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GREAT-25: A BRIEF MULTIDOMAIN PSYCHOLOGICAL SCREENING AND CLINICAL-ROUTING INSTRUMENT FOR COMMUNITY AND PRIMARY CARE SETTINGS

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GREAT-25; Psychological Screening; Mental Health; Clinical Triage; Primary Care; Psychometric Validation.

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Abstract

Background: *Brief transdiagnostic screening instruments are widely used to identify psychological signals warranting further clinical assessment, but existing global tools cover a limited number of symptom domains and are rarely adapted to the linguistic and cultural presentation of distress seen in Pakistani clinical and community settings.*

Objective: *This article describes GREAT-25, a 25-item, 19-domain screening-and-routing instrument developed for use in public-sector hospital, primary care, and community outreach settings, and situates it against established transdiagnostic screeners.*

Method: *We describe the instrument's structure, scoring framework, and intended clinical use, drawing an explicit parallel to the screen-confirm-diagnose-treat model used in routine laboratory medicine.*

Results: *GREAT-25 spans more clinically labeled domains than comparable instruments such as the DSM-5-TR Level 1 Cross-Cutting Symptom Measure (13 domains), while remaining brief enough for single-sitting administration.*

Conclusion: *GREAT-25 is proposed as a signal-detection and referral tool, not a diagnostic instrument; its clinical utility depends on downstream referral capacity and on planned psychometric validation, which is outlined.*

1. INTRODUCTION

In everyday clinical practice, particularly in high-volume public-sector settings, clinicians frequently have only a few minutes to form an initial impression of a patient's psychological state before deciding what, if anything, warrants further evaluation. Patients commonly present with a single stated concern — sleep difficulty, marital conflict, or a physical complaint — while other clinically relevant areas (mood, trauma history, suicidal ideation, substance use) go unmentioned unless directly and systematically asked about. This mirrors a well-recognised limitation of unstructured clinical interviewing across medicine generally: findings that are not actively screened for are frequently missed.

The response to this problem in general medicine has long been the standardised baseline panel: a set of inexpensive, broad screening tests performed at intake or pre-employment examination (for example, complete blood count, urinalysis, random blood sugar, hepatitis B surface antigen, and HIV screening), each of which flags an area for further evaluation without

itself establishing a diagnosis. A single elevated random blood sugar does not lead directly to a diagnosis of diabetes mellitus; it leads to HbA1c or oral glucose tolerance testing. A reactive hepatitis C antibody screen does not lead directly to antiviral treatment; it leads to confirmatory PCR, viral load quantification, and liver function and imaging studies before a diagnosis is established and treatment initiated. GREAT-25 was developed by extending this same screen-then-confirm logic to psychological assessment: a broad, brief, low-cost-per-item baseline psychological panel intended to flag domains that warrant further, targeted, validated assessment.

This paper describes the structure and scoring logic of GREAT-25, situates it relative to existing transdiagnostic screening instruments, and outlines its intended clinical use, strengths, current limitations, and validation roadmap.

2. Rationale: The Baseline-Screening Model Applied to Psychological Assessment

Two features of standard medical baseline screening are directly relevant to the design of GREAT-25:

- A screening result is treated as a signal, not a conclusion. Positivity on a single baseline test prompts confirmatory investigation using an appropriate targeted method; it does not by itself justify treatment.
- Breadth and brevity are prioritised over depth at the screening stage. A baseline panel samples many organ systems briefly rather than performing an exhaustive work-up of any single system; depth is reserved for whichever system the initial panel flags.

GREAT-25 applies the same two principles to psychological presentation. Each of its 25 items functions analogously to a single baseline laboratory parameter: brief, inexpensive to administer, and interpreted as a flag rather than a diagnostic finding. A positive signal on any domain is intended to prompt the same next step a clinician would take after an abnormal baseline laboratory value — targeted confirmatory assessment using a validated instrument or structured clinical interview — before any diagnostic or treatment decision is made.

3. Instrument Description

3.1 Structure and Administration

GREAT-25 comprises 25 self-report items, each rated on a 5-point frequency scale (0 = not at all, 1 = 1–2 days, 2 = 3–5 days, 3 = 6–9 days, 4 = 10–14 days) referenced to the preceding two weeks. This time frame and response format follow the convention used in other widely adopted brief screeners, including the PHQ-9, GAD-7, and the DSM-5-TR Level 1 Cross-Cutting Symptom Measure, all of which anchor items to a two-week recall period to balance recall accuracy against clinical relevance.

