An evaluation of the clinical utility of the College Adjustment Scales

Timothy B. Smith
Brigham Young University, tbs@byu.edu

Mark A. Nafziger
Utah State University

See next page for additional authors

Follow this and additional works at: https://scholarsarchive.byu.edu/facpub

Part of the Mental and Social Health Commons

BYU ScholarsArchive Citation
Smith, Timothy B.; Nafziger, Mark A.; and Couillard, Gwenna C., "An evaluation of the clinical utility of the College Adjustment Scales" (1997). All Faculty Publications. 3150.
https://scholarsarchive.byu.edu/facpub/3150

This Peer-Reviewed Article is brought to you for free and open access by BYU ScholarsArchive. It has been accepted for inclusion in All Faculty Publications by an authorized administrator of BYU ScholarsArchive. For more information, please contact scholarsarchive@byu.edu, ellen_amatangelo@byu.edu.
An Evaluation of the Clinical Utility of the College Adjustment Scales

Mark A. Nafziger, Gwena C. Couillard, and Timothy B. Smith

Counseling Center
Utah State University

Correspondence concerning this article should be addressed to Mark A. Nafziger, Counseling Center, Utah State University, Logan, UT 84322-0115.
Abstract

Comparisons of College Adjustment Scales (CAS) profiles with interview data from 748 clients generally supported the clinical usefulness of the CAS, although further refinements appear warranted.
An Evaluation of the Clinical Utility of the College Adjustment Scales

Research has documented that ever increasing numbers of students with increasingly serious psychological problems are served each year by college and university counseling centers (Bishop, 1990; Heppner et al., 1994; Stone & Archer, 1990). And as the numbers and severity of clients' problems increase, the need for identifying assessment devices that address the variety of problems faced by college students becomes more pressing.

One such screening instrument, The College Adjustment Scales (CAS), developed by Anton and Reed (1991) is a multidimensional inventory designed specifically for use in college and university counseling centers. The CAS is composed of 108 items scored on nine scales: Anxiety, Depression, Suicidal Ideation, Substance Abuse, Self-Esteem, Interpersonal Problems, Family Problems, Academic Problems, and Career Problems. It was normed on responses from 1,146 college and university students throughout the United States, and the CAS manual (Anton & Reed, 1991) reports acceptable psychometric data from five studies.

Although several researchers (Chandler & Gallagher, 1996; Heppner et al., 1994; Turner, Valtierra, Talken, Miller, & DeAnda, 1996; Wiswell, 1995) have used the CAS as an outcome measure, and Wiswell (1995) has further investigated the construct and convergent validity of the CAS, no research into
its clinical utility as a screening device has been reported in the literature. The present study was conducted to evaluate the clinical usefulness of the CAS in a university counseling center by having CAS profiles rated on their ability to confirm clinical impressions based on intake interviews and to provide the intake interviewer with new information not gleaned during the interview process.

Method

Participants

This study examined 748 CAS profiles from students who requested psychological services at the Utah State University (USU) Counseling Center from October of 1993 to January of 1996. Of the students who completed the CAS and an intake interview, 497 were women and 251 were men ($M = 25.35$ years, $SD = 6.94$ years). Of the sample, 674 (90%) were White and 74 (10%) were people of color, including international students and members of all major American racial/ethnic groups.

Counseling Center staff members participated in the research as intake interviewers who rated CAS profiles. All five professional staff members (3 women and 2 men) participated in the research. Four were licensed psychologists, and one was a licensed marriage and family therapist ($M = 5$ years post-licensure experience). Graduate assistants and practicum students from USU’s Professional-Scientific psychology doctoral program also participated as intake interviewers and profile
Prior to their intake interviews, USU students seeking psychological services at the Counseling Center completed the CAS, along with a personal data sheet and a client's rights form. After a 50-60 minute intake interview, the staff member who conducted the interview wrote a two-page intake report, which summarized the interviewer's clinical observations and impressions, along with information about the student's presenting problem(s) and concerns, family and psychosocial history, past medical and psychological treatment, and treatment recommendations.

The therapist conducting the intake interview was kept blind to the client's CAS profile until after both the interview and the written summary report had been completed. Following their completion, the staff member would then evaluate the student's CAS profile and rate its usefulness along two dimensions. First, the CAS profile was rated in terms of its usefulness in confirming the interviewer's clinical impressions and conclusions. A one to four scale (1 = little or no confirmation, 2 = some confirmation, 3 = reasonably good confirmation, 4 = excellent confirmation) was utilized in rating the confirmatory value of the CAS. Second, the CAS profile was
Evaluation of the utility of the CAS in terms of its value in providing new information not gleaned during the intake interview. A one to four scale (1 = little or no new information, 2 = some new information, 3 = a fair amount of new information, 4 = a very significant amount of new information) was also used on this second dimension. Both the professional staff members and the doctoral students also participated in reliability training discussions designed to standardize the intake and rating procedures so that they would be understood and performed by all staff members in a similar way.

Results

The ratings of the ability of the CAS to confirm the clinical impressions and conclusions of Counseling Center interviewers were generally favorable. Of the 744 profiles, 42 (5.6%) were rated as providing little or no confirmation; 110 (14.8%) were rated as providing some confirmation; 325 profiles (43.7%) were found to provide reasonably good confirmation; and 267 profiles (35.9%) were found to provide excellent confirmation.

