THE FACTOR STRUCTURE AND CONCURRENT VALIDITY OF THE ALCOHOL USE DISORDER IDENTIFICATION TEST BASED ON A NATIONALLY REPRESENTATIVE UK SAMPLE

MARK SHEVLIN* and GILLIAN W. SMITH

Psychology Research Institute, University of Ulster, Northland Road, Londonderry, Northern Ireland BT48 7JL, UK

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Abstract — Aims: To assess the psychometric structure and construct validity of the alcohol use disorder identification test (AUDIT) as part of a computer assisted interview. Confirmatory factor analyses were conducted testing one to three factor models. The factors in these models were correlated with demographic variables and scores relating to perceived wellbeing, verbal IQ, and neurotic and psychosomatic symptoms to assess construct validity of the factor solutions. Results: A two factor solution was deemed to appropriately fit the data, measuring alcohol consumption and alcohol related problems. Correlations between the two factors on demographic, wellbeing, neurotic and psychosomatic symptomology were significantly different. Conclusions: The two factor solution suggests an advantage to investigating factor specific cut off scores for both consumption and alcohol related problems given their difference in predictive validity on both health and demographic variables.

The Alcohol Use Disorder Identification Test (AUDIT) was designed as a brief screening instrument to detect hazardous drinking behaviours in the past year (Reinert and Allen, 2002). It is one of the most commonly used screening instruments and aims to detect problem drinking rather than established alcoholism (Allen et al., 1997).

The original AUDIT represented three conceptual domains; consumption (items 1–3), dependence (items 4–6) and alcohol related consequences (items 7–10) suggesting three underlying dimensions (Saunders and Aasland, 1987). Despite this, the scoring of the scale involves summing all items to provide a possible range of score from 0 to 40, with a score of 8 or more being suggested as an indicator of hazardous drinking behaviour. This scoring method implies a unidimensional (one factor) scale structure with equal weight given to each item in computing the final score. Subsequent evidence regarding the construct validity of the AUDIT, in particular the number of dimensions that are being measured, has been equivocal. Support for one, two and three factor models have been based on both exploratory and confirmatory factor analytic methods (CFA).

A one dimensional structure of the questionnaire was supported by Skipsey et al. (1997) based on a principal components analysis (PCA) of hazardous drinking in drug dependent patients (N = 82). El-Bassel et al. (1998) found a similar structure in a population of women offenders in a New York City jail facility (N = 400), also using PCA. Carey et al. (2003) also drew this conclusion in an investigation of the factor structure of the AUDIT in the language most suitable for their sample of psychiatric patients in India (N = 671) using both PCA and CFA on the structure predicted by the exploratory procedure. In all these studies the one factor represented hazardous drinking.

There has been greater research support for a two-factor model. Medina-Mora et al. (1998) explored the factor structure using a translated version of the AUDIT in a non-clinical male Mexican population (N = 2050). Using exploratory factor analysis with varimax rotation, they reported a two factor solution, representing patterns of intake (items 1–3) and alcohol problems (items 4–9). Item 10 loaded on both factors. O’Hare and Sherrer (1999) also used a PCA with varimax rotation which supported a two factor model explaining 60% of the variance. They used a sample of undergraduates from the University of Rhode Island (N = 312). The two factors were similar in structure to the Medina-Mora model, although item 8 loaded on both factors and item 10 loaded highly on factor two.

