Adult, Child, & Family Psychosocial Domains	
Summary of Psychosocial Domains Selected by 2015 Institute of Medicine	
Domain	**Target Areas**
Sociodemographic	• Sexual orientation • Race/ethnicity • Country of origin/U.S. born, or non-U.S. born • Education • Employment • Financial resource staring (e.g., food & housing insecurity)
Psychological	• Health literacy • Stress • Negative mood & affect (e.g., depression, anxiety) • Psychological assets (e.g., conscientiousness, patient engagement/activation, optimism, self-efficacy)
Behavioral	• Dietary patterns • Physical activity • Tobacco use & exposure • Alcohol use
Individual-Level Social Relationships & Living Conditions	• Social connections & social isolation • Exposure to violence
Neighborhoods & Communities	• Neighborhood & community composition characteristics (e.g., socioeconomic & racial/ethnic characteristics)
Helsing, K. (2015,October 31-November 4). Capturing Social and Behavioral Domains and Measures in Electronic Health Records [Conference session]. American Public Health Association Annual Meeting and Exposition, Chicago, IL., United States.	

Adult Psychosocial Assessments		
Measure	**Citation**	**Description, Validity, & Reliability**
Patient Health Questionnaire (depression) PHQ-9, PHQ-2	Kroenke, K. & Spitzer, R.L. (2002). The PHQ-9: A new depression and diagnostic severity measure. *Psychiatric Annals, 32*(9), 509-521. Gilbody, S., Richards, D., Brealey, S., & Hewitt, C. (2007). Screening for depression in medical settings with the Patient Health Questionnaire (PHQ): A diagnostic meta-analysis. *Journal of General Internal Medicine, 22*(11), 1596-1602.	The PHQ-9 and PHQ-2 can be self-or clinician-administered to assess depression. It incorporates DSM depression criteria with other leading major depressive symptoms. Often used in primary settings to screen and diagnose depression. PHQ-9 scores > 10 had a sensitivity of 88% and a specificity of 88% for Major Depressive Disorder. Reliability and validity of the tool have indicated it has sound psychometric properties. Internal consistency of the PHQ-9 has been shown to be high. The PHQ-9 can be accessed online at: https://www.phqscreeners.com/
Generalized Anxiety Disorder GAD-7, GAD-2	Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of internal medicine, 166*(10), 1092-1097. Rutter, L. A., & Brown, T. A. (2017). Psychometric properties of the generalized anxiety disorder scale-7 (GAD-7) in outpatients with anxiety and mood disorders. *Journal of psychopathology and behavioral assessment, 39*(1), 140-146.	The GAD-7 is a valid and efficient tool for screening for generalized anxiety disorder and assessing its severity in clinical practice and research. The GAD-7 demonstrates good internal consistency and convergent validity. Alphas all above 0.82 at intake and post-treatment, and correlations are large with other measures of anxiety and well-being, indicating high reliability and validity. The GAD can be accessed online at:

		https://www.tbh.org/sites/default/files/Generalized_Anxiety_Disorder_Screener_GAD7.pdf
Perceived Stress Scale	Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. Journal of health and social behavior, 24, 385- 396.	The Perceived Stress Scale assesses a patient's or caregiver's thoughts and feelings about coping, irritability, ability to handle problems, and anger over the past month. Each item is rated on a 5- point Likert-type scale ranging from 0 (never) to 4 (very often), with higher scores indicating higher levels of stress. The scale has good reliability and validity and has been used in diverse 5 medical settings. The Perceived Stress Scale can be purchased online at: http://www.mindgarden.com/132- perceived-stress-scale
Herth Hope Index (HHI)	Herth, K. (1992). Abbreviated instrument to measure hope: Development and psychometric evaluation. *Journal of Advanced Nursing, 17*(10), 1251-1259.	Herth Hope Index (HHI) is a 12 item Likert-type scale (1-4) that measures the following seven hope-fostering categories in patients: 1) interpersonal connectedness, 2) attainable aims, 3) spiritual base, 4) personal attributes, 5) light-heartedness, 6) uplifting memories, and 7) affirmation of worth). It also measures the following three hope hindering categories that can interfere with maintaining hope: 1) abandonment and isolation, 2) uncontrollable pain and discomfort, and 3) devaluation of personhood. Scores can range from 12 to 48, with higher scores meaning greater hope. The index has shown to be a reliable measure of hope with reliability scores ranging from 0.89 to 0.94. The Herth Hope Index can be accessed online at:

