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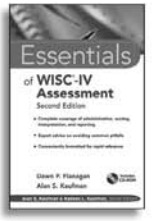

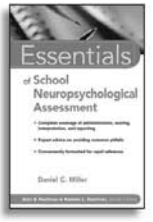

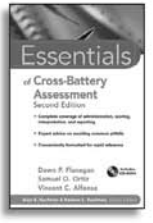

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To my family, with appreciation for your time, support, and understanding.

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Thank you all.

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Series Preface

In the *Essentials of Psychological Assessment* series, we have attempted to provide the reader with books that will deliver key practical information in the most efficient and accessible style. The series features instruments in a variety of domains, such as cognition, personality, education, and neuropsychology. For the experienced clinician, books in the series will offer a concise yet thorough way to master utilization of the continuously evolving supply of new and revised instruments, as well as a convenient method for keeping up to date on the tried-and-true measures. The novice will find here a prioritized assembly of all the information and techniques that must be at one's fingertips to begin the complicated process of individual psychological diagnosis.

Wherever feasible, visual shortcuts to highlight key points are utilized alongside systematic, step-by-step guidelines. Chapters are focused and succinct. Topics are targeted for an easy understanding of the essentials of administration, scoring, interpretation, and clinical application. Theory and research are continually woven into the fabric of each book—but always to enhance clinical inference, never to sidetrack or overwhelm. We have long been advocates of "intelligent" testing—the notion that a profile of test scores is meaningless unless it is brought to life by the clinical observations and astute detective work of knowledgeable examiners. Test profiles must be used to make a difference in the child's or adult's life, or why bother to test? We want this series to help our readers become the best intelligent testers they can be.

This *Essentials* book describes the Conners 3rd edition (Conners 3™), Conners Comprehensive Behavior Rating Scales (Conners CBRS™), and Conners Early Childhood (Conners EC™), and how each can best be used to describe behavioral, emotional, social, and academic issues of children and adolescents (and developmental milestones for young children). The Conners EC™ is normed for use with young children (2 to 6 years old), and the Conners 3™ and Conners CBRS™ are co-normed for use with school-aged children (6 to 18 years old); all three scales can be completed by parents or teachers, and a self-report form can be completed by 8- to 18-year-old youth. This book helps those who used the Conners' Rating Scales, Revised (CRS–R™) as they transition to these updated and improved assessment options. It also provides guidance for new examiners, suggesting structured techniques to

organize and understand the scores that are produced by scoring these rating scales, so that valuable information is not lost in interpretation and application. This book, written by one of the world's experts on the Conners Scales, reviews not only the fundamentals of these Conners assessments, but adds sophistication and depth for meaningful and responsible use of these tools in the evaluation of children and adolescents.

Alan S. Kaufman, Ph.D., and Nadeen L. Kaufman, Ed.D., Series Editors
Yale University School of Medicine

One

OVERVIEW

Elizabeth P. Sparrow
Sara R. Rzepa
Jenni Pitkanen

For decades the rating scales developed by Dr. C. Keith Conners have been used worldwide for assessment of children with Attention-Deficit/Hyperactivity Disorder (ADHD) and related issues. The Conners 3rd Edition (Conners 3) continues this tradition of excellence for ADHD identification and treatment monitoring. With the publication of the Conners Comprehensive Behavior Rating Scales (Conners CBRS), this standard of clinical utility and statistical foundations has been extended for assessment of a broad range of issues that occur in school-aged youth.[1] Most recently, these same techniques were applied for the development of a comprehensive rating scale for young children—the Conners Early Childhood (Conners EC). Rapid Reference 1.1 provides a quick snapshot of the three assessments.

The main objective of this book is to offer a comprehensive and user-friendly guide to the Conners 3, Conners CBRS, and Conners EC. This book was developed for those who work with youth 2 through 18 years old in educational, clinical, or research settings, including professionals in evaluation and treatment roles. The subsequent chapters explain the core "essentials" of Conners rating scale assessment and interpretation in a straightforward and understandable

1. The terms "youth" and "child/children" are used interchangeably throughout the book to include ages 6 through 18 years, rather than specifying "children and adolescents" every time. "Child/children" may also include young children who are 2 through 6 years old, as indicated by the context.

