

CHAPTER I

Psychosocial Impairment

Definition and Assessment

Defining Impairment and Related Concepts

Impairment in psychosocial functioning is a requirement for the definition of the vast majority of mental disorders, and even for the determination of some disabilities due to both medical and mental disorders. The term “to impair” or “impairment” has been defined in various dictionaries as follows: “to cause to diminish, as in strength, value, or quality” (*medical-dictionary.thefreedictionary.com/impairment*); “a disability, any loss of physiological, psychological, or anatomical structure or function” (*Wikipedia.org*); “weakening, damage, or deterioration, especially as a result of injury or disease” (*American Heritage Medical Dictionary*, 2009); “to make or cause to become worse; diminish in ability, value, excellence, etc.; weaken or damage” (*dictionary.reference.com*); “to damage or make worse by or as if by diminishing in some material respect” (*medical-dictionary.thefreedictionary.com/impairment*) or “a disorder in structure or function resulting from anatomic, physiologic, or psychologic abnormalities that interfere with normal activities” (*medical-dictionary.thefreedictionary.com/impairment*). The American Medical Association (2008) defines “impairment” as “a significant deviation, loss, or loss of use of any body structure or function in an individual with a health condition, disorder or disease.” This definition and subsequent guidelines are often used in determining workers’ compensation cases. Although DSM-IV-TR (American Psychiatric Association, 2000) provides no formal definition for the term “impairment,” the phrase “... causes clinically significant distress or impairment in social, occupational, or other important areas of functioning” (p. 8) is attached to the diagnostic criteria for most mental disorders set forth in the man-

ual. Explicit in the other definitions, yet only implied in the quotations given here, is that impairment is diminished functioning in important psychosocial domains of human life.

“Symptoms,” in contrast, are defined as follows: “any sensation or change in bodily function that is experienced by a patient and is associated with a particular disease” (*wordnetweb.princeton.edu*); “a departure from normal function or feeling which is noticed by a patient, indicating the presence of disease or abnormality” (*Wikipedia.org*); “something that a patient experiences in his or her body that is different from what is normal, and that may be the result of a disease or its treatment” (*gemzar.com*); “a sign of a disease or dysfunction (or illness)” (*medical-dictionary.thefreedictionary.com/impairment*); or “a feeling, sensation, or experience associated with or resulting from a physical or mental disorder and noticeable by the patient” (*medical-dictionary.thefreedictionary.com/impairment*). A “symptom” is therefore a physical, cognitive, or behavioral manifestation of a disorder, whereas “impairment” refers to the consequences that arise from the expression of the disorder and its symptoms. These consequences usually include functional ineffectiveness in one or more major psychosocial domains of human life.

The term “disorder” is also variously defined in the literature. For instance, a “mental disorder” is defined in DSM-IV-TR (American Psychiatric Association, 2000) as “a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom” (p. xxxi). No attempt is made either to specify the underlying source or origin of this syndrome/pattern, or to indicate what would distinguish it from other patterns that might not be disorders. It misses, in other words, the essence of the concept of “disorder.”

A widely considered and debated alternative view is provided by Wakefield (1992, 1997), who defines a “disorder” as a harmful dysfunction in an evolved mental or physical mechanism. He has borrowed the concept of “adaptation” (an evolved physical or mental mechanism) from the field of biology, and has made it the essence of the concept of “disorder”: Disorders are dysfunctional adaptations. Medical disorders are failures or reductions of functioning in physical adaptations (such as organ systems), and mental disorders represent failures or diminutions in psychological functions (e.g., intelligence, memory, thinking/reasoning, visual-spatial abilities, language) or psychosocial functions (e.g., mobility, self-care, self-sufficiency/independence, social exchange/reciprocity, mating/pair bonding, childrearing, receptiveness to pedagogy/education). Adaptations are functional mechanisms that evolved to solve a problem in the environment of a species. Evolved adaptations are thus not trivial features or characteristics. They are biologically costly for an organism to develop and maintain, and so must serve some useful purpose; that is, the benefits of an adaptation must outweigh the costs to an individual for possessing that mechanism. The loss of, failure in, or reduction in functional effectiveness of an adaptation therefore often results in serious consequences for the individual—a reduced ability or inability to continue effectively addressing the adaptive problems the adaptation evolved to solve. When the mechanism can no longer effectively do this, the adaptive problems return, and the environment reacts with adverse

consequences. Those consequences constitute the harm that may arise from such functional ineffectiveness.

Although the terms “impairment,” “deficiency,” “symptoms,” “disability,” and “disorder” are often used interchangeably in everyday conversation as well as in the medical, psychiatric, and psychological literatures, it is important not to confuse them. They represent separate components in the triadic sequence of events in reality—from the disorder to its symptoms (manifestations) to the functional impairment that ensues (ineffective performance and the harm that results). DSM-IV-TR (American Psychiatric Association, 2000) makes this distinction clear when it makes the requirement of impairment in major psychosocial activities a separate criterion for establishing the presence of a psychiatric disorder, apart from the presence of symptoms that result from or constitute the disorder. Impairment and symptoms are not identical either in their conceptualization or in reality. Research shows that severity of symptoms is only partially coupled to degree of impairment (Gordon et al., 2006; Lewandowski, Lovett, & Gordon, 2009). In other words, the extent of impairment does not have a perfect, direct relationship to the severity of symptoms, but is only partially predicted by that severity. This makes it clear that other factors besides symptoms alone contribute to the eventual level of psychosocial impairment an individual may experience.