Chung et al. (2002) performed a confirmatory factor analysis testing one and three factor structures (N = 173), on a version of the AUDIT which modified items 3, 6 and 8 for their population of adolescents presenting to an emergency department. They performed a subsequent PCA with varimax rotation and concluded the two factor structure to be superior, with items 1–3 loading on factor one (labelled ‘consumption’) and 4–10 on factor two (labelled ‘problems’). Kelly and Donovan (2001) used confirmatory factor analyses to test one, two and three factor models based on scores from 103 adolescents. A correlated two factor solution similar to that of Chung et al. (2002) was found to be the best fitting model, however, issues regarding model identification led to the exclusion of item 9 from the analysis. Karno et al. (2000) performed a confirmatory factor analysis based on a predominantly male (86%) sample of mental health clinic outpatients (N = 197). One and three factor models were tested and neither model provided adequate fit. Subsequent analyses using PCA, principal axis factoring (PAF) and maximum likelihood (ML) exploratory factor analyses indicated that a two-factor model represented the best fitting model (although in the PCA and PAF items 4 and 5 loaded on both factors, and in the ML model item 9 did not significantly load on either factor). Broadly speaking, this suggests that the two
factor solution of items 1–3 as consumption measures and the remaining items measuring problems exists for this population, however, some disagreement is evident within the results for items 4, 5 and 9. Maisto et al. (2000) in a PCA with varimax rotation (and supported by confirmatory factor analyses) on transformed data from primary care patients in Pennsylvania (N = 7035) found two factors; consumption (items 1–3) and dependence/consequences (items 4–9), with item 10 loading on both factors. Using samples from college students (N = 465) and court referred outpatients in community mental health and substance use treatment center (N = 135), Shields et al. (2004) also performed confirmatory factor analyses on the one, two and three factor models, and concluded superior fit for a correlated two factor solution in both populations on the basis of parsimony and chi-squared difference testing. Like many of the other papers drawing this conclusion, these two factors measured consumption (questions 1–3) and dependence/consequences (items 4–10).

Three papers note the factor structure of the AUDIT in a randomly selected general population sample. Conclusions by Bergman and Kallmen (2001) in a general Swedish population sample (N = 997) found a two factor solution (labelled ‘hazardous consumption’ – items 1–3 and ‘alcohol related problems’ items 4–10) using both CFA and EFA. Lima et al. (2005) in Brazil (N = 166) also concluded a superior fit for the two factor model using CFA and PCA methods on a translated version of the AUDIT which accounted for existing Portuguese translations of the instrument. These two factors were concluded to measure both consumption (questions 1–3) and alcohol related problems (questions 4–10). A four factor solution was proposed by Gmel et al. (2001) using confirmatory factor analyses on a modified version of the AUDIT. Modifications included a rewording of questions 1 and 2 to represent quantity frequency per occasion, with question 3 asking how often the individual had 8 drinks or more. This paper concluded the best structure as items 1 to 3 loading on one latent variable each with the remainder on a fourth latent variable. This would support the two factor model using CFA and PCA methods on the one, two and three factor models, and concluded superior fit for a correlated two factor solution in both populations on the basis of parsimony and chi-squared difference testing. Like many of the other papers drawing this conclusion, these two factors measured consumption (questions 1–3) and dependence/consequences (items 4–10).

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Method

Participants and data
The analyses were conducted on data from the ‘Psychiatric Morbidity of Adults living in Private Households, 2000’ survey (Singleton et al., 2001). This research focused on adults aged 16 to 74 years, who were recruited using a stratified multi-stage random probability sampling strategy. Interviews were successfully conducted with 8580 adults. All were resident in either Scotland, England or Wales. After listwise deletion of missing data the total effective sample size was N = 7849. The mean age of the sample was 45 years old (SD = 15.43), 54.1% were female and 93% were of white ethnic origin. The interview was conducted using computer assisted interviewing. Full details of the survey methods can be found in Singleton et al. (2001).

Measures
The following measures were used in this study:

AUDIT (Saunders and Aasland, 1987; Babor et al., 1992)
This is a 10-item scale referring to alcohol use in the past 12 months with a score ranging from 0 to 40. Internal reliability estimates for the scale over 18 studies had a median Cronbach’s alpha of above 0.80 and estimates of test-retest reliability ranging from 0.64 to 0.92 over three studies (Reinert and Allen, 2002).

Clinical Interview Schedule-Revised (CIS-R: Lewis and Pelosi, 1990; Lewis et al., 1992). Neurotic symptoms were measured using this scale and based on experiences in the week prior to interview. The CIS-R measures 14 neurotic symptoms according to the ICD-10 criteria and is summed to give a total CIS-R score. Higher scores are indicative of more neurotic symptoms being reported.

The National Adult Reading Test (NART: Nelson and O’Connell, 1978; Nelson and Willison, 1991). This is a test
of the ability to read and pronounce correctly 50 words, reflecting the extent of individual’s intellectual development in adulthood. Using algorithms recommended in Section 2 of the NART test manual, scores on the NART can be converted into WAIS-R Verbal IQ scores (Nelson and Willison, 1991).