Rapid Reference 1.1

Snapshot of the Conners Assessments

	Conners 3rd Edition (Conners 3)	Conners Comprehensive Behavior Rating Scales (Conners CBRS)	Conners Early Childhood (Conners EC)
Author	C. Keith Conners, PhD		
Publication date	2008	2008	2009
Purpose	Focused assessment of ADHD and most commonly co-occurring problems and disorders in school-aged children	Comprehensive assessment tool for a wide range of behavioral, emotional, social, and academic concerns in school-aged children	Broad coverage of important behavioral, emotional, social, cognitive, and developmental issues in young children
Age Range	Parent & Teacher: 6–18 years Self-Report: 8–18 years	Parent & Teacher: 6–18 years Self-Report: 8–18 years	Parent & Teacher: 2–6 years Self-Report: n/a

Available Forms	Conners 3[a] Conners 3 Short[a] Conners 3 ADHD Index[a] Conners 3 Global Index[b]	Conners CBRS[a] Conners Clinical Index[a]	Conners EC[b] Conners EC-BEH[b] Conners EC-BEH(S)[b] Conners ECGI[b] Conners EC-DM[b]
Minimum Reading Levels[c]	Parent & Teacher: 5th grade Self-Report: 3rd grade	Parent & Teacher: 5th–6th grade Self-Report: 3rd–4th grade	Parent: 3rd–5th grade Teacher: 5th grade Self-Report: n/a
Rater Requirements	Must have known and had the opportunity to observe child for at least one month. Cognitive abilities and reading level must be adequate (see above). Must be motivated to assist in assessment.		
Examiner Requirements	Administration and scoring: Formal training in clinical psychology or psychometrics is not required Interpretation: Graduate-level courses in tests and measurement at a university (or other documented equivalent training)		
Publisher	Multi-Health Systems, Inc. 1-800-456-3003 in the United States; 1-800-268-6011 in Canada; 1-416-492-2627 International www.mhs.com		

[a] Available in forms for completion by parent, teacher, or youth.
[b] Available in forms for completion by parent or teacher.
[c] Approximate range listed here for quick reference; varies by form used. See relevant test manual for details.

manner, including not only key information from the test manuals, but also practical tips and high-level interpretation guidelines. Chapter 1 provides a historical context for understanding the Conners assessments as well as a quick overview of each rating scale. Chapter 2 reviews key assessment tips, such as choosing which rating scale is best for a specific child and deciding which form to use. Scoring is covered in Chapter 3. Chapter 4 explains a straightforward technique for interpreting the Conners assessments, with special sections for integrating results across more than one version of the rating scales. Chapter 5 offers a critical review of the strengths and weaknesses of the Conners assessments, and Chapter 6 explores clinical applications. Finally, Chapter 7 illustrates use of the Conners 3, Conners CBRS, and Conners EC through several case studies. Throughout the book, Rapid Reference, Caution, and Don't Forget boxes draw attention to critical points. Tables present information succinctly, and figures illustrate information in graphic form. Each chapter ends with a Test Yourself section to help review and check retention of important concepts. Information contained in this book should support responsible and competent use of the Conners 3, Conners CBRS, and Conners EC.

This chapter includes an overview of appropriate ways to use rating scales and a brief history of the Conners assessments. Each of the new rating scales is described, with an overview of key features, changes from the Conners' Rating Scales–Revised™ (CRS–R™), and psychometric properties. See Rapid References 1.14, 1.18, and 1.23 for an overview of the content provided by each of the Conners assessments. Chapters 2, 3, and 4 in this book discuss the administration, scoring, and interpretation of each rating scale in more detail, including how to select which rating scale and form to use.