In short, it is fruitful to consider symptoms as the physical, cognitive, or behavioral manifestations of a disorder. Disorders are dysfunctions in physical or psychological (mental) adaptations that result in harm. Impairment represents functional ineffectiveness—the inability to perform effectively in major domains of human life (adaptive problems)—and its harmful consequences. When an individual no longer functions effectively in addressing the everyday major adaptive problems of human life, the environment “kicks back” in ways that are costly or harmful to the individual. Functional ineffectiveness in major life activities (adaptive domains), resulting in adverse consequences, is therefore at the heart of the concept of impairment.

In this view, impairment not only refers to functional ineffectiveness in addressing the major adaptive problems of human life; it also refers to the harm that this functional ineffectiveness creates for an individual. A reduction in functional effectiveness that leads to no harm whatsoever in the absence of any accommodations, treatment, or habilitation is a trivial if not nonexistent form of impairment. In other words, “no harm, no foul.” “Harm” in this definition typically refers to either increased risk for mortality, increased risk for morbidity (physical injury), or a significant adverse decline in functioning in a particular *major* human life activity (self-care, self-protection, self-sufficiency, social interaction, sexual relations, education, occupation, etc.). A “major life activity” in this perspective is one of the important adaptive domains that are largely or entirely universal to all mature humans and are necessary to their ability to sustain their survival, see to their welfare, and hence increase their long-term happiness (freedom from want or dissatisfaction). When the degree of dysfunction in an adaptation reaches a certain level, an individual may not be able to perform a major activity of daily life as well as the average, typical, or normal human; that is, the person has become significantly less effective. This ineffectiveness begins to have adverse consequences for the individual. Harm begins to accrue. Both the reduction in functional effectiveness and the attendant

harm are regarded as the essence of the concept of impairment. The adverse consequences can even serve as a gauge to the degree of functional ineffectiveness—the degree of one’s impairment.

A common element in various views on impairment is that the “normal” or “average” person serves as the standard against which the degree of functional ineffectiveness and attendant harm is to be judged (Gordon & Keiser, 1998). This is implied if not explicitly stated in the foregoing definitions of the terms “disorder” and “impairment.” It has also been made explicit in the U.S. government’s definition of the term “disability”—a term often used synonymously with “impairment.” The Americans with Disabilities Act (ADA; Public Law 101-336, 1990) refers to a “disability” as “an inability to function normally, physically or mentally.” (It goes on to describe a disability as an “inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last or has lasted for a continuous period of not less than 12 months,” and as “a physical or mental impairment that substantially limits one or more of the major life activities of [an] individual, a record of such an impairment, or being regarded as having such an impairment.”) The Equal Employment Opportunity Commission, which is responsible for issuing regulations in regard to the ADA, has offered this clarification: “An individual is not substantially limited in a major life activity if the limitation does not amount to a significant restriction when *compared with the abilities of the average person*” (emphasis added). Similarly, impairment or disability is “the inability to function in the normal or usual manner” (*medical-dictionary.thefreedictionary.com/impairment*). The normal, typical, or average person in the general population—not some highly intelligent, high functioning, highly specialized, or highly educated peer group—is thus the standard against which impairment is judged.

With these ideas as a background, this manual takes as its starting point that “impairment” begins with a loss or diminution in the functional effectiveness of human physical or mental adaptations. It views this functional ineffectiveness as often being dimensional, not categorical, in nature; that is, there can be degrees of diminution in the functioning of most physical or mental adaptations, as opposed to all-or-none effectiveness. When an individual’s ineffective functioning reaches such a magnitude that it begins to result in an inability to adapt to (solve) problems in the major domains of human life, adverse consequences arise for that individual (i.e., harm ensues). At that point or threshold, the person may be said to be impaired, disordered, or disabled.

This manual and the BFIS focus on the uppermost level of the trilevel hierarchy of impairment (physical, cognitive-behavioral, psychosocial)—the psychosocial arena of functional effectiveness. This is because the principal focus of the BFIS is on evaluating impairment in the context of psychiatric disorders or psychological problems, although it may also be of use in evaluating psychosocial impairment related to medical disorders. The major domains of human psychosocial life are likely to comprise the adaptive problems that some physical organs (the human brain) and most cognitive-behavioral adaptations evolved to address. It is probably at this level of adaptive problem solving where evolution (natural selection) has acted in the history of the species to create the lower-level cognitive-behavioral and even neurological adaptations.

As noted above, the normal, average, or typical human serves as the standard for judging functional ineffectiveness and its harmful consequences. To make such a determination, there must be information on the normal or general population against which an individual's reports can be compared. In other words, there must be norms available to assist with this judgment of impairment. That is one purpose of this manual: to provide normative information on the degree of functional ineffectiveness experienced (self-reported) by a representative sample of the adult general population in the performance of most major psychosocial domains of life activities.

Guidelines for Assessing Impairment or Disability

It is not the purpose of this manual to set forth detailed guidelines for the clinical evaluation of disorders and impairment. The American Medical Association, the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, and the American Academy of Pediatrics, among others, have published detailed practice standards that should be consulted for such information. Yet a brief summary of two sets of official guidelines can be helpful in providing an overview of the essential or basic structure of such an evaluation.