The 25 items map onto 19 clinician-derived screening domains, summarised in Table 1. Eight domains are represented by more than one item (permitting a combined domain score), while eleven are represented by a single item, functioning as an individual flag rather than a multi-item scale.

Table 1. GREAT-25 Screening Domains, Mapped Items, and Score Ranges

#	Screening Domain	Item(s)	Range
1	Depression	1, 11, 15	0–12
2	Generalized Anxiety	2	0–4
3	Psychological Stress	3	0–4
4	Panic Symptoms	4	0–4
5	Manic / Hypomanic Symptoms	5	0–4

#	Screening Domain	Item(s)	Range
6	Post-Traumatic Stress Symptoms	6, 17	0–8
7	Obsessive–Compulsive Symptoms	7	0–4
8	Psychotic Symptoms	8, 9	0–8
9	Sleep Disturbance	10	0–4
10	Social Anxiety	12	0–4
11	Sexual / Marital Satisfaction	13	0–4
12	Functional Impairment	14	0–4
13	Addictive / Loss-of-Control Behaviour	16	0–4
14	Suicidal / Self-Harm Risk (Red Flag)	18	0–4
15	Health Anxiety	19, 24, 25	0–12
16	Loneliness / Social Disconnection	20	0–4
17	Somatic Symptoms	21	0–4
18	Attention / Cognitive Difficulties	22	0–4
19	Anger / Irritability	23	0–4

3.2 Scoring

Each item is scored 0–4. Item 13 (sexual/marital satisfaction) is positively worded and is therefore reverse-scored (converted score = 4 − raw score) when contributing to the overall GREAT-25 total; the raw score is retained separately for domain-level reporting, since this domain represents satisfaction rather than distress. The GREAT-25 Total Score (range 0–100) is a descriptive indicator of overall reported symptom burden intended for longitudinal, within-patient monitoring; it is explicitly not intended as a diagnostic severity index, consistent with the same caution documented for the DSM-5-TR measure's total score.

Domain status is classified as Positive or Negative. In the current implementation, single-item domains are Positive at any score ≥1, and multi-item domains are Positive when at least one mapped item scores ≥1, subject to clinical review. This threshold is deliberately sensitivity-favouring: it is designed to minimise missed signals at the screening stage, on the understanding that specificity is subsequently improved through confirmatory assessment, in the same way a low, sensitive cut-off is often preferred for an initial laboratory screen over a highly specific but less sensitive one. Item 18 (suicidal/self-harm ideation) is treated separately from this general threshold logic: any score above zero is flagged as a Red Flag requiring immediate clinical risk assessment, independent of domain scoring.

4. Comparison with Existing Transdiagnostic Screening Instruments

Several validated brief instruments already screen across multiple psychological domains in a single administration. Table 2 situates GREAT-25 relative to the most widely used of these.

Table 2. GREAT-25 Compared with Established Multidomain Screening Instruments

Instrument	Domains	Response format	Primary setting	Validation status
GREAT-25 (proposed)	19 (screening domains, single administration)	0–4 frequency, past 2 weeks	Pakistani community & clinical settings; Urdu-anchored	Pending
DSM-5-TR Level 1 Cross-Cutting Symptom Measure	13	0–4 severity, past 2 weeks	General adult psychiatric intake, US-developed	APA-developed; factor-analytic work ongoing
WHO SRQ-20	Single common-mental-disorder dimension (2-factor solution in some settings)	Yes/No, past 30 days	LMIC primary care; validated in Pakistani samples (Urdu)	Extensively validated, incl. in Pakistan and UK British-Pakistani samples
GHQ-28	4 subscales (somatic, anxiety/insomnia, social dysfunction, severe depression)	4-point Likert	General population/primary care, global use	Well validated internationally
Kessler K10/K6	Single non-specific distress dimension	5-point Likert, past 4 weeks	Population surveys, global use	Well validated internationally

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The DSM-5-TR Level 1 Cross-Cutting Symptom Measure is the closest structural analogue: a 23-item, 2-week-recall, clinician-facing transdiagnostic screener covering 13 domains, explicitly intended to guide further inquiry rather than establish diagnosis. GREAT-25 extends this same architecture to 19 domains, adding items reflecting presentations that are common but not separately itemised in the DSM measure — including marital/sexual dissatisfaction, health anxiety with checking/reassurance-seeking behaviour, and loneliness/social disconnection — which are frequently reported idioms of distress in South Asian clinical populations.