USE OF RATING SCALES

A rating scale is simply a group of items that are rated on a specified scale to describe an individual. For example, a food critic might use a rating scale of one to five stars to rate a chef on the appearance, speed, and taste of his food. In the world of educational and psychological measurement, some rating scales are not much more complicated than those used by a food critic. Some rating scales are just a group of items that can be rated, and interpretation is a matter of opinion. At the other end of the spectrum are rating scales that are derived solely from statistical analyses with little input as to the clinical utility of the factors for diagnosis or treatment, or rating scales that are based entirely on results of a single research project without consideration of generalizability. Ideally, a rating scale that is used in the assessment and monitoring of a child will have a blend of these features, combining clinical wisdom with research data and statistical expertise. See Rapid Reference 1.2 for important features of rating scales.

Rapid Reference 1.2

Summary of Key Points to Consider in Rating Scale Selection

Ideally, a rating scale that is used in the assessment and monitoring of a child will have a blend of these features, combining clinical wisdom with research data and statistical expertise. Features to look for when selecting a rating scale include:

- Results that can be interpreted to answer your questions about a child and that can be explained to parents, teachers, and others who help the child.
- Item development and selection guided by clinicians with experience in relevant areas.
- Relevant research findings reflected in scale content and interpretation.
- Large and diverse standardization sample (i.e., considering different ages, genders, races/ethnicities, geographic regions, neighborhood types, and socioeconomic statuses), providing an appropriate comparison for each child assessed and helping to decide if any of these factors impact how results are interpreted (e.g., does age matter for this?).
- Data from relevant clinical groups, showing how results help distinguish between children with and without different diagnoses (i.e., specificity and sensitivity).
- Solid psychometrics, including reliability and validity, so you know how confident you can be that the rating scale is consistently measuring the targeted issues over different people and dates.
- Ease of use (administration, scoring, and interpretation).
- Results that help identify targets for treatment and then measure response to treatment.

Even when a rating scale has all of the features listed in Rapid Reference 1.2, it should not be used in isolation for assessment purposes. An assessment should be multimodal, based on information from multiple informants and multiple settings. A rating scale is only one mode of assessment; other modes might include interview, record review, observation, and direct assessment of knowledge, skills, and abilities. For example, you might review available records, interview the child and her parents, observe the child in the classroom and other settings, administer a rating scale, and administer tests of intellectual ability, academic achievement, and memory skills. This would be a multimodal evaluation. Assessments should not rely on information from a single source, but should include more than one informant. For children, informants can include parents, teachers, and service providers. Do not forget that the child is often a valuable source of information and that you are in fact an informant—your reactions to the child and your observations of him are very

relevant. Finally, an assessment should combine information from multiple settings. Typical settings for children include home, school, and community. School does not just mean the academic classroom, but it also includes aspects of the child's functioning in other parts of the schoolday (e.g., the hallway between classes, the lunchroom, the bus-stop, the playground, special classes like art, music, and gym). The community setting might be after-school care, neighborhood park, religious centers, grocery stores, or community centers. For adolescents, there may be a work setting as well.

DON'T FORGET

The "Multi's" of Responsible Assessment

1. Multi-modal: Use more than one mode of assessment (e.g., interview, record review, observation, rating scale, individual testing).
2. Multi-informant: Gather data from more than one informant (e.g., child, parents, teachers, other professionals, yourself).
3. Multi-setting: Gather data from more than one setting, considering physical settings (e.g., home, school, community) and functional settings (e.g., social interactions, structured settings).

Once all the "multi" requirements are met (i.e., multimodal, multi-informant, and multiple settings), it is also important to gather sufficient depth and breadth of information to help with differential diagnosis decisions. These include deciding if the child's symptoms are due to one thing or another, or possibly a combination of more than one factor. In some cases, the decision is not a simple yes/no but whether additional evaluation might be helpful in answering questions and forming a plan to help the child. Again, no single instrument can serve in isolation for differential diagnosis decisions.

