Conners' Adult ADHD Rating Scales–Self-Report: Long Version (CAARS–S: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
Duration:	3 minutes, 33 seconds
Administration Date:	April 14, 2022

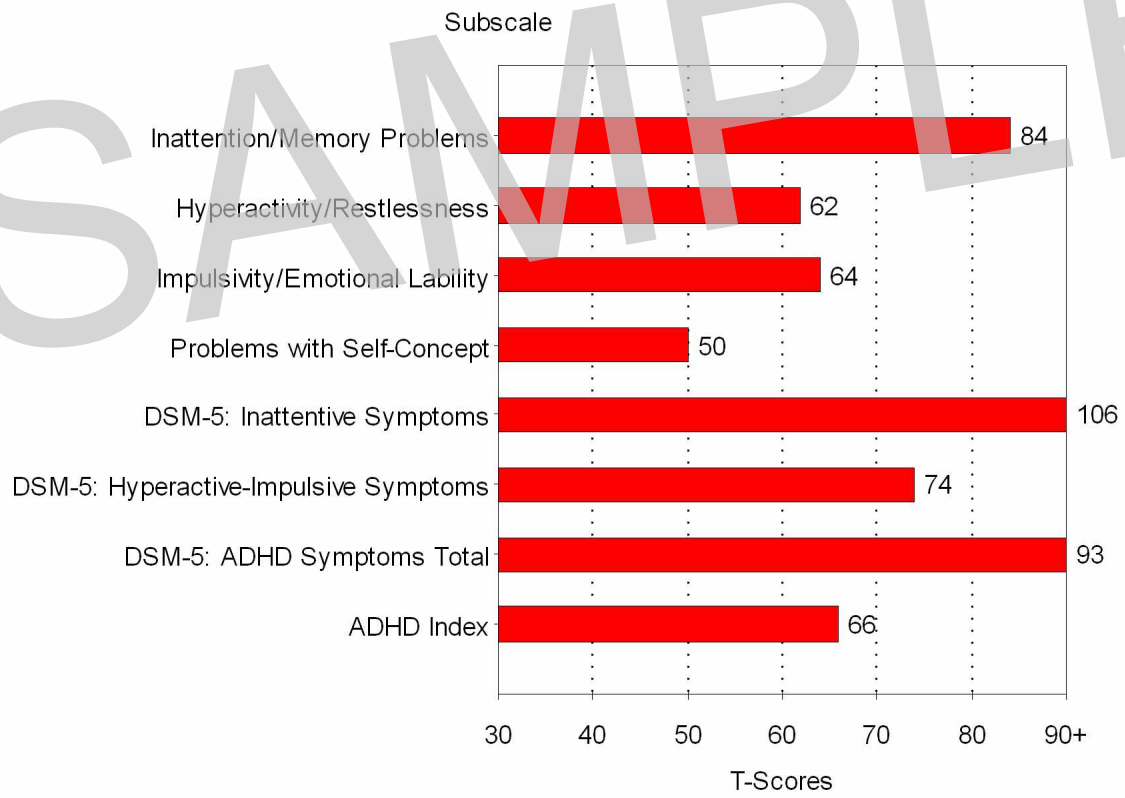
Introduction

The Conners' Adult ADHD Rating Scales–Self Report: Long Version (CAARS–S:L) is an assessment that prompts an adult to provide valuable information about themselves. This instrument is helpful when considering a diagnosis of ADHD or related problems. The normative sample includes 1026 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.

The computerized report is meant to act as an interpretive aid and should not be used as the sole basis for clinical diagnosis or intervention. This report works best when combined with other sources of relevant information. The 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 specific items to ensure that these generic interpretations apply. Highly idiosyncratic response patterns must be explored in other ways and on a case-by-case basis.

CAARS–S:L Subscale T-Scores

The following graph provides John's T-scores for each of the CAARS–S:L subscales.



Summary of Scores

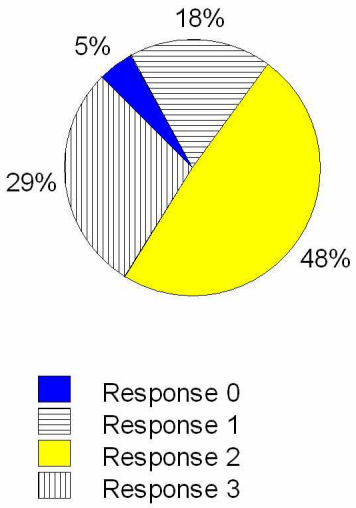
The following table summarizes John's scores and gives general information about how he compares to the nomative group. More interpretive data are provided later in this report.

