

2026年度

愛知淑徳大学 大学院

博士前期課程（4月入学1期）入学試験

外国語試験(英語) 問題

(心理医療科学研究科)

臨床心理学専修

<一般入試><内部推薦入試><特別選抜入試>

2025年9月27日(土) 実施

9:15~10:15

注意事項

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[共通外国語]

In the late 1950s and early 1960s, statisticians and doctors clashed over (1)one of the highest-profile medical questions of the century: Does smoking cause lung cancer? One of the most important scientific arguments against the smoking-cancer hypothesis was (2)the possible existence of unmeasured factors that cause both craving for nicotine and lung cancer. It was that innocuous word “caused.” It wasn’t the first time that physicians confronted perplexing causal questions: some of the greatest milestones in medical history dealt with identifying causative agents. In the mid-1700s, James Lind had discovered that citrus fruits could prevent scurvy, and in the mid-1800s, John Snow had figured out that water contaminated with fecal matter caused cholera. These brilliant pieces of detective work had in common a fortunate one-to-one relation between cause and effect. The cholera bacillus is the only cause of cholera; or as we would say today, it is both necessary and sufficient. If you aren’t exposed to it, you won’t get the disease. Likewise, a vitamin C deficiency is necessary to produce scurvy, and given enough time, it is also sufficient.

The smoking-cancer debate challenged this monolithic concept of causation. Many people smoke their whole lives and never get lung cancer. Conversely, some people get lung cancer without ever lighting up a cigarette. Some people may get it because of a hereditary disposition, others because of exposure to carcinogens, and some for both reasons.

Of course, statisticians already knew of one excellent way to establish causation in a more general sense: the randomized controlled trial (RCT). (3)But such a study would be neither feasible nor ethical in the case of smoking. How could you assign people chosen at random to smoke for decades, possibly ruining their health, just to see if they would get lung cancer after thirty years? It’s impossible to imagine anyone outside North Korea “volunteering” for such a study.

Without a randomized controlled trial, there was no way to convince skeptics, who were committed to the idea that the observed association between smoking and lung cancer was spurious. To them, some lurking third factor could be producing the observed association. For example, there could be a smoking gene that caused people to crave cigarettes and also, at the same time, made them more likely to develop lung cancer (perhaps because of other lifestyle choices). The confounders they suggested were implausible at best. Still, the onus was on the antismoking contingent to prove there was no confounder.

The US surgeon general’s report, in 1964, stated in no uncertain terms, “Cigarette smoking is causally related to lung cancer in men.” This blunt statement forever shut down the argument that smoking was “not proven” to cause cancer. The rate of smoking in the United States among men began to decrease the following year and is now less than half what it was in 1964. No doubt millions of lives have been saved and lifespans lengthened.

On the other hand, the triumph is incomplete. The period it took to reach the above conclusion, roughly from 1950 to 1964, might have been shorter if scientists had been able to call upon a more principled theory of causation. To justify the claim that smoking caused cancer, the surgeon general’s committee relied on an informal series of guidelines, called Hill’s criteria, named for University of London statistician Austin Bradford Hill. The Hill guidelines take us to a methodology-free world where (4)causality is decided on the basis of qualitative patterns of statistical trends. The Causal Revolution builds a bridge between these two extremes, empowering our intuitive sense of causality with mathematical rigor. But this

job would be left to the next generation.

The job of science is to put supposition aside and look at the facts. In 1948, Doll and Austin Bradford Hill teamed up to see if they could learn anything about the causes of the cancer epidemic. Of course Hill knew that an RCT was impossible in this case, but he had learned the advantages of comparing a treatment group to a control group. So he proposed to (5) compare patients who had already been diagnosed with cancer to a control group of healthy volunteers. Each group's members were interviewed on their past behaviors and medical histories. (6) To avoid bias, the interviewers were not told who had cancer and who was a control.