DON'T FORGET

Differential Diagnosis and Referrals

Gather sufficient breadth and depth of information to help you decide if the child's diagnosis is "either/or" (e.g., "Is it ADHD *or* something else?"), or if his diagnosis is "this and that" (e.g., "Does he have ADHD *and* comorbid CD?"). If you do not have expertise in an area that you think might be important for a child, get enough information to help you make a referral or to consult with a colleague.

When a rating scale has the features described above, and is used as part of a responsible assessment, it can contribute in a variety of ways, informing diagnosis, treatment planning/monitoring, research, and program evaluation. (See Chapter 6 for additional information on these applications of the Conners assessments.)

- Most people use rating scales primarily as diagnostic aids, as a rating scale can help you gather data from multiple settings and multiple raters. When referral questions are vague, information gathered by a rating scale can help focus initial efforts to begin assessment quickly and efficiently. Even when the referral is clear, results from a rating scale may identify additional issues to address or investigate through other modalities of assessment.
- Rating scales can be equally valuable in planning treatment. Results from raters in different settings can help you understand which settings are impacted by which issues and which settings do not seem to be affected. This information can help you discover potentially useful differences among raters/settings that could suggest interventions to try with a child in an RTI model (see also Rapid Reference 6.1). For example, if a child shows symptoms of anxiety and academic failure in a classroom with 25 students but is indistinguishable from peers in her reading group of 8 students, this might indicate the benefit of trying small group instruction for other subject areas while determining if the difference is content area, group size, or instructor characteristics (among other possible explanations). Results from rating scales can help identify target behaviors to address in treatment and can even help prioritize these targets. Rating scales can provide data to support treatment recommendations, showing why a particular suggestion is being made for the child in that setting.
- Once an intervention is begun, rating scales can help monitor changes in the child.[2] These might include improvement in the target behavior, lack of change, or deterioration in that area. Rating scales can indicate new areas that are emerging as concerns as old areas are addressed, or suggest a shift in relative importance of which target should be addressed first. Some rating scales can help track potential side effects of treatment—usually a consideration for pharmaceutical intervention. Results from a repeated rating scale can suggest considerations for change in a treatment

2. On the Conners assessments, the Reliable Change Indices (RCI) provide the absolute difference score needed to determine if there is a statistically significant change in scores between administrations. This provides utility when monitoring responses to intervention. See also Rapid Reference 6.2.

plan, whether adding services, decreasing intensity of services, shifting to maintenance levels, or discontinuing services.

- In research settings, rating scales offer a systematic way to identify children for inclusion in a research study or to identify children who might not be appropriate for that particular study. Data from rating scales are often used as a way to measure the outcome of a studied intervention or research manipulation.
- Finally, rating scales can be used programmatically. A rating scale can help screen a group of children to determine who might be candidates to participate in a special program (e.g., a reading enrichment program, a social skills group). Results from rating scales could be used to evaluate the effectiveness of such programs as might be needed when deciding whether to continue the program or to support continued funding for the program.

