEADY drinkers at B30, skip this section and resume the interview with E38.

The Episodic Pattern Chart allows for the recording of up to three different types of periodic drinking episodes. The boxes are not intended for recording particular single episodes (although this can be done) but rather for *types* of drinking occasions on which consumption exceeds the regular steady pattern. That is, the episodes recorded here will, in most cases, represent recurring types of episodes.

For PERIODIC drinkers, quantify episodic drinking here by specifying the type(s) and amount(s) of alcohol usually consumed during a drinking episode, the span of time (hours) over which the amount is usually consumed, and the frequency of such episodes (number that have occurred within the past 3 months). For the calculation of SECs and BAC for each episode type, consult the Scoring Procedures section of the CDP manual.

For COMBINATION drinkers, who also have reported a steady drinking pattern (B31), there is an important difference in how the Episodic Pattern Chart is completed. For these clients, record *only* those episodes that exceed the steady pattern (B31) by at least five drinks (SECs — see Scoring Procedures section in the CDP manual) on at least one drinking day. Thus if a client normally has 6 drinks (SECs) on Saturdays (steady pattern, recorded in B31), a heavier Saturday consumption of 11 drinks or more *would* qualify as an additional episode, whereas an occasional Saturday of having 10 drinks (SECs) would *not* qualify. This is an arbitrary research criterion for determining when an episode "significantly exceeds" the client's regular, steady drinking pattern. (For clinical or research purposes, other criteria could be applied if desired.) Episodes that qualify are recorded exactly as specified above for PERIODIC drinkers.

Up to three different types of episodes can be recorded

(although one may suffice). For each type, specify the quantity, hours, and frequency as indicated. "Hours" refers to hours of continuous drinking, a fact needed for the estimation of peak BAC resulting from an episode.

B34. Just as data from the Steady Pattern Chart (B31) are summarized in B32, so data from the Episodic Pattern Chart (B33) are summarized here in a quantity/frequency estimate. For calculation instructions see the Scoring Procedures section of the CDP manual.

B37. This item is a calculation, not a question to be asked during the interview. It combines quantity/frequency data obtained at B32 and B34, yielding a total quantity/frequency estimate for the past 3 months. Consult the Scoring Procedures section of the CDP manual for instructions. Do not attempt to perform these or other calculations during the interview process. The interview resumes with B38.

Pattern History

This section on Pattern History is completed for all clients regardless of their classification at B30.

B38. Ask as written. Record type(s) of beverage(s), amount(s) and hours taken to consume the total amount. Calculations are to be completed following the interview, according to instructions provided in the Scoring Procedures section of the CDP manual.

B41. Record how long ago. The purpose for this is to evaluate the most recent occasion on which withdrawal symptoms might have emerged. Record any medication used that might have inhibited withdrawal symptoms. Record any indications of withdrawal signs.

Alcohol-Related Life Problems

B45. This section yields two important problem summary scores. The Michigan Alcoholism Screening Test (Selzer, 1971) is embedded in these questions and yields a score that reflects severity of life problems related to drinking. The Ph scale is designed to reflect degree of severity of dependence on alcohol, emphasizing indicators of pharmacologic dependence. Note, however, that "dependence" is conceived more broadly than pharmacologic addiction alone, and includes behavioral indices such as morning drinking, blackouts, skipping meals, and hangovers. This is consistent with more general definitions of dependence

that have been employed in recent treatment evaluation research (e.g., Polich, Armor, & Braiker, 1981).

Administration of this portion of the BDP is straightforward. Ask the questions *exactly* as written, using the introductory statement provided. For each item, print either YES or NO on the response line (left column of lines). Do not leave any lines blank in this column. As for interviewing style in this section, be careful to take adequate time to read the list in a nonthreatening matter-of-fact manner. Do not rush through the items in "checklist" fashion. Give the person time to think about and answer each item. Scoring is done after the interview has been completed (consult instructions in the Scoring Procedures section of the CDP manual).

Associated Behaviors

Begin this section with a statement such as: *"Now I want to ask you about some other behaviors often related to drinking."* A reassurance of confidentiality of the interview may be in order at this point because of the sensitive nature of the information that follows.

Questions in this section are straightforward. Record client responses carefully.

B48. Record cigarettes per day, or indicate "00" for nonsmokers. Do not leave blank. If the client has never smoked cigarettes, indicate "NA" on the second line; otherwise record time since last cigarette. Specify that it is tobacco (not marijuana) that is being queried. Indicate any other use of tobacco.

B49. Indicate the client's self-perceived state of overweight or underweight by recording the number of pounds away from ideal weight. Use the appropriate arithmetic sign for over (+) or underweight (−). If metric, specify kg instead of pounds.

B50. Record all medications used, including nonprescription over-the-counter medications such as vitamins and aspirin. Ask specifically about each class of medication mentioned. Record the name of medication, dosage (if known), frequency of use, and purpose of medication. Indicate those medications taken by physician prescription, by printing YES or NO in the "Rx" column. For medications whose name or dosage is unknown, have the client check the prescription label.

B51. Information regarding other drug use is obtained via the

Other Drugs card sort (grey; cards D-1 through D-9). This permits nonverbal acknowledgement of drug use, which may be less threatening than direct questioning. Instructions for introducing this card sort are as follows:

> *"Here is a third set of cards for you to sort. Each card names a type of drug that people sometimes use. In the pile on the left I would like you to place those cards that name a kind of drug that you have tried at least once in your life. In the pile on the right, place the cards that name drugs you have never tried at all."* (When this has been completed, remove the pile on the right and then continue): *"Now I would like you to arrange these cards from the left pile according to how often you have taken each drug. On top, put the card that names the kind of drug you have used most often in your life, then the next most often, and so on down to the one you have used least often in your lifetime."*

When this process is finished, record the rankings on the Profile, marking the most frequently used drug as "1," the next as "2," and so on. As before, cards from the NO pile are indicated by leaving the corresponding lines blank.

Finally, inquire further regarding all drugs named in the left YES pile. Obtain and record the following information, as available: specific drugs used in each category, date of most recent use, frequency within the past 3 months, method of administration (oral, intravenous, inhaled, etc.), and any information about dose level. If not used in the past 3 months, enter "0" in the Frequency column but complete all other columns, including dose and method of administration at most recent use. Record the total number of cards placed in the YES pile (ever used) and the total number used in the past three months.

Relevant Medical History

B58. Actual measurement is preferable to client self-report of weight and height.