Therapists' ratings of the ability of the CAS to provide new information (in addition to that gathered during the intake interview) were less notable. Of the 748 profiles, 351 (46.9%) were rated as providing little or no new information; 256 (34.2%) were rated as providing some new information; 114 (15.2%) were judged as providing a fair amount of new
information; and 27 (3.6%) were rated as providing a very significant amount of new information.

Discussion

This study attempted to evaluate the clinical utility of the CAS, a screening inventory developed for use with college students. Overall, CAS was rated as providing reasonably good or excellent confirmation of clinical impressions in approximately 80% (592 of 744 cases) of the cases evaluated. Thus, CAS profiles were generally fairly congruent with the results of 50-60 minute long intake interviews; it would therefore appear that the CAS displayed acceptable clinical utility in this regard. However, the CAS was not as useful in providing additional clinical data, with therapists' ratings indicating that a fair amount or a very significant amount of new information was gained slightly less than 20% of the time. Thus, use of the CAS as a preliminary screening tool, but not as a sophisticated intake instrument, was supported by the present study.

However, several factors need to be considered in evaluating the meaning and significance of these results. First, the therapists who rated the instrument were not specifically asked to judge its clinical validity. Rather, the goal of the study was to assess the utility/usability of the instrument. Nevertheless, qualitative impressions provided by raters following the completion of the study were predominately in favor of the CAS as a clinically valid instrument. Clearly,
further psychometric validation could bolster this report.

Second, reasons for discrepancies between the CAS data and approximately 20% of the interviews (in which the rater did not strongly support the ability of the CAS to confirm clinical impressions) remains unknown. Nevertheless, the experience of the research team has led to several hypotheses. Many of these discrepancies appeared to reflect the fact that the CAS is a screening instrument that only assesses some problem areas that affect college student clients. For example, it does not yield information concerning eating disorders, sexual abuse, or sexuality issues, significant problems areas among university counseling center clients (Chandler & Gallagher, 1996). While psychological symptoms (e.g., depression, anxiety) related to eating disorders or experiences of sexual trauma are likely to be reflected on existing CAS scales, it can fail to confirm clinical impressions of client psychological functioning related to these other pertinent issues.

Third, it was the impression of this research team that more research is needed to determine the extent of the CAS's sensitivity in discriminating a generalized tendency towards anxiety and worry from clinical anxiety disorders (e.g., panic disorder and obsessive compulsive disorder) and from depression. Previous construct validity research by Wiswell (1995) has also suggested that the CAS Anxiety scale may measure a generalized tendency towards anxiety and worry as opposed to anxiety
evaluation of the utility disorders per se.

Fourth, while it is not surprising that the CAS did not generate much new information about a client's problems beyond that gathered during a 50-60 minute clinical interview, critical analysis of the results is still warranted. For example, despite training to the contrary, therapist may have unwittingly and unrealistically viewed their clinical impressions and conclusions as having been superior to the data gathered by the CAS. And although almost two-thirds of the interviews were conducted by licensed professional staff members, the rest were conducted by less experienced doctoral students.

A final significant issue involves the CAS's Suicidal Ideation (SI) scale. It is the impression of this research team that the SI scale was the most likely to yield "surprising" results. Specifically, the SI scale appeared to be significantly elevated (scores above the 98th percentile) in some cases where the clinical impression was not one of severe suicidal tendencies or risk. This included cases in which the SI scale was significantly higher than the Depression scale. Since significant numbers of students coming to college and university counseling centers report suicidal ideation and/or behavior (Heppner et al., 1996; Rudd, 1989), the ability of the CAS to screen for students who are significant suicide risks is important to evaluate.

We have hypothesized that the SI scale may yield inflated
scores in some cases because the wording of some questions is somewhat ambiguous with reference to the time frame involved. For example, item #24 ("I've thought about how I would take my life") and item #51 ("I've planned how to take my life") could be read as referring to a client's present suicidal ideation or to past ideation in the case of a client who is not currently suicidal or even depressed.

Concerns over what appeared to be a tendency for inflated scores on the SI scale in some profiles led our research team to identify, based on clinical judgement, three "critical items" from the scale to which therapists could refer in cases of a high SI scale. These were item #69 ("I think that it would be better to kill myself than to go on living"), item #78 ("I know exactly how I would end my life"), and item #96 ("I've attempted suicide in the past"), which suggests a greater potential for suicidal behavior.

In sum, it was the experience of the research team that the CAS performed adequately as a screening device, and appears to be suitable for use as part of an initial assessment process. It was found to be easy to administer, score, and interpret. It confirmed evaluative impressions in the majority of cases, and although it did not provide a great amount of new information, it seldom revealed unexpected mismatches of information. The addition of scales assessing issues related to eating disorders, a history of prior physical and sexual trauma, and sexual
identity concerns would perhaps improve the usefulness of the CAS in a counseling center setting. Further evaluations of its clinical validity also appear warranted, particularly regarding its Anxiety subscale. Such investigations and refinements could provide university and college counseling centers with a highly useful, valid, and appropriate tool to conduct preliminary client screenings.
Evaluation of the utility

References