Measure	Raw Score	T-Score	Guideline	Common Characteristics of High Scorers
Inattention/Memory Problems	32	84	Markedly atypical (indicates significant problem).	Difficulties may include trouble concentrating, difficulty planning or completing tasks, forgetfulness, absent-mindedness, being disorganized.
Hyperactivity/Restlessness	20	62	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	18	64	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	6	50	Average (typical score: should not raise concern).	Difficulties may include poor social relationships, low self-esteem and self confidence.
DSM-5: Inattentive Symptoms	26	106	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	18	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	44	93	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	2	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–S:L.

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

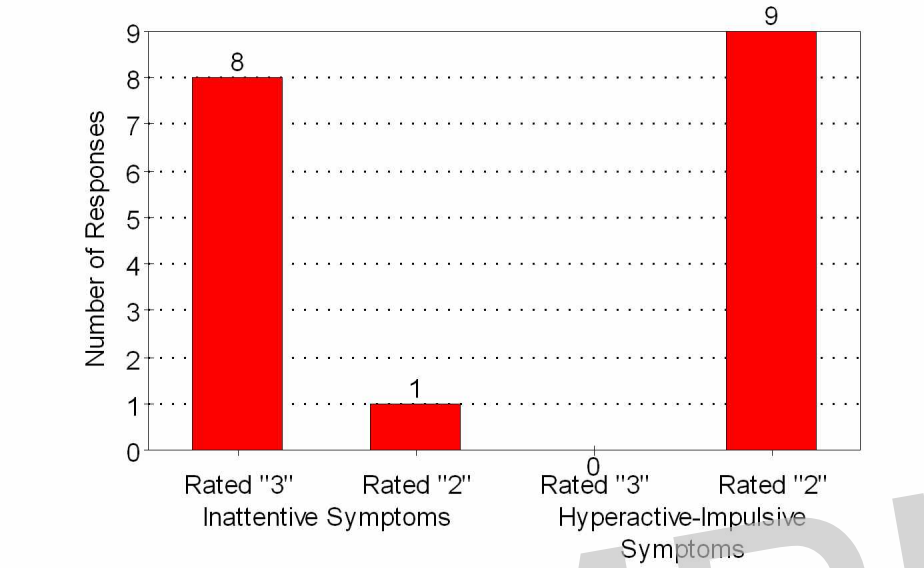


Response Key

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 John answered " Very much, Very Frequently" (3) or "Pretty much, Often" (2). The 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 respondent is either exaggerating current problems, or has denied the existence of problems previously. It is also possible, however, that behavior and attitudes are situation specific. That is, behavior and attitudes at home may be quite different than behavior and attitudes away from home (e.g., at work). Use of the CAARS observer form is recommended to help resolve 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 client'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 finding should be combined with other information to corroborate whether a diagnosis of ADHD is appropriate.

Inattention/Memory Problems: T-Score = 84

Marked elevated. John could experience serious difficulties with 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/Restlessness: T-Score = 62

Mildly elevated. The score obtained on this subscale indicates that John might have difficulty sitting still or remaining stationary for very long. He is likely to be more restless than most individuals, with a need to be always “on the go.” This score is mildly elevated, indicating some problems with restlessness and tolerating sedentary activities.

Impulsivity/Emotional Lability: T-Score = 64

Mildly elevated: John's score on the Impulsivity/Emotional Lability subscale is indicates that he may be 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 also likely to have a low tolerance for frustration, a tendency for moodiness and to be easily angered or irritated.

Problems with Self Concept: T-Score = 50

About average. The score on the Problems with Self-Concept subscale indicates that John's self-confidence is adequate and he probably feels comfortable in taking on new challenges.

Analysis DSM-5 Subscales

Inattentive Symptoms: T-Score = 106

John's responses indicate that five or more symptoms of the Inattentive Presentation of ADHD could be present. 8 of 9 items are rated "Very much, Very frequently", and 1 of 9 items are rated "Pretty much, Often".

Hyperactive-Impulsive Symptoms: T-Score = 74

John's responses indicate that five or more symptoms of 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 9 of the 9 items is rated "Pretty much, Often", there does seem to be sufficient reason to explore the possibility that John meets the DSM-5 criteria for Hyperactive-Impulsive Presentation of ADHD.

Combined ADHD: T-Score = 93

Based on John's self-report, there is strong evidence for a diagnosis of the Inattentive Presentation of ADHD. The evidence for Hyperactive-Impulsive Presentation is more moderate. Nonetheless, the possibility of 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 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;
- Screen 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–S: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