Guidelines of the American Medical Association

The medical model of evaluation of disorders and their impairments has been set forth in the United States by the American Medical Association (2008), as represented in Table 14-4 of its guidelines (p. 352). That table lists specific suggestions to address in conducting a mental and behavioral disorders examination. These recommendations include the following:

- Screen an individual for past and current substance abuse, to determine whether symptoms of substance abuse better account for psychiatric symptoms.
- Evaluate the person's legal history, especially concerning prior lawsuits, work-related injuries, bankruptcies, incarcerations, driving while intoxicated, restraining orders, and court-ordered child support.
- Obtain the person's military history, including overseas service, adjustment to service, discharge history, pay grade, military arrests, and disability pension.
- Note whether there is a pattern of overendorsing symptoms during the psychiatric interview.
- Assess the patient's motivation for returning to work.
- Determine whether symptom exaggeration or malingering is present.
- Ask about the patient's attitude to the third-party payer (employer, insurance company, etc.).
- Assess the influence of the litigation process on return to work.
- Determine whether adequate pharmacological and biological treatment has been provided, including whether the patient has accepted and complied with reasonable treatment.

Although these recommendations are helpful at a broad or general level, the judgments of impairment made by following these criteria and associated ratings have poor interrater reliability (Leclair, Leclair, & Brigham, 2009).

The American Medical Association guidelines for mental disorders specify six areas of functional impairment for review in this evaluation: self-care and personal hygiene; social and recreational activities; the capacity for travel, including driving and using public transportation; interpersonal relationships; the capacity for concentration, persistence, and pace; and employability. Five of these are psychosocial, and one, interestingly, is cognitive-behavioral (the capacity for concentration, persistence, and pace). In determining the presence of impairment, the evaluator is encouraged to review information from other reliable sources, such as records from inpatient hospitalization, outpatient treatment, day treatment programs, occupational therapy, work evaluations, and disability assessments. The patient's self-reports of symptoms and their impact on these six functional areas, along with the information gathered from these sources and the findings from the objective clinical examination, are to be analyzed by the examiner in making a judgment of impairment or disability. Any wide disparities or incongruities between the patient's self-reports and the other sources of information, including the clinical evaluation, should be scrutinized to determine the reasons for these disparities. (For a more detailed discussion of the American Medical Association guidelines, see Leclair et al., 2009.)

Guidelines of the Social Security Administration

In the United States, the Social Security Administration (2008; see also www.ssa.gov) has issued guidelines for the determination of work-related disability, which must be total and permanent, not partial or temporary. The individual must be unable to do the work he/she did before; the person must be unable to adjust to other work because of the medical condition; and the disability must be expected to last at least 1 year or to result in death. The evaluation of disability on the basis of a mental disorder requires sufficient evidence to (1) establish the presence of "medically determinable mental impairment(s)," (2) assess the degree of functional limitation the impairment or impairments impose, and (3) project the probable duration of the impairment(s). Generally, the examiner is encouraged to follow the American Medical Association guidelines as described above in making the determination of medically determinable mental impairment(s).

In the criteria for the guidelines concerning disability due to mental disorders, the presence of a mental disorder must result in limitations in one or more of four functional domains:

1. *Activities of daily living.* These include adaptive activities such as cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring appropriately for personal grooming and hygiene, using telephones and directories, and using a post office.

2. *Social functioning at work or in personal life.* This includes the capacity to interact independently, appropriately, effectively, and on a sustained basis with other

individuals. Social functioning includes the ability to get along with others, such as family members, friends, neighbors, grocery clerks, landlords, or bus drivers. A person may demonstrate impaired social functioning by, for example, a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, or social isolation. He/she may exhibit strength in social functioning by such things as the ability to initiate social contacts with others, communicate clearly with others, or interact and actively participate in group activities. The examiner also needs to consider cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity. Social functioning in work situations may involve interactions with the public, appropriate responses to persons in authority (e.g., supervisors), or cooperative behaviors involving coworkers.

3. *Concentration, persistence, and pace in completing tasks that are commonly part of work.* These are described as the ability to sustain focused attention and concentration sufficiently long to permit the timely and appropriate completion of tasks commonly found in work settings. Limitations in concentration, persistence, or pace are best observed in work settings, but may also be reflected by limitations in other settings.

4. *Decompensation or deterioration in work or work-like settings that may result in withdrawal from that situation or experiencing an exacerbation of symptoms,* as manifested by difficulties in performing activities of daily living, maintaining social relationships, or maintaining concentration, persistence, or pace. Episodes of decompensation may be demonstrated by an exacerbation in symptoms or signs that would ordinarily require increased treatment or a less stressful situation (or a combination of the two). Episodes of decompensation may be inferred from medical records showing significant alteration in medication; from documentation of the need for a more structured psychological support system (e.g., hospitalizations, placement in a halfway house, or a highly structured and directing household); or from other relevant information in the record about the existence, severity, and duration of the episode.

As in the American Medical Association guidelines, one domain is clearly cognitive-behavioral in nature (concentration, persistence, and pace). The other three are psychosocial (activities of daily living, social functioning, and work or employability).