		http://www.mywhatever.com/cifwriter/co ntent/41/pe1197.html
Zarit Burden Interview (ZBI)	Bédard, M., Molloy, D. W., Squire, L., Dubois, S., Lever, J. A., & O'Donnell, M. (2001). The Zarit Burden Interview: A new short version and screening version. *The Gerontologist, 41*(5), 652-657. Schreiner, A. S., Morimoto, T., Arai, Y., & Zarit, S. (2006). Assessing family caregiver's mental health using a statistically derived cut-off score for the Zarit Burden Interview. *Aging and Mental Health, 10*(2), 107-111.	Zarit Burden Interview (ZBI) was originally developed to assess caregiver burden of dementia patients. Because there are many similarities in the burden experienced by caregivers of patients with various illnesses, this measure is appropriate. The ZBI includes 22 items, 21 of which are Likert-type scale items (0=never to 4=almost always) related to health, finances, social life, and interpersonal relationships. There is also a valid and reliable 12-item version (short) and a 4-item version (screening). A cut-off score of 24-26 has predictive validity for caregivers at risk for depression. Furthermore, the ZBI has also been shown to be a valid and reliable measure with high internal consistency and test retest reliability. The Zarit Burden Interview can be accessed online at: https://dementiapathways.ie/_filecache/edd/c3c/89-zarit_burden_interview.pdf
Recent Life Changes (RLCQ)	Miller, M. A., & Rahe, R. H. (1997). Life changes scaling for the 1990s. *Journal of Psychosomatic Research, 43*(3), 279-292. Hobson, C. J., Kamen, J., Szostek, J., Nethercut, C. M., Tiedmann, J. W., & Wojnarowicz, S. (1998). Stressful life events: A revision and update of the Social Readjustment Rating	Recent Life Changes Questionnaire (RLCQ) is a tool that measures stress of individuals through life changing events. It has five categories: work, home and family, health, personal and social, and financial. The area under the receiver operating characteristic curve (ROC) of common mental disorders such as depression and anxiety was 0.64, where sensitivity was 66%, specificity

	Scale. *International journal of stress management, 5*(1), 1-23.	was 56% and the corresponding cut off from the adapted RLCQ was 750 The RLCQ can be accessed online at: https://michellecederberg.com/wp-content/uploads/2019/09/Recent-Life-Changes-Questionnaire-michellecederberg.com_.pdf
Alcohol Use Disorder Identification Test (Audit-10 and Audit-C)	Saunders, J. B., Aasland, O. G., Babor, T. F., De la Fuente, J. R., & Grant, M. (1993). Development of the alcohol use disorders identification test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption-II. *Addiction, 88*(6), 791-804. Bohn, M. J., Babor, T. F., & Kranzler, H. R. (1995). The alcohol use disorders identification test (AUDIT): Validation of a screening instrument for use in medical settings. *Journal of Studies on Alcohol, 56*(4), 423-432.	The AUDIT screening procedure with 10 or 3 items (brief) can be self- or clinician-administered and is linked to a decision process that includes brief intervention with heavy drinkers or referral to specialized treatment for patients who show evidence of more serious alcohol involvement. Another feature of the AUDIT is the optional Clinical Screening Procedure. This consists of two questions about traumatic injury, five items on clinical examination, and a blood test, the serum GGT. The Clinical Screening Procedure does not refer directly to problems with alcohol and may be particularly relevant for defensive patients in situations where alcohol-specific questions cannot be asked with confidence. Data suggest that the interviewer- or self-administered AUDIT have similar discriminant validity to identify hazardous-drinking and alcohol-dependent behavior. Internal consistency (Cronbach's alpha = 0.96). and Cohens Kappa (test-retest reliability) were both high K = 0.64 The AUDIT can be accessed online at: https://www.sbirt.care/pdfs/tools/AUDIT.PDF