The results of the study were shocking: out of 649 lung cancer patients interviewed, all but two had been smokers. This was a statistical improbability so extreme that Doll and Hill couldn't resist working out the exact odds against it: 1.5 million to 1. Also, the lung cancer patients had been heavier smokers on average than the controls.

The type of study Doll and Hill conducted is now called a case-control study because it compares "cases" (people with a disease) to controls. It is clearly an improvement over time series data, because researchers can control for confounders like age, sex, and exposure to environmental pollutants. (7) Nevertheless, the case-control design has some obvious drawbacks. It is retrospective; that means we study people known to have cancer and look backward to discover why. The probability logic is backward too. The data tell us the probability that a cancer patient is a smoker instead of the probability that a smoker will get cancer. It is the latter probability that really matters to a person who wants to know whether he should smoke or not.

In addition, case-control studies admit several possible sources of bias. One of them is called recall bias: although Doll and Hill ensured that the interviewers didn't know the diagnoses, the patients certainly knew whether they had cancer or not. This could have affected their recollections. Another problem is selection bias. Hospitalized cancer patients were in no way a representative sample of the population, or even of the smoking population.

In short, Doll and Hill's results were extremely suggestive but could not be taken as proof that smoking causes cancer.

Pearl, J., & Mackenzie, D. (2018). *The Book of Why : The New Science of Cause and Effect*. New York: Basic Books より、一部修正のうえ引用

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問1 下線部(1)の文章の内容に相当する部分を抜き出し、英語で答えなさい。

問2 下線部(2)を日本語に訳しなさい。

問3 下線部(3)の文章の理由を日本語で答えなさい。

問4 下線部(4)および(5)をそれぞれ日本語に訳しなさい。

(4)

(5)

問 5 下線部(6)を実現するために、どのような方法がとられたかを日本語で説明しなさい。

問 6 下線部(7)において Doll と Hill の case-control 研究の問題として挙げられている内容を本文に即して日本語で説明しなさい。

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愛知淑徳大学 大学院

博士前期課程（4月入学2期）入学試験

外国語試験(英語)問題

(心理医療科学研究科)

臨床心理学専修・視覚科学専修

<一般入試> <特別選抜入試> <内部推薦入試>

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以下の英文は、2022年にアメリカ精神医学会 (APA) が公開した『精神疾患の診断・統計マニュアル』(DSM-5-TR) の introduction の一部である。2023年には、日本語訳が日本精神神経学会から示され、「disorders」の訳が「障害」から「症」に変更された。それを踏まえて以下の問いに答えなさい。
解答は解答用紙を用いること。なお文中の下付き数字は、訳注のある語を指す。

Cross-Cutting Symptom Measures₁₎

Given that psychiatric pathologies are not reliably discrete with sharp boundaries from one another, clinicians need to shift their approach to assessment and look beyond the prototypical presentations that neatly coincide with DSM categories. To assist with that transition, Section III, “Emerging Measures and Models,”₂₎ provides the DSM-5 Level I Cross-Cutting Symptom Measure, developed to help clinicians assess all major areas of psychiatric functioning (e.g., mood, psychosis₃₎, cognition, personality, sleep) and more thoroughly uncover possible disorders, atypical presentations₄₎, subsyndromal conditions₅₎, and coexistent pathologies. (問1)

Just as the review of systems performed in general medicine acts as an inventory designed to call attention to symptoms or signs that otherwise could have been overlooked, the DSM-5 Level I Cross-Cutting Symptom Measure acts as a review of mental systems, intended to aid clinicians in better identifying latent disorders and symptoms in need of more detailed assessment (and potentially in need of treatment). The DSM-5 Level I Cross-Cutting Symptom Measure is recommended as an important component of the psychiatric evaluation of individuals presenting for psychiatric care, with The American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults endorsing its use as a first step in identifying and addressing the heterogeneity of symptoms across diagnostic categories. Self-, parent/guardian-, and child (age 11-17)-rated versions of the DSM-5 Level I Cross-Cutting Symptom Measure are available online without charge for clinical use at www.psychiatry.org/dsm5.