C. Motivational Information

Other Life Problems

C75. The Other Life Problems card sort evaluates current difficulties other than drinking, whether or not they are related to alcohol consumption (tan; cards G-1 through

G-18). There are three steps required to complete this card sort. Begin with the instruction:

> *"Now here is one more set of cards for you to sort. These cards describe other problems that people sometimes have. These may or may not be related to drinking. In the pile on the left I want you to place the cards that describe things that are at least somewhat of a problem for you currently. In the pile on the right place the cards describing things that are not at all problematic for you right now."*

No recording is required at this point. Remove the right pile and continue:

> *"Now I want you to arrange this pile from the left according to how much of a problem each one is for you now. On top put the one that is the biggest problem, and next the second biggest problem and so on down to the one that is the smallest problem for you now."*

When this has been completed, record the rank ordering of problems by placing a "1" next to the problem area at the top of the pile, a "2" next, and so on down to the bottom and least significant problem. Note that the problem list is arranged on the Profile form in alphabetical order for your convenience. Rank lines that correspond to cards placed in the right (no problem) pile are left blank.

Third, for all YES cards inquire whether the problem is or is not at least partly related to drinking, in the client's opinion: *"For each one of these cards, I would like your opinion as to whether or not the problem is at least partly related to drinking."* Place a checkmark (✓) *only* beside those problems considered by the client to be alcohol-related. On the *total* lines provided record the total number of problems (the number of cards placed in the left YES pile) and the total number of problems perceived to be alcohol-related (the number of checkmarks in the column on the right).

Motivation for Treatment

C76. Ask as written and record the client's response. (For optional content coding see Appendix A in the CDP manual.)

C77. Ask as written and record response.

C78-79. Ask as written. Check YES or NO. Do not leave blank. If YES specify.

C82. This item requires use of the six Treatment Goals cards (blue; cards H-1 through H-6). The cards must be arranged *in order* in front of the client: H-1, H-2, H-3, H-4, H-5, H-6. Ask: *"Which of these six statements best describes your own goal (in this program)?"* On the Profile form, mark (✓) the one chosen. If more than one is chosen, indicate which is first preference (1), and second preference (2).

C87. Ask exactly as written. Do not leave blank, and check only one alternative — the one with which the client agrees more strongly.

Drinker Type Ratings

C88. This item reuses the Drinker Types card set (orange; cards A-1 through A-6). Place the cards *in order* in front of the client and say:

> *"Here are six different types of drinkers, and I would like you to tell me which one, in your opinion, best describes you at the present time."*

After giving this instruction, note which card the client indicates, and record the number of that card (1, 2, 3, 4, 5, or 6) on the line marked "Self." Do not leave blank. Then if the client currently has a spouse or living-partner say:

"Now I'd like you to tell me the one that you think your (husband/wife/partner) would choose as best describing you."

Record this rating. Do not leave blank if the client has a spouse or living-partner. If the client has no spouse or living-partner, mark this line NA and skip to the next instruction:

"Which one do you think your closest friend would choose as best describing you?"

Record this rating. Do not leave blank. Then ask:

"Which one do you think most people who know you would choose as best describing you."

Record this rating. Do not leave blank.

Finally, check whether the rating given for "Self" is higher than, equal to, or lower than the rating given for "Most People." "Higher than" is defined as a higher numerical rating. Thus if the "Self" rating is 5 and the "Most People" rating is 4, the interviewer would mark line (1) higher than "most."

Scoring and Interpretation

Scoring Procedures

Several sections of the BDP require scoring in order to derive quantitative indices. Detailed procedures for scoring these sections are provided on pages 31-41 of the CDP manual (Miller & Marlatt, 1984). All instructions apply except for sections on "Effects of Drinking (C73)" (p. 40) and "Content Coding of Open-ended Questions" (p. 41), which are omitted from the BDP.

Interpretation

The BDP is designed to provide a structured data base that is useful both for research and for individual treatment purposes. The means and ranges of quantitative scores from the BDP vary widely depending on the population being studied. For comparative purposes, normative data from a sample of 103 outpatients at the University of New Mexico are provided in Appendix C of the CDP manual (Miller & Marlatt, 1984). Note, however, that these norms reflect less severity of symptoms than would be found in a typical inpatient population, and that individuals may be better compared to norms derived from the specific population being treated or studied.

Guidelines for professional interpretation of the BDP can be found in corresponding sections of the CDP manual (pp. 43-52). Specific interpretation of information from the BDP depends in part on the purposes to which it is to be applied and on the clinical judgment of the interviewer. Information from the BDP can be used, for example, in selecting optimal treatment approaches for clients (Miller & Hester, 1986), in predicting treatment outcome (e.g., Miller & Baca, 1983; Miller & Joyce, 1979), in comparing pretreatment with post-treatment data to assess individual or program effectiveness (e.g., Miller, Gribskov, & Mortell, 1981; Miller, Hedrick, & Taylor, 1983; Miller & Taylor, 1980; Miller, Taylor, & West, 1980), or as a baseline against which to compare progress in modifying drinking behavior during treatment or preventive interventions (e.g., Carpenter, Lyons, & Miller, 1985; Miller, 1982; Miller & Muñoz, 1982; Miller, Pechacek, & Hamburg, 1981).

Since 1983 the use of the BDP as a tool in increasing client motivation for treatment has also been explored. Too often pretreatment assessment data are collected but not shared in any systematic way with the client. The structured feedback of objective information can function as a motivating factor in helping clients to evaluate their current status and their need for change (Kristen-

son, 1983; Miller, 1983, 1985). The BDP has been used as part of a "Drinker's Check-up" that is offered to any drinker who is interested in determining what negative effects, if any, alcohol may be having in his or her life. The BDP is used in combination with the self-administered Alcohol Use Inventory (Horn, Wanberg, & Foster, 1986), a serum chemistry profile, and a brief neuropsychological screening battery sensitive to early alcohol impairment. Objective measures from the check-up are then given as feedback, in combination with normative ranges that permit the individual to assess his or her current standing. In this way, interpretation of BDP data to the client may be useful in increasing motivation for change. Follow-up assessments can also function as feedback of progress toward overall goals.

The Follow-up Drinker Profile

Administration

The FDP is a highly structured interview and can be conducted, with proper training and practice, by a broad range of professional and paraprofessional personnel. It is recommended that the FDP be administered by a person other than the client's therapist(s). In research applications the follow-up interviewer should be blind as to treatment group assignment of individuals being interviewed.

Comments on interview style as discussed for the CDP and BDP also apply in administering the FDP. The best style is a comfortable, conversational one including empathetic listening and reflection. It is important that the interviewer be thoroughly familiar with the FDP format to avoid excessive reliance on the form.

Similarly, the general rules for administering the CDP/BDP also apply to the FDP. Use of a pencil and clear printing will facilitate later interpretation. Every blank should be filled, and careful and complete notes should be taken to avoid ambiguities on later reading. Where specific wording for questions is provided, the proposed phrasing should be followed closely. Calculations should be performed after the interview has been concluded.

