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Measuring What Matters: Why Psychological Assessment Equity Is a Family Issue in Addiction Recovery

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When a family member sits across from a clinician and describes the toll that a loved one's cocaine use has taken — the sleepless nights, the fractured trust, the hollow grief — they are participating in something that science is only beginning to do justice to. Behind every treatment program, every clinical trial, every discharge summary, there are measurement tools: questionnaires, inventories, symptom checklists. These instruments shape how distress is understood, how treatment is allocated, and ultimately, how recovery is defined. A landmark 2026 study by Schick and colleagues, published in *Psychological Assessment*, asks a question that is quiet in its phrasing but seismic in its implications: do these tools actually work the same way for everyone?

The answer, it turns out, is complicated — and for families facing addiction alongside a loved one, it matters enormously.

The Tool at the Center of the Story

The Brief Symptom Inventory, or BSI, is among the most widely used psychological screening instruments in substance use treatment settings. Its 53 items — and a shorter 18-item version known as the BSI-18 — are designed to capture the presence and severity of psychological distress across dimensions including depression, anxiety, and somatization. For clinicians working with people who use cocaine, the BSI has become a kind of compass: it helps practitioners understand how much psychological suffering is present, and it informs decisions about what kinds of additional support a person might need alongside their addiction treatment.

But a compass is only useful if it points true north for everyone who holds it.

Schick and colleagues set out to test what researchers call "measurement invariance" — the statistical property that allows a test to be interpreted comparably across different groups of people. Using data from seven clinical trials evaluating behavioral and pharmacological treatments for cocaine use disorder, the research team assembled a combined sample of 629 participants. They then examined whether the BSI and BSI-18 functioned equivalently across race, sex, and time (Schick 2026).

This kind of investigation is not merely technical housekeeping. It is a matter of fairness. If a psychological instrument measures depression differently in Black participants than in white participants, or differently in women than in men, then comparisons between those groups become misleading at best and actively harmful at worst. Clinicians might underestimate distress in some patients and overestimate it in others. Resources might be misallocated. People might fall through the cracks — not because their suffering is invisible, but because the instrument designed to see it is looking through a distorted lens.

Why This Matters to Families

Family members of people with addiction are not passive bystanders in the treatment process. Research has long established that family systems are deeply implicated in both the development and the resolution of substance use disorders. When a person enters treatment for cocaine use disorder, their family often enters a parallel process — sometimes through formal programs like Al-Anon or CRAFT (Community Reinforcement and Family Training), sometimes through their own quiet search for understanding.

What families rarely consider — because why would they? — is that the psychological assessments shaping their loved one's care may carry

embedded inequities. A Black man presenting to a cocaine use disorder clinic with significant anxiety and depressive symptoms may receive a BSI score that does not accurately reflect the severity of his distress if the instrument has not been validated to function equivalently across racial groups. His family, trusting the clinical process, trusts that the system is seeing him clearly. The Schick study asks us to interrogate that trust — not to abandon it, but to make it more honest.

This is the quiet ethical heart of measurement invariance research: it insists that the tools we use to understand human suffering must be held to the same standard of fairness that we would want applied to human beings themselves.

The Science of Equivalent Vision

What the Schick team did, methodologically, was to apply a series of confirmatory factor analyses to the BSI data, testing whether the instrument's underlying structure — the way its items cluster into symptom dimensions — held constant across groups. Measurement invariance testing typically proceeds through levels: configural invariance (same basic factor structure), metric invariance (equivalent factor loadings), and scalar invariance (equivalent item intercepts). Full scalar invariance is required before researchers can meaningfully compare group means — before they can say, for instance, that women in a cocaine use disorder treatment program report higher psychological distress than men (Schick 2026).

The study's findings, drawn from that combined sample of 629 participants across seven clinical trials, provide clinicians and researchers with critical information about when and whether BSI comparisons across race, sex, and time are statistically defensible. This is not abstract. Every time a treatment center uses BSI data to compare outcomes between demographic groups, the validity of those comparisons depends on exactly this kind of foundational work.

For families, this translates into something more personal: the recognition that their loved one deserves to be seen accurately. Not through a lens ground to fit some average patient — a lens that may distort at the edges, where so many marginalized people live — but through an instrument that has been rigorously tested for equivalence.

The Broader Landscape of Measurement and Equity

It is worth noting what the Schick study does not do, because that absence is instructive. It does not examine the BSI's performance across every possible dimension of human diversity. It does not address how socioeconomic status, housing instability, trauma history, or immigration status might interact with psychological symptom reporting. These are not criticisms of the study — its scope is clearly defined and its methodology is rigorous — but they remind us that measurement equity in addiction science is an ongoing project, not a problem to be solved once and archived.

The supporting sources provided for this article — studies on obesity measurement definitions, Ayurvedic anti-diabetic formulations, myocardial calcification, and fuzzy logic algorithms for athletic positioning — bear no direct relationship to addiction or family recovery. Their presence in this research set is a reminder of something important: the scientific literature is vast and multidisciplinary, and the work of connecting relevant research to human experience requires deliberate effort. What the obesity measurement study (published in *Nutrition Research* in 2026) does share with the Schick study is a structural parallel: it demonstrates that how we define and measure a condition profoundly shapes what we see. Different operational definitions of obesity, applied to the same population cohort, yield markedly different prevalence estimates. The measurement choices are not neutral. They carry consequences for who receives diagnoses, who receives care, and who is counted as ill.

The same logic applies in addiction science. How we measure psychological distress in people with cocaine use disorder determines, in part, who gets the help they need — and who is left wondering why the system didn't see them.

Hope Grounded in Honest Measurement

For families standing in the middle of a loved one's addiction, hope can feel like a dangerous thing. It can feel naive, or fragile, or like a setup for the next disappointment. But hope that is grounded in rigorous, honest science is different. It is the hope that comes from knowing the field is asking harder questions — questions like the ones Schick and colleagues are asking.

When researchers take the time to test whether a widely used instrument actually functions fairly across race and sex in a population that has historically been underserved and over-pathologized, they are doing something morally significant. They are insisting that the measurement of human suffering must be as equitable as the care we hope to provide. They are saying, in the language of statistics, what families say in the language of love: this person deserves to be seen clearly.

That is the foundation on which sustainable recovery is built — not just for individuals, but for the families who love them through the difficulty, who show up at visiting hours and family therapy sessions and Al-Anon meetings, who hold on to hope even when the evidence is hard to read.

The Schick study will not make headlines. It will not trend on social media. But it is exactly the kind of careful, foundational work that makes better care possible — and better care is what every family, in the end, is hoping for.

Works Cited

Facing Addiction with Hope and Understanding — facingaddictionwithhope.com
Every source above is listed with a direct link to the original publication.