The *Personal Experience Inventory for Adults* (PEI-A) gives substance abuse service providers a comprehensive, standardized self-report inventory to assist in problem identification, treatment referral, and individualized planning associated with addressing the abuse of alcohol and other drugs by adults. Not a screening tool, the PEI-A is an assessment instrument that yields comprehensive information about an individual’s substance abuse patterns and problems. Because substance abuse does not usually occur in isolation, the PEI-A also helps to identify the psychosocial difficulties of the referred individual.

Substance abuse treatment for adults has recently expanded beyond the narrow focus on alcoholism that has largely characterized adult rehabilitation services since World War II. This trend has introduced a new set of issues into the assessment of substance abuse. As more and more adults enter treatment having abused multiple substances, mental health professionals have had to modify their diagnostic approaches and adopt increasingly sophisticated problem identification strategies. The PEI-A is specifically designed to meet the need for greater scope in the assessment of problems related to substance abuse.

The PEI-A closely resembles the Personal Experience Inventory (PEI; Winters & Henly, 1989), which is designed for use with adolescents. The PEI has been accepted as a standard in the field of substance abuse assessment; it is used in a wide range of contexts, including private treatment facilities and public agencies. Based on the same methods and principles as the PEI, including the involvement of treatment providers, the PEI-A extends the age range of the original instrument: The PEI is recommended for use with individuals who are 12 to 18 years old, and the PEI-A with those who are 19 or older. Like the PEI, the PEI-A is computer scored only, with reports available by mail or by fax, or through the use of a microcomputer disk.

**PEI-A Scales**

The PEI-A has two parts. The Problem Severity section (Part I) consists of 120 items organized into 10 Problem Severity scales (5 Basic and 5 Clinical), 3 Validity Indicators, and direct measures of alcohol and drug use consumption (frequency, duration, and onset). A scale that measures treatment receptiveness is also included in this section. The Psychosocial section (Part II) consists of 150 items distributed across 8 Personal Adjustment scales, 3 Environmental scales, 10 Problem Screens, and 2 Validity Indicators.

**Problem Severity Basic Scales**

**Personal Involvement With Drugs.** The 25-item Personal Involvement With Drugs scale measures problem severity based on the client’s degree of behavioral and psychological involvement with alcohol and other drugs. High scores on this scale suggest frequent use, use in inappropriate settings, use for psychological benefit or self-medication, restructuring of activities to accommodate use, loss of control, and chronic use leading to withdrawal symptoms. Low scores on this scale suggest relatively infrequent use and no signs of preoccupation or loss of control.

**Physiological Dependence.** As its name implies, the 7-item Physiological Dependence scale measures the physiological signs of dependence, focusing on tolerance and withdrawal symptoms.

**Effects of Use.** The 9 items in the Effects of Use scale address the immediate psychological, physiological, and behavioral effects of drug and alcohol use. Most of the items on this scale refer to negative or aversive states and feelings.

**Social Benefits of Use.** Scores on the 7-item Social Benefits of Use scale reflect substance use that is perceived by the client as increasing his or her social confidence and acceptance by others.

**Personal Consequences of Use.** The 13 items in the Personal Consequences of Use scale primarily focus on the client’s alcohol- or drug-related difficulties with friends, employers, co-workers, social institutions, and his or her spouse or partner. Some items on this scale pertain to behavioral changes that may be related to these consequences.

**Problem Severity Clinical Scales**

**Recreational Use.** The 5-item Recreational Use scale measures the client’s use of alcohol and other drugs in settings and situations that are generally considered to be recreational or social.
Transsituational Use. The 8-item Transsituational Use scale represents substance use in a variety of physical settings, particularly inappropriate ones (e.g., work), and use across a range of temporal settings (e.g., early morning).

Psychological Benefits of Use. The score on the 7-item Psychological Benefits of Use scale indicates the extent to which the client uses alcohol and other drugs to reduce negative emotional states, including loneliness, depression, boredom, and anxiety, and to enhance pleasurable states.

Preoccupation. The 8-item Preoccupation scale addresses the planning of future drug use, the restructuring of activities to promote private or social use, and rumination about use.