Two of the reusable CDP card sets are required for administration of the FDP: "Other Drugs" (grey, cards D-1 through D-9) and "Other Life Problems" (tan, cards G-1 through G-18).

When to Interview

Recommended intervals for follow-up interviews are at 3, 6, 12, and 24 months following the termination of formal treatment. Other follow-up intervals may be chosen, however, without altering any other aspect of the interview.

A 3-month interview is recommended to evaluate short-term outcome status and to detect recent or impending relapse. This may improve aftercare by permitting earlier detection and prevention of problems. A 6-month interview is recommended because recent data suggest that 6 months is the minimum period of abstinence that can be considered to be a stable outcome (Polich, Armor, & Braiker, 1981). Shorter spans of follow-up may not be predictive of longer-term status. Longer follow-ups at 12 and 24 months are also recommended to obtain a more stable picture of the individual's long-range outcome. In some cases, stability will not be achieved until more than two years following treatment.

The administration of a breath test is also recommended as a standard practice, to screen for blood alcohol concentration (BAC) prior to interviewing. Such a BAC test eliminates doubt as to whether the individual has been drinking recently, increases confidence in the validity of follow-up data, and serves as a small further verification of self-report.

Introducing the FDP

It is helpful, before beginning the interview, to give the client a general picture of the nature of the interview. This will vary, depending upon the setting and purpose of the interview. A sample introduction follows:

> *"I'm going to be talking with you for about an hour today. The purpose of this interview is to find out how you are doing at present and to get some specific information about what has been happening since we last saw you. I'll be asking you a number of specific questions, and I'll be following a standard outline that we use here at the clinic. I'll try to make the questions as clear as I can, and many of these you have been asked before. If you aren't sure what I mean, however, please ask. The most important thing is for you to answer as honestly and accurately as you can. This information helps us in evaluating our treatment programs and making them better for people who will come here in the future. There is nothing for you to fill out right now, but I do want to emphasize how important it is for you to be as accurate as possible in your answers. Are you ready to start?"*

Demographic Update (Items 1-6)

The interviewer should carefully record the client's name and (if appropriate) identification (ID) number, as well as the date and year of intake and follow-up. Length of follow-up is specified in

weeks or months. This can be either time since intake or time since treatment termination, but a consistent system should be used.

Record the client's present age (1), local address including zip code (2), and current telephone number (3). If significant others are being interviewed for collateral information, record any change in name, address, or telephone number for collaterals (4). The name and address of the "person through whom you can be located if we lose contact" should also be updated from the CDP or BDP item A4. This updating of information aids greatly in locating the client for further follow-up interviews.

Current marital (5) and employment (6) status are indicated by checking one and only one alternative. Regardless of marital status checked, indicate the number of times the client has been married, including a present marriage as one of the marriages. (Never married = 0). If the client is unemployed, indicate the date of most recent employment. For all clients indicate the title of the present or most recent job.

Present Drinking Pattern (Items 7-13)

The purpose of these questions is to obtain an accurate quantitative picture of the client's drinking during a specified index period (usually 3 months) preceding the interview. For clients who have been totally abstinent (no drinks at all) during the follow-up period, check the ABSTINENT line at item 7 and skip to item 13. Otherwise follow exactly the instructions for these items as specified for the CDP/BDP. The corresponding items on the CDP/BDP are:

FDP Item	7	8	9	10	11	12
CDP/BDP Item	B30	B31	B32	B33	B34	B37

Items 7-12 on the FDP intentionally parallel the same items asked at intake on the CDP and BDP, and also parallel the procedures used to interview collaterals at these same points. This permits direct pre/post-treatment comparisons (CDP or BDP vs. FDP) and the validation of self-report (FDP vs. Collateral Interview Form).

Item 13 is asked only of clients who have been abstaining prior to the follow-up interview. Specify the date of the client's last drink, as closely as the client can estimate it. Calculate the approx-

imate duration of abstinence in weeks or months, and verify this duration with the client. Ask, "What were the main reasons why you stopped drinking?" Record the client's responses. Skip question 13 for clients who continue to drink regularly.

Problems and Dependence (Item 14)

This section quantifies recent negative consequences (problems) of drinking and symptoms of alcohol dependence. For clients who have been totally abstinent during the follow-up period, leave this section blank and skip to item 15. For all others, introduce this section with the introductory statement provided, asking the questions *exactly* as written. If the follow-up period is less than 12 months, then use the shorter index period, usually 3 months, in this introduction.

For each item answered "No," leave all the lines blank for that item. When an item is answered "Yes" for the past year, mark (x) the "Past Year" line for that item. Then inquire whether the same experience has occurred within the past 3 months [mark (x) if Yes] and within the past week [mark (x) if Yes]. Again, if desired, an index period other than three months can be used. The same index period should be used here and in items 7-13. For follow-ups shorter than 12 months, use only the "Past 3 months" and "Past week" columns. Note that a mark (x) on the "Past Week" line *requires* a mark on the "Past 3 months" and "Past Year" lines, because any experience that has occurred during the past week has also, by definition, occurred within the past three months and the past year. Similarly, any experience marked (x) for "Past 3 months" must also be marked for "Past Year." The reverse is not true, however. An experience may have occurred within the past year, but not within the past three months or the past week (e.g., seven months ago).

Additional Help (Item 15)

For all clients ask:

"Since you completed this program, have you sought any additional kinds of help in relation to your drinking? Have you..."

Then read each of the alternatives. For items answered "No," leave all lines blank. Where the client says, "Yes," mark (x) the "Ever" line. Then indicate also whether this has occurred within the past year and within the past 3 months. As with 14, an item marked (x) as having occurred within the past three months necessarily must be marked as having also occurred within the past year and "ever."

The "Ever" line may be marked without marking other lines, however, if the help was sought more than a year ago. Where requested, specify the approximate number of visits that the client has *ever* made.

Other Substance Use (Items 16-18)

For all clients, including alcohol abstainers, ask (at item 16):

"Do you smoke cigarettes?"

If "Yes," determine the average number of cigarettes per day. If "No," inquire:

"Have you ever been a smoker?"

If the client answers "Yes" to this question, specify the approximate date of the last cigarette. If client has never smoked cigarettes, indicate "NA" on the second line. For all clients, inquire about other types of tobacco use and specify these, if applicable.

At item 17, specify present body weight, preferably by weighing. Inquire whether the client is satisfied with this weight:

"Are you satisfied with your present weight, or do you think that you are overweight or underweight?"

