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For children with mental health problems, impairment results in a diminished ability to perform at developmentally expected levels. Impairment in daily life activities can include dysfunction or an absence of adaptation in social, emotional, psychological, or occupational/academic domains, and it is a core component of nearly all childhood and adolescent mental health disorders. Currently, the American Psychiatric Association's (APA's) *Diagnostic and Statistical Manual of Mental Health Disorders, Fourth Edition, Text Revision (DSM-IV-TR, 2000)* requires impairment in daily life functioning for the diagnosis of the externalizing (e.g., attention deficit/hyperactivity disorder [ADHD], oppositional defiant disorder [ODD], and conduct disorder [CD]) and internalizing (e.g., anxiety and mood-related) disorders, and impairment in social or academic functioning is a cardinal feature of other disorders of childhood and adolescence (e.g., autism, learning disabilities, substance abuse).

4.1 Importance of Impairment for Child and Adolescent Disorders

With the advent of the *DSM*, substantial research and professional attention has been devoted toward developing and implementing *DSM* symptom-related assessments (e.g., Pelham, Fabiano, & Massetti, 2005), and *DSM* symptoms have been

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used as primary outcome measures in large treatment outcome studies (e.g., MTA Cooperative Group, 1999; Treatment for Adolescents with Depression Study [TADS] Team, 2004). Relative to symptoms, however, attention devoted toward impairment in daily life functioning has lagged. As described in this chapter, there is considerable justification for emphasizing impairment in evaluations and interventions; as it is a key contributor to referral for intervention, it should be the major outcome evaluated during and after intervention, and it is the best predictor of long-term outcomes for children and adolescents.

Importantly, it is impairment in daily life functioning, not putative *DSM* symptoms, that typically results in referral for treatment or services (e.g., Angold, Costello, Farmer, Burns, & Erkanli, 1999; Lavigne et al., 1998). For example, (Angold et al., 1999) reported that children who had evidence of psychosocial impairment, whether or not they met criteria for a *DSM* disorder, were typically involved in clinical treatment setting efforts. Further, children who met symptom criteria for a *DSM* disorder but did not have impaired functioning were generally not receiving clinical services. Costello & Shugart, 1992 investigated rates of *DSM* symptoms in pediatric and psychiatric settings and reported that there were a considerable number of children who did not meet symptom count criteria for *DSM* externalizing disorders but were nonetheless experiencing significant psychosocial impairment. Intensity of service use is also related to severity of impairment, with more restrictive and costly treatments generally implemented for more impaired children and adolescents (McDermott, McKelvey, Roberts, & Davies, 2002).

Second, impaired domains of functioning, and not *DSM* symptoms, are one aspect of the social validity of a treatment. Social validity relates to the “meaningfulness” of the goals of treatment, intervention procedures, and the way outcomes of the treatment are defined and evaluated (Foster & Mash, 1999; Kazdin, 1977; Wolf, 1978). For instance, referring problems as reported by parents and teachers rarely include *DSM* symptoms such as “fidgeting” or “psychomotor agitation or retardation nearly every day.” Rather, parents and teachers report that the child is actively rejected by peers, is failing academic classes in school, disrupts family and classroom routines, and does not get along with adults. These latter areas are those that are the socially valid targets of intervention; it is these areas of impairment that should receive the attention of intervention efforts, and whether treatment improves functioning in these domains is the primary means for assessing treatment outcome (Foster & Mash, 1999).

Third, with an eye toward treatment planning, the identification and evaluation of impaired functional domains is a critical task because the putative *DSM* symptoms do not provide information on the function of problematic behavior (Scotti, Morris, McNeil, & Hawkins, 1996). Take, for example, the symptom of “distractibility.” A child who has this item endorsed on a structured interview or rating scale as occurring at least “pretty much” would have the item count toward a *DSM* diagnosis. However, the item in and of itself provides no information on the extent to which this behavior is a problem for the child and what causes, maintains, or exacerbates the behavior. Even worse, a perusal of the *DSM* illustrates that this symptom could be part of inattention related to ADHD, a mood disorder (either depressed or