**Psychosis Screening Questionnaire (PSQ; Bebbington and Nayani, 1995).** The PSQ was used to assess psychotic symptoms within the past year. The PSQ has five probe questions (plus secondary questions) enquiring about mania, thought insertion, paranoia, strange experiences and hallucinations. It has been found to have sensitivity 92% and specificity of 95%. High scores indicate greater endorsement of psychosis-like symptoms.

**SF-12 Health Survey (Ware et al., 1996).** The SF-12 was designed as a brief version of the SF-36 which measures two components, physical and mental health. In general population surveys, it has been found that the two components are also designed as a brief version of the SF-36 which measures two components, physical and mental health. In general population surveys, it has been found that the two components are also factors in the SF-12 (Jenkinson and Layte, 1997).

### Analysis

A series of confirmatory factor models were specified and estimated using maximum likelihood parameter estimation. Analyses were conducted using LISREL 8.70 (Joreskog and Sorbom, 2004a). Covariance and asymptotic weight matrices were calculated using PRELIS 2.7 (Joreskog and Sorbom, 2004b). Using an asymptotic weight matrix allows for weaker assumptions in the distribution of the observed variables and by presenting a more accurate estimate of the population matrix, improving both the fit of the model and the test statistics (Satorra, 1992; Curran et al., 1996).

As recommended by Hoyle and Panter (1995) goodness of fit for each of the proposed models was determined using the Satorra-Bentler scaled chi-square (S-B\(\chi^2\)), the incremental fit index (IFI; Bollen, 1989), and the comparative fit index (CFI; Bentler, 1990). A chi-square which is not significant and values in excess of 0.95 for both the IFI and CFI indicate acceptable model fit. The root-mean-square error of approximation (RMSEA; Steiger, 1990) with 90% confidence intervals were also reported, with acceptable fit for the RMSEA value less than 0.05, and values up to 0.08 indicating reasonable errors of approximation in the population (Joreskog and Sorbom, 1993). Hu and Bentler (1999) also recommend the use of the standardized root-mean-square residual (SRMR; Joreskog and Sorbom, 1981). It is considered that values of less than 0.08 indicate acceptable model fit (Hu and Bentler, 1998). Comparative fit of the models were assessed using the expected cross-validation index (ECVI; Browne and Cudeck, 1989), which is used for the purpose of comparing models with the smallest value representative of superior fit.

Three models were specified and estimated. Model 1, the unidimensional model, was implied by the scoring procedure and supported by Skipsey et al. (1997). Here all items were specified to load on a single factor. Model 2, the two factor model, specifies the factors of ‘alcohol consumption’ (items 1–3) and ‘alcohol related problems’ (4–10). Model 3 specified three factors, ‘alcohol consumption’ (items 1–3), ‘dependence’ (4–6) and ‘related problems’ (7–10). For all models the error covariances were fixed to zero, and all the factors were free to covary. The predictive validity was assessed by correlations between the summed scores for the factors derived from the three alternative factor models and health and demographic variables.

### Results

The mean AUDIT score for the entire sample was 5.68 (SD = 4.53). The mean score for men (M = 7.01; SD = 5.02) was higher than that for women (M = 4.55; SD = 3.71), this difference was statistically significant, (t = 1.6514.70) = 24.29, \(P<0.01\). Hazardous drinking (measured as AUDIT score of 8 or more) was found in 38.8% males and 18.6% females (26.4% overall).

#### Confirmatory factor analysis

Table 1 reports the fit indices for the three proposed model structures.

For Model 1 the S-B\(\chi^2\) was large relative to the degrees of freedom, although caution is exercised when interpreting the chi-square as a measure of model fit given a large sample size due to the increased power of the test (Tanaka, 1987). All other fit indices indicated acceptable fit. Models 2 and 3 also also were also adequate descriptions of the sample data and provided better fit than Model 1 in terms of all the fit indices. The ECVI also indicated that Models 2 and 3 were better than Model 1 by having lower values. However, the difference between Models 2 and 3 in terms of fit was marginal. The IFI and CFI are higher, and the RMSEA and SRMR are lower for Model 3; however this model is less parsimonious than Model 2.

The factor loadings for models 2 and 3 are presented in Table 2. For both models the factor loadings are all positive, high, and statistically significant. For Model 2 the standardized loadings ranged from 0.26 to 0.92 and the factors correlate moderately at 0.54 (\(P<0.05\)). For Model 3 the standardized loadings ranged from 0.26 to 0.91. The consumption and dependence factors correlated at 0.47 (\(P<0.01\)).