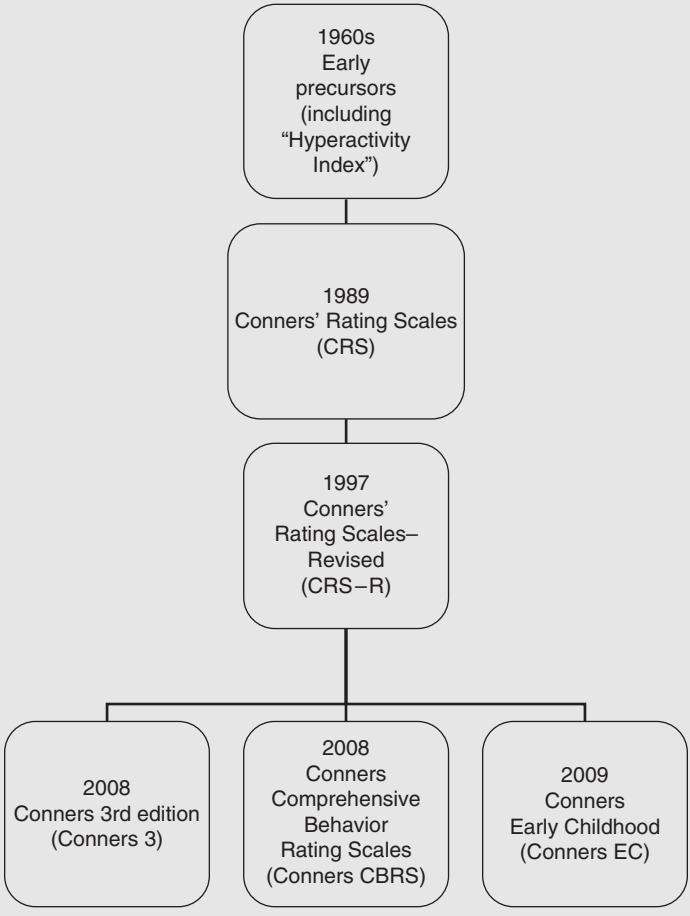
In summary, rating scales should reflect a combination of clinical, statistical, and research supports. When used for assessment purposes, they should be part of a complete evaluation that integrates data from multiple modalities, informants, and settings to obtain sufficient information for differential decisions or referrals. Rating scales can be used in a variety of ways, for individuals and groups of children. With this information in mind, let's take a look at the background for the Conners 3, Conners CBRS, and Conners EC.

HISTORY AND DEVELOPMENT OF THE CONNERS ASSESSMENTS

The Conners line of assessments has grown from a lifetime of clinical work and research (see Rapid Reference 1.3 for an overview of the timeline, and Rapid Reference 1.4 for a summary of published Conners rating scales). The earliest versions of rating scales by Dr. Conners were developed in the 1960s when he was training at Johns Hopkins Hospital. While studying the effects of stimulant medications on juvenile delinquents, Dr. Conners discovered that parents and teachers were effective observers of behavioral changes exhibited by this group of youth. He developed a list of items, grouped by problem area, that he could use to quantify changes parents and teachers observed. This list of items was shared with colleagues, who gathered further information about how parents and teachers rated children at different ages. Over time, sufficient data were collected to be a useful comparison when determining if a child's results were typical or atypical. Some felt the list of items was too long for use when monitoring a child's response to treatment, so Dr. Conners worked to create a shorter form. He selected the 10 best items for distinguishing children with hyperactivity from those without hyperactivity and called this the "Hyperactivity Index" (referencing the DSM-II diagnostic term in

Rapid Reference 1.3

History of the Conners Assessments



use at that time). It was not uncommon to see very faint copies of the Hyperactivity Index being used at that time, as the original typed list was photocopied many times and distributed. As copies reached the point where they could not be read, individual clinicians retyped the form, resulting in many variations in formatting and even wording as unintentional changes were made.

In the 1980s, Dr. Conners partnered with a small start-up company that was developing tests—Multi-Health Systems, Inc. (MHS). He worked with MHS to gather a more comprehensive normative sample, and in 1989, the first copyrighted version of the items was published as the Conners' Rating Scales (CRS). The CRS became very widely used across the globe and was translated into many languages. After many validation studies were conducted and published, the CRS was established as the gold standard for assessment of what is now called ADHD. Over the next 10 years, additional data were collected, items were reviewed, and statistical analyses were conducted. This led to revision of the CRS, and in 1997 the Conners' Rating Scales–Revised (CRS–R) was released for rating children ages 3 to 17.

The CRS–R reflected a larger, more diverse normative sample and improved psychometric properties. It expanded the rater options from parent and teacher by adding an adolescent self-report form (for use with youth ages 12 to 17). Items based on DSM-IV criteria for ADHD were added. In addition to continuing in-depth coverage of ADHD, the CRS–R included conduct problems, cognitive problems, family issues, emotional lability, and anger control. Items reflecting internalizing features were added, such as anxiety, psychosomatic symptoms, and perfectionism; coverage of these features was facilitated by the addition of the adolescent self-report form. The historic "Hyperactivity Index" (also known as the "Conners 10-item" or the "Abbreviated Symptoms Questionnaire [ASQ]") was updated and labelled the "Conners Global Index" to reflect its utility in identifying children with general pathology (not just hyperactivity). A statistically derived index was developed using the best items for distinguishing between children with ADHD and children in the general population; this was called the "ADHD Index." The physical forms for the CRS–R were improved, including simplified hand-scoring options and new feedback/progress forms. Both "long" and "short" forms were made available.

