

Conners' CRS-R Rating Scales—Revised

Conners-Wells' Adolescent Self-Report Scale: Long Version (CASS:L)

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Interpretive Report

Client Name:	John Sample
Age:	14
Gender:	Male
Grade:	9
Normative Data Type:	Continuous Age
Duration:	N/A - QuikEntry
Administration Date:	December 30, 2004 (Online)



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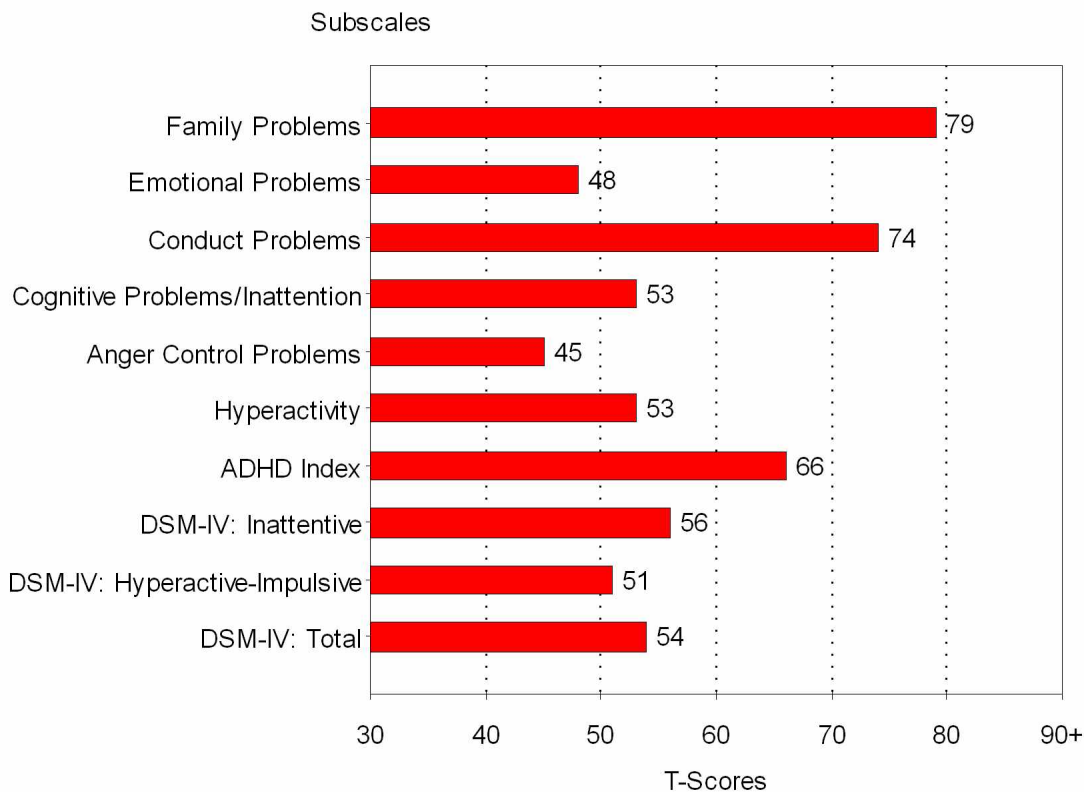
Introduction

The Conners' Adolescent Self-Report Scale: Long Version (CASS:L) is an assessment tool that prompts adolescents to provide valuable information about themselves. This instrument is helpful when a diagnosis of ADHD (or related problems) is being considered. The normative sample includes 3,394 adolescents. This report provides information about the adolescent's score, how he or she compares to other adolescents, and what subscales are elevated. See the Conners' Rating Scales–Revised 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. This report works best when combined with other sources of relevant information.

CASS:L T-Scores

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



Summary of Subscale Scores

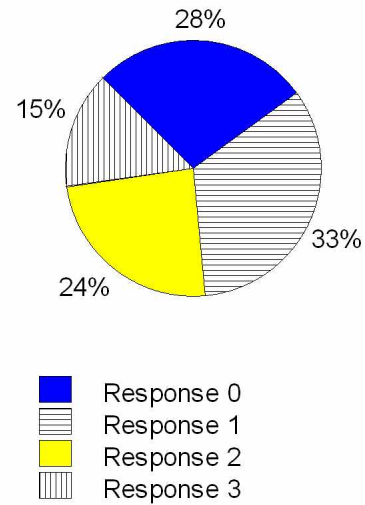
The following table summarizes John's subscale scores and gives general information about how he compares to the normative group. More interpretive data are provided later in this report.