elevated mood), a generalized anxiety disorder, or a post-traumatic stress disorder. For one child, the function of the behavior could be to avoid tasks he or she dislikes, and the behavior is limited to situations in which a demand is placed on the child. For another child, he or she may appear distractible because of an attempt to avoid intrusive thoughts. A third child may not have psychological problems at all and instead have auditory problems that impair his or her ability to follow a conversation effectively. Obviously, effective interventions for this behavior will require different approaches depending on the function of the behavior and the nature of the impairment; in this example, the intervention for the first child may focus on increasing motivation, for the second child, a cognitive-behavioral approach that includes exposure to the feared thought, and for the third child accommodations for hearing impairment. The negative *impact* of the symptom on the child's functioning is what is conceptualized as impairment—in all three cases, we suspect the child would experience negative outcomes related to the symptom of distractibility. However, rather than spending valuable clinician and patient time establishing whether the child is distractible “just a little” or “pretty much,” assessment efforts should be devoted toward determining the function, extent, and impact of the behavior on functioning and how to reduce the negative impact of the behavior in functional life domains.

Fourth, and perhaps most important, impairment in functional domains during childhood are the best predictors of negative short-term and long-term outcomes, and improvement in impaired domains must be achieved to avoid continued problems throughout development. Longitudinal studies have demonstrated functional impairment in childhood is predictive of future adolescent problems (Costello, Angold, & Keeler, 1999). For example, poor peer relationships in childhood, inconsistent and ineffective parenting, and academic underachievement all predict a host of negative outcomes in adolescence and adulthood (Chamberlain & Patterson, 1995; Christle, Jolivette, & Nelson, 2005; Coie & Dodge, 1998; Dishion, Nelson, & Yasui, 2005; LaGreca & Harrison, 2005), whereas to our knowledge, the symptoms of *DSM* disorders are *not* strong predictors of adolescent or adult outcomes (e.g., Mannuzza & Klein, 1999). Thus, improvement in functioning in the areas of impairment is necessary to divert the child's developmental trajectory from these negative outcomes.

It is also worth noting that symptoms of a *DSM* disorder typically do not provide any information on the child's current levels of adaptive functioning or strengths, which may also predict long-term outcomes. In addition to reducing impaired areas of functioning, treatment efforts also focus on promoting the development of positive behaviors and competencies. A comprehensive assessment of impairment will include a consideration of adaptive abilities and behavioral competencies, and these behaviors will also be monitored and targeted in treatment.

4.2 Domains of Child and Adolescent Impairment

A prototypical child from a family who seeks services will present with problems across functional domains, including in his or her relationships with peers and siblings; relationships with parents, teachers, and other adults; academic progress in

school; and disruption in family and classroom functioning or routines. For many children, these difficulties will be apparent across domains of functioning, meaning treatments will need to address impairment in the home, school, and peer group settings.

Peer relationship problems are often impaired in children and adolescents referred for psychological services (Bukowski & Adams, 2005). For example, researchers have long known that children with ADHD (e.g., Pelham & Bender, 1982) or conduct problems (Coie & Dodge, 1998) have problems in peer relationships. Problems may range from simply being ignored by other children (e.g., not being picked to play in recess activities, being the only child not invited to a classmate's birthday party) to being actively rejected by other children (e.g., being bullied during recess). A child with ADHD or CD may also tease and be teased by peers, get into fights with other children, and exhibit inappropriate social skills (e.g., is a poor sport during games).

Adult relationships may also be an area of impaired functioning. Problems include noncompliance to adult commands and instructions and argumentative behavior. Furthermore, the negative behavior exhibited by children with disruptive behavior disorders seriously affects family and classroom functioning (e.g., Fischer, 1990). It is not uncommon for parents to report that they no longer go out to dinner at a restaurant, attend Sunday worship services, or attend family parties and social gatherings as a direct result of their child's behavior. Similarly, teachers may observe impaired children in their classrooms require constant one-to-one attention to complete even the simplest of tasks, require extra attention during field trips or other activities outside the classroom (e.g., music class), or fail to complete academic assignments accurately and in a timely manner. Children with internalizing disorders might have comparable impacts on family or classroom functioning. For example, a child with depression may spend large portions of the school day in the nurse's office with somatic complaints.

An additional area of impairment is in the domain of academic achievement. The primary feature of the specific learning disabilities is impairment in academic functioning. Other disorders may also result in impaired academics. For example, a child with school phobia may fail to attend classes and therefore may experience a lag in academic achievement or with social development. Children with ADHD may perform poorly due to failing to hand in completed homework or long-term projects. Furthermore, behaviors that may be relatively easy for most students, such as completing independent seatwork assignments, remembering to bring home all needed materials for homework, and note taking, may be extremely difficult for children with ADHD.

