Adult, Child, and Family Psychosocial Assessments

Currently there is no standard regarding which psychosocial assessments providers in primary and tertiary medical settings should regularly assess and track (Helsing, 2015). Recently, a committee of health experts selected by the Institute of Medicine (IOM) recommended 12 social and behavioral domains be routinely assessed and recorded in patients’ electronic health records; the committee referred to them as, “psychosocial vital signs” (Helsing, 2015, p. 8). Based on research suggesting these domains are linked to health outcomes and the availability of reliable and valid tools to measure them, the committee recommended regularly asking about the following 12 psychosocial vital signs: 1) alcohol use; 2) race and ethnicity; 3) residential address; 4) tobacco use and exposure; 5) census tract-median income; 6) depression; 7) education; 8) financial resource strain; 9) intimate partner violence; 10) physical activity; 11) social connections and social isolation; and 12) stress (Helsing, 2015) (see Table 11.1 for list of psychosocial domains and target areas recommended by IOM selected 2015 committee of health experts).
Table 11.1 Summary of Psychosocial Domains Selected by 2015 IOM Committee

<table>
<thead>
<tr>
<th>Domain</th>
<th>Target Areas</th>
</tr>
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<tbody>
<tr>
<td>Sociodemographic</td>
<td>• Sexual orientation</td>
</tr>
<tr>
<td></td>
<td>• Race/ethnicity</td>
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<tr>
<td></td>
<td>• Country of origin/U.S. born or non-U.S. born</td>
</tr>
<tr>
<td></td>
<td>• Education</td>
</tr>
<tr>
<td></td>
<td>• Employment</td>
</tr>
<tr>
<td></td>
<td>• Financial resource strain (e.g., food and housing insecurity)</td>
</tr>
<tr>
<td>Psychological</td>
<td>• Health literacy</td>
</tr>
<tr>
<td></td>
<td>• Stress</td>
</tr>
<tr>
<td></td>
<td>• Negative mood and affect (e.g., depression, anxiety)</td>
</tr>
<tr>
<td></td>
<td>• Psychological assets (e.g., conscientiousness, patient engagement/activation, optimism, self-efficacy)</td>
</tr>
<tr>
<td>Behavioral</td>
<td>• Dietary patterns</td>
</tr>
<tr>
<td></td>
<td>• Physical activity</td>
</tr>
<tr>
<td></td>
<td>• Tobacco use and exposure</td>
</tr>
<tr>
<td></td>
<td>• Alcohol use</td>
</tr>
<tr>
<td>Individual-Level Social Relationships and Living Conditions</td>
<td>• Social connections and social isolation</td>
</tr>
<tr>
<td></td>
<td>• Exposure to violence</td>
</tr>
<tr>
<td>Neighborhoods and Communities</td>
<td>• Neighborhood and community composition characteristics</td>
</tr>
<tr>
<td></td>
<td>(e.g., socioeconomic and racial/ethnic characteristics)</td>
</tr>
</tbody>
</table>


We agree with the IOM committee’s recommendation that providers routinely measure and track psychosocial vital signs at the beginning of a patient’s treatment (close to diagnosis) and throughout care, especially the psychological and individual-level social relationships domains and target areas listed above in table 11.1. For example, parents and their children we recommend the following be routinely assessed: 1) stress levels; 2) negative mood and affect
(e.g., depression and anxiety); 3) family routines before and after the parental illness; 4) family communication (directly communicate, limited open communication, indirect style of communication, no communication); and, 5) quality of child’s relationship and attachment to ill parent and among two-parent families to the healthy parent (secure, insecure, ambivalent attachment) (Murphy et al., 2009; Sperry, 2005; 2014).

**Adult Assessments**

Below Table 11.2 describes some helpful adult assessments that have been used, however, this is not an exhaustive list of adult assessments (see Corcoran, K., & Fischer, J. (2013). *Measures for Clinical Practice and Research, Volume 1: Couples, Families, and Children* (Vol. 1). Oxford University Press for list of adult assessments).