Subscale	Raw Score	T-Score	Guideline	Common Characteristics of High Scorers
Family Problems	28	79	Markedly Atypical (Indicates significant problem)	Perceive family as uncaring, harsh, or overly critical. Feel emotionally distant from family members.
Emotional Problems	6	48	Average (Typical score: Should not raise concern)	Have low self-esteem and little self-confidence. Feel lonely and isolated. Worry a lot.
Conduct Problems	21	74	Markedly Atypical (Indicates significant problem)	Break rules, have problems with authority, engage in antisocial activities.
Cognitive Problems/Inattention	12	53	Average (Typical score: Should not raise concern)	Learn slowly, organizational problems, difficulty completing tasks, concentration problems.
Anger Control Problems	5	45	Average (Typical score: Should not raise concern)	Are easily angered and irritated.
Hyperactivity	11	53	Average (Typical score: Should not raise concern)	Difficulty sitting still, cannot stay on task, restless, impulsive.
ADHD Index	19	66	Moderately Atypical (Indicates significant problem)	Identifies adolescents 'at risk' for ADHD.
DSM-IV: Inattentive Symptom Count (max of 9)	11 1	56	Slightly Atypical (Borderline: Should raise concern)	Correspondence with the DSM-IV diagnostic criteria for Inattentive type ADHD.
DSM-IV: Hyperactive-Impulsive Symptom Count (max of 9)	9 0	51	Average (Typical score: Should not raise concern)	Correspondence with the DSM-IV diagnostic criteria for Hyperactive-Impulsive type ADHD.
DSM-IV: Total Symptom Count (max of 18)	20 1	54	Average (Typical score: Should not raise concern)	Correspondence to DSM-IV criteria for Combined type ADHD.

Item Responses

The following response values were entered for the items on the CASS: L. The pie graph shows the distribution of responses.

Item	Response	Item	Response	Item	Response
1.	3	31.	0	61.	3
2.	0	32.	1	62.	0
3.	2	33.	2	63.	1
4.	1	34.	3	64.	2
5.	1	35.	1	65.	1
6.	2	36.	2	66.	0
7.	3	37.	2	67.	0
8.	2	38.	1	68.	1
9.	3	39.	0	69.	0
10.	1	40.	1	70.	2
11.	0	41.	2	71.	1
12.	2	42.	0	72.	0
13.	0	43.	1	73.	0
14.	1	44.	2	74.	1
15.	2	45.	0	75.	2
16.	2	46.	1	76.	0
17.	1	47.	1	77.	3
18.	3	48.	0	78.	1
19.	0	49.	0	79.	0
20.	2	50.	2	80.	1
21.	3	51.	3	81.	1
22.	0	52.	0	82.	1
23.	1	53.	1	83.	2
24.	1	54.	3	84.	2
25.	3	55.	1	85.	3
26.	0	56.	1	86.	2
27.	2	57.	0	87.	1
28.	0	58.	3		
29.	0	59.	1		
30.	2	60.	1		

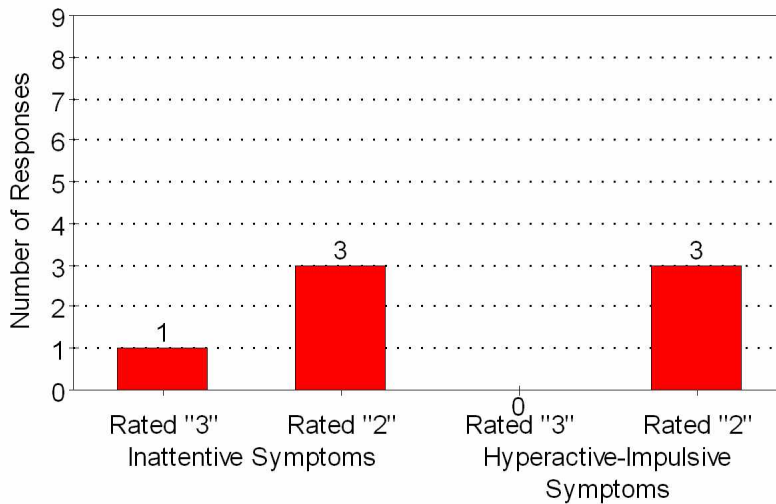


Response Key

- 0 = Not true at all (Never, Seldom)
- 1 = Just a little true (Occasionally)
- 2 = Pretty much true (Often, Quite a Bit)
- 3 = Very much true (Very Often, Very Frequent)

DSM-IV Subscales: Elevated Responses

The following graph shows the number of items for which the respondent answered Very Much True ("3") or Pretty Much True ("2"). The 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 reasons 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, it is possible, however, that John is either exaggerating or denying problems that may exist.