Specify perceived overweight or underweight in pounds, using the appropriate arithmetic sign to indicate overweight (+) or underweight (−).

Finally, for item 18, use the Other Drugs card set (grey; cards D-1 through D-9) and give this instruction:

"Now here is a set of cards for you to sort. Each card names a type of drug that people sometimes use. In the pile on the left I would like you to place those cards that name a kind of drug that you have used at least once during the past [three months]. In the pile on the right, place the cards that name drugs you have not used at all during the past [three months]. (When this has been completed, remove the pile on the right and then continue, if the pile on the left contains more than one card): *Now I would like you to arrange these cards from the left pile according to how often you have taken each drug. On top, put the card that names the kind of drug you have used most often during the past [three months], then the next most often, and so on down to the one you have used least often in the past [three months]."*

An index period longer than three months can be used, if desired.

Record the rankings, marking the most frequently used drug as "1," the next as "2," and so on. Lines corresponding to cards placed in the right ("No") pile are left blank. Then specify for each drug from the left ("Yes") pile the specific drug(s) used, date of most recent use, frequency of use during the past three months, method of administration, and any available information on typical dose.

Other Life Problems (Item 19)

Use the Other Life Problems card set (tan; cards G-1 through G-18) from the CDP and give this instruction:

"Now here is another set of cards for you to sort. These cards describe other problems that people sometimes have. These may or may not be related to drinking. In the pile on the left I want you to place the cards that describe things that have been at least somewhat of a problem for you during the past [three months]. In the pile on the right place the cards describing things that have not been a problem at all during the past [three months]."

No recording is required at this point. Remove the right pile and continue:

"Now I want you to arrange this pile from the left according to how much of a problem each one has been for you over the past three months. On top put the one that has been the biggest problem, and next the second biggest problem, and so on down to the one that has been the smallest problem for you."

When this has been completed, record the rank ordering of problems by placing a "1" in the "Rank" column next to the problem area at the top of the pile, a "2" next, and so on down to the bottom and least significant problem. Note that the problem list is arranged in alphabetical order for your convenience. Lines corresponding to cards that were placed in the right ("No") pile are left blank.

Finally, for all "Yes" cards, inquire whether the problem has or has not been related to drinking, in the client's opinion:

"Now for each one of these cards, I would like your opinion as to whether or not the problem has been at least partly related to your drinking during the past [three months]."

Place a check mark in the second column only beside those problems considered by the client to have been alcohol-related. For clients who have been totally abstinent during the index period, this final step can be omitted because the interest here is in the

relationship of problems to current drinking. Nevertheless the rest of this item should be completed for abstainers.

Self-ratings (Items 20-24)

Fold the FDP form so that only the page with these items is showing, and place it in front of the client, giving this instruction:

"Now here are five questions for you to answer. Please read each one carefully, and answer it according to the instructions. If you have any questions or you aren't sure how to answer, please ask me."

When the client has completed items 20-24, take the interview form back, check it to be sure that the client has answered all five questions, then resume with item 25.

Open-ended Questions (Items 25-30)

These are optional open-ended questions for obtaining feedback on the client's perceptions of the treatment program. Ask as written and record the client's responses.

Scoring and Interpretation

Basic guidelines are provided here for scoring and interpretation of each section of the FDP. Refer to Appendix A for sample data obtained from the FDP in a population of problem drinkers at follow-up interviews 3-8 years after treatment.

Demographic Update (Items 1-6)

No scoring is required, and interpretation is straightforward. Accurately updated information here can facilitate contacting the client for subsequent follow-up interviews.

Present Drinking Pattern (Items 7-13)

Quantification of drinking pattern follows the same rules as specified for the CDP manual (pp. 32-35). Specific consumption indices such as total SECs per week, total drinking days, and estimated peak BAC (Item 8) can be compared with corresponding items from the CDP or BDP completed at intake. An index of change, the percent of baseline consumption, can be calculated by dividing post-treatment by pre-treatment level. Consumption at follow-up can also be compared with standard cut-off points (e.g., less than 3 drinks per day on average, BAC peak less than 80 mg%) for the purpose of classifying clients with regard to absolute level of consumption (cf. Miller & Taylor, 1980; Miller, Taylor, & West, 1980).

Consequences and Dependence (Item 14)

To score this section, total each of the three columns (Past Week, Past 3 Months, and Past Year) *separately* for Consequences and for Dependence. The Consequences Totals consist of the number of marks in each column for the upper ten questions. The Dependence Totals are weighted sums. For each mark in a column, print next to that mark the score indicated in parentheses to the left of the item lines. Thus, a Yes for "Drinking before noon" yields one point, whereas "Severe shaking after heavy drinking" yields three points. These scores are then summed for the lower 12 items to produce totals. Dependence totals, unlike Consequence totals, are *not* the simple number of marks in each column, but rather are the sum of weighted scores.

Consequences. The Consequences total provides a quantitative measure of negative life consequences of drinking, other than symptoms of dependence. The distinction between consequences and dependence has been employed in other outcome research (e.g., Polich et al., 1981), although these two variables are significantly intercorrelated. [In a 3-8 year follow-up study conducted at the University of New Mexico, a Pearson product-moment correlation of $r = .43$ ($N = 88$, $p < .001$) was obtained between Consequences and Dependence scores on the FDP.] Note that the Consequences score does not correspond directly with the MAST score from the CDP or BDP, which inquires about a larger number of symptoms over the client's entire lifespan. Rather, the items of the Consequences scale (adapted from MAST items) reflect adverse life consequences of drinking during the follow-up period. MAST items reflecting subjective labeling of drinking (1, 5, and 6) or help-seeking (8, 11, 20, 21, 22, 23) have been omitted. The MAST item asking the client about liver trouble (17) has been reworded to inquire more generally about alcohol-related health problems. If desired, a roughly comparable intake score can be calculated by totaling client responses from the CDP or BDP (B45) for corresponding items. The corresponding items are:

CDP/BDP (B45)	3	9	10	12	13	14	15	17	24	25
FDP (Consequences)	1	2	3	4	5	6	7	8	9	10

It should also be recalled that the MAST inquires about experiences that have *ever* occurred during the client's lifetime, whereas the FDP inquires about a specified follow-up interval. For this

reason and because of item rewordings, FDP Conseqences totals should not be considered equivalent to intake measures from the CDP or BDP.

The severity of consequences is best judged from the specific nature of the negative consequences reported, although the total Consequences score can be used. The loss of a job, for example, is subjectively a more severe consequence than having missed work for two days. Polich, Armor, and Braiker (1981) have indicated that the presence of even a single problem or dependence symptom in combination with continued drinking is a negative prognostic sign. The presence of such signs may warrant additional intervention.