Loss of Control. The 10-item Loss of Control scale is a measure of the client’s inability to abstain from the use of alcohol or other drugs, and of his or her inability to use them in moderation when they are available.

Problem Severity Validity Indicators

Infrequency-1. The 5 items in the Infrequency-1 scale pertain to extremely unlikely substance use behavior. A high score on this scale may be associated with “faking bad” (exaggerating problems or otherwise deliberately responding in a manner intended to present oneself in a negative light), or with inattention or random responding.

Social Desirability-1. The basis for the 6-item Social Desirability-1 scale is the 33-item Crowne-Marlowe Social Desirability Scale (Crowne & Marlowe, 1960), a frequently used measure of defensiveness. An elevated score on this scale suggests “faking good” (minimizing problems or otherwise distorting responses to present oneself in a favorable light).

Self-Deception. The 7-item Self-Deception scale, based on Paulhaus’ Social Desirability Scale (Paulhaus, 1984), measures self-deceptive attitudes among psychologically distressed clients. An elevated Self-Deception score is likely to be associated with a “faking good” response set.

Treatment Receptiveness

The Treatment Receptiveness scale is composed of 6 items intended to measure the client’s willingness to change and to participate in treatment. Because the treatment receptiveness construct is still under empirical investigation, its utility in clinical settings is not known at this time.

Drug Use Frequency, Duration, and Age at Onset

The Problem Severity section concludes with 20 items that examine the frequency, duration, and age at onset of the client’s substance use. Eleven items inquire about the frequency with which he or she has used any of 11 different types of drugs during the last 5 years, the last 12 months, and the last 3 months. These items were adapted from those used in national surveys of adolescents and young adults (e.g., Johnston, Bachman, & O’Malley, 1987). The 11 drug categories are as follows: alcoholic beverages; marijuana and hashish; LSD and other psychedelics; cocaine and crack; amphetamines; barbiturates; tranquilizers; heroin; narcotics other than heroin; steroids and anabolic steroids; and glue and other inhalants.

The abuse of prescription drugs, the administration of drugs by intravenous injection, and the use of drugs by female clients while pregnant are each addressed by separate items. A final set of six items inquire about the age at which the client first used alcohol, marijuana, and other drugs, and the age at which he or she began using them regularly.

Psychosocial Personal Adjustment Scales

Negative Self-Image. The 10-item Negative Self-Image scale reflects lack of self-esteem and self-regard, personal dissatisfaction, and feelings of incompetence.

Psychological Disturbance. The 11 items in the Psychological Disturbance scale reflect different aspects of psychological distress, including difficulties with mood and thinking.

Social Isolation. The 8-item Social Isolation scale addresses the client’s perception of his or her social discomfort and incompetence, and the level of his or her distrust of others.

Uncontrolled. The 10 items in the Uncontrolled scale focus on the client’s tendency to display aggressiveness and defy authority figures.

Rejecting Convention. The 8 items in the Rejecting Convention scale address the extent to which the client engages in oppositional behavior and rejects traditional beliefs about right and wrong (e.g., lies, or breaks rules).

Deviant Behavior. High scores on the 10-item Deviant Behavior scale suggest actual participation in unlawful or antisocial behavior.

Absence of Goals. Elevated scores on the 9-item Absence of Goals scale represent a lack of goals and expectations, including career plans.

Spiritual Isolation. High scores on the 7-item Spiritual Isolation scale indicate a lack of belief in a spiritual force, the absence of spiritual experiences, and little use of prayer.

Psychosocial Environmental Scales

Peer Drug Use. The 7-item Peer Drug Use scale measures the client’s perception of the use of alcohol and other drugs by his or her friends and acquaintances.

Interpersonal Pathology. The 11 items in the Interpersonal Pathology scale are associated with physical or sexual abuse in the home, severe family dysfunction, and interpersonal dysfunction.

Estrangement in the Home. High scores on the 8-item Estrangement in the Home scale reflect a lack of family solidarity, and the presence of marital, intrafamilial, or interpersonal conflict.

