Conners' Adult ADHD Rating Scales–Observer Report: Long Version (CAARS–O:L)

By C. Keith Conners, Ph.D., Drew Erhardt, Ph.D., and Elizabeth Sparrow, Ph.D.

Interpretive Report

Client Name:	**John Sample**
Age:	30
Gender:	Male
Observer's Name:	Jane Sample
Observer's Relation:	Spouse
Observer's Age:	28
Observer's Gender:	Female
Duration:	N/A - QuikEntry
Administration Date:	December 21, 2004

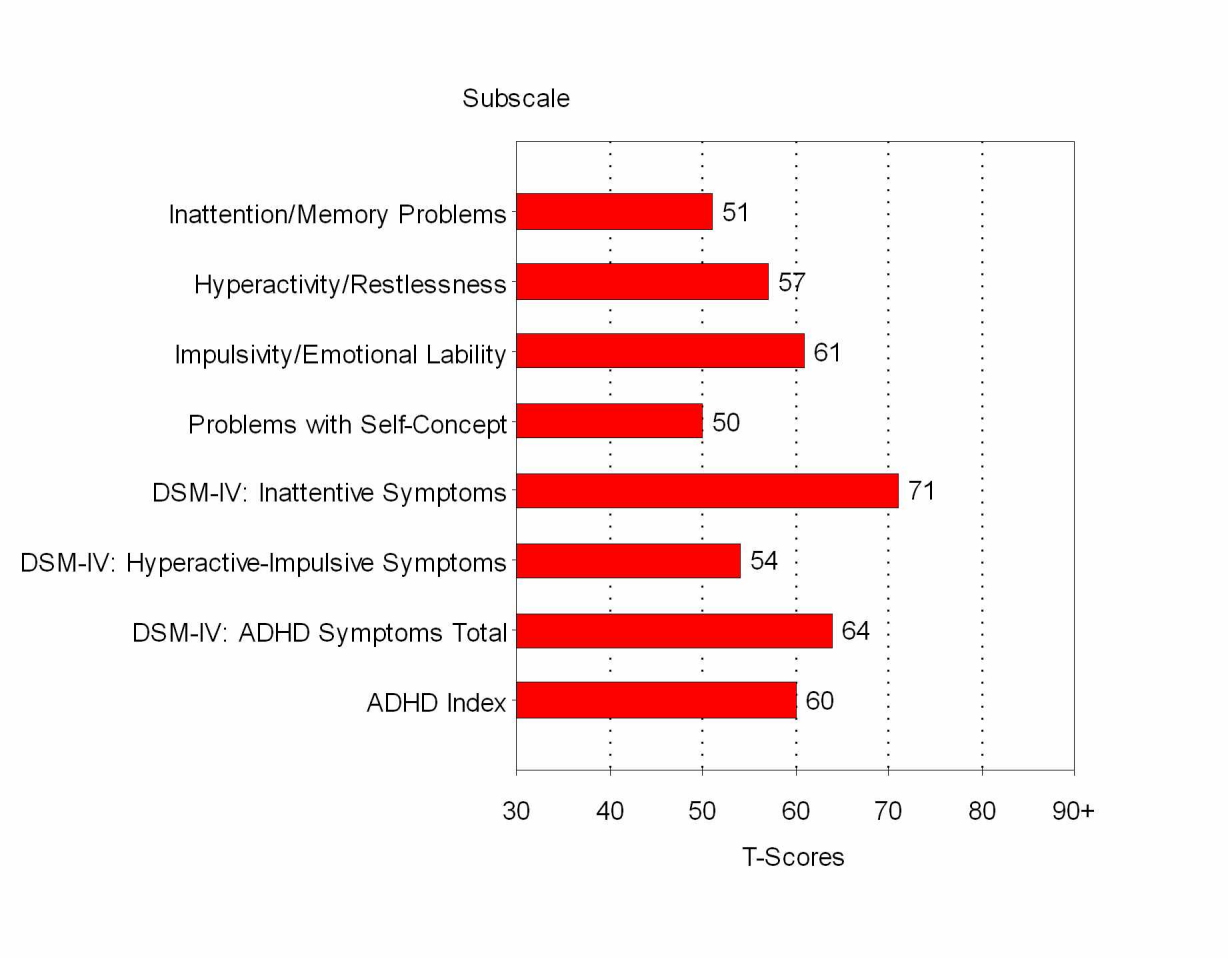
Introduction

Conners' Adult ADHD Rating Scales–Observer: Long Version (CAARS–O:L) is an assessment tool that prompts an observer to provide valuable information about the client. This instrument is helpful when considering a diagnosis of ADHD or related problem. The normative sample includes 943 adults. This report provides information about the adult's score, how he or she compares to other adults, and what subscales are elevated. See the Conner's Adult ADHD Rating Scales Technical Manual (published by MHS) for more information about the instrument.