Impact of Cultural Norms and Practices

The boundaries between normality and pathology vary across cultural contexts for specific types of behaviors. Thresholds of tolerance for specific symptoms or behaviors differ across cultural contexts, social settings, and families. Hence, the level at which an experience becomes problematic or is perceived as pathological will differ. The judgment that a given behavior, experience, or concern requires clinical attention depends on cultural norms that are internalized by the individual and applied by others around him or her, including family members and clinicians. To accurately assess potential signs and symptoms of psychopathology, clinicians should routinely consider the impact of cultural meanings, identities, and practices on the causes and course of illness, for example, through any of the following factors: levels of vulnerability and the mechanisms of specific disorders (e.g., by amplifying fears that maintain panic disorder or health anxiety); social stigma and support generated by family and community responses to mental illness; coping strategies that enhance resilience in response to illness or help-seeking pathways to access health care of various types, including alternative and complementary

treatments; and acceptance or rejection of a diagnosis and adherence to treatments, affecting the course of illness and recovery. (問2) Cultural contexts also affect the conduct of the clinical encounter, including the diagnostic interview. Cultural differences between the clinician/members of the treatment team and the individual have implications for the accuracy and acceptance of diagnosis, as well as for treatment decisions, prognostic considerations, and clinical outcomes.

Sex and Gender Differences

Sex and gender can influence illness in a variety of ways. First, sex may exclusively determine whether an individual is at risk for a disorder (e.g., as in premenstrual dysphoric disorder). Second, sex or gender may moderate the overall risk for development of a disorder as shown by marked differences in the prevalence and incidence rates for selected mental disorders in men and women. Third, sex or gender may influence the likelihood that particular symptoms of a disorder are experienced by an individual. For example, ADHD may manifest differently in boys and girls. Sex or gender may also have other effects on the experience of a disorder that are indirectly relevant to psychiatric diagnosis. For example, certain symptoms may be more readily endorsed by men or women, and this endorsement contributes to differences in service provision (e.g., women may be more likely to recognize a depressive, bipolar, or anxiety disorder and endorse a more comprehensive list of symptoms than do men) (問3).

- 訳注 1) Cross-Cutting Symptom Measures:横断的症候尺度測定
2) “Emerging Measures and Models,”=「新しい尺度とモデル」
3) psychosis=精神症(精神病)
3) atypical presentations=典型的な状態とは異なる非定型の症状
4) subsyndromal conditions=症候が診断基準に達していない状態

出典：Diagnostic and Statistical Manual of Mental Disorders : Fifth Edition Text Revision DSM-5-TR™

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問1. Cross-Cutting Symptom Measures で述べられている下線部の内容を全訳しなさい。

問2. Impact of Cultural Norms and Practices で述べられている、臨床家が検討すべき留意点(波線部分)について、下線部の内容を全訳しなさい。

問3. Sex and Gender Differences で述べられている内容について、200字以内にまとめなさい。

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専門科目試験問題

(心理医療科学研究科 心理医療科学専攻 臨床心理学専修)

<一般入試>

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[一般基礎]

問1. 心理学研究における観点から、以下の各用語について簡潔に説明しなさい。

- (1) 分散
- (2) 独立変数と従属変数

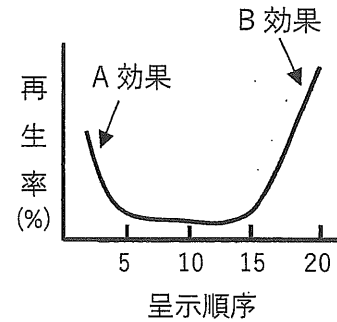
問2. ある不安障害を抱える20人の実験参加者に対して認知行動療法(CBT)を実施し、治療前後の不安スコアを比較することでその効果を検証することにした。これに関して、以下の問に答えなさい。