Notably, these problems in important domains of daily life functioning are rarely included in the behavioral symptoms in the *DSM*. In addition, any evaluation of impairment typically measures a child's strengths, skills, and abilities. Eventual treatment efforts will work not only to reduce the occurrence of problematic behaviors but also to increase competencies in these areas of adaptive functioning.

4.3 Impairment Measures

Below we briefly review an impairment measure for children and adolescents not discussed elsewhere in this volume. Since the publication of the first edition of this volume, a number of nationally standardized measures designed to assess impairment have been published (Barkley, 2016; Goldstein & Naglieri, 2015). Perhaps because impairment has been *implicit* but not *explicit* in previous versions of the *DSM*, few practical means of measuring impairment across functional domains have been developed. Some impairment-rating procedures have been developed to quantify a child's overall level of functional impairment. In clinical and research settings, commonly used global impairment scales include Axis V of the *DSM* (American Psychiatric Association, 2000), which is a modified version of the Global Assessment Scale (Endicott, Spitzer, Fleiss, & Cohen, 1976). The version most commonly used with children and adolescents is the Children's Global Assessment Scale (CGAS; Setterberg, Bird, & Gould, 1992).

Respondents on the CGAS rate the child's current level of functioning on a scale from 1 to 100, with scores of 1 relating to the most serious impairment in functioning and 100 relating to the best level of functioning. Raters refer to a behavioral descriptor for every ten points on the scale and can make a rating anywhere in the range from 1 to 100. The CGAS has been used in epidemiological, research, and clinical settings, and it evinces good reliability and validity. Advantages of the CGAS include its good psychometric properties and its ability to be completed quickly and over repeated administrations.

However, global measures of impairment have limitations. They provide no information on specific impaired areas of functioning, which is critical for treatment planning, monitoring, and evaluation. Therefore, many other scales have been developed to assess functional impairment in specific domains. For example, a portion of the widely used Child Behavior Checklist (CBCL) and Teacher Report Form (TRF; Achenbach & Rescorla, 2001) asks parents about adaptive functioning, such as the child's participation and proficiency in social activities, academic achievement, and receipt of special services in school. Measures such as the Teacher Assessment of Social Behavior (TASB; Cassidy & Asher, 1992), the Social Skills Rating Scale (SSRS; Gresham & Elliott, 1990), and peer sociometric ratings may be used to evaluate impairment in children's peer interactions. The effects of a child's behavior problems on the family may be measured by the Impact on Family Scale (IFS; Sheeber & Johnson, 1992) or the Daily Hassles Scale (Crnic & Greenberg, 1990). In addition, a child's impairment in academic functioning may be determined through standardized intelligence and academic achievement tests or school report cards.

Although these measures, and others, may be used to measure specific domains of impairment, they have limitations. For example, some require the rater to answer a large number of questions (e.g., the SSRS), some require multiple raters (e.g., sociometrics, which requires a group of children to make negative or positive

nominations of peers), and others require the use of lengthy and therefore expensive psychological tests (e.g., intelligence and academic achievement testing) or observation for a lengthy time period (e.g., academic grades). Finally, most focus on a single domain of impairment, which means that a battery of measures such as these must be administered to obtain a comprehensive assessment of impairment (see Lahey et al., 1998, for an example of such an approach). This means that raters and clinicians must invest significant time to evaluate impairment, which is impractical for large-scale screenings or repeated assessments in clinical or applied research settings.

Due to these limitations, other researchers have worked to develop multidimensional measures of impaired functioning. Table 4.1 lists commonly used multidimensional measures of impairment, a brief description of each, and a general review of the psychometric properties of each measure. We briefly review each of these measures next.

4.3.1 Columbia Impairment Scale

The Columbia Impairment Scale (CIS; Bird et al., 1993, 1996) is a 13-item measure that assesses multiple areas of psychosocial functioning, including interpersonal relationships, occupational, or academic functioning, and use of leisure time, in addition to some questions on broad areas of psychopathology (e.g., feeling sad or unhappy). Respondents are instructed to rate each item on a scale from zero (no problem) to four (very big problem), and the measure can be completed by a parent or other adult informant as well as a child/adolescent. The parent CIS evinces good indices of reliability (Bird et al., 1993) and validity (e.g., correlates with measures of functioning such as whether the youth was in treatment or had been expelled/suspended from school; Bird et al., 1996).