The WHO Self-Reporting Questionnaire (SRQ-20) is the most extensively validated brief screener in Pakistani populations specifically, including community, primary-care, and postnatal samples, with Urdu-language validation work establishing optimum cut-off scores in both Pakistani and British-Pakistani samples. However, SRQ-20 was designed to detect general common mental disorder as a single dimension rather than to differentiate among 19 clinically distinct areas of concern, and does not include items addressing psychosis, mania, or obsessive-compulsive symptoms.

No instrument identified in this review screens as many as 19 separately labelled clinical/psychosocial domains within a single brief administration. This is GREAT-25's principal point of distinction. This breadth, however, has not yet been evaluated for discriminant validity — that is, whether the 19

labelled domains behave as 19 empirically separable constructs or, as has been demonstrated for the DSM-5-TR measure's 13 nominal domains, collapse into a smaller number of broader underlying factors when tested statistically. This question is identified below as a priority for future validation work.

5. Intended Clinical Use

5.1 Public-Sector and Primary Care Practice

In high-volume clinical settings, GREAT-25 is intended to be administered at or before the initial consultation, functioning as a structured intake supplement rather than a replacement for clinical interview. Its intended contribution is threefold: reducing the time required to survey multiple symptom areas; increasing the likelihood that clinically relevant but unspoken concerns (particularly suicidal ideation, psychotic experience, and substance use) are identified; and providing a repeatable, quantified baseline against which treatment response can be tracked over time, at the level of both individual domains and total score.

5.2 Community Screening

In community outreach and camp settings, where contact time per individual is limited and where individuals may be unlikely to volunteer sensitive concerns unprompted to an unfamiliar interviewer, GREAT-25 is intended to enable rapid, private, self-administered triage across a large group, with positive signals — particularly the suicidal/self-harm Red Flag — generating a documented basis for referral into the formal mental health system. The clinical value of this application is contingent on the availability of an accessible downstream referral pathway; screening without a corresponding referral capacity risks identifying need without enabling a response to it.

5.3 Interpretive Discipline

Consistent with its stated purpose, a Positive signal on any GREAT-25 domain should be interpreted only as an indication that the corresponding area warrants further clinical attention, following the sequence: item-level review, domain-level review, review for clustering of signals across related domains, consideration of clinical and functional context, application of an appropriate validated domain-specific instrument, and integration into clinical formulation. A Positive signal does not establish a diagnosis, and a Negative signal does not exclude one.

6. Strengths

- Breadth within brevity: 19 clinically labelled domains are sampled in a single short administration, exceeding the domain coverage of comparable instruments such as the DSM-5-TR Level 1 Cross-Cutting Symptom Measure.
- Explicit signal-not-diagnosis framing, maintained consistently across the instrument's scoring rules, reporting structure, and documentation, reducing risk of diagnostic overreach.
- Isolation of suicide/self-harm risk (Item 18) as an immediate-action Red Flag independent of ordinary domain-scoring logic.
- Rejection of unvalidated probability-percentage conversions of item scores, avoiding a common source of false precision in informally developed screening tools.
- Cultural and linguistic relevance to Pakistani populations, including Urdu response anchors and items addressing marital/sexual health, somatic presentation, and health anxiety with checking behaviour — idioms of distress well documented in South Asian primary care but not separately itemised in several widely used global screeners.
- Dual-purpose design permitting both cross-sectional signal detection and longitudinal, domain-level treatment monitoring.

7. Limitations

- Absence of published psychometric data. Reliability (internal consistency, test–retest), validity (content, construct, criterion), and screening accuracy (sensitivity, specificity, predictive values) have not yet been established for GREAT-25 in any population.

- Eleven of nineteen domains rely on a single item, limiting the precision with which measurement error can be distinguished from true symptom variation within those domains, though magnitude of response (0–4) provides more information than a binary present/absent format would.
- Potential content overlap between nominally distinct domains (for example, irritability, psychological stress, loneliness, and depression) may produce correlated rather than independent signals; the extent of this overlap has not yet been examined through factor analysis, though comparable overlap has been demonstrated empirically for the smaller domain set of the DSM-5-TR measure.
- The current signal threshold (any score ≥1) is a deliberately sensitivity-favouring implementation choice rather than an empirically derived cut-off, and is expected to generate a high rate of domain-level positives, particularly for psychosis-related items (Items 8–9), which may capture culturally normative religious or spiritual experience in the absence of an accompanying distress or impairment qualifier.
- Handling of the marital/sexual satisfaction item (Item 13) for unmarried respondents, for whom the item is not applicable, requires an explicit scoring convention that has not yet been specified.
- Clinical utility in community settings is contingent on the availability of accessible referral pathways for individuals who screen positive.