Cut Down, Annoyed, Guilty, and Eye-Opener (CAGE) Screener	Ewing, J.A. (1984). Detecting alcoholism: The CAGE questionnaire. *Journal of the American Medical Association, 252*(14), 1905- 1907. U.S. Preventive Services Task Force. (2004). Screening and behavioral counseling interventions in primary care to reduce alcohol misuse: Recommendation statement. *Annals of Internal Medicine, 140*(7), 554-6.	An internationally used assessment instrument for identifying problem drinking. Particularly popular with primary caregivers, the questions can be used in the clinical setting using informal phrasing and are most effective when used as part of a general health history. The CAGE should NOT be preceded by questions about how much or how frequently the patient drinks. The CAGE has demonstrated high test-retest reliability (0.80-0.95), and adequate correlations (0.48-0.70) with other screening instruments. The questionnaire is a valid tool for detecting alcohol abuse and dependence in medical and surgical inpatients, ambulatory medical patients, and psychiatric inpatients (average sensitivity 0.71, specificity 0.90). The CAGE can be accessed online at: https://nationalpaincentre.mcmaster.ca/documents/cage_questionnaire.pdf
Edinburgh Postpartum Depression Scale 10- or 3-item (EDPS)	Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *The British journal of psychiatry*, *150*(6), 782-786. Martínez, P., Magaña, I., Vöhringer, P. A., Guajardo, V., & Rojas, G. (2020). Development and validation of a three-item version of the Edinburgh Postnatal Depression Scale. *Journal of Clinical Psychology*, *76*(12), 2198-2211.	A set of ten (or three) screening questions that can indicate whether a mother has symptoms that are common in women with depression and anxiety during pregnancy and in the year following the birth of a child. The psychometric properties of the EPDS in primary health care were: 86% sensitivity (correctly identifying true cases), 78% specificity (correctly identifying people without the condition) and 73% positive predictive value (proportion of respondents scoring positive in the test who had a mental disorder diagnosed The EDPS can be accessed online at:

		https://med.stanford.edu/content/dam/sm/ppc/documents/DBP/EDPS_text_added.pdf
Primary Care PTSD Screen for DSM-V (PC-PTSD-5)	Prins, A., Bovin, M. J., Kimerling, R., Kaloupek, D. G, Marx, B. P., Pless Kaiser, A., & Schnurr, P. P. (2015). Primary Care PTSD Screen for DSM-5 (PC-PTSD-5) [Measurement instrument]. Available from https://www.ptsd.va.gov	Five-item screen designed to identify individuals with probable PTSD. Those screening positive require further assessment, preferably with a structured interview. Research with the PC-PTSD has shown good test-retest reliability (r = 0.83) and predictive validity against the Clinician Administered PTSD Scale (CAPS; r = 0.83). The PC-PTSD-5 can be accessed online at: https://www.ptsd.va.gov/professional/assessment/documents/pc-ptsd5-screen.pdf

Control Preferences Scale (CPS)	Degner, L. F., Sloan, J. A., & Venkatesh, P. (1997). The Control Preferences Scale. *The Canadian Journal of Nursing Research,29*(3), 21–43.	Assesses the degree of control an individual wants to assume when decisions are being made about medical treatment. The CPS consists of five cards that each portray a different role in treatment decision-making using a statement and a cartoon. These roles range from the individual making the treatment decisions, through the individual making the decisions jointly with the physician, to the physician making the decisions. The scale has been tested in a variety of populations, ranging from the general public to highly stressed groups. The CPS has proven to be a clinically relevant, easily administered, valid, and reliable measure of preferred roles in health-care decision-making. See Appendix 2 for CPS: https://medprogram.med.unsw.edu.au/sites/default/files/_local_upload/others/ILP_Example5.pdf