4.3.2 Child and Adolescent Functional Assessment Scale

The Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, Doucette-Gates, & Liao, 1999; Hodges & Kim, 2000; Hodges & Wong, 1996) is a multidimensional measure of impairment. Following a clinical interaction that includes an interview, record review, or consultation with treatment providers or other professionals, the CAFAS asks an interviewer to rate the child across eight domains (e.g., behavior toward self and others) and to rate the caregiver (i.e., the environment) on two domains. Psychometric studies of the CAFAS indicate that the measure demonstrates good internal consistency and the measure is consistent across raters (Hodges & Wong, 1996). Furthermore, the CAFAS is sensitive to changes in functioning due to treatment efforts (Hodges et al., 1999).

Table 4.1 Multidimensional measures of impairment

Impairment measure	Description	Reliability	Validity
Columbia Impairment Scale (CIS; Bird et al., 1993, 1996)	<ul style="list-style-type: none"> Completed by lay interviewer or parent 13-item scale that asks about functioning across functional domains 	<ul style="list-style-type: none"> Evidence of internal consistency ($r = .82$ to $.89$) and test-retest reliability for the parent version ($r = .89$) 	<ul style="list-style-type: none"> Evidence of concurrent validity when compared to parent CGAS Mean scores higher in clinical participants compared to community respondents
Children's Global Assessment of Functioning (CGAS; Bird, Canino, Rubio-Stipec, & Ribera, 1987, 1990; Shaffer et al., 1983)	<ul style="list-style-type: none"> Respondents rate each domain on a scale from 0 to 4 	<ul style="list-style-type: none"> Less internal consistency ($r = .70$ to $.78$) and test-retest reliability for child raters ($r = .69$) 	<ul style="list-style-type: none"> Correlates with other psychosocial measures of dysfunction; parent version exhibited more evidence of validity than child-rated version
	<ul style="list-style-type: none"> Adapted from adult Global Assessment Scale Scores range from 0 to 100 with descriptions of behavior and functioning for every ten points Typically completed by a clinician after interview/records review Nonclinician version may be completed by parents 	<ul style="list-style-type: none"> Evidence of test-retest reliability when completed by a clinician ($r = .74$ to $.84$) Evidence of interrater reliability for clinicians ($r = .69$ to $.87$) 	<ul style="list-style-type: none"> Correlates highly with other global measures of impairment ($r = .80$ to $.92$) Scores related to service use and severity of behavior problem ratings
Impairment Rating Scale (IRS; Evans et al., 2005; Fabiano et al., 2006)	<ul style="list-style-type: none"> Completed by a parent and teacher Items ask raters to report on functioning across important domains Includes space for a rater to provide a narrative of problematic behaviors 	<ul style="list-style-type: none"> Evidence of temporal stability over 4 months and 1 year for parent and teacher version Moderate to high interrater reliability between parents and teachers 	<ul style="list-style-type: none"> Correlates moderately with parent and teacher CGAS Correlates moderately with objective measures of problematic behavior Predicts use of mental health and school services

(continued)

Table 4.1 (continued)

Impairment measure	Description	Reliability	Validity
Child and Adolescent Psychiatric Assessment (CAPA; Angold & Costello, 1995; Angold et al., 1995, 1999)	<ul style="list-style-type: none"> Built into a psychiatric diagnostic interview Symptoms counted only if impairing 	<ul style="list-style-type: none"> Evidence of temporal stability on the child version Kappa coefficients range from .55 (conduct disorder) to 1.0 (substance abuse/dependence) 	<ul style="list-style-type: none"> Children with impaired functioning rated on the CAPA more likely to be receiving services
Child and Adolescent Functional Assessment Scale (CAFAS; Hodges et al., 1999; Hodges & Kim, 2000; Hodges & Wong, 1996)	<ul style="list-style-type: none"> After disorder-specific symptom questions are completed, interviewer also rates incapacities across important life domains Includes eight scales to assess child behavior and two scales for the child's environment 	<ul style="list-style-type: none"> Internal consistency ($r = .73$ to $.78$) 	<ul style="list-style-type: none"> Higher ratings of impairment obtained for children with more "severe" disorders and behavioral indices of impairment such as academic grades, school attendance, contact with the police Sensitive to treatment effects
	<ul style="list-style-type: none"> Completed by a rater after a review of records, interviews with relevant respondents, and discussions with others involved in the case Yields a score for each subscale and a total score Training manual available for completing the measure 	<ul style="list-style-type: none"> Interrater reliability for total score ($r = .92$ to $.96$) 	

