

Assessment of Functional Impairment in Spanish Children

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Le present travaux vérifie l'applicabilité et la validité du CAFAS, un instrument pour évaluer l'incapacité fonctionnel dans une population espagnole. L'échantillon est formé par 441 malades ambulatoires psychiatriques d'entre 8 et 17 années et leurs parents, et aussi par un échantillon de 74 malades ambulatoires pédiatriques. On a applique différents instruments pour évaluer l'incapacité fonctionnel, la psychopathologie, et autres variables psychologiques. La fiabilité intra observateur varie entre modérée et bonne. L'accord entre les ponctuations obtenues avec l'information des parents et des enfants varie entre faible et modérée. Les corrélations avec autres mesures d'incapacité et du fonctionnement sont significatives mais modérée. Les ponctuations CAFAS différencient significativement les enfants avec et sans psychopathologie. Les résultats obtenus avalisent l'utilisation du CAFAS pour les études en psychopathologie, en incapacité fonctionnel et pour planifier interventions et services de santé mental.

The present work tests the applicability and validity of the CAFAS, an instrument for assessing functional impairment, in the Spanish population. The sample included 441 psychiatric outpatients from 8 to 17 years old and their parents, and a pediatric group of 74 outpatients. Different instruments for assessing functional impairment, psychopathology, and other related variables were used. Interrater reliability ranged from moderate to very good. Weak-to-moderate agreement between CAFAS scores based on information from parents and children was obtained. Correlations with other measures of impairment and functioning were moderate. CAFAS scores differentiated significantly between children with and without psychopathology. These results permit the use of the instrument for studies on psychopathology and functional impairment, and for planning intervention and mental health services.

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INTRODUCTION

Functional impairment refers to the consequences or impact that psychological symptoms or disorders have on the life of the child with respect to performance of everyday functions (Üstun & Chatterji, 1997). Measures of functional impairment are useful for studies of treatment effectiveness, planning services, service eligibility determination, evaluating and planning of programs, or as an aid in case definitions in epidemiological studies and in nosology. But, mainly, they are used as outcome indicators.

Available instruments of level of functioning could be classified either as one-dimensional or multidimensional. The former conceive functional impairment as one construct, synthesising in a single score the amount of impairment that the psychological symptoms cause to the child. The Children's Global Assessment Scale (CGAS; Shaffer, Gould, Brasic, Ambrosini, Fisher, Bird, & Aluwahlia, 1983), which is completed by the clinician after clinical examination, and the Columbia Impairment Scale (CIS; Bird, Shaffer, Fisher, Gould, Staghezza, Chen, & Hoven, 1993), which is answered by parents or children, are examples.

On the other hand, multidimensional measures differentiate areas of functional impairment. The Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1995b) has eight scales that reflect different areas of functioning (see below). With the extensive information obtained after clinical examination, clinicians are required to rate the most unfavorable functioning in each area during the period assessed, taking into account the child's age, sex, and social class, as well as the norms for the community in which the child is living. Age of application is from 7 to 17 years old. CAFAS has shown moderate internal consistency and good test-retest and interrater reliability (Hodges, 1997). Reference made by the items to specific observable behaviors in each area of functioning supports content validity. CAFAS total score significantly predicted more restrictive care, higher cost of services required, more bed days, subsequent service utilisation, contacts with the law, and poor school attendance (Hodges, Doucette-Gates, & Liao, 1999; Hodges & Kim, 2000). Concurrent-criterion validity was studied by differentiating groups of children in diverse treatment modalities. Higher scores on CAFAS were obtained by inpatients or children in residential treatment than by outpatients (Hodges, 1997). Some of the limitations of CAFAS are that the scales have not been empirically derived and that, in many cases, the descriptors provided are linked to symptomatology rather than to the functional consequences of symptomatology on adaptation and functioning.

In the Spanish context there is a lack of multidimensional measures of level of functioning for children and adolescents. The multidimensional structure of the CAFAS and its relative ease of use made it a very helpful

instrument for clinical practice and for research. On this basis, the present study was designed to test the applicability and validity of the CAFAS in mental health assessment of Spanish children and adolescents.