Child & Adolescent Psychosocial Assessments		
Measure	**Citation**	**Description, Validity, & Reliability**
PHQ-A	Johnson, J. G., Harris, E. S., Spitzer, R. L., & Williams, J. B. (2002). The patient health questionnaire for adolescents: validation of an instrument for the assessment of mental disorders among adolescent primary care patients. *Journal of Adolescent Health*, *30*(3), 196-204. Richardson, L. P., McCauley, E., Grossman, D.	Severity Measure for Depression—Child Aged 11–17 (adapted from PHQ9 modified for Adolescents [PHQ-A]). Overall diagnostic agreement (clinical interview and PHQ-A) coefficients of $\kappa = 0.62$ and $\kappa = 0.77$ were obtained in the white and nonwhite subsamples, respectively.

	C., McCarty, C. A., Richards, J., Russo, J. E., ... & Katon, W. (2010). Evaluation of the Patient Health Questionnaire-9 Item for detecting major depression among adolescents. *Pediatrics*, *126*(6), 1117-1123.	The PHQ-A can be accessed for free: https://missionhealth.org/wp-content/uploads/2018/04/Adolescent-Depression-Screening-PHQ-A-Form.pdf
The Screen for Child Anxiety Related Disorders (SCARED)	*Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999).* Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): A replication study*. Journal of the American Academy of Child and Adolescent Psychiatry, 38*(10), 1230–6.	SCARED is a 41-item inventory rated on a 3-point Likert-type scale. It comes in two versions; one asks questions to parents about their child and the other asks these same questions to the child directly. The purpose of the instrument is to screen for signs of anxiety disorders in children. SCARED has been found to have strict measurement invariance, strong test-retest reliability, and adequate external validity with a clinician-rated measure of anxiety. The child and parent SCARED screeners can be accessed online at: https://www.ohsu.edu/sites/default/files/2019-06/SCARED-form-Parent-and-Child-version.pdf

Mood and Feelings Questionnaire Child and Parent Versions (MFQ-C and MFQ-P)	Wood, A., Kroll, L., Moore, A., & Harrington, R. (1995). Properties of the Mood and Feelings Questionnaire in adolescent psychiatric outpatients: A research note. *Journal of Child Psychology and Psychiatry, 36*(2), 327-334.	The child version (MFQ-C) is completed by the child and the parent version (MFQ-P) asks the same questions, but is completed by the parent about the child's or adolescent's behavior. There is a 32-item and a 10-item version. It is a valid and reliable measure to quickly (takes 5 to 10 minutes to complete) and effectively evaluate core symptoms of depression within the last two weeks, in children ages 8 to 18. The MFQ-C and MFQ-P can be accessed online at: https://devepi.duhs.duke.edu/measures/the-mood-and-feelings-questionnaire-mfq/
Behavioral Health Screening Tool (BHS)	Diamond, D., Levy, S., Begans, K.B., Fein, J.S., Wintersteen, M.B., Tien, Al, & Creed, T. (2010). Development, validation, and utility of internet-based, behavioral health screen for adolescents. *Pediatrics, 126*(1), 163-170.	The BHS tool is a web-based screening tool developed to evaluate depressive symptoms, suicidality, and behavioral health among youth. The BHS evaluates 13 domains (demographic, medical, school, family, safety, substance use, sexuality, trauma, nutrition and eating, psychosis, anxiety, depression, suicide and self-harm) using 54 required items and 34 follow-up items. It takes approximately 7 minutes for adolescents ages 12-18 to complete. Adolescents complete the BHS before meeting with a medical provider, then the web-based system automatically scores a report that the provider reviews. It automatically scores depression, anxiety, suicide, traumatic distress, substance use, and eating disorders and identifies youth strengths. Data can be downloaded into