- (1) この検証に用いる統計的検定として、「対応のあるt検定」と「対応のないt検定」のいずれを選択すべきかを述べ、その理由を説明しなさい。
- (2) t検定の結果、有意確率(p値)が0.03であった。有意水準を5%とする場合、この結果をどのように解釈すべきかを述べなさい。

問3. 心理学研究において、3つ以上の群の平均値を比較する際に用いられる「分散分析(ANOVA)」に関して、以下の問に答えなさい。

- (1) 一要因分散分析(一元配置分散分析)の基本的な考え方について、「群間分散」と「群内分散」の両方の用語を用いて説明しなさい。
- (2) 一要因分散分析の結果、主効果が認められたため、事後検定として「多重比較」を行うことにした。複数ある多重比較法の中から一つを選び、その名称と当該手法について説明しなさい。

問1. 20個の単語を3秒に1個の間隔で呈示し、単語呈示直後に自由再生を求める記憶実験を行った。この実験結果から、単語が呈示された順序によって再生率が異なることが明らかになった。右図はこの実験結果を示す。



- (1) 図に描かれている曲線の名称を答えなさい。
- (2) 図中の A 効果、B 効果の名称を答えなさい。
- (3) A 効果、B 効果が認められた理由を、二重貯蔵モデル (Atkinson & Shiffrin, 1971) に基づいて説明しなさい。
- (4) A 効果は残し、B 効果を消失させるためには、この記憶実験にどのような手続きを加えたらよいだろうか。考えられる実験手続き、及びその手続きを加える理由を説明しなさい。

問2: 次の a~d の文が正しいければ○を、間違っていれば×を解答欄に記入しなさい。

- a. 樹状突起は細胞体から伸びる 1 本の突起で、受け取った情報を次のニューロンに伝達する役割を持つ。
- b. 生体のホメオスタシス機能を担うのは体性神経系である。
- c. 跳躍伝導とは、ニューロン間の情報伝達において、送り手ニューロンと受け手ニューロン間の情報伝達のことを指す。
- d. 大脳は大脳縦裂により左半球と右半球に分けられる。

問1. 以下の事例を読み、次の問題に回答しなさい。

<事例>

高校3年生のAさんは、最近学校に行けなくなり、家で過ごす時間が増えている。母親はAさんのことを「怠けているだけ」と言い、父親は無関心である。Aさんは「自分はダメな人間だ」とカウンセラーに繰り返し話す。

- (1) この事例から考えられるAさんの心理的問題を述べなさい。
- (2) この事例において、家族への支援方法を述べなさい。ここでの家族とは、事例に登場する母親と父親を指す。

問2.

- (1) 心理職が守るべき倫理原則として適切なものは以下のA~Dのうちどれか。全て選びなさい。

<選択肢>

- A. クライエントの自己決定を尊重する
 - B. クライエントの秘密を守る
 - C. クライエントの情報は、家族の求めがあれば開示してよい
 - D. クライエントの福祉を最優先に考える
- (2) 心理職が守秘義務を破ることが許される状況について、具体的な例を挙げて説明しなさい。また、その理由についても述べなさい。

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専門科目試験問題

（心理医療科学研究科）

臨床心理学専修

<一般入試>

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[一般基礎]

1. (この問題には志望する専修にかかわらず、必ず解答すること。)

以下の2問に解答しなさい。

問 1. 帰納的科学研究と演繹的科学研究とについて、その概要を例をあげて論じるとともに、両研究の関係について論じなさい。(解答は解答用紙に記述すること。)

問 2. 実験や調査による測定において、実験者や調査者の要因が測定データに影響を与えることを実験者効果という。実験者効果について具体例を3例以上あげて論じなさい。(解答は解答用紙に記述すること。)

[一般専門科目 心理学 I]

問 1. レヴィン (Lewin) は、個人の社会的行動を $B = f(P, E)$ と関数表記で図式化した。この図式が意味することを、簡潔に説明しなさい。ただし、 B 、 P 、 E が表すものについては日本語で表記すること。

