

<b>Outcome Measure</b>	<b>Awareness Questionnaire (AQ)</b>
<b>Sensitivity to Change?</b>	Yes
<b>Population</b>	Adult
<b>Domain</b>	Measures of Self
<b>Type of Measure</b>	Self-report /significant other discrepancy score
<b>ICF-Code/s</b>	b1, b2
<b>Description</b>	<p>The AQ is a rating scale, using clinician, informant and/or self-ratings to measures patient's awareness of functioning in physical, cognitive, and behavioural domains as well as functioning in community activities.</p> <p>The AQ is 17-item scale, with three statistically derived subscales: Motor-sensory (4 items), Cognition (7 items), and Behavioral/affective (6 items). It can be used in a number of ways to measure awareness, but the most common method is to use (at least) two sources of information. Raters indicate how well the patient can perform in various areas at the time the questionnaire is completed, compared with how well the patient could perform before being injured. The discrepancy between the patient's self-report and that of the informant/clinician is calculated and that score represents the measure of awareness on the AQ.</p> <p>Administration time is approximately 10 minutes.</p> <p>Items are rated on a 5-point scale: 1 (much worse [than before the injury]), 2 (a little worse), 3 (about the same), 4 (a little better), 5 (much better) Raw scores can range from 17 to 85, with a score of 51 indicating that the patient is rated as functioning at a level "about the same" as his/her preinjury level.</p> <p>Discrepancy scores are obtained by subtracting the informant's score from the self-rating score and range from -68 to +68. Higher positive discrepancy scores indicate greater impairment of self-awareness.</p>
<b>Properties</b>	<p>See Tate (2010) for full details.</p> <p><i>Internal consistency:</i> For total score for both Self &amp; Informant <math>\alpha = .88</math></p> <p><i>Inter-rater reliability:</i> No information available.</p> <p><i>Test-retest reliability:</i> No information available.</p> <p><i>Construct validity:</i> Factor analysis supports three components or subscales: cognitive, behavioural/affective and motor/sensory.</p> <p><i>Convergent/divergent validity:</i> Higher correlation with expected similar ratings:  Clinician vs Informant: <math>r = .44</math>  Clinicians vs DRS: <math>r = -.46</math>, vs FIM <math>r = .35</math>  Lower correlation with expected dissimilar ratings:  Self vs Clinicians: <math>r = -.06</math>, vs Informant: <math>r = .06</math>  Self vs DRS: <math>r = .13</math>, vs FIM: <math>r = -.08</math></p> <p><i>Sensitivity/responsivity:</i> Able to detect changes (reduced AQ discrepancy</p>

	score) in the context of an awareness intervention (Schmidt, Fleming, Ownsworth & Lannin, 2013) and recovery/development of awareness between the acute recovery phase and 12 months follow-up
<b>Advantages</b>	Brevity (only 17 items) Strong psychometric properties <sub>7</sub> Well established use in TBI – inpatients, outpatients and community AQ is in the public domain via the COMBI site AQ can also indicate heightened awareness of deficits (unlike SADI) – as supported by cluster analysis study (Ownsworth, Fleming et al. 2007)
<b>Disadvantages</b>	Reliance on collateral ratings and the usual issues affecting their reliability (relative/clinician), no test-retest reliability
<b>Additional Information</b>	Unlike other awareness scales (except SADI), the AQ requires comparison between pre-injury and post-injury abilities (thus people can indicate that they are worse or better relative to their own functioning). Note: clinicians are usually unfamiliar with people’s pre-injury functioning.
<b>Reviewers</b>	Tamara Ownsworth

### References

For all references:

Tate, R. L. (2010) *A compendium of tests, scales, and questionnaires: The practitioners guide to measuring outcomes after acquired brain impairment*. Psychology Press.