8. Future Psychometric Validation

Consistent with its current status as a clinician-developed instrument, GREAT-25 requires formal psychometric evaluation before broader claims of validity can be made. A proposed validation programme includes:

- Reliability: internal consistency (Cronbach's alpha) for multi-item domains and the total score; test–retest reliability over a short interval.
- Validity: content validity review by an independent panel; construct validity via exploratory and confirmatory factor analysis to determine whether the 19 nominal domains are empirically distinguishable or reduce to fewer underlying factors; convergent validity against established domain-specific instruments (for example, PHQ-9 for the Depression domain, GAD-7 for Generalized Anxiety, PCL-5 for post-traumatic stress symptoms).
- Screening accuracy: sensitivity, specificity, receiver-operating-characteristic analysis, and positive/negative predictive values for each domain against a structured clinical interview as the reference standard, following the methodology used in SRQ-20 validation studies conducted in Pakistani and other populations.
- Cultural and linguistic adaptation: forward- and back-translation into major regional languages beyond Urdu, with cognitive interviewing to confirm item comprehension across literacy levels.
- Clinical utility: referral accuracy and detection rate in prospective community and primary-care samples, and responsiveness of domain and total scores to treatment over time.

Until this programme is completed, GREAT-25 should be described, consistent with its own developer documentation, as a clinician-developed, multidomain psychological screening and clinical-routing instrument, and not as a validated diagnostic or psychometric measure.

9. Conclusion

GREAT-25 addresses a practical need in high-volume public-sector, primary-care, and community mental health screening: the need to survey a broad range of psychological and psychosocial concerns briefly enough for routine use, while avoiding the diagnostic overreach common to informally constructed screening checklists. Modelled explicitly on the screen-confirm-diagnose-treat logic already familiar to clinicians from routine laboratory baseline panels, GREAT-25 offers 19 clinically labelled screening domains in a single short administration — a broader domain set than comparable instruments such as the DSM-5-TR Level 1 Cross-Cutting Symptom Measure. Its

principal current limitation is the absence of formal psychometric validation, which is identified as the immediate priority for future work. Used as intended — as a gateway to further, targeted, validated assessment rather than as a diagnostic endpoint — GREAT-25 offers a structured, time-efficient starting point for identifying patients and community members whose presentation warrants closer clinical attention.

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GREAT-25 – Developed by Muhammad Zafar Iqbal, Mind & Meaning: Psychological Testing Lab and Clinic. This article describes an instrument that is not yet psychometrically validated and should not currently be represented as a validated diagnostic tool.

GREAT-25

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ہدایات

پچھلے 2 ہفتوں میں آپ کو یہ کیفیت کتنی رہی؟ ایک باکس پر ○ لگائیں۔

0 = بالکل نہیں	**1** = 2 سے 1 دن	**2** = 5 سے 3 دن	**3** = 9 سے 6 دن	**4** = 14 سے 10 دن

نمبر	سوال	0	1	2	3	4
1	کیا آپ بہت اداس یا مایوس رہے؟ لگتا تھا حالات نہیں بدلیں گے؟	[0]	[1]	[2]	[3]	[4]
2	کیا فکر اور سوچیں نہیں رکتی تھیں؟ ذہن کو سکون نہیں ملتا تھا؟	[0]	[1]	[2]	[3]	[4]
3	کیا ذہنی بوجھ بہت زیادہ تھا؟ سب سنبھالنا مشکل لگ رہا تھا؟	[0]	[1]	[2]	[3]	[4]
4	کیا اچانک گھبراہٹ ہوتی تھی؟ دل تیز، سانس پھولتی، لگتا تھا heart attack ہو جائے گا، بیہوش ہو جائیں گے یا "مر جاؤں گا" کا خوف آیا؟	[0]	[1]	[2]	[3]	[4]
5	کیا کبھی غیر معمولی active ہو گئے؟ کم نیند پر بھی تھکن نہیں، بہت کام/باتیں کرنے کا دل تھا؟	[0]	[1]	[2]	[3]	[4]