General Examination of the Profile

There are one or more substantial subscale elevations. The highest elevations relate to different areas of behavior suggesting the possibility of comorbidity. More specific information about the areas that are elevated can be obtained from examining the subscale descriptions given below.

Examination of Subscale Scores

ADHD Index: T-Score = 66

Moderately elevated. This index consists of the best set of CASS items for identifying adolescents "at risk" for ADHD. John's score on this index is moderately elevated indicating possible ADHD. This finding should be combined with other information to corroborate whether a diagnosis of ADHD is appropriate.

Family Problems: T-Score = 79

Markedly elevated. John's responses indicate that he may perceive family members to be uncaring, harsh, or overly critical. In extreme cases, youths scoring high on this scale feel emotionally distant or detached from family members.

Emotional Problems: T-Score = 48

About average. The score on the Emotional Problems subscale is average meaning that John expresses no unusual feeling of sadness, anxiety or nervousness. He probably has adequate self-esteem and self-confidence.

Conduct Problems: T-Score = 74

Markedly elevated. Youths scoring high on this subscale are likely to break rules and have problems with persons in authority. They are also more likely than most individuals their age to have engaged in antisocial activities. In some cases, the misbehavior can be extremely serious (e.g., destruction of property, taking drugs).

Cognitive Problems/Inattention: T-Score = 53

About average. The score on the Cognitive Problems subscale is average. John doesn't indicate any persistent or severe impairment with learning or memory. He probably has satisfactory organizational skills and is probably able to complete work, tasks or schoolwork as expected most of the time. In addition, John is probably capable of sustained mental effort and can be attentive when required.

Anger Control Problems: T-Score = 45

About average. The score on the Anger Control Problems subscale is about average. This means that John feels that he does not get angry too often and feels quite capable of controlling his anger most of the time.

Hyperactivity: T-Score = 53

About average. The score on the Hyperactivity subscale is about average. This indicates that John feels that he is able to sit still, and is not overly restless or impulsive.

DSM-IV: Inattentive: T-Score = 56

Six or more symptoms of ADHD are required for Inattentive subtype of ADHD to be present. The responses here indicate that these criteria would not be met. However, given that close to six symptoms may be present (i.e., 1 of 9 items are rated "Very Much True"), 3 of 9 items are rated "Pretty Much True"), further investigation of the possible presence of the Inattentive subtype of ADHD may be warranted.

DSM-IV: Hyperactive-Impulsive: T-Score = 51

John's responses to the DSM-IV items suggest that the criteria for the Hyperactive-Impulsive subtype of ADHD would not be met. Six or more symptoms of ADHD are required, but only 0 of 9 items are rated "Very Much True" and only 3 of 9 items rated "Pretty Much True".

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Integrating Results with Other Information

The following subscale scores are elevated and potentially could be cause for concern:

- Family Problems
- Conduct Problems
- ADHD Index

These results must be incorporated with other information before drawing any conclusions. 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 severity, frequency, situational specificity, and duration;
- An educational assessment that covers both academic functioning and classroom behavior;
- An overview of the individual's intrapsychic processes, including self-image and sense of efficacy with family, peers, and school;
- Child and family interaction patterns and family structure;
- An assessment of neurological status, when related problems are indicated by other evidence.

CASS:L results interpreted without considering these other factors may have limited validity.

Considering Intervention

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 intervention should be individualized, and the goals/targets of each intervention should be clearly specified. All of the following types of intervention should be considered.

Parent-Based Intervention

Involves educating parents about the disorder or concern (e.g., ADHD), and teaching parents behavior management skills so they can reduce negative behavior in their children and promote adaptive functioning.

School-Based Intervention

This can involve both academic and behavioral intervention.

Child-Based Intervention

The child is taught to monitor, evaluate, and reinforce himself with respect to target behaviors.

Pharmacologic Intervention

Medication is often effective (with ADHD) but should only be used after careful consideration of the child's particular symptomatology. The choice of drug, dosage and potential side effects must be considered.

In many cases, these and other intervention approaches can be used in combination with each other to produce the optimal results.

Date Printed: Thursday, December 30, 2004

End of Report