Changing the CRS–R

In 2003, the research and development team at MHS began gathering feedback from users of the CRS–R to update and revise the CRS–R into the Conners 3. Team members included Dr. Conners (the author of the Conners assessments), Dr. Sparrow (clinical consultant for the project), and MHS staff. During many conversations, we realized the need to develop a comprehensive rating scale that was built on the same principles as the CRS–R: guided by clinical experience and research, supported by solid psychometrics and statistical analyses, and useful to professionals who work with children and adolescents. As the rating scale grew longer and longer, it became clear that one rating scale could not responsibly

Rapid Reference 1.4

Published Conners Assessments Over the Years

		Parent (P)	Teacher (T)	Self-Report (SR)
Conners 3rd Edition (Conners, 2008)				
Full length	Conners 3	Conners 3–P	Conners 3–T	Conners 3–SR
Short	Conners 3 Short Conners 3(S)	Conners 3–P(S)	Conners 3–T(S)	Conners 3–SR(S)
Index/Auxiliary	Conners 3 Global Index Conners 3GI	Conners 3GI–P	Conners 3GI–T	—
	Conners 3 ADHD Index Conners 3AI	Conners 3AI–P	Conners 3AI–T	Conners 3AI–SR
Conners Comprehensive Behavior Rating Scales (Conners, 2008)				
Full length	Conners CBRS	Conners CBRS–P	Conners CBRS–T	Conners CBRS–SR
Index/Auxiliary	Conners Clinical Index Conners CI	Conners CI–P	Conners CI–T	Conners CI–SR

		Parent (P)	Teacher (T)	Self-Report (SR)
Conners Early Childhood (Conners, 2009)				
Full length	Conners EC	Conners EC–P	Conners EC–T	—
Behavior	Conners EC BEH	Conners EC BEH–P	Conners EC BEH–T	—
Developmental Milestones	Conners EC DM	Conners EC DM–P	Conners EC DM–T	—
Short	Conners EC BEH(S)	Conners EC BEH–P(S)	Conners EC BEH–T(S)	—
Index/Auxiliary	Conners EC Global Index Conners ECGI	Conners ECGI–P	Conners ECGI–T	—
Conners' Rating Scales–Revised (Conners, 1997)				
Full length	Conners' Rating Scales–Revised: Long CRS–R:L	CPRS–R:L	CTRS–R:L	CASS:L[a]
Short	Conners' Rating Scales–Revised: Short CRS–R:S	CPRS–R:S	CTRS–R:S	CASS:S[a]

Index/Auxiliary	Conners' Global Index CGI	CGI–P	CGI–T	—
	Conners' ADHD/DSM-IV Scales CADS	CADS–P	CADS–T	CADS–A
Conners' Rating Scales (Conners, 1989, 1990)				
Full length	Conners' Rating Scales (CRS) Long Form	CPRS-93 item	CTRS-39 item	—
Short	Conners' Rating Scales (CRS) Short Form	CPRS-48 item	CTRS-28 item	—
Index/Auxiliary	Abbreviated Symptom Questionnaire (ASQ; Hyperactivity Index)	ASQ–P	ASQ–T	—

[a] CASS = Conners-Wells' Adolescent Self-Report Scales

serve as both a focused ADHD tool and a comprehensive survey. Thus, the Conners CBRS was added to the development plan to provide broad coverage of important clinical issues in children and adolescents, and the Conners 3 was streamlined to serve as a focused ADHD tool.