### Table 1. Fit indices for the alternative models of the Alcohol Use Disorder Identification Test (AUDIT)

<table>
<thead>
<tr>
<th>Item</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>S-B(\chi^2)</td>
<td>1456</td>
<td>488</td>
<td>401</td>
</tr>
<tr>
<td>df</td>
<td>35</td>
<td>34</td>
<td>33</td>
</tr>
<tr>
<td>(P&lt;0.000)</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>RMSEA</td>
<td>0.072</td>
<td>0.041</td>
<td>0.038</td>
</tr>
<tr>
<td>90% CI</td>
<td>0.069–0.075</td>
<td>0.038–0.045</td>
<td>0.035–0.042</td>
</tr>
<tr>
<td>ECVI</td>
<td>0.60</td>
<td>0.18</td>
<td>0.14</td>
</tr>
<tr>
<td>IFI</td>
<td>0.96</td>
<td>0.99</td>
<td>0.99</td>
</tr>
<tr>
<td>CFI</td>
<td>0.96</td>
<td>0.99</td>
<td>0.99</td>
</tr>
<tr>
<td>SRMR</td>
<td>0.074</td>
<td>0.048</td>
<td>0.041</td>
</tr>
</tbody>
</table>

S-B\(\chi^2\); Satorra-Bentler Chi-Square; RMSEA, Root mean square of approximation; ECVI, Expected cross-validation index; IFI, Incremental fit indices; CFI, comparative fit indices; SRMR, Standardized root mean square residual.
Table 2. Standardized factor loadings (standard errors) for two factor model of the AUDIT

<table>
<thead>
<tr>
<th>Item</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How often do you have a drink containing alcohol?</td>
<td>0.46 (0.01)</td>
<td>0.46 (0.01)</td>
</tr>
<tr>
<td>2. How many drinks containing alcohol do you have on a typical day when you are drinking?</td>
<td>0.68 (0.02)</td>
<td>0.68 (0.02)</td>
</tr>
<tr>
<td>3. How often do you have six or more drinks on one occasion?</td>
<td>0.92 (0.01)</td>
<td>0.91 (0.01)</td>
</tr>
<tr>
<td>4. How often during the last year have you found that you were not able to stop drinking when you started?</td>
<td>0.70 (0.02)</td>
<td>0.72 (0.02)</td>
</tr>
<tr>
<td>5. How often during the last year have you failed to do what was normally expected of you because of drinking?</td>
<td>0.71 (0.02)</td>
<td>0.74 (0.02)</td>
</tr>
<tr>
<td>6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?</td>
<td>0.51 (0.02)</td>
<td>0.53 (0.02)</td>
</tr>
<tr>
<td>7. How often during the last year have you had a feeling of guilt or remorse after drinking?</td>
<td>0.65 (0.02)</td>
<td>0.64 (0.02)</td>
</tr>
<tr>
<td>8. How often during the last year have you been unable to remember what happened the night before because of your drinking?</td>
<td>0.67 (0.02)</td>
<td>0.69 (0.02)</td>
</tr>
<tr>
<td>9. Have you or someone else been injured because of your drinking?</td>
<td>0.26 (0.02)</td>
<td>0.26 (0.02)</td>
</tr>
<tr>
<td>10. Has a relative, friend, doctor or health worker been concerned about your drinking or suggested you cut down?</td>
<td>0.44 (0.02)</td>
<td>0.44 (0.02)</td>
</tr>
<tr>
<td>Factor Correlations</td>
<td>Factor one</td>
<td>Factor three</td>
</tr>
<tr>
<td></td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Factor one</td>
<td>0.55 (0.01)</td>
<td>1.00</td>
</tr>
<tr>
<td>Factor two</td>
<td>0.64 (0.01)</td>
<td>0.94 (0.02)</td>
</tr>
<tr>
<td>Factor three</td>
<td>1.00</td>
<td>1.00</td>
</tr>
</tbody>
</table>

Note. All factor loadings and factor correlations statistically significant ($P < 0.05$) and standard errors in parenthesis.