METHODS

Sample

The sample included 515 children and adolescents from 8 to 17 years old. In the psychiatric group, there were 441 (86%) successive outpatient children with a mean age of 13.3 years ($SD = 2.4$), admitted to three primary mental health services for children and adolescents from the public network from within an urban community in the area of Barcelona (Spain). Fifty-six per cent ($n = 246$) were boys. Socioeconomic Index (Hollingshead, 1975) distribution was: 1 per cent high; 10 per cent high-mean; 15 per cent mean; 43 per cent mean-low, and 30 per cent low. Ninety-five per cent of the children in this group had some form of psychopathological syndrome and 84 per cent had two or more diagnoses. Assessment was part of ordinary diagnostic procedure.

The pediatric group used for criterion validity comparisons comprised 74 (22%) outpatient children from the public network with a mean age of 11.9 years ($SD = 2.5$). They were treated for minor physical problems and did not suffer any chronic disease. Fifty-one per cent ($n = 38$) were boys. Socioeconomic index was: 3 per cent high; 4 per cent high-mean; 7 per cent mean; 32 per cent mean-low, and 54 per cent low. Forty-six per cent of the children in this group had some psychological disorder, as the parents of subjects who tend to participate (rate of participation was 65 per cent) in these studies do so because they suspect the existence of problems.

Measures

Diagnostic Interview for Children and Adolescents-IV (DICA-IV). The diagnostic status of the children was established with the semi-structured Diagnostic Interview for Children and Adolescents-IV (DICA-IV; Reich, Leacock, & Shanfeld, 1997). It covers the most frequent diagnostic categories in children and adolescents, following DSM-IV definitions. The DICA has been adapted and validated for the Spanish population (de la Osa, Ezpeleta, Doménech, Navarro, & Losilla, 1997; Ezpeleta, de la Osa, Júdez, Doménech, Navarro, & Losilla, 1997). Diagnoses combined the information from parents and children: the symptom was present if the parent or the child reported it.

Items within the conduct disorder section of the interview pertaining to difficulties in functioning that were not included in the diagnostic algorithm

(i.e. number of contacts with police, school suspensions) were checked against CAFAS scores for concurrent validity.

Child and Adolescent Functioning Assessment Scale (CAFAS). The CAFAS, described above, records the extent to which a young person's mental health disorder is disruptive of functioning in each of eight psychosocial areas, reported by children and/or parent (Hodges, 1995a): *Role performance* indicates how well the child accomplishes relevant roles at *Schoolwork*, at *Home*, and in the *Community*. *Behavior toward others* reflects the adequacy of the child's behavior toward other people. *Mood/Self-harm* displays difficulties in mood modulation (*Mood/lethargy*) or the presence of *Self-harmful behavior*. *Substance use* records the degree of maladaptive drug and alcohol consumption. *Thinking* registers problems in cognitive processes. Each scale is scored in 4 levels of impairment: 0, indicating no impairment (or minimum); 10, denoting mild problems or distress; 20, moderate impairment, and 30, severe impairment. For each severity level, multiple items (behavioral descriptions) are given and the rater selects those items that describe the child's most severe level of functioning. Scale scores are generated with the highest registered level of severity. The scale can be rated in about 10 minutes. Scale scores can be entered on the CAFAS profile to obtain a graphic representation of the child's level of functioning across the eight scales that identify the areas in which the subject is most impaired.

The CAFAS was translated from English into Spanish by the first author. A committee of three bilingual clinical psychologists then checked the author's translation for accuracy and meaning and formed a consensus view on the wording of each item. This version of the scales was then reviewed by a Spanish philologist to ensure that the grammar and meaning were correct. This Spanish version is available from the author (hodges@provide.net).