**Table 11.2 Adult Psychosocial Assessments**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Citation</th>
<th>Description, Validity, and Reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beck Depression Inventory-II</strong></td>
<td>Beck, A.T., Steer, R.A., and Brown, G.K. (1996). “Manual for the Beck Depression Inventory-II”. San Antonio, TX: Psychological Corporation</td>
<td>The <em>Beck Depression Inventory (BDI-II)</em> measures depressive symptoms in adults (Beck et al., 1996). It includes 21 items, with higher scores indicating more severe depression. Clinical cut-off scores are: 0-13= minimal, 14-19= mild, 20-28= moderate, and 29+= severe. The BDI-II is a reliable and valid measure of depression that has been used in many clinical settings. BDI-II can be ordered at: <a href="http://www.pearsonclinical.com/psychology/products/10000159/beck-depression-inventoryii-bdi-ii.html#tab-pricing">http://www.pearsonclinical.com/psychology/products/10000159/beck-depression-inventoryii-bdi-ii.html#tab-pricing</a></td>
</tr>
<tr>
<td><strong>State-Trait Anxiety Inventory (STAI)</strong></td>
<td>Spielberger, C.D., Gorsuch, R.C., Lushene R.E., Vagg P.R., &amp; Jacobs, G.A. (1983). <em>Manual for the</em></td>
<td>The <em>State-Trait Anxiety Inventory (STAI)</em> measures anxiety. It includes 20 items (4-point Likert scale), approximately half of</td>
</tr>
<tr>
<td>Instrument</td>
<td>Description</td>
<td>Reference(s)</td>
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<tr>
<td>State-Trait Anxiety Inventory</td>
<td>The State-Trait Anxiety Inventory (STAI) is a widely used, two-component measure of anxiety that assesses both state and trait anxiety. The State Anxiety subscale (STAI-S) assesses anxiety that is present, and the Trait Anxiety subscale (STAI-T) assesses anxiety that is absent.</td>
<td>Novy, D.M., Nelson, D.V., Goodwin, J., &amp; Towzee, R.D. (1993). Psychometric comparability of the State-Trait Anxiety Inventory for different subpopulations. Psychological Assessment, 5, 343-349. doi:10.1037/1040-3590.5.3.343</td>
</tr>
<tr>
<td>Center Epidemiological Depression Scale (CES-D)</td>
<td>The Center for Epidemiological Studies Depression Scale (CES-D) is a widely used, 20-item self-report valid and reliable scale that measures current levels of depressive symptoms in the general population, focusing on depressed mood during the past week.</td>
<td>Radloff, L.S. (1997). The CES-D Scale: A self-report depression scale for research in the general population. Applied Psychological Measures, 1, 385-401.</td>
</tr>
<tr>
<td>Perceived Stress Scale</td>
<td>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.</td>
<td>Cohen, S., Kamarck, T., &amp; Mermelstein, R. (1983). A global measure of perceived stress. Journal of health and social behavior, 24, 385-396.</td>
</tr>
<tr>
<td>Medical Outcome Study Short Form-36 (MOS SF-36)</td>
<td>Ware Jr, J. E., &amp; Sherbourne, C. D. (1992). The MOS 36-item short-form health survey (SF-36): I. Conceptual framework and item selection. <em>Medical care</em>, 30, 473-483.</td>
<td>Medical Outcome Study Short Form-36 (MOS SF-36) is a multi-item Likert-type scale that assesses the following eight health concepts in a patient: 1) limitations in physical activities because of health problems, 2) limitations in social functioning because of physical or emotional problems, 3) limitations in usual role activities because of physical health problems, 4) bodily pain, 5) general mental health, 6) limitations in usual role activities because of emotional problems, 7) vitality, such as energy/fatigue, and 8) general health perceptions. Providers need to ask for permission to use the scoring manual. The MOS SF-36 has been shown to have item-discriminant validity as well as scale reliability and can be found at: <a href="http://www.rand.org/health/surveys_tools/mos/mos_core_36item.html">http://www.rand.org/health/surveys_tools/mos/mos_core_36item.html</a></td>
</tr>
<tr>
<td>Spiritual Well-Being Scale</td>
<td>Paloutzian, R. F., &amp; Ellison, C. (1982). Spiritual well-being scale. <em>Nyack, NY</em>. D'Costa, A. (1995). Review of the Spiritual Well-Being Scale. In C. Conoley (Ed.), <em>Mental Measurement Yearbook, 12th edition</em> (pp. 983-984). Lincoln, NE: Buros Institute of Mental Measurements, University of Nebraska Press.</td>
<td>Spiritual Well-Being Scale is a 20-item measurement with sound psychometric properties that targets a patient’s self-reported relationship with God and his or her life satisfaction. Answers provided on the scale will reflect a patient’s personal beliefs regarding their well-being, with higher scores meaning higher perceptions of well-being and lower scores reflecting lesser perceptions. Likert-type scale items range from “strongly disagree” (score of 1) to “strongly agree” (score of...</td>
</tr>
<tr>
<td><strong>Herth Hope Index (HHI)</strong></td>
<td>Herth, K. (1992) Abbreviated instrument to measure hope: development and psychometric evaluation. <em>Journal of advanced nursing</em>, 17(10), 1251-1259.</td>
<td>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. A copy of the Herth Hope Index can be found at: <a href="http://www.mywhatever.com/cifwriter/content/41/pe1197.html">http://www.mywhatever.com/cifwriter/content/41/pe1197.html</a></td>
</tr>
<tr>
<td><strong>Zarit Burden Interview (ZBI)</strong></td>
<td>Zarit, S.H., &amp; Zarit, J.M. (1987). <em>Instructions for the Burden Interview</em>. Technical Document, University Park, PA: Pennsylvania State University Schreiner, A. S., Morimoto, T., Arai, Y., &amp; Zarit, S. (2006). Assessing family caregiver's mental health</td>
<td>Zarit Burden Interview was originally developed to assess burden of caregivers of dementia patients, but because there are many similarities in the burden experienced by caregivers of patients with various illnesses, this measure is appropriate. It includes 22 items, 21 of which are Likert-type scale items (0=never to 4=almost always) related to</td>
</tr>
</tbody>
</table>
using a statistically derived cut-off score for the Zarit Burden Interview. Aging and Mental Health, 10(2), 107-111. A cut-off score of 24-26 has predicative validity for caregivers at risk for depression. Furthermore, the ZBI has also been shown to a valid and reliable measure with high internal consistency and test-retest reliability.