This computerized report is an interpretive aid and should not be used as the sole basis for clinical diagnosis or intervention. These results are most useful when combined with other sources of relevant information. CAARS results are based on the individual's current functioning and thus cannot be used to establish the childhood onset of symptoms, which is necessary for diagnosis. The report is based on an algorithm that produces the most common interpretations for the scores that have been obtained. Test users should review the individual's responses to ensure that these generic interpretations apply. Highly idiosyncratic response patterns must be explored in other ways on a case-by-case basis.

CAARS–O:L Subscale T-Scores

The following graph provides T-scores for each of the CAARS–O:L subscales.



Summary of Subscale Scores

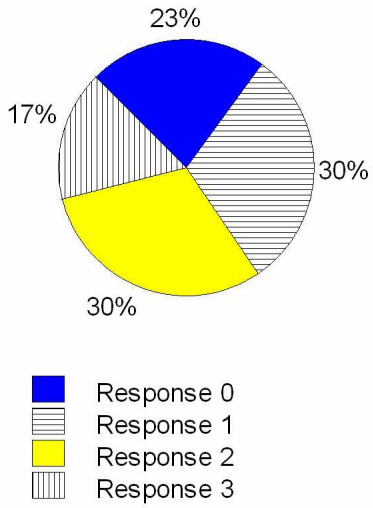
The following table summarizes John's subscale scores and gives general information about how he compares to the normative group. More interpretive data are provided later in this report.

Subscale	Raw Score	T-Score	Guideline	Common Characteristics of High Scorers
Inattention/Memory Problems	12	51	Average (typical score: should not raise concern)	Difficulties may include trouble concentrating, difficulty planning or completing tasks, forgetfulness, absent-mindedness, being disorganized.
Hyperactivity/Restlessness	17	57	Slightly atypical (borderline: should raise concern)	Difficulties may include problems with working at the same task for long periods of time, feeling more restless than others seems to be, fidgeting.
Impulsivity/Emotional Lability	19	61	Mildly atypical (possible significant problem)	Difficulties may include engaging in more impulsive acts than others do, low frustration tolerance, quick and frequent mood changes, feeling easily angered and irritated by people.
Problems with Self-Concept	5	50	Average (typical score: should not raise concern)	Difficulties may include poor social relationships, low self-esteem and self-confidence.
DSM-IV: Inattentive Symptoms	19	71	Markedly atypical (indicates significant problem)	Behave in a manner consistent with the Inattentive subtype of ADHD, described in the DSM-IV.
DSM-IV: Hyperactive-Impulsive Symptoms	10	54	Average (typical score: should not raise concern)	Behave in a manner consistent with the Hyperactive-Impulsive subtype of ADHD, described in the DSM-IV.
DSM-IV: ADHD Symptoms Total	29	64	Mildly atypical (possible significant problem)	Behave in a manner consistent with the DSM-IV diagnostic criteria for Combined type ADHD.
ADHD Index	16	60	Slightly atypical (borderline: should raise concern)	Identifies individuals 'at risk' for ADHD.

Item Response Table

The following response values were entered for the items on CAARS–O:L.

Item	Response	Item	Response
1.	**0**	35.	**2**
2.	**1**	36.	**0**
3.	**2**	37.	**1**
4.	**3**	38.	**0**
5.	**0**	39.	**1**
6.	**2**	40.	**2**
7.	**0**	41.	**3**
8.	**1**	42.	**2**
9.	**0**	43.	**1**
10.	**1**	44.	**0**
11.	**0**	45.	**1**
12.	**2**	46.	**2**
13.	**3**	47.	**3**
14.	**0**	48.	**2**
15.	**1**	49.	**1**
16.	**2**	50.	**0**
17.	**3**	51.	**1**
18.	**2**	52.	**2**
19.	**1**	53.	**3**
20.	**1**	54.	**2**
21.	**2**	55.	**1**
22.	**3**	56.	**0**
23.	**0**	57.	**1**
24.	**2**	58.	**2**
25.	**1**	59.	**3**
26.	**0**	60.	**2**
27.	**1**	61.	**1**
28.	**2**	62.	**0**
29.	**3**	63.	**1**
30.	**2**	64.	**2**
31.	**0**	65.	**3**
32.	**1**	66.	**1**
33.	**2**		
34.	**3**		