Important to note in both these sets of guidelines is that the examiner is to analyze the patient's self-reports of symptoms and their impact on the four or six functional domains, to determine how consistent this information is with that obtained from the other sources. This is fine—but nowhere in either set is there any consideration of comparing a patient's self-reports against those of a general population sample to determine the extent to which the patient's reports are normal, typical, or deviant (abnormal). This raises the question of just how much typical, average, or normal people consider themselves to be functioning effectively or ineffectively (impaired) in these psychosocial domains. The answer is that until now, no one has really known; it has been left to clinicians to make that determination. But on what are clinicians relying in doing so? Besides their training and experience, most likely the reports of their patients. That may explain why the results of such evalua-

tions are often found to be unreliable across examiners (Leclair et al., 2009). None of the other sources of information to be consulted in an examination provide that type of normative information, either. The American Psychiatric Association (Pincus et al., 1991) studied the consistency of the Social Security Administration guidelines against the actual statutory requirements for being declared disabled in the legislation related to Social Security Disability Insurance, and it gave a number of recommendations for improving the guidelines. However, none of these involved collecting normative information from the general population on the extent of its self-reported impairment in these psychosocial domains.

This is not to say that some structured methods for evaluating psychosocial impairment have not been used previously in the research literature on the subject. Several certainly have; however, none of them were given to a large sample of the general U.S. population to determine the extent to which this population would have self-reported various degrees of functional impairment in specific psychosocial domains. Only a sampling of the methods can be considered here, but they are typical of the rest.

Methods for Evaluating Psychosocial Impairment

Clinician Ratings

Of the four commonly used clinician ratings for determining the presence of psychosocial impairment to be considered here, the one most often cited is the Global Assessment of Functioning (GAF) Scale set forth in the current version of the DSM—at this writing, DSM-IV-TR (American Psychiatric Association, 2000, p. 34). The clinician giving this relatively simple rating on a single scale from 0 to 100 is to “consider psychological, social, and occupational functioning on a hypothetical continuum of mental health–illness,” but is not to include “impairment . . . due to physical (or environmental) limitations.” To understand this hypothetical continuum, consider what the lowest rating of 10 represents: **“Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death”** (p. 34; bold in original). Contrast this with what the highest rating of 100 represents: **“Superior functioning in a wide range of activities, life’s problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms”** (p. 34; bold in original).

Although the intent of the GAF Scale is laudable—that is, to provide clinicians with at least some guidance in making a judgment of the degree to which a mental disorder is associated with impairment—several problems exist with such a simple global judgment. Not the least of these have been repeated findings of low inter-judge agreement on the scaling in the absence of training. The scale also does not distinguish among various major domains of psychosocial functioning, consistent with the American Medical Association and Social Security Administration guidelines. And so it cannot be made clear just what the specific nature of the impairment is, or, more precisely, in what domains of life the impairment is occurring. Lower ratings appear to represent not just more severe but more pervasive impair-

ment across multiple domains. Yet the nature of these domains is unclear. Just as important is the lack of any information on just how the general population would be rated on such a scale, which would serve as a critical benchmark for determining what is normal or average for adult humanity, or at least adults in the United States. If a clinician has no information on how the general population would fare on such a scale, then the reliability (and hence validity) of such judgments will surely be limited.

A clinician rating scale related to the GAF Scale is the more focused Social and Occupational Functioning Assessment Scale (SOFAS), which is provided in an appendix to DSM-IV-TR for further study (American Psychiatric Association, 2000, p. 818). The instructions direct the clinician to “consider social and occupational functioning on a continuum from excellent functioning to grossly impaired functioning.” In contrast to the GAF Scale, the SOFAS admonishes the clinician to “include impairments in functioning due to physical limitations, as well as those due to mental impairments.” This proposed scale can be illustrated by what its lowest rating of 10 represents: “Persistent inability to maintain minimal personal hygiene. Unable to function without harming self or others or without considerable external support (e.g., nursing care and supervision).” Its highest rating of 100 reflects this: “Superior functioning in a wide range of activities.”

A study on the construct validity of the SOFAS (Patterson & Lee, 1995) found that its scores were independent of Axis I, Axis II, and psychoactive substance dependence diagnoses, suggesting that it is assessing a construct apart from general psychopathology. This is a good thing not only for the construct of impairment, but also for the requirement in DSM-IV-TR that impairment be a separate criterion for establishing a diagnosis of a mental disorder from the specific symptom criteria. If impairment was simply another form of psychopathology, this requirement would be moot. The study by Patterson and Lee (1995) also found that six factors appeared to contribute to these ratings, accounting for nearly 52% of the variance in the ratings: patients’ access to and use of transportation; medication compliance; number of agency referrals; current living situation; current potential for violence; and degree of social support. Though it is clear that the SOFAS (and probably the GAF Scale, on which it is based) is capturing a global construct of impairment, the same limitations are inherent in both scales. Again, the lack of information on the functioning of the general population throws clinicians back on their own limited experience and training in this regard, and hence their judgments have limited reliability and validity.