Columbia Impairment Scale (CIS). The CIS (Bird et al., 1993) was used for studying concurrent validity. Having 13 items, the CIS evaluates impairment in interpersonal relations, areas of psychopathology, school or work, and the use of leisure time, over the six previous months. The scale has proved to have high internal consistency and test-retest reliability, as well as good criterion validity with other measures of impairment. Factor analyses did not confirm the four areas of functioning, and a unique factor emerged (Bird et al., 1993). The Spanish translation provided by the author (H.R. Bird) was used. The CIS was answered by parents and children in an interview format with the aim of avoiding missing data. The CIS codifications were not affected by clinical judgment, as the interviewers directly registered the answers provided by parents or children. CIS original response alternatives were changed to three categories. For studying concurrent validity more in depth, the unifactorial score plus the scores of the four areas were used.

Child Behavior Checklists (CBCL). The CBCL (Achenbach, 1991), adapted and studied in the Spanish population (Sardiner, Pedreira, & Muñiz, 1997), was used as an additional measure of psychopathology. CBCL has 113 items containing different behavioral and emotional problems.

Self-Perceived Role Competence (S-PRC). The S-PRC (Beiser, Lancee, Gotowiec, Sack, & Redshirt, 1993) evaluates self-perceived academic and social competence on two scales: instrumental competence (13 items) and social competence (12 items for parents' version and 9 for children's version). In the original sample, the questionnaire has demonstrated satisfactory reliability and inter-informant agreement. Higher scores correspond to better competence.

Other variables related with functioning were used for concurrent validity: relationships with teachers and friends (0: much better than others to 5: much worse than others), and information on school grades (1: almost all As to 9: almost all failures). No clinical judgment was applied in these questions, as the information was recorded directly as provided by parents and children.

Procedure

After obtaining informed written consent from parents and oral assent to participate in the study from children, different interviewers simultaneously interviewed the children and the parents. Clinical information to assess CAFAS lifetime functional impairment was obtained from the DICA-IV. Instructions were given to rate impairment due to psychopathology (symptoms identified in DICA-IV). After the interviews, parents and children answered the paper-format questionnaires. The interviewer assessing the child was unaware of the information provided by the parent, and vice versa.

Interviewers were trained in the use of all the assessment instruments (DICA, CAFAS). All the raters have a clinical background and knowledge of child development and psychopathology. The CAFAS raters were trained following Hodges' specifications (Hodges, 1995, 1997). After working jointly on the demonstration vignettes of the training manual, the raters had to complete 10 reliability vignettes in a self-administered format. The criterion for satisfactory reliability was a quadratic weighted kappa or intra-class correlation coefficient of .80 or higher. Inter-interviewer reliability for the present study was calculated on a random sample of 20 referred subjects pertaining to the study (10 parents and 10 children). The ratings given by the two clinical child psychologists were used as the criterion for comparing ratings from the different interviewers observing the interviews. Except for inter-interviewer agreement, CAFAS information on parents and children was analysed separately.

Statistical Analysis

SPSS version 12.0 for Windows was used for statistical analyses. Inter-interviewer and parent-child agreement was calculated through absolute agreement intraclass correlation coefficient (ICC) for quantitative scales, with its equivalent quadratic weighted kappa coefficients being used for categorical scales (Fleiss & Cohen, 1973).

Spearman's correlation was used to analyse the relationships between CAFAS scales, the CIS, S-PRC, and information about relationships with teachers and friends and school grades. To avoid circularity of information, the ratings of CAFAS derived from the parent's diagnostic interview were related with independent information provided by the child about relations with professors, peers, contact with police, grades, and suspensions. Similarly, the ratings of CAFAS derived from the children's diagnostic interview were related with the parents' report on these variables. S-PRC questionnaires were related with the CAFAS of the same informant and parents' CBCL was correlated with CAFAS of parents and children.

To study criterion validity, differences between the means of functional impairment in each of the psychopathological groups were calculated through multiple regression models in order to adjust them by sex, age, and socioeconomic status. An individual analysis was done for each criterion and information from parents and children was treated separately.