4.3.3 Child and Adolescent Psychiatric Assessment

The Child and Adolescent Psychiatric Assessment (CAPA) integrates the assessment of impairment with a structured diagnostic interview, asking the informant to rate impairment specific to each symptom group (e.g., ADHD, depression, etc.; Angold et al., 1995). The CAPA is a structured psychiatric interview administered by an interviewer to both children and parents. Interviewers are trained to ask about the presence, frequency, and intensity of diagnostic symptoms. Then, interviewers rate the degree to which the symptoms have incapacitated the individual across a number of important functional domains (e.g., family life and relationships). The CAPA has demonstrated acceptable indices of reliability and good indicators of validity, and it has been used in epidemiological as well as clinical settings.

4.3.4 Impairment Rating Scale

The Impairment Rating Scale (IRS; Evans, Allen, Moore, & Strauss, 2005; Fabiano et al., 2006) is a multidimensional measure that assesses functioning across domains developed for children with ADHD. The IRS asks the rater to place an “X” on a continuum from “no problem; definitely does not need treatment or special services” to “extreme problem; definitely needs treatment or special services.” There is also space for the rater to describe in a narrative fashion his or her reasoning for the rating or to provide additional information or examples regarding the extent of the impairment. Because the IRS can be completed by a parent or teacher without clinician involvement, the only clinical cost is the time spent to review and score it. It is unique in that it is a rating scale completed by the child’s parent and teacher, making it a quick and low-cost alternative to assessments that require an interviewer. The IRS exhibits concurrent, discriminant, and convergent validity and acceptable levels of temporal stability. The IRS is also sensitive to changes in behavior modification or pharmacological interventions (e.g., Fabiano et al., 2007). Research indicates a score of three or greater on the measure reliably identifies children with ADHD and does not identify those without the disorder.

As Table 4.1 indicates, there are a number of well-studied, psychometrically sound instruments for assessment of impairment. Depending on the explicit goal of a particular assessment, one measure may be preferred over another. Clinicians/researchers must decide on the best approach to assessing impairment given their needs.

4.3.5 Illustrative Case

In an effort to describe a practical approach to measuring impairment in a child client, we describe a prototypical case in our clinic for children with ADHD and then walk through the steps included in the assessment, beginning with the initial referral, meetings with the parents, the approach to treatment, and the strategies for

assessing treatment outcomes. Following this, we present general guidelines for the assessment of impairment in children and adolescents.

Peter Smith is a 9-year-old boy who lives with his parents, John and Jane Smith, and his younger brother and sister. He attends third grade at the local public elementary school. He has had long-standing behavior problems dating back to preschool, and he was referred to the clinic in October of the current school year due to parent and teacher concerns about behavior. Before the initial clinic intake, his parent and teacher were mailed the IRS to complete. Figure 4.1 displays the responses on the parent IRS, and Fig. 4.2 displays the teacher IRS responses.

Before the initial meeting with the parents, the clinician should review and score the IRS. The IRS is scored by placing a transparency over the line where the rater placed an "X". The line is divided into seven equal segments labeled 0 (no problem) to 6 (extreme problem). The segment within which the "X" is placed constitutes the score. Research indicates any score greater than or equal to three is within the clinically impaired range for a child Peter's age (Fabiano et al., 2006). Thus, with the exception of self-esteem (not surprising given the literature on positive illusory bias in children with ADHD; Hoza, Pelham, Dobbs, Owens, & Pillow, 2002), Peter's parent and teacher agree that he is impaired across all major functional domains in both the home and school setting. The narrative information provided on the parent and teacher IRS provides additional explanatory and contextual information on impairment, and this information naturally leads to follow-up questions that may be asked during the clinical interview.