		an EMR and aggregated for monitoring quality assurance at clinics. It is a valid and reliable online self-report adolescent behavioral health measure that is being used in primary care, emergency departments and health units, mental health clinics, crisis services, and school settings. For more information about the BHS contact: guy.diamond@drexel.edu
Security Scale	Kerns, K.A., Tomich, P.L., Aspelmeier, J.E., & Contreras, J.M. (2000). Attachment-based assessments of parent-child relationships in middle childhood. *Developmental Psychology, 36*(5), 614-626.	The Security Scale is a 15-item valid and reliable measure that assesses childrens' perceptions of attachment during middle childhood and adolescence. This scale provides a continuous measure of security, evaluating a child's belief in the responsiveness and availability of the attachment figure, the child's use of the attachment figure as a safe haven, and the child's report of open communication with the attachment figure. The Security Scale presents children with descriptions of two types of children and asks which type of child they are most like. Items are scored from 1 to 4, with greater attachment security represented by a higher score. Scores on the Security Scale have adequate internal consistency and evidence of validity based on security scores correlated with self-esteem, peer acceptance, behavioral conduct, physical appearance, and scholastic competence. For a copy of the Security Scale, contact: kkerns@kent.edu

The Attachment Style Classification Questionnaire	Finzi, R., Har-Even, D., Weizman, A., Tyano, S., & Shnit, D. (1996). The adaptation of the attachment styles questionnaire for latency-aged children. *Psychologia: Israel Journal of Psychology, 5*(2), 167-177.	The 5-item self-report questionnaire based on the Hebrew version of the Attachment Questionnaire (AQ). The AQ was modified to assess familial and extrafamilial relationships and yields scores on three attachment categories: 1) Secure, 2) Anxious/Ambivalent, and 3) Avoidant. Children are given an attachment classification based on the highest scores they receive in a category. Internal consistency for the scales ranged from .69 - .81. Two-week test-retest reliability was reported as .87 - .95. For a copy of the AQ, contact rikifnz@biu.013.net.il / http://www.biu.ac.il/faculty/rikifnz
Parental Illness Impact Scale-Revised (PIIS-R)	Schrag, A., Morley, D., Quinn, N., & Jahanshahi, M. (2004). Development of a measure of the impact of chronic parental illness on adolescent and adult children. The Parental Illness Impact Scale (Parkinson's disease). *Parkinsonism & Related Disorders, 10*(7), 399-405. Morley, D., Selai, C., Schrag, A., Thompson, A. J., & Jahanshahi, M. (2010). Refinement and validation of the Parental Illness Impact Scale. *Parkinsonism & Related Disorders, 16*(3), 181-185.	The PIIS-R is a 51-item reliable and valid self-report measure that youth complete regarding how their parent's illness impacts the following six domains:1) social development, 2) independence, 3) responsibility, 4) burden of daily help, 5) impact on family functioning, and 6) friends' reactions. Each item is scored from 1 to 5; 5 indicates the best level of functioning. Higher scores indicate better levels of functioning. It has also been adapted for general parental illness and not just Parkinson disease (see Morley et al., 2010). For a copy of the PIIS-R, contact: ruth.stein@einstein.yu.edu