Another clinician rating scale is the Sheehan Disability Scale (DISS; Sheehan, 1983), although it can also be completed directly by the patient. The scale consists of three global domains or items, with each rated 0–10 in degree of impairment (the anchor points are not at all [0], mild [1–3], moderate [4–6], marked [7–9], and extreme [10]). The three domains on the DISS are work/school, social/leisure, and family life/home. Scores of 5 or higher are said to be worth clinical attention, as they are more likely to be associated with impairment. The DISS also asks about (1) how many days an individual missed school or work due to his/her symptoms or was to carry out normal daily responsibilities; and (2) how many days his/her productivity was reduced by the symptoms even if the person went to school or work. The scale seems to have been created specifically for evaluating people with panic,

phobic, other anxiety, or depressive symptoms. But a subsequent paper by the developer (Sheehan, Harnett-Sheehan, & Raj, 1996) presented results for other psychiatric disorders, suggesting that the DISS could be extended for use beyond patients with anxiety or mood symptoms. The scale can be completed in 1–2 minutes by either a patient or a clinician. It has been used in psychopharmacology research and seems to be sensitive to treatment effects (Leon, Shear, Portera, & Klerman, 1992; Sheehan et al., 1996). An analysis of some of the scale's psychometric properties found satisfactory internal consistency (.56–.74 at first administration) and a single-factor structure, suggesting a general impairment dimension underlying the specific item domains of work/school, social/leisure, and family life/home (Leon et al., 1992).

Sheehan and colleagues (1996) cited their own work and that of others indicating that severity of symptoms was only partially coupled with severity of disability (impairment) on the DISS: Not all disorders resulted in disability, and not everyone with a particular disorder received a score indicating disability on the scale. This partial decoupling of severity of symptoms from severity of impairment would be noted again in the field of attention-deficit/hyperactivity disorder (ADHD) 10 years later (Gordon et al., 2006). Also, treatments that reduced symptoms did not necessarily result in corresponding decreases in disability. Thus symptoms did not equate directly with disability (impairment), as the authors noted. The 1996 study also reported that disability scores in 102 psychiatric inpatients increased with age among patients, as well as among those with higher education. Higher scores were found among those who were widowed, separated, or divorced than among those who were living in a "family situation." No relationship was found for gender or age of onset of disorder, but number of prior hospitalizations was linked to increased current disability scores.

As with the GAF Scale and the SOFAS, no normative information exists for the DISS concerning the degree of impairment that would be found in a general population sample. This makes it difficult to judge whether the ratings provided by either the clinician or the patient on this scale are actually deviant relative to the reports that would be given by the average or normal person. Yet comparison to normative information on the general population is essential to the determination of impairment, as it is inherent in its very definition.

The Psychiatric Impairment Rating Scale (PIRS; Parmegiani, Lovell, Skinner, & Milton, 2001) is yet another means by which a clinician rating of impairment due to a psychiatric disorder can be obtained. The PIRS asks about functioning in various domains of major life activities that are very similar to those stipulated in the Social Security Administration and American Medical Association guidelines: self-care and hygiene; social and recreational; travel; social function; concentration, persistence, and pace; and employability. This should not be surprising, since these are the domains contained in the Workcover legislation for New South Wales, which were modeled on the Social Security Administration guidelines in the United States and are consistent with the American Medical Association guidelines. The PIRS was developed for the New South Wales Motor Accidents Authority in Australia and is also used in other Australian states. However, its validity and coverage as a measure of impairment associated with psychiatric disorders have been questioned by

Australian mental health professional groups, such as the Australian Psychological Association (see Davies, 2008).

The PIRS is made up of six scales, each designed to evaluate a specific area of functional impairment. The six functional impairment scales are each scored with a 5-point, anchored scale. The two *middle* scores (of the six) are summed and translated to a percentage of impairment from 0% to a maximum of 50%. Evidence suggests that this restriction in the ratings results in reduced correlations with other measures and significantly biases the assessed disability in a downward direction (Davies, 2008). Although this scale has high content or face validity, it lacks empirical evidence to support other forms of validity, such as construct, divergent, and criterion validity (Bryant, 2000). These limitations undermine its use as a measure of impairment (Davies, 2008). Correlations among the scale items suggest that the domains of employability; concentration, persistence, and pace; social and recreational; and self-care and hygiene probably form a single factor. The social function domain is less related to these other domains and may represent a separate smaller factor.

Yet another clinician-rated scale for assessing psychosocial impairment as a function of psychiatric disorder is the Longitudinal Interval Follow-up Evaluation—Range of Impaired Functioning Tool (LIFE-RIFT; Leon et al., 1999). This is a semi-structured interview that evaluates four domains of psychosocial functioning: work, interpersonal relations, recreation, and global satisfaction. In each domain, impairment is rated on a 1–5 scale (1–2 = no impairment, 3 = mild, 4 = moderate, 5 = severe; 0 = not applicable, 6 = no information). The work domain actually subsumes three more specific domains (employment, home, and student); the interpersonal relations domain refers specifically to spouse, children, other relatives, and friends. Global satisfaction and recreation are not broken down further. Factor analysis reveals a single-factor solution (Leon et al., 1999). Internal consistency of the scale is satisfactory (Cronbach's $\alpha = .82$). The scale has reasonable stability (intra-class correlations of .55–.61), has high interrater reliability ($r = .94$), and is sensitive to and predictive of recovery 6 months later (Leon et al., 1999). It not only readily distinguished depressed from normal control groups in one study, but was even sensitive to the level (severity) of depressive episodes (Judd et al., 2000). Although most of the research on the LIFE-RIFT has been done with depression, studies have also shown its utility with anxiety disorders (Warshaw, Keller, & Stout, 1994) and adult ADHD (Safren, Sprich, Cooper-Vince, Knouse, & Lerner, 2010). The study by Safren and colleagues (2010) indicated that adult ADHD was chiefly associated with work impairment ratings and, to a lesser degree, ratings of impaired interpersonal relations. The interpersonal relations and global satisfaction domains were associated with depression, while global satisfaction was associated with anxiety.