Figure 4.3 illustrates a portion of an initial intake interview. In clinical practice, the majority of intake time should be devoted to identifying, operationalizing, and understanding the child's areas of impairment. This portion of the assessment is where the clinician collects more detailed information on the nature and extent of impairment, and this information should be collected in a manner that is integrated with treatment planning. As Fig. 4.3 illustrates, the clinician reviews intake ratings and the parent report of presenting problems and then works with the parent to operationalize and review the antecedents, consequences, and setting events of the targeted behavior. For example, for the targeted behavior of completing homework in the specified time, the parents described antecedents that encompassed tasks that included writing and situations for which they were feeling time pressure. The clinician also obtains information on consequences; for the child, these include escape/avoidance of an aversive task, and for the parents these consequences include their own feelings of frustration. Behavior modification strategies such as time-out have not been effective consequences according to the parent. Clinicians also obtain information during this interview on the child's strengths and competencies and ask the parent about the impact of the targeted behavior for the child in the short and long term. Similar to other global ratings of impairment (e.g., Shaffer et al., 1983), the clinician also provides an overall global rating of the impact of the behavior using IRS methodology (Fabiano et al., 2006). If this procedure is repeated for the child's main presenting problems, the result of the initial assessment should be a list of target behaviors and parent-generated information on the nature, severity, and function of each.

Chronis, 1998); Pelham et al., 2001, 2002, 2005, and it is a procedure aligned with a long tradition of using contingency management with children with disruptive behavior in clinical and educational settings (e.g., Hops & Walker, 1988).

In addition to being an effective treatment for ADHD, the DRC is also an efficient and effective procedure for monitoring outcomes in the child's important areas of psychosocial functioning (Pelham et al., 2005). It is sensitive to environmental

Impairment Rating Scale -- Teacher

Child's Name: Peter Smith

Teacher's Name: Mrs. Jones

Date Completed: 10/4/07

Instructions: In the space below, please describe what you see as this child's primary problems. Also, please describe how this child's problems have affected the following areas and complete the rating at the end of each: (1) his or her relationship with other children, (2) your relationship with him or her, (3) his or her academic progress, (4) your classroom in general, and (5) his or her self-esteem. Continue on a separate sheet if necessary. **For the ratings, please mark an "X" on the lines at the points that you believe reflect the impact of the child's problems on this area and whether he or she needs treatment or special services for the problems. PLEASE COMPLETE BOTH SIDES OF THIS FORM.**

(1) How this child's problems affect his or her relationship with other children

Peter does not work well with other children. I have moved his desk away from the other children due to numerous complaints about him poking or teasing the other children. During science, many of the activities are partner-based, and even though it is only October, children already do not want to be his partner.

No Problem | _____ X _____ | Extreme Problem
Definitely does not need treatment or special services Definitely needs treatment or special services

Regardless of whether this child is popular or unpopular with peers, does he or she have a special, close "best friend" that he or she has kept for more than a few months? (Please circle)

YES NO

(2) How this child's problems affect his or her relationship with the teacher

I feel like I have a good relationship with Peter. I try to help him with his behavior. However, it becomes difficult to teach the class with his constant interruptions.

No Problem | _____ X _____ | Extreme Problem
Definitely does not need treatment or special services Definitely needs treatment or special services

(3) How this child's problems affect his or her academic progress

Peter is a bright young man. It is clear he is learning the material I am teaching. However, his grades are affected by late or missing assignments and projects. It is clear he is not studying his spelling words or multiplication facts at home.

No Problem | _____ X _____ | Extreme Problem
Definitely does not need treatment or special services Definitely needs treatment or special services

Fig. 4.2 Sample teacher impairment rating scale

Child's Name: Peter Smith

Date:

Daily Report Card

School

	Math		Spelling		Subjects/Times Lang. Arts		Science		Social Studies	
1. Completes seatwork within time provided.	Y	N	Y	N	Y	N	Y	N	Y	N
2. Returns completed homework.	Y	N	Y	N	Y	N	Y	N	Y	N
3. Exhibits appropriate behavior toward classmates (i.e., is respectful, keeps hands to self) with no more than one reminder to do so.	Y	N	Y	N	Y	N	Y	N	Y	N
4. Needs no more than one prompt to follow directions.	Y	N	Y	N	Y	N	Y	N	Y	N

Comments: _____

Home

	Morning	Subjects/Times After-school		Evening		
1. Has all materials needed for homework (assignment book completely filled-out, books, folders, notebooks)	N/A	Y	N	N/A		
2. Returns completed homework.	N/A	Y	N	N/A		
3. Has no more than 1 time out for arguing with siblings.	Y	N	Y	N	Y	N

Daily Consequences

80-100% of "yes's" 60 minutes of screen-time (computer, tv, videogames) OR
 60 minutes later bedtime

70-80% of "yes's" 30 minutes of screen-time (computer, tv, videogames) OR
 30 minutes later bedtime