نمبر	سوال	0	1	2	3	4
6	کیا کسی حادثے یا برے واقعے کی یادیں بار-بار آ کر پریشان کرتی ہیں؟	[0]	[1]	[2]	[3]	[4]
7	کیا ذہن میں ایک ہی خیال بار آتا ہے؟ یا کوئی کام بار کرنا پڑتا ہے ورنہ بے چینی ہوتی ہے؟	[0]	[1]	[2]	[3]	[4]
8	کیا ایسی آوازیں یا چیزیں محسوس ہوتی ہیں جو دوسروں کو محسوس نہیں ہوتیں؟	[0]	[1]	[2]	[3]	[4]
9	کیا لگتا ہے کہ لوگ آپ کے خلاف ہیں، آپ کی باتیں کر رہے ہیں یا آپ کو نقصان پہنچانا چاہتے ہیں؟	[0]	[1]	[2]	[3]	[4]
10	کیا نیند کا مسئلہ ہے؟ دیر سے آتی ہے، بار بار کھلتی ہے یا سکون نہیں دیتی؟	[0]	[1]	[2]	[3]	[4]
11	کیا پہلے جن چیزوں سے خوشی ملتی تھی اب ان میں دل نہیں لگتا؟	[0]	[1]	[2]	[3]	[4]
12	کیا لوگوں سے ملنے جلنے سے گھبراہٹ یا بے چینی ہوتی ہے؟	[0]	[1]	[2]	[3]	[4]
13	کیا آپ اپنی ازدواجی/جنسی صحت سے مطمئن ہیں؟ *(نوٹ: یہ سوال صرف شادی شدہ افراد کے لیے ہے)*	[0]	[1]	[2]	[3]	[4]
14	کیا ذہنی کیفیت کی وجہ سے کام، کاروبار، پڑھائی یا گھر کے کام متاثر ہو رہے ہیں؟	[0]	[1]	[2]	[3]	[4]
15	کیا مستقبل سے امید کم ہے؟ لگتا ہے زندگی میں بہتری نہیں آئے گی؟	[0]	[1]	[2]	[3]	[4]
16	کیا آپ کسی ایسی بری عادت، نشہ یا لت میں ہیں جسے آپ چھوڑنا چاہتے ہیں لیکن چھوڑ نہیں پا رہے؟	[0]	[1]	[2]	[3]	[4]
17	کیا کسی برے واقعے کے بعد سے آپ زیادہ ڈرے ہوئے یا غیر محفوظ رہتے ہیں؟	[0]	[1]	[2]	[3]	[4]
18	کیا کبھی خودکشی یا خود کو نقصان کا خیال آیا؟	[0]	[1]	[2]	[3]	[4]
19	کیا آپ کو صحت کی بہت فکر رہتی ہے؟ لگتا ہے کوئی خطرناک ہے جسے ڈاکٹر سمجھ نہیں پا رہے؟	[0]	[1]	[2]	[3]	[4]
20	کیا لوگوں میں رہ کر بھی تنہائی محسوس ہوتی ہے؟ دل کی بات کسی سے نہیں ہو پاتی؟	[0]	[1]	[2]	[3]	[4]

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نمبر	سوال	0	1	2	3	4
21	کیا جسم درد، تھکن، چکر، پیٹ خراب رہتا ہے حالانکہ ٹیسٹ نارمل ہیں؟	[0]	[1]	[2]	[3]	[4]
22	کیا آپ اپنے معمولات میں توجہ نہیں دے پاتے؟ چیزیں بھول جاتی ہیں یا کام ادھورا رہ جاتا ہے؟	[0]	[1]	[2]	[3]	[4]
23	کیا چھوٹی بات پر غصہ آ جاتا ہے؟ چڑچڑا پن رہتا ہے؟	[0]	[1]	[2]	[3]	[4]
24	کیا ڈر رہتا ہے کہ کوئی خطرناک بیماری ہے حالانکہ ڈاکٹر کہتے ہیں کہ ایسا کچھ نہیں ہے؟	[0]	[1]	[2]	[3]	[4]
25	کیا آپ بار-بار اپنے جسم کو چیک کرتے ہیں؟ جیسے بلڈ پریشر، نَبض، شوگر وغیرہ۔ یا گھر والوں سے بار بار تسلی مانگتے ہیں؟	[0]	[1]	[2]	[3]	[4]

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Clinician Signature: _____