問 2. 次の 3 つについて、それぞれ援助行動の抑制にどのように影響するか、簡潔に説明しなさい。

- (1) 傍観者効果
- (2) 非援助コスト
- (3) 原因の帰属 (統制の所在について)

問 3. 自己呈示行動に関する以下の設問に答えなさい。

- (1) 自己呈示行動の一つに、セルフ・ハンディキャッピングと呼ばれるものがある。セルフ・ハンディキャッピングとはどのような行動パターンであるか説明しなさい。
- (2) テダスキとノーマン (Tedeschi & Norman) は、自己呈示行動を 2 つの次元に基づいて分類している。この 2 つの次元を示す用語を、次元ごとに記述しなさい。
- (3) セルフ・ハンディキャッピングについて、テダスキらの 2 次元の分類に基づいて説明しなさい。

[一般専門科目 臨床心理学]

問1. 人間性心理学について説明しなさい。

問2. ロジャーズ (Rogers, C. R.) によって創始されたクライエント中心療法に関する以下の問題に回答しなさい。

(1) ロジャーズは、何らかの心の苦悩や苦痛に対して心理支援を求める者たちを表す用語として、それまで一般的な呼称であった「患者」ではなく「クライエント」を使用しはじめた。この「クライエント」の意味を記述しなさい。

(2) 「患者」ではなく「クライエント」という用語を使用しはじめた理由を説明しなさい。

(3) ロジャーズは、クライエントに建設的な人格変化をもたらすためのカウンセラーの本質的態度のひとつとして共感的理解をあげた。この共感的理解について説明しなさい。

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小論文(課題図書)試験問題

(心理医療科学研究科)

臨床心理学専修

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[特別小論文]

問1. 筆者は面接者が面接において「聞いているだけ」の場合、「ひとつの共生関係が成立する」と述べています。それについて下記の問題に答えなさい。

- 1) 上記はどのようなことを指しているか述べなさい。
- 2) その場合、クライアントは面接者がその事態に気が付くようにヒントを出してくると述べていますが、それはどのようなヒントなのか述べなさい。

問2. クライアントに対する共感において、「殺人的な憎しみ」「死んでしまいたいほどの絶望」の理解には何が必要か述べなさい。

また、それはなぜかについて筆者がどのように述べているか、説明しなさい。

問3. 筆者は「サーチライトや旋回する鳶というメタファ」はどのような聴き方だと言っているか説明しなさい。

また、ここで察知されるものは何か説明しなさい。

問4. 「聴き方ステップ⑦」において、筆者は「聴くこと」からどのようにしていくことが重要と述べているか説明しなさい。

また、それについて自分自身の意見を述べなさい。

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[特別小論文]

- 問1. 心理療法的面接での「聴き方」について、「沈黙を学ぶこと」が重要な理由を述べなさい。
- 問2. 精神分析的な聴き方について、「あえて、自分を盲目にする」(Freud,S) というのはどのような意味か説明し、その意義を述べなさい。
- 問3. 「転移を生きながら、聴いていること」というのはどのような意味か説明し、それについての自分の考えを述べなさい。

2026年度

愛知淑徳大学 大学院
博士後期課程（4月入学）入学試験
外国語試験(英語)問題

(心理医療科学研究科)

スポーツ・健康医科学専修

<一般入試>

2026年2月18日（水）実施

9：15～11：15

注意事項

- 1 試験開始の合図があるまで、この問題用紙を開いてはいけない。
- 2 解答用紙には、受験番号および氏名を正しく記入すること。
- 3 試験中に問題文の誤字、脱字等に気づいた場合は、手をあげて試験監督者に知らせること。
- 4 問題用紙は試験終了後、持ち帰ること。

[外国語試験 (英語)]

次の論文を読み、問いに答えなさい。

Introduction

Social determinants of health (SDOH) are the nonmedical factors that influence health outcomes. They are the conditions in which persons are born, live, learn, work, play, worship, and age that affect a wide range of health risks, functioning, and quality of life. Examples of SDOH measures include economic stability, transportation availability, housing and food security, access to health care, built environment, and social connectedness. SDOH are driven by intersecting systematic influences such as economic policies and institutional racism that unequally affect different populations. SDOH and health-related social needs (HRSN) play a significant role in health status, health care utilization, and well-being of individual persons and populations. Whereas HRSN focus primarily on screening and connecting persons to resources and services to fulfill unmet social needs, SDOH exist at the community or population level and reflect the policies and environments that support health or create barriers to health. Some adverse SDOH have been linked to a higher risk for poor health outcomes, including chronic diseases.