0.05), the consumption and alcohol related problems factors at 0.64 ($P < 0.05$), and the dependence and alcohol related problems factors at 0.94 ($P < 0.05$). Although the correlation between the dependence and alcohol related problems factor in Model 3 is quite high, neither model can be rejected given the fit statistics in Table 1. The choice of best model should be made on the basis of parsimony and evidence of unique predictive validity of the factors. That is, the three-factor model would have to provide additional useful information compared to the two-factor model to be considered as an acceptable factor structure.

Reliability and variance explained

Reliability analyses were conducted on the three proposed model solutions. The single factor solution had a Cronbach’s alpha 0.78, with the two factor solution 0.69 and 0.66 for factors one and two respectively. The three class solution had reliability of 0.69, 0.65 and 0.58 respectively for each of the three factors.

Variance explained by the single factor in the one factor solution only accounts for 30.11% of the variance in the data. Looking at the two factor solution, factor one explains 50.03% of the variance in items 1 to 3 and factor 2 explains 34.21% of the variance in items 4 to 10. Finally, within the three factor solution, the three factors account for 58.17%, 13.61% and 13.15% respectively of the variance in the model.

Predictive validity

The unique predictive validity of each of the factors in Model 2 and 3 was assessed in terms of their correlations with health and demographic variables. The correlations for the one factor model demonstrate that a multidimensional structure offers more information than a unidimensional model. The correlations and significance values can be found in Table 3. The aggregate score of all the items, representing the unidimensional structure (Model 1), correlates significantly with all variables except the physical component of the SF-12. The correlations of the two factors from Model 2 indicates that the factors are conceptually distinct as there are differentially associated with the criterion variables. The correlations indicate a different association between the physical and mental component of the SF-12, with consumption having a low but significant positive correlation with physical health and dependence/consequences having a low but significant negative correlation with mental health. Furthermore, PSQ total score correlates only with dependence and consequences with a significant difference between factors. All other health and demographic variables correlates significantly with factors.
The factors are essentially interchangeable. These factors are conceptually very similar and that no further variables and the dependence and the alcohol related consequences factors are very similar. This would suggest that these factors are conceptually very similar and that no further explanatory power comes from having an additional factor. The factors are essentially interchangeable.

CONCLUSION

Three alternative factor models were proposed and tested based on data from a national survey of Great Britain. Whilst there was a slight statistical advantage to the three factor solution in terms of fit indices, the additional factor (over a two factor model) did not offer additional unique predictive validity. The high correlation between factors two and three of the three factor model resulted in almost identical correlations with all health and demographic criterion variables. Maisto et al. (2000) drew similar conclusions when looking at correlations with other alcohol measures only.

As predicted none of the correlations were particularly high, however it is of note that there is some disparity between the factors regarding physical and mental health (as measured by the SF-12), with mental health being associated with dependence and consequences and physical health being significantly related to consumption patterns. If the scale was treated as unidimensional, there was no significant relationship between physical health and hazardous drinking. These relationships may be worth the attention of further research and in depth measurement instruments to explore this finding. In addition, the PSQ score was only associated with consumption patterns. If the scale was treated as unidimensional, there was no significant relationship between the physical health and hazardous drinking. These relationships may be worth the attention of further research and in depth measurement instruments to explore this finding.

Chung et al. (2002) suggested that the value of having a multidimensional or unidimensional scale depends on the goals of the instrument. Treating the scale as two dimensions would have benefits regardless of the use of the scale. If the AUDIT is being used in research as a variable to indicate hazardous drinking, the conceptual differences between consumption and the consequences/dependences of drinking have demonstrated unique predictive validity and relation to different additional and related variables. If the AUDIT is being used as a screening instrument, for example in a primary care setting, creating scores for two factors may marginally increase the time involved in scoring and interpretation. However, it could additionally be argued that excessive consumption, whether or not an individual is experiencing any further alcohol related problems also needs investigation given the disparity between scores on the mental and physical SF-12 components. With this in mind, it may be advantageous to explore factor specific cut points to assist clinicians with administration and interpretation.

It is worthy of comment that the factor loadings for item 9 was very low (0.29). The poor functioning of this item has been reported previously by Karno et al. (2000) and Kelly and Donovan (2001). Lima et al. (2005) excluded this item because it was not generating score variability.

In conclusion, with mounting evidence that scores derived from the AUDIT are best explained in terms of two correlated dimensions it would appear timely to explore the possibilities of scoring and interpreting the scale in a manner that is consistent with such findings.

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REFERENCES