Several problems are immediately evident with all of these clinician-based rating methods for evaluating psychosocial impairment. First, the range of major life activity domains they cover is seriously restricted: They address mainly the domains of self-care; work or employability; social functioning; and concentration, persistence, and pace. This is understandable, given the focus of some clinician rating systems on the determination of work-related disability, as in the American Medical Association and Social Security Administration guidelines. A few systems also

address travel (mobility) and recreation. It is not clear why the domain of recreation would be considered a significant domain of human impairment separate from social functioning. Nor is it evident why concentration is considered a major domain of psychosocial functioning; rather, it is an important cognitive ability, especially for productive work. Yet if one is concerned more broadly with the range of major domains of life activities in which humans engage (especially in developed countries), then financial management, sexual behavior and relations, participation in organized community activities (church, clubs, organizations, sports, societies, etc.), marriage/cohabiting/dating, childrearing, driving, and health maintenance, among others, should probably be included. Education is also a major life activity—for young adults, obviously, but increasingly for adults of all ages still participating in the work force. This is so because of demands for ongoing adult education as part of many occupations, as well as retraining in new occupations or specialties for career advancement or reemployment after layoff. Yet the domain of education is not mentioned in any of these clinician rating systems.

Second, the range of possible ratings is often relatively truncated (a 4- or 5-point scale). As Davies (2008) has noted for the PIRS, limiting the range of rated impairment may restrict the range of correlations a scale is likely to have with other impairment measures. It may also result in a bias toward a rather low threshold for establishing the presence of impairment or disability.

Third, nationally normative data are not available to determine the extent to which the ratings on these methods would be distributed in a general population sample. Such information is indispensable to comparing an individual's rated level of impairment to the level typically reported by or assigned to the general, average, or normal population. If the "average person" standard is to serve as the benchmark for establishing someone as clinically significantly impaired, then information about that "average person" (the general population distribution) needs to be available. This is also important, given that the clinician rating relies heavily upon and so is significantly correlated with the patient-reported severity of symptoms and impairments (Davies, 2008). As a source of information about degree of impairment, a clinician rating is thus not really independent from a patient self-report; rather, it is chiefly a proxy for those self-reports, filtered through the experience, training, and even biases of the clinician doing the rating.

A fourth problem, as Davies (2008) has noted in critiquing the PIRS, is that no information has been presented for these methods to show that domain ratings by clinicians have any validity. Researchers must establish the validity of these ratings by demonstrating relationships to other measures of impairment in those same domains. For example, ratings of functioning at work must show relationships to work history, adverse events in occupational functioning, archival records (e.g., days worked, days absent, sick leave, or workers' compensation claims), employer ratings of job performance, and so on.

Patient Self-Ratings of Psychosocial Impairment

Several patient-completed rating scales exist for the evaluation of psychosocial impairment. One is the Impairment Rating section of the Patient Mood Chart

(PMC; Parker, Tully, Olley, & Barnes, 2007). A patient completes this scale daily, using a 0–3 Likert scale to rate the degree to which his/her depression impaired functioning in three domains: (1) work; (2) interactions with colleagues, family, and friends; and (3) ability to get things done. Parker and colleagues (2007) found that the PMC Impairment Rating correlated $-.53$ with the SOFAS (see above) and with other measures of depression and anxiety. Given that the clinician-rated SOFAS is largely driven by the patient's self-reports, such a correlation between the patient self-rating on the PMC and the SOFAS is not surprising. It is relatively weak evidence for validity. Certainly more evidence than this for the validity and utility of this measure is desirable.

Another patient-completed rating scale is the Clinical Impairment Assessment (CIA; Bohn et al., 2008). This is a 16-item rating scale in which each item is rated on a 0–3 Likert scale for frequency of difficulties (0 = not at all, 3 = a lot). It is intended specifically for patients with an eating disorder, and it concerns the impact of their eating symptoms on their mood and self-perception, social functioning, and work functioning. Only the latter two domains would be placed in the arena of psychosocial functioning. The developers found that both a global single-factor solution and a three-factor solution (Personal, Cognitive, Social) worked to describe the scale's underlying dimensions. The CIA correlated well (.68) with clinician-rated psychosocial impairment and with the patient-completed Eating Disorders Questionnaire.

A relatively simple patient self-rating scale is the Work and Social Adjustment Scale (WSAS; Mundt, Marks, Swear, & Griest, 2002). This is a short 5-item rating of degree of impairment secondary to a disorder that is to be specified by the clinician or researcher. The items can be presented and recorded over the telephone, using digitized voice recordings of instructions and items and a touch-tone keypad telephone. Each item is rated on a 0–8 Likert scale for degree of impairment in that domain. The specific domains to be rated are work, managing a home, social leisure, private leisure, and ability to form and maintain close relationships. The initial study of the scale found acceptable test–retest reliability (.73) and internal consistency (.79–.81). The scale correlated .76 with the Hamilton Depression Scale and .81 with clinician-rated impairment. Factor analysis in two separate studies (involving patients with depression and obsessive–compulsive disorder, respectively) revealed a single underlying factor consistent with other scales evaluating psychosocial impairment.