This study measured the prevalence of adverse SDOH and HRSN across U.S. adult populations using data from the 2022 Behavioral Risk Factor Surveillance System (BRFSS). Understanding disparities in SDOH and HRSN among populations is essential to determining and deploying strategies toward advancing health equity. (1)For the first time, data from a new Social Determinants and Health Equity (SD/HE) module in BRFSS were used to investigate adverse SDOH and HRSN by race and ethnicity in the United States.

Methods

Data Source

BRFSS is a state-based landline and cellular telephone survey of noninstitutionalized U.S. civilian residents aged ≥18 years. BRFSS collects data on health-related risk behaviors, chronic diseases and conditions, health care access, and use of preventive services in all 50 states, the District of Columbia, and participating U.S. territories. The optional SD/HE module was introduced in 2022. Details of the 2022 BRFSS survey and SD/HE module are described elsewhere; data were collected by 39 states, District of Columbia, Puerto Rico, and U.S. Virgin Islands. SD/HE module questions were developed based on the Center for Medicare & Medicaid Services' Accountable Health Communities Health-Related Social Needs Screening Tool and from a previous BRFSS SDOH optional module administered in 2017. SDOH measures include employment instability, food insecurity, housing insecurity, utility insecurity, and lack of reliable transportation. HRSN measures included life dissatisfaction, lack of social and emotional support, social isolation or loneliness, receiving food stamps or Supplemental Nutrition Assistance Program (SNAP), and mental stress. Two additional adverse SDOH measures, lack of health insurance and cost barrier for needed medical care, were from the BRFSS core section.

Prevalence of adverse SDOH and HRSN were examined by race and ethnicity, which were categorized as non-Hispanic (NH) American Indian or Alaska Native (AI/AN), NH Asian (Asian), NH Black or African American (Black), NH Native Hawaiian or other Pacific Islander (NH/OPI), NH White (White), NH multiracial (multiracial), or Hispanic or Latino (Hispanic) based on self-identified race and ethnicity information. The analysis included

323,877 participants (among 338,778 survey respondents) with complete demographic and general health status information.

Data Analysis

Those who responded “don’t know/not sure,” refused to answer, or had missing responses for demographic variables (except for those with unknown income) were excluded. Participants with missing information for a specific SDOH or HRSN were excluded from the respective analyses.

Weighted prevalence estimates were calculated overall and by racial and ethnic group, U.S. Census Bureau regions, and covariates (age, sex, education, marital status, income, and self-rated health). Statistical significance was determined based on whether there was an overlap between 95% CIs for any two estimates. Adjusted prevalence estimates were obtained by conducting log-linear regression analyses with a robust variance estimator, which adjusted for covariates. Analyses were conducted using SAS-callable SUDAAN (version 11.0.3; RTI International) to account for the complex survey design. This activity was reviewed by [CDC 注1](#), deemed not research, and was conducted consistent with applicable federal law and CDC policy.

Results

The most commonly reported adverse SDOH or HRSN were social isolation or loneliness (31.9%) and lack of social and emotional support (24.8%), which are proxies for social connectedness. Receiving food stamps or SNAP was most prevalent among Black adults (21.9%) and AI/AN adults (21.3%); lack of reliable transportation was most prevalent among AI/AN adults (16.2%). The following were most prevalent among NH/OPI adults: lack of social and emotional support (38.3%), loss or reduced hours of employment (21.4%), food insecurity (29.0%), housing insecurity (22.8%), and experiencing threat to shut off utility services (19.2%). Life dissatisfaction (11.2%) and social isolation or loneliness (41.0%) were most prevalent among multiracial adults. Lack of health insurance (21.0%) was most prevalent among Hispanic adults. The lowest prevalences of most adverse SDOH and HRSN measures were among Asian and White adults.

