



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:	45
Gender:	Male
Observer's Name:	Jane Sample
Observer's Relation:	Spouse
Observer's Age:	48
Observer's Gender:	Female
Duration:	2 minutes, 51 seconds
Administration Date:	April 14, 2022



Copyright © 2002 Multi-Health Systems Inc. All rights reserved.
P.O. Box 950, North Tonawanda, NY 14120-0950
3770 Victoria Park Ave., Toronto, ON M2H 3M6

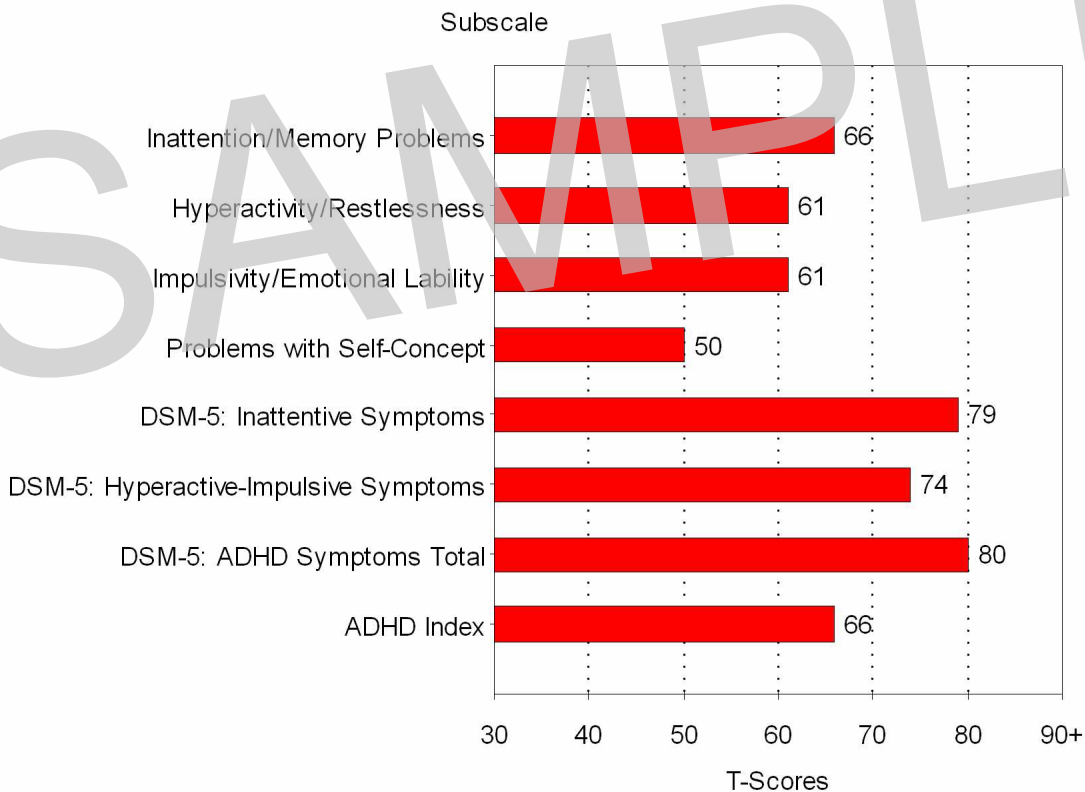
Introduction

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 Scores

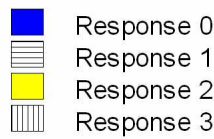
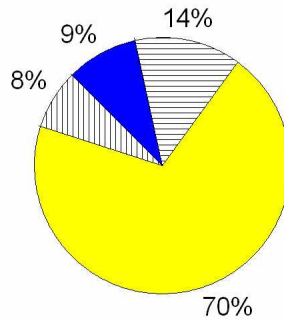
The following table summarizes John's scores and gives general information about how he compares to the normative group. More interpretive data are provided later in this report.

Measure	Raw Score	T-Score	Guideline	Common Characteristics of High Scorers
Inattention/Memory Problems	25	66	Moderately atypical (indicates significant problem).	Difficulties may include trouble concentrating, difficulty planning or completing tasks, forgetfulness, absent-mindedness, being disorganized.
Hyperactivity/Restlessness	18	61	Mildly atypical (possible significant problem).	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-5: Inattentive Symptoms	21	79	Markedly atypical (indicates significant problem).	Behave in a manner consistent with the Inattentive Presentation of ADHD, described in the DSM-5.
DSM-5: Hyperactive-Impulsive Symptoms	16	74	Markedly atypical (indicates significant problem).	Behave in a manner consistent with the Hyperactive-Impulsive Presentation of ADHD, described in the DSM-5.
DSM-5: ADHD Symptoms Total	37	80	Markedly atypical (indicates significant problem).	Behave in a manner consistent with the DSM-5 diagnostic criteria for Combined Presentation of ADHD.
ADHD Index	20	66	Moderately atypical (indicates significant problem).	Identifies individuals 'at risk' for ADHD.
Inconsistency Index	5	N/A	Probably valid.	High scores indicate that the participant may have been responding haphazardly, may have been unmotivated, and/or may have been trying to distort his or her results.