The self-report scale of impairment most relevant to this manual is the Impairment Rating Scale (IRS), part of an adult ADHD rating scale used in our earlier research (Barkley & Murphy, 1998, 2006). The IRS served as the prototype for the BFIS (see Chapter 2). It contained 10 domains of major life activities, each rated on a 0–3 Likert scale (rarely or not at all, sometimes, often, and very often) to indicate the frequency with which an individual experienced impairment in these domains as a result of ADHD symptoms. The domains included home life; work; educational activities; social interactions; marriage and dating; leisure activities; driving; money management; community activities; and handling daily responsibilities. Individual ratings could be analyzed separately, but typically two scores were computed from this scale: (1) the Total Impairment Score, or the total of all domain ratings; and (2) the Percent Domains Impaired score, or the percentage of domains rated as

being impaired (responses of often or very often—i.e., ratings of 2 or 3). The IRS was used in several studies of adults with ADHD and showed satisfactory divergent validity in discriminating adults with ADHD from Clinical control and Community control adults. It was also used in research on children with ADHD followed to adulthood whose ADHD persisted, compared to those with nonpersistent ADHD or a Community control group (Barkley et al., 2008). Interrater reliability (self- vs. other-reports) was satisfactory, and the ratings were associated with several other specific measures of impairment in these various domains, as well as with the clinician SOFAS rating.

It is certainly the case that self-report rating scales assessing quality of life (see Frisch, Cornell, Villaneuva, & Retzlaff, 1992, for an example) may overlap in their domain content with rating scales of impairment (work, recreation, social relationships, family, etc.). But the former scales are not evaluating the degree of functional ineffectiveness and harm being self-reported in these areas, which is the meaning of impairment. Instead, quality-of-life scales evaluate the extent of satisfaction, happiness, or well-being with these domains of life. Degree of happiness or satisfaction in any domain may be low, but this does not mean that individuals necessarily consider themselves as functioning ineffectively or being impaired or disabled in them.

Some of the same problems noted above for clinician ratings of psychosocial impairment also plague these and other patient rating scales. Although the range of major life activity domains appears to be broader on many of these scales, especially the 10-domain IRS, even these appear to miss some important domains of adult life (such as sexual behavior and relations, childrearing, and health maintenance). They may also cluster some domains into global categories, such as social functioning, rather than distinguishing among relations with family, with friends, and with strangers or acquaintances, for instance. In addition, the ranges of item ratings for many of these scales are restricted, as are those for many clinician rating systems; this restriction creates artificially low relationships with other measures of impairment in those domains. Moreover, little if any information is available on just how valid the individual domain ratings are in capturing actual impairment in each domain, as judged by other methods or sources for evaluating that domain. For instance, do those who rate themselves as impaired in work actually have other evidence for such impairment that correlates with this domain rating? Showing that ratings of impairment are distinct from ratings of psychopathological symptoms, as many of these scales have done, is fine as one source of evidence for the validity of impairment as a distinct construct from psychopathology. But it is not sufficient evidence of construct, discriminant, or criterion validity. Furthermore, these scales, like the clinician rating methods, lack normative information on a nationally representative sample of adults that would permit some determination of the position of these self-ratings within the larger distribution of self-rated impairment in a general population sample. For this reason, these rating scales cannot be used in clinical practice or other settings for the evaluation of impairment in patients or for other purposes in which the issue of psychosocial impairment is exceptionally important.

Suggestions for Assessing Psychosocial Impairment

As suggested by the American Medical Association and others, the clinical assessment of psychosocial impairment in adults should typically include the following:

- An initial interview to determine the nature of the impairments, the major life domains in which they may be occurring, and the symptoms/disorders that may be giving rise to them.
- A careful history of the patient's symptoms, other concerns, medically relevant information, and prior evaluations for and treatments received for these same complaints.
- A determination of the developmental inappropriateness of the symptoms, relative to those reported by members of the general population.
- Establishing the age of onset and course of the impairments and relevant disorders to date.
- A physical exam, if functional impairment is thought to have arisen from a medical disorder.
- Psychological testing, if general cognitive ability, academic achievement, or specific neuropsychological abilities are believed to be affected and contributing to impairment in psychosocial functioning.
- Ruling in or out other treatable medical and psychiatric disorders that may be contributing to the clinical presentation, symptoms, and impairments that are concerns of the patient.
- Reviewing the available archival records related to particular domains of psychosocial impairment that may be of key importance to the purpose of the evaluation (work-related records, official driving records, official criminal records, educational transcripts or report cards, prior medical records related to disability determinations, prior medical and psychiatric evaluation and treatment records, military records, etc.).
- Corroborating the self-reports of psychosocial impairment (and symptoms) through the reports of others who know the patient well.
- *A determination of the degree of statistical deviance (abnormality) of the patient's self-reported impairment relative to that of the general population.*

This last source of information is not included in other guidelines for the evaluation of impairment or disability, but it is essential to establishing the position of the individual relative to the normal, average, or typical human (the average of the general population). After all, if impairment is to be judged in relation to the average person, as recommended by the ADA and as implied or explicit in various definitions of the term, then some means of comparing the individual's complaints about his/her psychosocial functioning to those given by the general population is indispensable to the determination of impairment.