Parent & Child Psychosocial Assessments		
Family Functioning		
Measure	**Citation**	**Description, Validity, & Reliability**
Family Assessment Device (FAD)	Miller, I. W., Epstein, N. B., Bishop, D. S., & Keitner, G. I. (1985). The McMaster family assessment device: reliability and validity. *Journal of Marital and Family therapy, 11*(4), 345-356.	The FAD measures structural, organizational, and transactional characteristics of families. It has 7 subscales that assess: 1) affective involvement, 2) affective responsiveness, 3) behavioral control, 4) communication, 5) problem solving, 6) roles, and 7) general family functioning. The measure includes 60 statements that mothers, fathers, and children ages 12 and older can complete. Family members are asked to rate how well each statement describes their own family. The FAD is scored by adding the responses (1-4) for each scale and dividing by the number of items in each scale (6-12). Higher scores indicate worse levels of family functioning. The FAD is a reliable and valid measure that has been adapted for different cultures and used in clinical practice to identify families experiencing problems, and evaluate change following treatment. The FAD can be accessed online at: https://isucounselingresources2017.weebly.com/uploads/1/1/3/4/11344496/family_assessment_device.pdf
Dyadic Family Relationships		

Dyadic Adjustment Scale (DAS) (parent report)	Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family*, *38*(1) 15-28.	The Dyadic Adjustment Scale (DAS) is a 32-item questionnaire that measures an individual's perceptions of his/her relationship with an intimate partner. The DAS and its 4 subscales are internally consistent and stable over the interval examined in this study. The DAS can be accessed online at: https://arc.psych.wisc.edu/self-report/dyadic-adjustment-scale-das/
Revised Child Report of Parental Behavior Inventory (CRPBI-30)	Schludermann EH, Schludermann SM. (1988). Children's Report on Parent Behavior (CRPBI-108, CRPBI-30) for older children and adolescents. Winnipeg, MB, Canada: University of Manitoba, Department of Psychology. .	CRPBI-30 is a 30-item self-report scale adapted from the 108-item original measure in which children rate their parent's behavior across three dimensions. The first subscale—psychological control versus psychological autonomy—measures the degree that a parent implements guilt, love withdrawal, avoidance, and other psychological methods with the intent to control behaviors. This measure has demonstrated strong reliability and predictive validity in children and adolescents. Internal consistency for each of the three subscales was good (Cronbach's a's 5 0.74 - 0.88). To obtain the CRPBI-20, contact: alderfer@email.chop.edu for a copy.
Coping with Illness in the Family		
Impact on Family Scale (IOF) (parent report)	Stein, R.E.K. & Riessman, C.K. (1980). The development of the Impact on Family Scale: Preliminary findings. *Medical Care, 18*(4), 465-472. Stein R.E.K. & Jessop D.J.	IOF is a 27 item scale, designed for use with parents or caregivers of children with medical conditions, that assesses impact of pediatric illness on the family, looking at four subscales including

	(2003). The impact on family scale revisited: further psychometric data. *Developmental and Behavioral Pediatrics, 24*(1), 9-16.	financial impact; familial-social impact, personal strain, mastery. Reliability and validity: Cronbach alphas (internal consistency) are high (total impact – in the high .80s, financial .68 - .79), coping (.46 - .52), and construct validity is well established. To obtain the PIIS-R, contact, Dr. Ruth Stein: ruth.stein@einstein.yu.edu
Coping Health Inventory for Parents (CHIP) (parent report)	McCubbin, H.I., McCubbin, M.A., Patterson, J.M., Cauble, A.E., Wilson, L.R. & Warwick, W. (1983). CHIP-Coping Health Inventory for Parents: An Assessment of Parental Coping Patterns in the Care of the Chronically Ill Child. *Journal of Marriage and the Family*, *45*(2), 359-370.	The CHIP is a 45-item measure of a parent's response to managing demands when a child has a serious or chronic medical condition. Parents and caregivers complete the measure in a Likert-style format. Reliability and validity: Alpha reliabilities for the 3 subscales listed above are .79, .79, and .71 (Patterson, McCubbin and Warwick, 1990). To obtain the CHIP, contact: Dr. Hamilton McCubbin, Dean, School of Family Resources, University of Wisconsin, Madison WI 53706-1575. Publisher: National Council of Family Relations
Goodman, J.M. & Nutting, R. (2021). Psychosocial Assessments. University of Rochester, Rochester, NY.		