Dependence. The Dependence items correspond directly to the Ph Scale for alcohol dependence generated on the CDP or BDP (B45). The Dependence Total reflects the severity of dependence symptoms remaining at follow-up. The corresponding item numbers are:

CDP/BDP (B45)	2	4	7	16	18	19	26	27	28	29	30	31
FDP	11	12	13	14	15	16	17	18	19	20	21	22

In comparing this score with the intake (CDP or BDP) score from B45, however, be aware that the latter was based on occurrence of these events *ever* during the person's lifetime, and not only at the time of intake. In follow-ups at 3-8 years after treatment, a strong correlation [$r\,(87) = .80$, $p < .0001$] was found between the Dependence total from the FDP and the Alcohol Dependence Scale (Skinner & Horn, 1984) for the same 3 month period.

The following ranges are suggested as working guidelines in interpreting Dependence scores:

Alcohol Dependence Score

01-04 = Mild symptoms of dependence
05-10 = Definite and significant symptoms of dependence
11-14 = Substantial dependence
15-20 = Severe dependence

Additional Help (Item 15)

Totals here are the simple sum of marks in each column. This provides an index of additional sources of help used. The

number of additional contacts or visits may be a more informative index of help sought beyond the particular program being evaluated.

Other Substance Use (Items 16-18)

Convert cigarette consumption into cigarettes per day. For the Other Drugs card sort, count the number of classes of drugs marked in the left column to obtain the Total Drug Classes Used index. The "Total Past 3 months" will be the same, provided the client instructions focused on the past 3 months as the index period. If a longer index period was used, then calculate a separate total number of drug classes used in the past 3 months. This can be compared directly with the same index obtained at intake (B51 on the CDP and BDP). Cigarette consumption and weight can likewise be contrasted with intake values (B48 and B49).

Other Life Problems (Item 19)

The Total Number of Problems consists of the number of Yes responses recorded in the left column, and should correspond to the rank order of the last (least significant) problem card. The Total Number of Problems Alcohol-Related consists of the number of check marks recorded in the right column. This total will always be less than or equal to the Total Number of Problems score. These totals are quantitative indices of the extent of other remaining life problem areas in general, and of residual problems specifically related to drinking. A comparable intake index can be obtained from C75 of the CDP or BDP.

Self-ratings (Items 20-24)

No scoring is necessary. Item 20 represents the client's subjective comparison of current drinking with pre-treatment consumption. This rating is sometimes found to be at variance with quantitative change in reported alcohol consumption. It provides an indication of the client's perception of progress. For total abstainers, this item is uninformative because the self-rating will presumably always be "1."

Item 21 is a subjective rating of satisfaction with current drinking. This may indicate motivation for additional change, because it reflects the discrepancy between the client's desired and present states (Miller, 1985). Of clinical interest, for example, would be a heavy drinking client who indicates total satisfaction, or an abstainer who expresses strong dissatisfaction.

Item 22 assesses subjective comfort with control of drinking.

High scores do not discriminate successful from unsuccessful controlled drinkers. In our 3-8 year follow-ups, we found that high scores on this scale characterized both asymptomatic drinkers and unimproved cases. Abstainers showed no consistent pattern. It has been our clinical experience that drinkers who score low on this scale (feel constantly on guard), even though they may appear to be well-controlled drinkers by quantitative standards, tend over time to become abstainers.

Items 23 and 24 are designed to be measures of two different kinds of self-efficacy (Bandura, 1982). Item 23 is completed by abstainers only and represents "abstinence efficacy," estimated confidence in remaining abstinent. Lower scores (under 80%) on this scale may signal an impending relapse and the need for further evaluation and change.

Item 24 reflects what might be called "control efficacy," the client's perceived ability to maintain self-control over alcohol consumption *when drinking*. Abstaining clients are instructed to complete this item with regard to possible drinking in the future. Individuals convinced of the "One drink, one drunk" assumption would score low on this scale. Once again, high scores do not necessarily predict success with a moderation goal.

Open-ended Questions (Items 25-30)

Classification categories have been devised for content analysis of open-ended questions. A set of categories suitable for classifying responses to item 25 can be found on pages 64-65 of the CDP manual. We have used the following categories to classify helpful aspects of a treatment program:

Helpful Program Effects (Items 26-27)

Categories:

A. **None:** no answer, "can't think of any helpful effects."

B. **Positive awareness:** "helped me realize how serious my problem was," "made me think about my drinking," "caused me to stop denying my alcoholism," "helped me see how much of life I was missing."

C. **Positive relationship:** "felt like people cared about me," "my therapist really listened to me," "I liked the staff and other patients," "the people here really helped me."

D. **Problem improvement:** "helped me decide to quit," "helped me cut down on my drinking," "felt less anxious and depressed."

Harmful aspects of a program experience can be similarly classified:

Harmful Program Effects (Item 28)

Categories:

A. **None:** no answer, "can't think of any harmful effects."

B. **Negative awareness:** "I felt like my problem wasn't all that bad," "helped me to deny my alcoholism," "didn't confront me enough," "didn't really teach me anything."

C. **Negative relationship:** "I felt torn apart," "all I got was a label and a lecture," "pushed me too hard," "my privacy wasn't respected," "I wasn't treated like a person," "didn't like my therapist," "my therapist didn't like me."

D. **Problem deterioration:** "I felt even more depressed after the program and started drinking more," "my drinking just got worse."

The Collateral Interview Form

Guidelines for Interviewing Significant Others for Collateral Information

The Collateral Interview Form is designed to parallel self-report data obtained from the CDP, BDP, or FDP (Miller, Crawford, & Taylor, 1979). Interviewers should be familiar with the CDP or BDP administration procedures before undertaking collateral interviews.

It is highly desirable to interview each significant other (SO) privately and individually, even if the SO is to be directly involved in a treatment process. This diminishes the elicitation of client defensiveness or intimidation of the SO. Interview by telephone is often quite satisfactory, although in-person interviews can also be useful.

Obtaining Client Permission

It is ethically questionable to initiate an assessment interview with an SO without the client's knowledge and consent. As a routine part of research and treatment, it is desirable to obtain a separate informed consent and permission to contact SOs (see Appendix B). This is best presented as a *routine* part of the assessment process that is helpful in evaluation, treatment, and research efforts. A standard format is to request the names of three persons who fit the following description:

1. they know the client fairly well and are in frequent contact with the client,
2. they would know about the client's drinking pattern, and would be willing to discuss it,
3. they have telephones where they can be reached,
4. they could talk in confidence about the client's drinking without causing problems or embarrassment to the client.