The Zarit Burden Interview can be accessed online at: http://www.aafp.org/afp/2000/1215/p2613.html

<table>
<thead>
<tr>
<th>Measure</th>
<th>Citation</th>
<th>Description, Validity, and Reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Depression Inventory (CDI)</td>
<td>Kovacs M. (1981). Rating scales to assess depression in school-aged children. Acta Paedopsychiatr, 46, 305-315.</td>
<td>Most widely used self-report measure is the Children’s Depression Inventory (CDI), which was adapted from the Beck Depression Inventory (BDI) and is reliable and valid for diverse samples of children 7 to 18 years of age (Steele et al., 2006). The CDI includes 27 items that assess behaviors associated with depression (e.g., sleep disturbance, anhedonia, suicidality, and appetite loss).</td>
</tr>
</tbody>
</table>

Child and Adolescent Assessments

There are many valid and reliable self-report psychosocial measures for school-age children (ages 10 and older) (see table 11.3). In table 11.3, we review some of these assessments (depressive symptoms: CDI, anxiety: RCMAS, mood and feelings: MFQ-C/P, impact of parent’s illness: PIIS-R, and behavioral health symptoms: BHS) that have been used to assess school-age children. We recommend that at minimum providers evaluate depressive symptoms (CDI: Kovacs, 1981), anxiety (RCMAS: Reynolds & Richmond, 1997), and how the child is coping with his/her parent’s illness (PIIS-R; Morley et al., 2010; Schrag et al., 2004).

Table 11.3 Child and Adolescent Assessments
| **Revised Child Manifest Anxiety Scale (RCMAS)** | Reynolds C.R. & Richmond, B.O. (1997). What I Think and Feel: A revised measure of Children's Manifest Anxiety. *J Abnorm Child Psychology, 25*(1),15-20. | The *Revised Children’s Manifest Anxiety Scale (RCMAS)* includes 37 items, rated as true or not. A general anxiety factor and 3 subscales of anxiety have been identified. Extensive reliability (alpha=.85 and adequate internal consistency), validity (e.g., correlation of .85 with State-Trait Anxiety Inventory [STAI] for Children and significant correlation with teacher observations), and normative data have been documented. A cutoff score of 42 indicates severe anxiety. The RCMAS can be purchased at: http://www.wpspublish.com/store/p/2934/revised-childrens-manifest-anxiety-scale-second-edition-rcmas-2.html |
| **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*, 327-334. Freely available at: devepi.duhs.duke.edu/mfw.html | The Mood and Feelings Questionnaire 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 is a self-report measure designed for children, adolescents, and their parents; there is a longer 32-item and a shorter 10-item version. 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 their child’s or adolescent’s behavior. The MFQ-C and MFQ-P is available at: devepi.duhs.duke.edu/mfw.html |
The Parental Illness Impact Scale-Revised 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, independence, responsibility, burden of daily help, impact on family functioning and 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).  
The PIIS-R can be used after contacting the developer of this measure (http://www.ncbi.nlm.nih.gov/pubmed/19939722) |
The Behavioral Health Screening Tool is a web-based screening tool developed to evaluate depressive symptoms, suicidality, and behavioral health among youth. 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. 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,
Family Assessments

There are many valid and reliable self-report measures parents and their school-age children can complete (see table 11.4). In table 11.4, we review some of these family assessments that have been used. We recommend that at minimum providers evaluate parent-child attachment (Security Scale: Kerns et al., 2000), parent-child communication (General Communication: Barnes & Olson, 2010), family routines (FRI: Jenson et al., 1983), and how the family functions (FAD: Miller et al., 1985).