RESULTS

The means for the CAFAS total score in the psychiatric group (child: 44.8, SD: 31.1; parent: 51.6, SD: 27.6) were higher ($p < .0005$) than those of the pediatric group (child: 7.3, SD: 12.4; parent: 7.2, SD: 12.4). Additionally, in the psychiatric group, though not in the pediatric group, the means derived from parents' information were higher than those derived from children (difference = 6.6, 95% CI = 4.0 to 9.2). Around 56 per cent of the psychiatric children and none of the pediatric children had scores reflecting total moderate or high impairment. There were no significant differences between boys and girls in the total impairment score for any of the groups (psychiatric or pediatric). However, the linear association chi-square test showed that, according to child information, boys tended to present significantly more impairment in school ($p < .0005$), at home ($p < .01$), and in the community ($p < .01$), and girls in mood/emotion ($p < .0005$), self-harm ($p < .0005$), substances ($p < .01$), and thinking ($p < .03$). Parents' information produced higher scores in incapacity in the school ($p < .0005$) for boys, and in mood/emotion ($p < .0005$) and self-harm ($p < .0005$) for girls. There were small differences in age in the psychiatric group. For every year older, functional impairment scores increase 3.1 points (95% CI = 2.0 to 4.1) according to

TABLE 1
Reliability of CAFAS

<i>CAFAS subscales</i>	<i>Inter-interviewer (N = 20) kappa (95% CI)</i>	<i>Parent-child (N = 441) kappa (95% CI)</i>
Role performance		
School/Work	.81 (.65 to .97)	.54 (.48 to .60)
Home	.86 (.73 to .98)	.44 (.36 to .52)
Community	.73 (.57 to .88)	.43 (.28 to .57)
Behavior toward others	.45 (.22 to .68)	.40 (.31 to .49)
Mood/Self-harm		
Mood/emotion	.80 (.63 to .98)	.50 (.42 to .57)
Self-harmful behavior	.94 (.88 to 1)	.51 (.44 to .57)
Substance use	.64 (.01 to 1)	.48 (.35 to .61)
Thinking	.81 (.48 to 1)	.40 (.24 to .57)
	ICC (95% CI)	ICC (95% CI)
Total based on 8 scales	.80 (.51 to .92)	.54 (.46 to .61)

Note: kappa: Quadratic weighted kappa; ICC: Intraclass correlation coefficients.

parents' information and 5.6 (95% CI = 4.5 to 6.7) according to children's information, indicating that the older the age, the higher the impairment scores. Total functional impairment scores in both the psychiatric and pediatric groups were higher for children of lower socioeconomic status, but the Jonckheere-Terpstra non-parametric trend test showed no significant differences.

Quadratic weighted kappa coefficients for inter-interviewer agreement in a randomly selected group of 20 subjects taken from the psychiatric sample ranged from good to very good (.79 to .94), except for behavior towards others (.45) and for substance use (.64) (Table 1). The intraclass correlation coefficient for quantitative scales was good. In general, the inter-interviewer reliability was good and there was concordance in the way the CAFAS was coded by raters involved in the study.

The analysis of the agreement between the information provided by parents and by children for rating the CAFAS showed moderate concordance (Table 1), indicating that both sources are necessary for assessing the functional incapacity. Kappa coefficients ranged from .40 (Thinking) to .54 (School). For the total score, the ICC coefficient was also moderate.

Table 2 synthesises the concurrent validity of the CAFAS with the CIS, separately for parents and children. The correlations were significant but low. CAFAS scales correlated in the expected direction with CIS subscales. As anticipated, School/Work obtained high relations with CIS-School/Work (this was the highest relationship), Home with CIS-Relationships, Behavior toward Others with CIS-Relationships, Mood Scales and Substance