After providing the names, addresses, and telephone numbers of SOs, the client is asked to read and sign the statement of permission and informed consent, which specifies the nature of information to be exchanged and the conditions of confidentiality. A typical contract is a one-way flow of information: data are requested from the SO, but no information regarding the client will be divulged to the SO without the client's explicit permission. Furthermore it should be stipulated that information provided by the SO is not revealed to the client. (This condition must be altered, however, if the SO information is to be used to confront the client with inconsistencies.)

Preparation for Initial Contact

To facilitate understanding, a letter of explanation is sent to each SO approximately one week before placing the initial call. This letter (sample in Appendix C) explains the nature, purpose, and conditions of the interview.

In preparation for the SO interview, the interviewer should complete the basic information section (Part I) of the Collateral Interview Form (CIF). When the interview has been completed, record the actual date and time of interview.

Getting the Right Person

When placing the call, ascertain that you *are* speaking to the SO, because permission for exchange of information is restricted to that particular person.

"Hello, may I speak to [both names of SO] please?"

If you do not reach the SO personally, you are *not* at liberty to reveal the purpose of your call or to indicate your affiliation with an alcohol research/treatment program. If asked who is calling, say "My name is [both names]. When could I call back to reach _____ ?" If pressed as to the purpose of your call, say, "I'm calling about a professional matter," or some other unrevealing but honest response (e.g. "I'm calling from the University").

First Contact with an SO

If this is the first time that the SO has been called, you have the reponsibility of explaining the purpose of your call. This is eased by the explanatory letter. For example:

"Hello, my name is [both names] and I'm with [the Alcohol Research and Treatment Project]. I'm calling about your [friend/brother/wife/employee, etc.], _____ .

Did you receive the letter that we sent explaining that we would be calling?"

The answer to this question will usually be Yes, but in either event give a brief review of the purpose of the call, following information provided in the letter. Emphasize the importance of accuracy and the conditions of confidentiality. Give a context:

"We ask everyone in our program for permission to contact a few people who are close to them, and who can help us to evaluate how effective our programs are. I'd like to talk with you now, and also call you again after about _____ months."

Administration

Getting the Interview Started

If the SO has been interviewed before, you need only remind the SO of this fact after introducing yourself, as above:

"I believe that we've called you before"

Set an approximate time requirement and inquire as to whether this is a convenient time to talk:

"If you have about ten minutes, I'd like to get your impressions of _____ and particularly of [his/her] drinking pattern at the present time. Is this a good time to talk?" (If not, arrange a time to call back.)

Alcohol Consumption Information (Part II)

Usually the best opening question is a general one about the SO's perceptions of the client's drinking. This avoids setting up a question/answer format where you get only what you ask for.

"Tell me how you see _____'s drinking at the present time."

This can be followed with elaborating questions about observed effects, concerns, and specific pattern. This can be used as a transition into specifics needed from the interview.

Responding to Information. A reflective listening style is recommended in responding to information provided by the SO. The use of paraphrasing and reflection both encourages the SO to continue talking, and serves to ensure that the interviewer is understanding what the SO means. This style can also be used to deal with SO hesitancies by acknowledging them. For example, if

the SO (as is common) protests that he or she cannot tell you how much the client drinks, you might respond, "It *is* hard to say exactly, and I realize you're not around all the time. But whatever estimates you can give based on what you know would be helpful." Then go right back into specific questioning or bracketing (see below).

Getting Specific. Part II requires obtaining specifics about drinking pattern. Use the Steady Pattern Chart to record data regarding a typical week of drinking. Introduce this with, "What is _____'s drinking like in an average week?" and then follow guidelines provided previously for CDP/BDP, paralleling procedures for interviewing the client (Items B31-32). Similarly, complete the Periodic Pattern Chart if the SO reports heavier drinking episodes in addition to, or instead of, a steady pattern. Introduce this item saying, "Are there times when _____ drinks more than the usual amount?" and again follow procedures presented previously (B33-34).

Record the specific information provided. Do not attempt to score or transform data during the interview, but obtain enough information so that you can do this later. Determine as specifically as you can: (1) what beverage(s) the client drinks, and their alcohol concentration; (2) amount of beverage(s) consumed; (3) when the person drinks, and over what spans of time (for estimating blood alcohol concentration [BAC]).

For all information obtained, indicate whether it is based on drinking that the SO actually *observed*, or whether the SO is guessing without observation. Code O (observed) or G (guessed) in the lower right-hand corner of each box in which drinking is recorded. This is used to determine the relative credibility of information sources.

"I don't know". Almost every SO will say at first, "I don't know" when asked about specific drinking. If this is accepted at face value, very little useful information will be obtained. Proceed to elicit whatever specific information the SO *can* provide. You can help here with guiding questions such as, "When you *are* with her, what does she normally drink?" or "Well, to start with, *what* does she drink?" or "When are you with him while he's drinking?"

Bracketing. Bracketing is a useful technique for getting a more accurate estimate. It involves starting at the extremes and working toward an accurate estimate. Start with an amount likely to be too high and then present an amount at the other extreme that is likely to be too low, continuing to focus on a more exact estimate. Sample:

"Would you say that she drinks more than a case of beer a day?" (No) "But is it more than one or two beers a day?" (Definitely) "More than three six-packs?" "More than one six-pack?" and so on.

Anchoring. In trying to establish a certain event in time (such as the last time the client had a drink) it can be useful to ask the SO to link it to major events such as holidays. Bracketing can also be helpful. Sample:

"Well, would it have been more than six months ago?" (Yes) "More than a year ago?" (Probably not) "Do you think it might have been before or after Christmas?"

Relative Comparisons. Once a specific pattern has been established, it can be useful to use that as a standard against which to compare other days or patterns.

"Now would that be the pattern for other days, too, or just on Wednesdays?"

"How about Saturdays? Would you say his drinking would be more than or less than on a weekday, or about the same?"

Guessing. When the SO does not actually observe drinking, encourage a guess based on whatever information might be available. Does the SO see empty bottles or cans? How intoxicated does the person appear to be, relative to times when a known quantity has been consumed? Be sure to code these data with a "G" (guess) to distinguish them from observational data (O).

Alcohol-Related Problems (Part III)

Part III is for inquiry regarding negative consequences from drinking and symptoms of alcohol dependence. At *intake* these questions are asked with regard to the past in general (has it *ever* happened?), whereas at follow-up a specific index period is used (e.g. past three months) to correspond with the index period used on the FDP. Follow the introductory wording provided and then ask each of the individual questions. Mark (X) all that the SO answers in the affirmative ("Yes, this has happened to the client").

With regard to help-seeking, record any knowledge the SO has of specific instances and kinds of help that the client has sought for drinking problems.

At follow-up, Part III is omitted for clients reported to have been abstinent for the past three months.