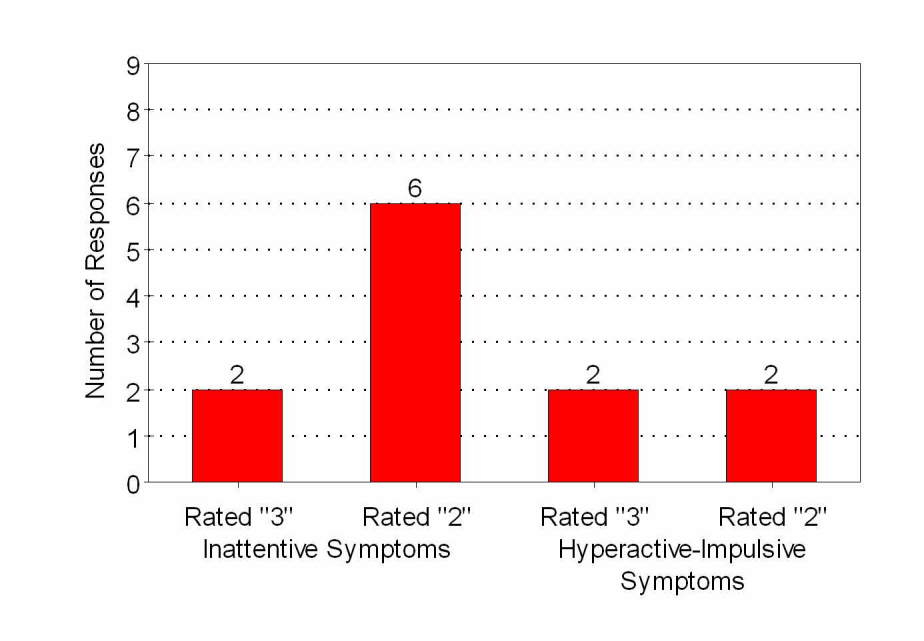


Response Key:

0 = Not at all, Never
1 = Just a little, Once in a while
2 = Pretty much, Often
3 = Very much, Very frequently

DSM-IV Subscales: Elevated Responses

The following graph shows the number of items for which the observer answered "Very Much, Very Frequently"(3) or "Pretty Much, Often" (2). These answers are grouped by DSM-IV subscale. The DSM-IV subscales are interpreted in more detail later in this report.



Validity Assessment

If the findings presented here conflict with other sources of information, then the reason(s) for the conflicting information should be considered and the results described in this report should be interpreted with these reasons in mind.

If these results conflict with other information, then it is possible that the observer is either exaggerating current problems, or problems were denied previously. It is also possible however, that the respondent's behavior and attitudes are situation specific. That is, behavior and attitudes at home may be quite different from behavior and attitudes away from home (e.g., at work). Use of the CAARS self-report form is recommended to help resolve any apparent inconsistencies.

An examination of the individual item responses reveals some possible inconsistencies. Quite different responses were given to items with similar content. If possible, discrepancies in the responses to items should be discussed with the observer. Some items may have been misunderstood, or perhaps the observer was unwilling or unable to give a clear picture of John's behavior and attitudes (e.g., due to lack of sufficient exposure to his behavior)

The following item pairs reveal inconsistent responses that should be explored further.

Item pairs with similar content	Response	Score Differential
11. 49.	0 1	1
40. 44.	2 0	2
13. 27.	3 1	2
30. 47.	2 3	1
19. 23.	1 0	1
6. 37.	2 1	1
26. 63.	0 1	1

Examination of Subscale Scores

ADHD Index: T-Score = 60

Slightly elevated. This index consists of the best set of items on CAARS for identifying adults "at risk" for ADHD. The observer report indicates that John's score on this index is somewhat higher than normal. However, unless other information also suggests an attention problem, the ADHD Index score is not high enough to justify serious concern.

Inattention/Memory Problems: T-Score = 51

About average. The score on the Inattention/Memory Problems subscale indicates that the observer doesn't perceive any persistent or severe impairment in the areas of learning and memory. John probably has satisfactory organizational skills and is likely to complete tasks or projects as expected most of the time. In addition, he is probably capable of sustained mental effort and can be attentive when required.

Hyperactivity/Restless: T-Score = 57

Slightly elevated. The score obtained on this subscale indicates that John is perceived as having some difficulty sitting still or remaining stationary for very long. Also, John is probably slightly more restless than most individuals.

Impulsivity/Emotional Lability: T-Score = 61

Mildly elevated. The Impulsivity/Emotional Lability subscale score indicating that John is perceived to be an individual who is somewhat prone to emotional responses/behaviors like getting upset or having temper outbursts. John is likely to engage in more impulsive acts, both verbally and behaviorally, than is typical of others. He is likely to have a relatively lower tolerance for frustration, a tendency for moodiness, and is easily angered or irritated.