TABLE 2
Concurrent Validity of CAFAS with CIS

CAFAS ¹	CIS									
	Total		Relationships		Psychopathology		School/Work		Leisure	
	r	(95% CI)	r	(95% CI)	r	(95% CI)	r	(95% CI)	r	(95% CI)
<i>N</i>	427 (430)									
School/Work ²	.38***	.30***	.18***	.14**	.18***	.17***	.65***	.47***	.10*	-.01
Home ²	.46***	.37***	.42***	.26***	.38***	.26***	.37***	.26***	.07	.01
Community ²	.29***	.24***	.25***	.07	.26***	.19***	.26***	.27***	.09	.01
Behavior toward others ²	.45***	.33***	.41***	.24***	.34***	.27***	.24***	.31***	.31***	.14**
Mood/emotion ²	.10*	.32***	.01	.21***	.31***	.41***	-.19***	-.08	.15**	.29***
Self-harmful behavior ²	.05	.23***	.06	.16***	.17***	.26***	-.17***	-.02	.04	.19***
Substance use ²	.20***	.27***	.18***	.14**	.19***	.21***	.13**	.09	.09	-.04
Thinking ²	.01	.14***	.01	.10*	.08	.16***	-.05	-.09	.03	.19***
Total based on 8 scales ³	.54***	.55***	.38***	.33***	.51***	.47***	.42***	.32***	.24***	.20***

¹ Normal font: parent data; *italic*: children data; ² Spearman correlations; ³ Pearson correlations; All confidence intervals of *r* are available from first author.

* $p < .05$; ** $p < .01$; *** $p < .001$.

Use with CIS-Psychopathology, and total score with CIS-Total scores. Thinking attained few significant correlations when the child was the informant. Parents' information tended to obtain higher correlations in school, home, community, and behavior towards others and children in mood scales, substance, and thinking.

Table 3 presents the main correlations between CAFAS scales and other variables possibly related with functioning. Correlations ranged from low to moderate. Higher correlations were found between the variables and the theoretically most-related CAFAS scale. High scores in schoolwork (difficulties in functioning at school) were associated with low instrumental competence, high externalising CBCL scores, difficulties in relationships with teachers, suspensions, and lower grades. Bad functioning at home was correlated with externalising problems and other measures of general psychopathology (CBCL total and number of diagnoses). Negative behavior that has an impact on others (community) was associated with greater contacts with the police, externalising behavioral problems, and suspensions, while impairment in behavior towards others was related with lower social competence, difficulties in peer and teacher's relationships, and higher psychopathology. Mood scales (mood/emotion and self-harm behavior) correlated highly with the number of diagnoses in DICA-IV and internalising CBCL scores. These scales attained more significant relationships when the functional impairment was rated from children information. Substance abuse correlated significantly with contacts with police, grades, bad relationships with teachers, and CBCL externalising. The correlations of thinking were the lowest and were obtained in psychopathology scales. The CAFAS total score was significantly related to all the variables (the exception was relationships with peers from parent's CAFAS).

Table 4 displays the criterion validity of CAFAS calculated for different models of psychopathology. Total scores on CAFAS, with information from either the children or parents, were significant differentiators of healthy and psychopathological children: those with psychological disorders in the diagnostic interview had higher impairment scores. Mean total CAFAS scores based on parents' information ranged from 23 to 36 for psychopathological and healthy children, and from 18 to 35 for scores based on children's information. Furthermore, the data indicate that the total CAFAS score increases about 9 or 10 points for every disorder present in the child.

DISCUSSION

The results of the study indicate that CAFAS works well in referred Spanish samples and is a valuable measure of functioning for clinical and research uses.

TABLE 3
Relationships of CAFAS Scales with Different Indicators of Functioning and Psychopathology (Spearman Correlations)