An essential method for assessing most of these issues remains the clinical interview, of course. Behavior rating scales of psychiatric symptoms are also highly useful, but for initial screening for risk of disorders and for establishing the degree of developmental deviance (age-inappropriateness) of the patient's symptoms

when mental disorders are believed to be the source of the functional impairment. Psychological testing may be useful as well in establishing the extent of cognitive-behavioral impairment, should that be a possible source of the difficulties experienced at the higher level of psychosocial impairment. And, as the American Medical Association makes plain, a physical examination is often essential to establish the presence of medical disorders that may also be contributing to psychosocial impairment. Until now, well-normed rating scales of functional impairment in major psychosocial domains were not widely available to permit clinicians to do likewise for the major life activities that may be functionally impaired by these symptoms and related mental or medical disorders. The BFIS was developed to fill that void. The BFIS is also exceptionally convenient for evaluating change in psychosocial impairment resulting from various interventions, such as medications or efforts at rehabilitation. In addition, it can be used to evaluate possible pre- to post-injury changes in psychosocial impairment status.

The Seven Sources of Information

As emphasized in the various governmental and professional guidelines for evaluating impairment, no single source of information can serve as the sole basis or “gold standard” for making the final determination of the existence and degree of psychosocial impairment. Seven types or sources of information are frequently needed in making such a determination:

- Patient self-reports of symptoms and impairments
- Patient-reported history of symptoms and impairments
- Psychological testing, where necessary
- Physical (medical) examinations, as appropriate
- Archival (official) records (the “paper trail” of impairment)
- Population norms for comparison to the self-reported symptoms and impairments
- Reports of significant others who know the patient well

Again, these last two sources and types of information are rarely if ever mentioned in guidelines for conducting evaluations of disability; however, they can provide valuable information to which the information obtained from the other sources can be compared, and vice versa. Indeed, the determination of the extent to which self-reported impairment compares to that provided by a general population sample would seem to be essential for this determination, as noted above.

Triangulating the Sources

A clinician should then engage in a process of triangulating these sources of information against each other and against the clinician’s own training and experience in these matters, to arrive at a final determination of impairment. A useful metaphor for evaluating these different sources of information in arriving at a determination of impairment is the global positioning system (GPS) method. The GPS method triangulates one source of information about an individual’s position against two or

more other sources to arrive at a reasonably accurate report of the individual's geographical location on the planet. Likewise, a clinician should arrive at a patient's degree of impairment relative to that of the general population by comparing multiple sources of information about the patient against each other. Truth is an assembled thing, and this is certainly true in the area of impairment determination in clinical practice. Each source of information is judged against that provided by two others to gauge the integrity or validity of the initial source. And then this process is repeated across all seven of the domains listed above, so that all possible combinations of three-way comparisons are achieved. This process is more likely to lead the clinician to arrive at the most valid and reasonable approximation of reality—in this case, the individual's degree of psychosocial impairment.

Malingering

A major problem in disability or impairment determinations is the possibility of malingering. "Malingering" is defined in DSM-IV-TR as "the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs" (American Psychiatric Association, 2000, p. 739). There is a substantial literature on this issue that cannot be reviewed here (see Lovett, Gordon, & Lewandowski, 2009, for a more detailed discussion). Suffice to say that even the American Medical Association and Social Security Administration guidelines warn clinicians to evaluate the possibility that individuals are feigning the severity of their symptoms and impairments, usually for some personal gain.

There is no unequivocally guaranteed, foolproof means of detecting malingering. In the realm of psychological evaluations, one often sees "validity scales" included in such assessment methods as personality tests. In neuropsychology, "effort tests" may be given to trick a patient into believing that the test being given is one evaluating disability, when in fact it is being used to detect feigning. Whenever some obvious or external benefit is a possible result of the determination of impairment, clinicians should be alert to the possibility of malingering (Lovett et al., 2009). No single method of assessment can necessarily be free of the possibility of feigning or malingering, so no single approach can serve as a surefire means of detecting it. Probably the best means of detecting possible malingering is the method of triangulating sources of information against each other, discussed just above. When all possible combinations of three-way comparisons have been considered, a clinician can gain a more thorough perspective not only on the issue of impairment, but on the possibility of malingering. That is because it is rarely if ever possible for an individual to coordinate the data provided by all these sources so that they are consistent with and abet the scheme of misrepresentation.

Summary

This brief introduction to the nature and assessment of psychosocial impairment has argued for a distinction among the terms "symptom," "disorder," and "impair-

ment/disability,” so as to avoid confusion in readers’ thinking and in their evaluation of the literature on these topics. Symptoms can be considered as the physical, cognitive, and behavioral manifestations of a disorder. They often form patterns or syndromes as described in DSM-IV-TR. Disorders are dysfunctions in physical or psychological (mental) adaptations that result in reducing or diminishing individuals’ functional effectiveness in meeting the demands of daily life. Such ineffectiveness leads to harm. Impairment represents both this functional ineffectiveness in major domains of daily life activities *and* the harm resulting from it. Impairment is diminished functioning relative to that of the normal, average, or typical adult; it is *abnormal* in its degree, and thus must be judged relative to the “normal person” standard. Various guidelines exist for the determination of impairment, and various structured assessment tools have been developed for assisting with that determination (clinician ratings, patient self-ratings). But until now there has been little or no normative information available on the extent to which adults in the general population view themselves as being impaired in the major domains of life activities. Yet comparing an individual to this general population would seem to be an indispensable part of the larger process of assessing the individual’s impairment. The BFIS was developed to address that void.

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