Problems with Self Concept: T-Score = 50

About average. This score indicates that John is perceived as possessing self-confidence and probably feels comfortable in taking on new challenges.

Analysis of the DSM-IV Subscales

Inattentive Symptoms: T-Score = 71

The observer's report indicates that six or more symptoms of the Inattentive Subtype of ADHD could be present. The stringent requirement is that at least 6 items be rated "Very much, Very frequently" before suggesting a possible DSM-IV diagnosis. However, if you combine the fact that 2 of 9 items are rated "Very much, Very frequently," with the observation that 6 of 9 items are rated "Pretty much, Often" there does seem to be sufficient reason to explore the possibility that this individual meets the DSM-IV criteria for the Inattentive Subtype of ADHD.

Hyperactive-Impulsive Symptoms: T-Score = 54

Six or more symptoms of ADHD are required for the Hyperactive-Impulsive Subtype of ADHD to be present. The responses here indicate that this criterion has not been met. However, given that close to six symptoms could be present (i.e., 2 of 9 items are rated "Very much, Very frequently" and 2 of 9 items are rated "Pretty much, Often"), further investigation of the possible presence of the Hyperactive-Impulsive Subtype of ADHD is warranted.

Combined Type ADHD: T-Score = 64

Based on the observer's report, there is strong evidence for a diagnosis of the Inattentive Subtype of ADHD. The evidence for the Hyperactive-Impulsive Subtype is more moderate. Nonetheless, the possibility of the Combined Type of ADHD should be considered.

General Examination of the Profile

There are three substantial subscale elevations. One of these elevations is on a general index scale that is indicative of hyperactivity and/or attentional deficits (i.e., ADHD). The second elevation indicates a potential problem with inattentiveness. The third elevation indicates potential problems in one or more of the following areas: Hyperactivity, Impulsivity, Restlessness, Emotional Lability, and Self-Concept. The subscale descriptions given will provide additional pertinent information.

Integrating Results with Other Information, and (if required) Determine Intervention Strategy

The following subscale scores are elevated (T-Score > 60) and potentially could be cause for concern:

- Impulsivity/Emotional Lability
- DSM-IV: Inattentive Symptoms
- DSM-IV: ADHD Symptoms Total

These results must be incorporated with other information before drawing any conclusions. At a minimum, it is recommended that a comprehensive evaluation include

- A history of the pregnancy, delivery, and developmental milestones from infancy;
- A family history of psychiatric disorders;
- Assessment of specific symptoms, including onset, severity, frequency, chronicity, situational specificity, and duration;
- A functional assessment that covers school history, employment history, and work records;
- An overview of the individual's intrapsychic processes, including self-image and sense of efficacy with family, peers, and work;
- Current family interaction patterns and family structure;
- Screening for medical and psychiatric disorders and life circumstances that can lead to symptoms that mimic ADHD;
- An assessment of neurological status, when indicated by other evidence.

CAARS–O:L results interpreted without considering these other factors may have limited validity.

There are a large number of possible treatment approaches and the choice of which treatment is most appropriate can vary from case to case. The following resources are recommended for use in making treatment decisions:

Barkley, R. A. (1997). *ADHD and the nature of self-control*. New York: Guilford Press.

Barkley, R. A. (1998). *Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment* (2nd ed.). New York: Guilford Press.

Biederman, J. (Presenter), Spencer, T. (Presenter), & Wilens, T. (Presenter). (1997). *Medical management of attention deficit hyperactivity disorder* [Videotape Series]. Plantation, FL: Specialty Press.

Conners, C. K. (Ed.). (1996 --). *Journal of Attention Disorders*. Toronto, ON: Multi-Health Systems Inc.

Conners, C. K. & Jett, J. L. (1999). *Attention deficit hyperactivity disorder in adults and children: The latest assessment and treatment strategies*. Kansas City, MO: Compact Clinicals.

Dawson, P. & Guare, R. (1998). *Coaching the ADHD Student*. Toronto, ON: Multi-Health Systems Inc.

Hallowell, E. M. & Ratey, J. J. (1995). *Driven to distraction: Recognizing and coping with attention deficit disorder from childhood through to adulthood*. New York: Simon & Schuster.

Ingersoll, B. D. & Goldstein, S. (1993). *Attention deficit disorder and learning disabilities: Realities, myths and controversial treatments*. New York: Doubleday.

Additional information can be obtained by contacting this organization:

Children and Adults with Attention Deficit Disorders (C.H.A.D.D.)
National Office
499 NW 70th Avenue, Suite 109
Plantation, FL
USA 33317

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End of Report