Item Response Table

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

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

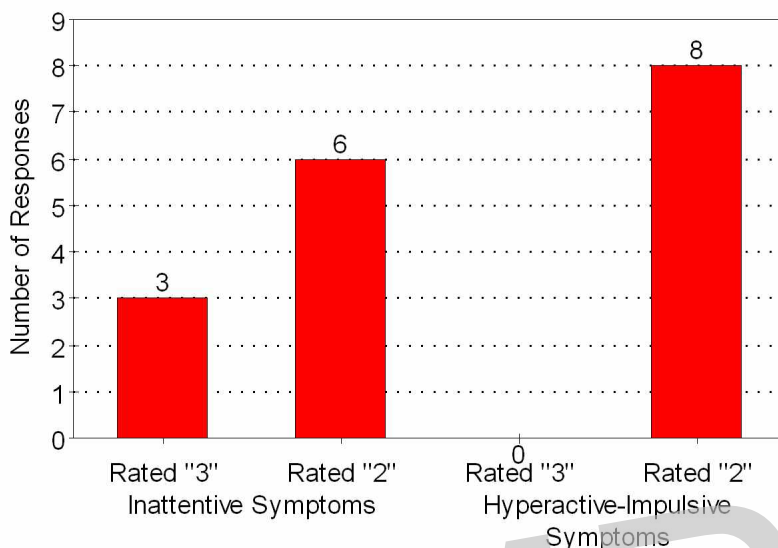


Response Key:

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

DSM-5 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-5 subscale. The DSM-5 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 a relatively consistent response style. However, relatively low scores on the Inconsistency Index do not guarantee validity. It is recommended that test users consider additional information gathered from other sources (e.g., assessment instruments, interview data) and from the observer's behavior during completion of this measure to help in determining whether the test results are valid.

Examination of Subscale Scores

ADHD Index: T-Score = 66

Moderately elevated. This index consists of the best set of items on CAARS for identifying adults "at risk" for ADHD. John's score on this index is notably elevated, indicating possible ADHD. This result from the observer report should be combined with other information to corroborate whether a diagnosis of ADHD is appropriate.

Inattention/Memory Problems: T-Score = 66

Moderately elevated. High scorers tend to learn more slowly than do most individuals. The observer's report indicates that John could experience difficulty organizing or planning his work, completing tasks or projects, and concentrating on tasks that require sustained mental effort. A number of items on this subscale indicate some difficulties related to memory and inattentiveness.

Hyperactivity/Restless: T-Score = 61

Mildly elevated. The elevated score obtained on this subscale indicates that John is perceived to have difficulty sitting still or remaining stationary for very long. Also, John is probably more restless than most individuals. The score is mildly elevated, indicating some problems with restlessness and tolerating sedentary activities.

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-5 Subscales**Inattentive Symptoms: T-Score = 79**

The observer's report indicates that five or more symptoms of the Inattentive Presentation of ADHD could be present. The stringent requirement is that at least 5 items be rated "Very much, Very frequently" before suggesting a possible DSM-5 diagnosis. However, if you combine the fact that 3 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-5 criteria for the Inattentive Presentation of ADHD.

Hyperactive-Impulsive Symptoms: T-Score = 74

The observer's report indicates that five or more symptoms of the Hyperactive-Impulsive Presentation of ADHD could be present. The stringent requirement is that at least 5 items be rated "Very Much, Very frequently" before suggesting a possible DSM-5 diagnosis. However, if you combine the fact that none of the 9 items is rated "Very much, Very frequently" with the observation that 8 of the 9 items is rated "Pretty Much, Often," there does seem to be sufficient reason to explore the possibility that this individual meets the DSM-5 criterion for the Hyperactive-Impulsive Presentation of ADHD.

Combined ADHD: T-Score = 80

Based on the observer's report, there is moderate although not substantial evidence for a diagnosis of either the Inattentive Presentation or the Hyperactive-Impulsive Presentation of ADHD. In addition, the possibility of the Combined Presentation of ADHD should be considered.

General Examination of the Profile

There are several substantial subscale elevations. Two of these elevations are on general index scales indicative of hyperactivity and/or attentional deficits (i.e., ADHD). The other elevations could also indicate hyperactivity and/or problems in one or more of the following areas: Impulsivity, Restlessness, and Emotional Lability. More specific information about the areas that are elevated can be obtained from examining the subscale descriptions.

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:

- Inattention/Memory Problems
- Hyperactivity/Restlessness
- Impulsivity/Emotional Lability
- DSM-5: Inattentive Symptoms
- DSM-5: Hyperactive-Impulsive Symptoms
- DSM-5: ADHD Symptoms Total
- ADHD Index

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

Phone: (305) 587-3700 Fax: (305) 587-4599

Date Printed: April 14, 2022

End of Report

SAMPLE