60-70% of "yes's" 15 minutes of screen-time (computer, tv, videogames) OR
 15 minutes later bedtime

Weekly Consequences

80-100% of "yes's" Choice of weekend activity with Mom or Dad (movie, park)

Fig. 4.4 Sample daily report card (DRC) for the school and home setting

outcome of treatment efforts. Based on the information presented in Figs. 4.1, 4.2 and 4.3, a clinician may choose to focus on academic-related targets such as seatwork and homework completion. Further, Peter appears to have difficulty negotiating peer interactions at home and at school. Figure 4.4 illustrates a sample DRC that might be constructed initially to target Peter's impaired areas of functioning at home and at school. Importantly, many of the goals are phrased in a positive way to promote Peter's development of adaptive behavioral skills. Because the targets selected are clinically meaningful, the DRC can also double as an individualized target behavior evaluation (ITBE; Pelham et al., 2005). As such, the percentage of targets that earn a "yes" before consequences are introduced, as consequences are added, and as additional treatment modifications occur (e.g., Peter is made to complete homework immediately after school before he can engage in other activities) will yield information on the effectiveness of treatment in an ongoing fashion. Clinicians can also be confident this progress monitoring is socially valid and clinically meaningful because the targets are directly linked from concerns at referral. The ITBE/DRC may also be modified as needed. For example, should Peter's parents decide to reintroduce him to a Little League activity, a goal that targets his active participation throughout the activity might be supportive of this transition.

4.4 Guidelines for Assessment

Based on this review of impairment rating scales, a few guidelines for assessment may be generated. First, assessment of impairment in daily life functioning should be a cornerstone of any psychological assessment. Second, these assessments should utilize multidimensional measures to adequately capture the topography of impaired functioning. Third, the measures utilized should lend themselves to efficient, reliable repeated assessments to permit the monitoring of treatment outcomes. Fourth, measures should provide useful information for treatment planning as clinically meaningful targets of treatment are those that are related to impaired functioning. We discuss each of these guidelines in turn.

As mentioned, the research literature on measures for assessing *DSM* symptoms dwarfs that of impairment measures. However, recent prominent publications have emphasized the importance of measuring functional outcomes. For example, the American Academy of Pediatrics (2000) clinical assessment guidelines for ADHD emphasize the assessment of impaired functioning by parents and teachers. The treatment guidelines for ADHD state “the primary goal of treatment should be to maximize function” (American Academy of Pediatrics, 2001, p. 1036). If these guidelines are followed, the assessment of impairment should be heavily emphasized in psychological assessments from the initial meeting through treatment.

Multidimensional measures of impairment have advantages over global measures in clinical settings. Global measures are useful for epidemiologic or research activities, but in clinical settings, specific information on impaired areas of functioning is needed. For instance, a clinician using a global rating that indicated impaired functioning would then have to proceed with an assessment to determine the specific behaviors that contributed to the negative rating. Collecting a multidimensional measure across domains (e.g., academic, family, peer relationships) has more practical clinical utility as it permits the clinician to obtain a comprehensive picture of the child’s current levels of functioning.

Once an initial diagnosis and functional assessment are obtained, clinician efforts should be dedicated to treatment planning, monitoring, and evaluation. For this reason, measures of functional impairment should be brief and efficient and lend themselves to repeated assessments (Pelham et al., 2005). Longer, expensive measures of functional impairment, such as those embedded in interviews administered by a clinician, are undesirable for these assessment goals. It is recommended that clinicians use assessment measures that are brief and easy to score. This permits repeated assessments that will promote an ongoing measure of the child’s functioning and feedback directly into treatment planning and modification.

Finally, clinicians should use measures of impairment that are directly related to intervention. Assessments of impairment should lead directly to the establishment of target outcomes that can be operationalized in intervention plans. For this reason, measures must go beyond classifying a child as impaired, or not, and instead document the specific problems the child is experiencing (e.g., failing academic classes; being rejected by peers). These target outcomes then become the yardstick that clinicians, parents, teachers, and the child use to measure progress related to treatment.

4.5 Conclusion

Many measures of impairment have been developed and validated of late. It is hoped that researchers and clinicians continue to emphasize the measurement of impairment in their work. Policy-makers and decision-makers should also begin to emphasize the importance of impairment, both as a means of identifying children in need of intervention and as the main means of evaluating treatment outcomes.

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