Indicators of functioning and psychopathology	CAFAS ¹																	
	Role performance						Mood/Self-harm											
	School/Work	Home	Community	Behavior toward others	Mood/emotion	Self-harm behavior	Substance use	Thinking	Total									
S-PRC Competence																		
Social	-.11*	-.03	-.08	.01	.16**	.06	-.26***	-.14*	-.06	-.17**	.01	-.10	-.06	-.001	-.06	-.12*	-.21***	-.13*
Instrumental	-.49***	-.34***	-.28***	-.16**	-.18***	-.15**	-.21***	-.19***	.09	.14*	.07	-.07	-.07	-.14*	.01	-.08	-.36***	-.32***
Relationships with professors	.33***	.32***	.23***	.24***	.18***	.24***	.13**	.16***	-.03	-.13**	-.07	-.03	.17***	.09*	-.06	-.01	.26***	.22***
Relationships with peers	-.05	.04	-.13**	.05	-.10*	.004	.05	.22***	.17***	.09	.10*	-.02	.10*	-.01	.01	.10*	.05	.11*
Contact with police	.17***	.20***	.24***	.18***	.35***	.37***	.20***	.21***	-.01	-.09	.004	.01	.26***	.24***	.01	-.03	.25***	.21***
Grades	.46***	.47***	.15**	.21***	.13**	.18***	.11*	.14**	-.12*	-.18***	-.03	-.15**	.12*	.11*	-.003	.04	.28***	.22***
Suspensions	.31***	.33***	.19**	.17***	.34***	.32***	.19***	.17***	-.06	-.18***	-.05	.01	.10*	.16**	.00	-.03	.27***	.18**
Psychopathology CBCL parent																		
Internalising-T	.07	.11	.09	.11	.09	.07	.15**		.36***	.28***	.16**	.06	.10	.07	.20***	.09	.33***	.26***
Externalising-T	.30***	.37***	.35***	.45***	.35***	.28***	.34***	.32***	-.04	-.14*	.04	.05	.15**	.17**	.08	-.03	.47***	.34***
Total-T	.28***	.33***	.30***	.35***	.30***	.24***	.34***	.35***	.11	.02	.07	.01	.14	.11*	.16***	.03	.49***	.35***
Number of diagnoses	.18***	.16	.28***	.29***	.19***	.16***	.28***	.21***	.34***	.54***	.12*	.29***	.06	.31***	.11*	.22***	.44***	.53***

¹ Normal font: parent data, $n = 438$; *Italic*: children data, $n = 440$. Significance: * $p < .05$; ** $p < .01$; *** $p < .001$. All confidence intervals of r are available from first author.

TABLE 4
 Criterion Validity of CAFAS Total Score in Different Psychopathological Groups

<i>Disorders</i>		N	<i>Total CAFAS based on 8 scales*</i>	
			<i>Difference of means*</i>	<i>95% CI</i>
Disruptive vs. healthy	Parent	222/110	36.5	30.9 to 42.1
	Children	146/172	35.4	29.5 to 41.4
Mood vs. healthy	Parent	81/110	36.0	28.8 to 43.2
	Children	73/172	33.3	25.9 to 40.8
Anxiety vs. healthy	Parent	113/110	28.0	21.9 to 34.0
	Children	84/172	27.3	21.2 to 33.4
Eating vs. healthy	Parent	20/110	37.0	25.9 to 48.2
	Children	20/172	18.3	7.5 to 28.8
Elimination vs. healthy	Parent	59/110	23.2	16.1 to 30.4
	Children	29/172	24.9	22.5 to 36.2
Psychopathology vs. healthy	Parent	244/110	27.3	21.8 to 32.9
	Children	189/172	24.4	19.2 to 29.5
Number of disorders ¹	Parent	438	8.8	7.6 to 10.1
	Children	440	10.3	8.8 to 11.7

(*) Models adjusted by sex, age, and socioeconomic status.

¹ Mean increment for each disorder (adjusted by sex, age, and socioeconomic status).

The mean level of impairment in the psychiatric sample was moderate relative to outpatients who typically show lower levels of psychopathology. There were no differences in total impairment by gender, but higher impairment was associated with higher ages and lower socioeconomic status. Boys and girls did differ in the areas of incapacity identified. Girls were more impaired in the scales assessing psychopathology (mood, substances, and thinking), and boys in the scales related to overt behaviors (school, home, community).