Table 11.4 Parent-Child and Family Assessments

<table>
<thead>
<tr>
<th>Measure</th>
<th>Citation</th>
<th>Description, Validity, and Reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security Scale</td>
<td>Kerns, K.A., Tomich, P.L., Aspelmeier, J.E., &amp; Contreras, J.M. (2000). Attachment-based assessments of parent-child relationships in middle childhood. <em>Dev Psychol</em>, 36, 614–626.</td>
<td>The Security Scale is a 15-item valid and reliable measure that assesses children’s 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.</td>
</tr>
</tbody>
</table>
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 Kerns Security Scale, contact the developer at: kkerns@kent.edu

| Short Form Interaction Behavior Questionnaire (IBQ) | Prinz, R.J., Foster, S., Kent, R.N., & O’Leary, K.D. (1979). Multivariate assessment of conflict in distressed and non-distressed mother-adolescent dyads. *J Appl Behav Anal, 12*, 691-700. | The *Interaction Behavior Questionnaire (IBQ)* is a valid and reliable measure that evaluates agreement and conflict in parent-child dyads. The original IBQ was adapted into a short form consisting of 20 true/false items assessing communication-conflict behavior. Higher scores indicate a more positive relationship with parents.

Copy of IBQ can be found at: https://books.google.com/books?id=vAPtAgAAQBAJ&pg=PA328&lpg=PA328&dq=Copy+of+Short+Form+Interaction+Behavior+Questionnaire&source=bl&ots=omaahF1LIF&sig=ui6i72YfqZ9O-6XTJWG-z3hexfk&hl=en&sa=X&ved=0CD4Q6AEwBGoVCh2flh4zPy6qmxIVQVo-Ch2fvdVd#v=onepage&q=Copy%20of%20Short%20Form%20Interaction%20Behavior%20Questionnaire&f=false |

| General Communication | Barnes, H.L., & Olson, D.H. (1985). Parent-adolescent communication and the circumplex model. *Child Development, 56*(2), 438-447. | This general communication measure has 10 questions that ask about general communication between a parent and his/her adolescent child. Each question is scored on a 4-point Likert scale ranging from 1 (strongly disagree) to 4 (strongly agree). It is a valid and reliable measure; higher scores indicate better communication.

A copy of the General Communication Measure can be found at: https://books.google.com/books?id=3LCOAwAAQBAJ&pg=PA330&dq=Copy+of+Short+Form+Interaction+Behavior+Q |
| **Family Routines Inventory (FRI)** | Jenson, E.W., James, S.A., Boyce, W.T., & Hartnett, S.A. (1983). The family routines inventory: Development and validation. *Social Science Medicine, 17*, 201-211. | The Family Routines Inventory (FRI) is a 28-item parenting measure that focuses on family routines in the home. It provides information about continuity and predictability in the child’s environment. The FRI is rated on a 4-point scale; high scores indicate a high level of routine. It is a reliable and valid measure.

The FRI can be found at: [http://www.psychwiki.com/dms/other/labgroup/Measufsdfsdbger345resWeek1/Eliabeth/Jensen1983.pdf](http://www.psychwiki.com/dms/other/labgroup/Measufsdfsdbger345resWeek1/Eliabeth/Jensen1983.pdf) |
| **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, and 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.

It 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 found at: [http://chipts.ucla.edu/wp-content/uploads/downloads/2012/02/Mc](http://chipts.ucla.edu/wp-content/uploads/downloads/2012/02/Mc) |
There are helpful articles and books that review valid and reliable family assessments which providers can consider using (see Pritchett et al., 2011).

**Professional Readings and Resources**


Patterson, J., & Williams, L. (2009). *Essential skills in family therapy: From the first interview to termination*. Guilford Press.

**References**


Institute of Medicine (2001). Committee on Quality Health Care in America. Crossing the
Quality Chasm: A New Health System for the 21st Century. Washington, DC:
National Academies Press.

inventory: Development and validation. *Social Science Medicine, 17*, 201-211.


Löwe, B., Decker, O., Müller, S., Brähler, E., Schellberg, D., Herzog, W., & Herzberg, P. Y.
(2008). Validation and standardization of the Generalized Anxiety Disorder Screener
(GAD-7) in the general population. *Medical care, 46*(3), 266-274.

Integrated Care (2nd edition)*. Washington, D.C. American Psychological Association
Publications.

assessment device: reliability and validity. *Journal of Marital and Family therapy, 11*(4),
345-356.


Pakenham, K., & Ireland, M. (2010). Youth adjustment to parental illness or disability: The role of illness characteristics, caregiving, and attachment. *Psychology, Health & Medicine, 15*(6), 632-645. doi:10.1080/13548506.2010.498891


doi:10.1023/A:1025751206600