Psychosocial Problem Screens

The PEI-A also screens for problems in the following areas: Suicide Risk, Work Environment Risk, Past Family Pathology, Other Impulse-Related Problems, Significant
Other Drug Problem, Sexual Abuse Perpetrator, Physical Abuse Perpetrator, Physical/Sexual Abuse Victim, Need for Psychiatric Referral, and Miscellaneous (high-risk sexual behavior, HIV/AIDS risk, gang membership, and physical disability).

**Psychosocial Validity Indicators**

**Infrequency-2.** The 11 items in the Infrequency-2 scale have very low rates of endorsement. A high score may reflect “faking bad,” inattention, or random responding (e.g., “I do not like warm, sunny days”; “I would rather lose a game than win”).

**Social Desirability-2.** The Social Desirability-2 scale is another 10-item subset of the Crowne-Marlowe Social Desirability Scale.

**Applications and Limitations**

The PEI-A was designed primarily as a clinical descriptive tool for use by addiction professionals to assist in the identification of problems associated with adults’ use of alcohol and other drugs. The PEI-A is most appropriate for use in settings where treatment is being considered for clients who are suspected of having problems associated with the use of alcohol and other drugs. Specifically, the PEI-A was developed to measure the following characteristics:

1. The presence of the psychological, physiological, and behavioral signs of alcohol and other drug abuse and dependence
2. The nature and style of drug use (e.g., consequences, personal effects, and setting)
3. The onset, duration, and frequency of use for each of the major drug categories
4. The characteristics of psychosocial functioning, especially factors identified as precipitating or maintaining drug involvement and expected to be relevant to treatment goals
5. The existence of behavioral or mental problems that may accompany drug use (e.g., sexual abuse or co-addiction)
6. The sources of invalid response tendencies (e.g., “faking bad,” “faking good,” inattention, or random responding)

The PEI-A is intended to supplement a comprehensive assessment process. A complete assessment includes reports from significant others, as well as behavioral observations, laboratory analyses, and other psychological tests. These different sources may yield multiple hypotheses about the nature of the client’s problems. Ideally, the assessment information will converge on a clear, workable hypothesis. When that does not happen, it is important to examine the discrepancies further and consider alternative hypotheses.

The PEI-A is a norm-referenced test. Clients’ scores are compared with those of relevant reference groups (patients in drug treatment and an unselected group of individuals in nonclinical settings). This approach to measurement contrasts with the process of diagnosis, in which symptoms are tallied and assigned discrete labels.

The PEI-A can be used for research on adult alcohol and drug abuse. Groups of subjects can be defined on the basis of high and low scores on relevant scales. The PEI-A can also serve as a pre- and post-assessment tool in treatment outcome studies. Because the PEI-A is framed in a lifetime context, however, its use at post-testing requires the making of appropriate adjustments in the instructions.

The materials required for using the PEI-A depend on the scoring modality employed. For the mail-in and fax versions, the items are presented on a set of computer-scannable forms, upon which the client marks his or her responses. The microcomputer version may be taken “online” at the computer, or it may be administered using a separate microcomputer answer booklet, from which the responses are keyed into the computer at a later time for scoring. For a complete description of these options, see the section entitled “Computer Services for the PEI-A” at the back of this Manual.

PEI-A users are expected to have an adequate understanding of test construction and test use principles. Users should be familiar with the contents of this Manual, and with the testing guidelines prescribed by the American Psychological Association (1985).

**About This Manual**

The PEI-A Manual is divided into two parts. Part I, which is called the Administration, Scoring, and Interpretation Guide, encompasses this chapter as well as chapters 2 and 3, and presents everything required for the application of the instrument. Chapter 2 gives directions for administering the PEI-A, and briefly discusses the scores yielded by the computerized scoring system. Chapter 3 provides the reader with an interpretive scheme and also presents case studies that demonstrate how PEI-A results may be used as part of a substance use assessment. Part II, which is called the Technical Guide and includes chapters 4 and 5, describes the construction, standardization, and psychometric properties of the PEI-A. Chapter 4 describes the development of the PEI-A, including item selection and scale construction. Chapter 5 describes the procedures used to standardize the PEI-A, as well as evidence for its reliability and validity. It is expected that users will wish to treat the Administration, Scoring, and Interpretation Guide as a source of everyday information about the test, and the Technical Guide as more of a reference work.