Improvement Ratings (Part IV)

Part IV is not completed at first contact because it requests SO ratings of improvement *relative to* intake. In order to ask these questions at treatment termination or follow-up, it is necessary to know the month of intake (see Part I).

Each question is asked as written, except that the specific alternatives are *not* to be read. The first question, for example, is:

"Relative to [month of intake], would you say that _____ is drinking more now, or less, or about the same?"

If the SO responds "about the same," the answer is complete and is coded as "4." If the SO responds either "more" or "less," bracketing is used (For example, "a little more, a lot more, or in between?"). This will suffice to determine the proper response to be coded in most cases.

Additional Information

In the space provided at the end of the interview form, record any additional information provided by the SO that should be reported. Also record any specific information that may be helpful to future interviewers in completing the SO interview. Examples would be optimal times to reach the SO, specific hesitancies of the SO, emotional reactions of the SO, additional information about the relationship between SO and client, a request not to be contacted again, an anticipated move or change in telephone number, SO's cooperativeness or mood during the interview.

Scoring and Interpretation

Alcohol Consumption

Data from the Steady Pattern Chart are converted into Standard Ethanol Content (SEC) units according to procedures specified in the CDP manual (pp. 32-34). Estimates are derived for the total number of drinks (SECs) per week and the number of SECs per drinking day (divide SECs per week by the number of nonabstinent days per week). A blood alcohol concentration (BAC) peak is also estimated based on the heaviest period of drinking during a typical week, projecting from a BAC table (See Appendix D in the CDP manual, c.f. Matthews & Miller, 1979).

Quantity/frequency of consumption is summarized for the Steady Pattern Chart by multiplying the number of SECs per week

by 13 (thus estimating the number of drinks from this pattern over a 3 month period).

The Episodic Pattern Chart data are likewise converted into SEC and BAC estimates (CDP manual, pp. 34-35). For each type of episode, calculate the total number of SECs consumed and the peak BAC. The number of SECs per episode is multiplied by the number of such episodes in the past 3 months. These products are then summed to yield a Quantity/Frequency estimate of the number of SECs consumed in periodic drinking over a 3 month period. (Caution: Do not count drinks twice — once in Steady and once in Episodic calculations. Consult the CDP manual, pp. 34-35, for details.)

The "Consequences" section of Part III is scored by totaling the number of problems checked ("Yes").

The "Dependence" section of Part III is scored by assigning points for every item checked ("Yes"). The appropriate number of points to assign for a given "Yes" answer is indicated in parentheses with each item. (For example, being unable to remember part of what happened [blackout] results in 1 point, whereas a convulsion or seizure after drinking results in 4 points.) For every item checked ("Yes"), record the appropriate number of points on the corresponding line and then total these to derive the Dependence score.

The alcohol consumption, consequences, and dependence scores are directly comparable to self-report measures obtained from the FDP (see descriptions earlier in this manual). The Dependence Total from the CIF at intake is also comparable to the Ph (physical dependence) Score from the BDP or CDP. The Consequences Total, however, represents a subscale of items from B45 of the BDP or CDP, and is not directly comparable to any BDP or CDP index. If desired, a parallel intake measure from the BDP or CDP could be calculated by totalling the corresponding items from B45 (3, 9, 10, 12, 13, 14, 15, 17, 24, and 25). Note that SOs are asked more generally about client's health problems in relation to drinking (CIF item III-8), whereas the MAST item (CDP item B45-17) is more restrictively worded to ask about liver problems.

Several guidelines can be used to reconcile self-report with SO information: (1) Regard the client's self-report to be accurate if it is less favorable than SO reports; (2) Give greater credence to *observed* data from the SOs than to guesses; (3) Regard observed data from SOs to be more accurate if they are less favorable than client self-report; (4) If possible, ask the client to help reconcile discrepancies in which SOs report less favorable outcomes. (This

requires an understanding with SOs that their information could be shared with the client.) Data regarding the convergence of self-report and collateral data using these procedures are provided in Appendix B.

Rules for Preparing a Composite Collateral Profile

Another approach for assembling complete collateral information is to construct a composite collateral profile. A composite collateral profile can be constructed by combining SO data into the Steady Pattern Chart and Episodic Pattern Chart of a blank Collateral Interview Form. The result is a composite picture of the client's alcohol consumption, combining the best information available from all SO sources. If only one SO was able to provide *quantitative* data, the composite SO data are the same as the data for that single SO. When quantitative data were obtained from more than one SO, a composite is constructed according to the following rules.

1. Begin with the Steady Pattern Chart. A decision is made separately for each time block, based upon the *best* SO data for that block (morning, afternoon, or evening of each day).
2. If only one SO has provided data for a given time block, the data from that SO are used.
3. If more than one SO has provided data for a given time block but if one SO observed the drinking whereas another guessed, the data from the one observing SO (including abstinence) are used and the data from the guessing SO are ignored.
4. If more than one SO has provided data for a given time block and if all have provided data of equal credibility (all guessed or all observed), an arithmetic average of their data for that block will be used.
5. When the composite Steady Pattern Chart has been completed, calculate weekly SECs, total drinking days, average SECs per drinking day, and BAC peak as for the individual profile.
6. Construct an Episodic Pattern Composite Chart following the same rules (1-4) as above. Then calculate Total SECs and Peak BAC as for an individual profile.
7. Calculate total Quantity/Frequency estimates as for an individual profile.

For Consequences and Dependence scores, construct (on a blank CIF) a composite by checking each item that was reported by

any SO, then summing to obtain Consequences and Dependence totals. For Improvement ratings, calculate an arithmetic average but omit any "9" scores (cannot or will not say). For Change estimates (final item), calculate an arithmetic average.

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Appendices

Appendix A: Sample Data from the Follow-up Drinker Profile

This appendix presents data on selected quantitative variables from the FDP. These data were collected during follow-up interviews with 88 clients (43% women) at 3 to 8 years following their treatment for alcohol abuse. These individuals had all received outpatient treatment from the Alcohol Research and Treatment Project at the University of New Mexico. These data are presented for comparative purposes, but should not be considered normative for other populations. Samples from other settings (inpatient, detoxifications, etc.) and other locations will vary substantially. Note that variance is substantial within this sample; standard deviations frequently exceed means in magnitude.