Inter-interviewer agreement was good but needs to be assessed in the light of this being a small sample ($N = 20$) as confidence intervals for the kappa and ICC values are widely spaced. The scales with the lowest concordance, though in the moderate range, were in behavior toward others and substance use. Difficulties for coding in behavior towards others, which indicates the need to work more thoroughly on this area in training, and low prevalence in substance use, could explain these results. Using global measures of functional impairment (CGAS) in Spanish samples, inter-rater reliability was good (Ezpeleta, Granero, & de la Osa, 1999). Our results are in agreement with previous reports that have found that holistic strategies (CGAS) obtain higher agreement than decomposed ones (CAFAS) (Voskuij & Sliedregt, 2002). Goals for assessment of functional impairment should help to decide what the best strategy is. If the goal is to decide if a child needs intervention or not, a global strategy could be used, but if the objective is to plan the

areas of intervention, then a decomposed instrument, such as the CAFAS, could be more appropriate.

According to information provided from parents and children in the diagnostic interviews, the level of impairment rated shows agreement at a moderate level. The same happened with global measures (CGAS) in a Spanish sample (Ezpeleta et al., 1999). This is not an inconsistent result because, in child and adolescent psychopathology studies, parent-child disagreement is more the rule than the exception (Jensen, Rubio-Stipec, Canino, Bird, Dulcan, Schwab-Stone, & Lahey, 1999). Contrary to what has been observed when using diagnostic interviews, where children report more psychopathology than parents do (Rubio-Stipec, Canino, Shrout, Dulcan, Freeman, & Bravo, 1994), the impairment mean reported by parents in the current study was higher than that reported by children. That is, although children report more symptoms than those reported by their parents, the symptoms perceived by parents are considered to be more severe and more disruptive of daily life.

Measures of impairment are significantly related at a moderate level. When scales tended to reflect "global" indicators of functioning (CAFAS total and CIS-total) higher and consistent correlations (parent and children) were attained. For those scales measuring specific incapacities in unrelated areas (i.e. School/work and CIS-relationships), the correlations were low; when the scales assessed similar areas, however, the correlations were acceptable (i.e. School/work and CIS-school work). Notwithstanding this, even when a good relationship was foreseen, the correlations were not impressively high. Two important factors may help to explain how this low association refers to the nature of the informant and the rater. First, CAFAS is filled in by the interviewer/clinician after the clinical assessment or diagnostic interview. However, the CIS is completed by the parents or children without the "filter" of the clinician. And second, when interpreting these correlational results, it is important to bear in mind that different procedures are used in the CAFAS and CIS. CAFAS proposes specific problematic behaviors grouped in specific areas, according to the level of impairment that is indicative of bad functioning. On the other hand, CIS presents 13 difficulties in functioning in a self-report or questionnaire format.

CAFAS scores in the studied sample have proven concurrent validity, since children who received high scores on the CAFAS scales also had a greater number of problems in other indicators of bad functioning such as instrumental competence, more psychopathology, poor interpersonal relationships with peers and teachers, a negative attitude towards school, and difficulties with legal authorities.

The correlations with measures of psychopathology (CBCL and number of diagnoses) were also moderate. Different studies have demonstrated that psychopathology and impairment are not the same constructs (Angold, Costello, Farmer, Burns, & Erkanli, 1999; Ezpeleta, Keeler, Erkanli, Costello,

& Angold, 2001; Hodges & Kim, 2000; Pickles, Rowe, Simonoff, Foley, Rutter, & Silberg, 2001); therefore, although they are expected to be closely related, the correlation is not perfect. The number of symptoms or their severity is not equivalent to level of impairment or degree of dysfunction (Hodges et al., 1999). A child could have two or more symptoms, such as wetting the bed or having a tic, which may cause no incapacity.

In the translation of the instrument to other languages, the most important efforts in adaptation must be focused on matching the system of mental health care, justice, and education of the new culture with the levels of functioning defined in the CAFAS. This primarily affects the community scale and, to a lesser extent, the school scale.

The results of this paper provide needed information related to multi-dimensional functional impairment instruments for children and adolescents in Spain. CAFAS could be a helpful instrument for planning intervention and following its effectiveness, and for planning and organising mental health services. The adequate properties of the instrument permit its use for studies on psychopathology and functional impairment.

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