Differences by Demographics and Health Status

The prevalence of adverse SDOH and HRSN also differed by other demographic characteristics and by general health status. For example, with increasing age, educational level, and household income, the prevalence of adverse SDOH and HRSN generally decreased. Adults who reported fair or poor self-rated health had the highest prevalence for all adverse SDOH and HRSN. Adults living in the U.S. Census Bureau South Region had the highest prevalences of receiving food stamps or SNAP, food insecurity, experiencing threat to shut off utility services, lack of health insurance, and cost barrier for needed medical care.

Adjusted Analyses

After adjustment for covariates, when compared with that of White adults, the prevalence of life dissatisfaction was 24% higher for multiracial adults, 14% lower for Black adults, and 33% lower for Hispanic adults; lack of social and emotional support ranged from 6% more prevalent in the Hispanic group to 76% more prevalent in the Asian group. Across all other racial and ethnic groups compared with White adults, the majority of prevalence estimates

were higher for loss or reduced hours of employment (22% to 73%), receiving food stamps or SNAP (31% to 77%), food insecurity (35% to 133%), housing insecurity (34% to 105%), experiencing a threat to shut off utility services (50% to 149%, except for 39% lower among Asian adults), lack of reliable transportation (8% to 86%), and cost barrier for needed medical care (23% to 49%). Lack of health insurance coverage was 92% more prevalent for Hispanic adults than for White adults. The prevalence of mental stress was lower for three groups when compared with White adults: 22% less for Hispanic adults, 25% less for Black adults, and 39% less for Asian adults.

Discussion

In this large state-based survey of adverse SDOH and HRSN among U.S. adults, significant differences were reported among racial and ethnic groups in measures of social and emotional support, employment instability, food insecurity, housing insecurity, and utility and transportation instability. Estimates indicate elevated prevalences of adverse SDOH and HRSN among AI/AN, Black, NH/OPI, multiracial, and Hispanic adults when compared with White adults. Most adverse SDOH and HRSN estimates were not significantly different between Asian and White adults. Adults who reported having fair or poor health were more likely to have adverse SDOH and HRSN than those reporting better health. Disparities in chronic disease prevalence, severity, complications, and management, as well as related risk factors among racial and ethnic groups, are well documented. For example, racial and ethnic differences in cardiovascular disease mortality among U.S. adults that are not indicative of biologic differences but intersecting systematic influences are correlated with adverse SDOH.

This study identified the extent of differences in adverse SDOH and HRSN among racial and ethnic populations, and by U.S. Census Bureau regions, demographic characteristics, and general health status. (2) Findings are consistent with the differential impact that societal structural and systemic infrastructure have on SDOH and HRSN among racial and ethnic populations in the United States. Further studies using the BRFSS SD/HE module will examine which SDOH and HRSN are most relevant to specific health outcomes and whether addressing these SDOH and HRSN could lead to improvement in health equity.

注1 米国疾病予防管理センター

出所: Town M, Eke P, Zhao G, et al. 出題のためタイトル記載せず. MMWR Morb Mortal Wkly Rep 2024;73:204–208. DOI: <http://dx.doi.org/10.15585/mmwr.mm7309a3> より出題に合わせて一部改変した

- 問1 SDOH および HRSN は何の略語として文中で用いられているか。それぞれ英語で答え、その意味を日本語で述べなさい。
- 問2 下線 (1) を日本語に訳しなさい。
- 問3 下線 (2) を日本語に訳しなさい。
- 問4 本研究の限界として考えられる点を3点列挙し、それぞれの理由とあわせて日本語で述べなさい。
- 問5 本論文にふさわしいタイトルを考え、日本語で答えなさい。