VARIABLE	Mean	S.D.	Range
8A. Total SECs per week	21.0	25.3	0-109
8B. Total drinking days per week	3.7	3.1	0-7
8C. Average # drinks per day	3.5	3.9	0-16
8D. Estimated Peak BAC for week	70	98	0-600
9. Total SECs/3 mo. (steady)	277.7	353.1	0-1664
10. Highest BAC/episode	47.1	95.4	0-438
11. Total SECs/3 mo. (episodic)	25.0	130.2	0-1200
12. Total Q/F SECs past 3 mo.	300.1	365.2	0-1664
13. Months abstinent	38.6	26.6	5-99
14. Consequences in past week	0.1	0.3	0-1
14. Consequences in past 3 mo.	0.3	0.6	0-3
14. Consequences in past year	0.5	0.8	0-3
14. Dependence in past week	0.7	1.5	0-7
14. Dependence in past 3 mo.	2.0	2.5	0-9
14. Dependence in past year	2.7	3.1	0-12
15. AA meetings ever attended	78.9	287.7	0-2000
15. Total additional help ever	1.2	1.4	0-5
15. Total additional help past year	0.5	0.9	0-4
15. Total help past 3 mo.	0.3	0.7	0-4

VARIABLE	Mean	S.D.	Range
16. Cigarettes per day	7.6	15.2	0-80
17. Weight satisfaction	7.8	10.5	−10 to +55
18. Other drugs used ever	2.1	1.9	0-8
18. Other drugs used past 3 mo.	0.6	0.7	0-3
19. Life problems total	4.8	3.5	0-13
19. Life problems, alcohol-related	1.2	2.2	0-11
20. Change in drinking	1.8	1.4	1-7
21. Satisfaction with status	2.9	1.9	1-7
22. Drinking comfort	4.9	2.0	1-7
23. Abstinence efficacy	92.1	12.6	50-100
24. Control efficacy	61.1	36.5	0-100

Frequency Distributions

VARIABLE	Response	Number (%)
5. Marital status	1. single, never married	3 (3%)
	2. married, living with partner	56 (64%)
	3. married, separated	2 (2%)
	4. widowed	0
	5. divorced	27 (31%)
5. Number of times married	0	3 (3%)
	1	57 (66%)
	2	23 (26%)
	3	3 (3%)
	4	1 (1%)
6. Employment status	1. full time	45 (51%)
	2. part time	8 (9%)
	3. retired	16 (18%)
	4. unemployed	4 (5%)
	5. homemaker	15 (17%)
7. Present Drinking Pattern	Abstinent	25 (28%)
	Periodic	9 (10%)
	Steady	39 (44%)
	Combination	15 (17%)
16. Smoking status	Never	22 (25%)
	Smoker	30 (34%)
	Ex-smoker	36 (41%)
20. Change Rating	1 — a lot less	53 (61%)
	2	10 (12%)
	3	10 (12%)
	4 — about the same	12 (14%)
	5	0
	6	0
	7 — a lot more	2 (2%)

VARIABLE	Response	Number (%)
21. Satisfaction Rating	1 — totally satisfied	34 (40%)
	2	8 (9%)
	3	4 (5%)
	4 — fairly satisfied	21 (25%)
	5	9 (11%)
	6	6 (7%)
	7 — totally unsatisfied	3 (4%)
22. Drinking Comfort	1 — feel constantly on guard	8 (11%)
	2	4 (5%)
	3	6 (8%)
	4	10 (13%)
	5	10 (13%)
	6	18 (24%)
	7 — feel complete control	20 (26%)
29. Disease or Bad Habit?	1. Disease	53 (65%)
	2. Bad Habit	29 (35%)

Appendix B: Sample Data from the Collateral Interview Form

The following data were obtained from Collateral Interview Form telephone interviews with significant others of the same sample described in Appendix A, at 3 to 8 years following treatment. Of the total sample of cases (N = 89), 77 (87%) provided one or more collaterals (one collateral, 13%; two collaterals, 22%; three collaterals, 53%). The total number of collaterals provided was 200. Interviews were obtained from collaterals in 85% of the cases and drinking estimates in 83% of the cases.

The following are descriptive statistics for drinking data provided by collaterals, and the comparable self-report indices from clients. In cases where multiple estimates were obtained from collaterals, the highest (least favorable) estimate was used.

	Collateral Data		Self-Report Data	
VARIABLE	Mean	S.D.	Mean	S.D.
Drinks (SECs) / week	19.2	23.6	21.0	25.3
Drinking days / week	3.2	3.1	3.7	3.2
Peak BAC (steady)	47.0	84.1	70.4	98.0
Total SECs / 3 months	323.3	471.7	300.1	365.2
Peak BAC (episode)	67.8	112.6	47.1	95.5
Months abstinent	35	24.9	38.6	26.6
Consequences / 3 months	0.3	0.8	0.3	0.6
Dependence / 3 months	2.3	2.5	2.0	2.5

The convergence of quantitative measures was assessed by calculating Pearson product-moment correlations between self-report and collateral report. The results are shown below:

	N	r
Drinks (SECs) per week	72	.76***
Peak BAC (steady)	65	.39***
Peak BAC (episode)	65	.36**
Consequences / 3 months	44	.37*
Dependence / 3 months	41	.63***

*$p < .07$ **$p < .002$ ***$p < .001$

Appendix C:
Sample Letter to Significant Others

The following is a sample letter that can be sent to significant others in preparation for a telephone interview to obtain collateral information about clients. The points numbered 2 and 3 may be altered depending upon the clinic's policies and practices with regard to exchange of information.

Dear [ ]:

Our clinic is continually developing and evaluating methods for helping people to avoid and overcome problems with alcohol. We are asking for your help in this effort.

[ ] is presently participating in one of our programs. As part of our evaluation, we ask every participant in our programs for the names of several people who know them well, whom they trust, and who are in fairly close contact with them. We then call these people to discuss each participant's present condition, and particularly his or her current drinking pattern. The person named above has given us your name as a trusted person who could provide us with the information we need.

Within the next week or so you will be receiving a telephone call from a member of our staff. The purpose of this call is for us to obtain a clearer understanding of the person and his or her drinking pattern at present. Your help will be greatly appreciated.

We want you to understand several things before we call:

1. We will be calling you with the direct written permission of the person named above, and we will be calling you with his or her full knowledge. There is nothing secret about the fact that we will be calling you, and you can feel free to discuss it with the person if you wish.
2. All information that you provide will be kept in strict confidence. Even the person named above will not be told (by us) what you have said.
3. Because of our policy of confidentiality, we will not be able to provide you with any information about the person's involvement or progress in our program.

4. You certainly are not required to divulge information to us. Your help can be very valuable, however, in our effort to discover and develop more effective programs for helping people to avoid alcohol problems.
5. It is extremely important that the information you give us be as accurate as possible. We would rather have *no* information than to have inaccurate or misleading information. We depend upon your honesty and accuracy.

We greatly appreciate your assistance. If you have any questions, feel free to call us at [XXX-YYYY].

Sincerely,

[signature]