We reviewed the entire DSM-IV-TR and available research publications to determine which clinical constructs were most critical for inclusion on these two rating scales. Approaching this daunting task from many different angles, we agreed to select the initial constructs from a domain-based perspective as well as a DSM-based perspective. Domains and subcategories were generated from a review of clinic referrals and relevant research literature (see Rapid Reference 1.5 for a summary of these goals for content inclusion). We agreed to include information to help clinicians identify when the validity of results might be questionable. Items asking about impairment associated with symptoms were also added, given the importance of establishing impairment for educational identification and for DSM-based diagnosis. Finally, we set the goal of creating rating scales that would go beyond labeling a problem, continuing with identifying intervention goals and ways to monitor progress in treatment.

Rapid Reference 1.5

Content Goals for Conners 3 and Conners CBRS

Domain	Subcategory	DSM-IV-TR Diagnostic Categories
Behavioral	• Aggressive/Oppositional behaviors • Hyperactive/Impulsive behaviors	• Attention and Disruptive Behavior Disorders (ADHD, ODD, CD)
Emotional	• Irritability, anxiety (worrying, separation fears, perfectionism) • General distress, symptoms of depression	• Anxiety Disorders (GAD, SAD, Social Phobia, OCD, Panic Attack, Specific Phobia, PTSD) • Mood Disorders (Major Depressive Episode, Manic Episode)
Social	• Social skills, social interests, social isolation	• Pervasive Developmental Disorders (Autistic Disorder, Asperger's Disorder)

Academic/ Cognitive	• Subject-specific difficulties • Inattention • Executive deficits	• Specific Learning Disorders
Other	• Predicting potential for violence • Risk factors for possible suicide attempt • Physical symptoms (medication side effects and/ or emotional correlates)	• Substance Use, Pica, Tics, Trichotillomania, Enuresis and Encopresis

Another topic of discussion was possible expansion of the self-report age-range. The CRS–R Adolescent Self-Report was limited to 12- to 17-year-olds based on opinions about the age at which a child could accurately and reliably describe his own symptoms. During the interval between publication of the CRS–R and this development project, research suggested that the CRS–R Adolescent Self-Report could be reliably used by children as young as 8 years old (Parker, Bond, Reker, & Wood, 2005). While some of the team members were skeptical, we agreed to collect self-report pilot data from children ages 8 and up, then revisit the issue. Pilot data confirmed the earlier publication; self-report data were reliable for children as young as 8 years old. These findings were supported by further analyses of self-report data from the full standardization sample. Thus, the Conners 3 and Conners CBRS both have self-report forms for use by children ages 8 through 18 years.

While planning the Conners 3 and Conners CBRS, one more critical issue emerged in discussion. Continuing to cover the same age range as the CRS–R (3 through 17 years old) significantly limited our choice of items; either items were so general that they did not capture important concerns, or items were inappropriate for part of the age-range. We and others commented that parents and teachers of young children tended to skip certain items when responding to the CRS–R (typically academic items), preventing some scales from being scored. Important questions to aid early identification and intervention efforts were not included as they did not apply to school-aged children. After some discussion, the team decided to create a separate scale for young children (the Conners EC) and to concentrate on school-aged youth with the Conners 3 and Conners CBRS.

Given our desire to create a developmentally appropriate rating scale for use with young children, the team did not limit the Conners EC to a downward

Rapid Reference 1.6

Key Development Goals

Conners 3:

- Thorough and reliable ADHD assessment
- Added emphasis on associated features and commonly comorbid disorders
- New normative data and updated psychometric properties
- School-age focused age range
- Content alignment across Parent, Teacher, and Self-Report forms
- Simplification of DSM-IV-TR scale language
- Addition of new features (e.g., validity scales, executive functioning)
- Increased links to intervention

Conners CBRS:

- Comprehensive coverage of issues that arise in school-aged youth
- Strong statistical foundation and diagnostic utility
- Links to identification and diagnosis
- DSM-IV-TR symptoms for a number of diagnoses
- Links to intervention and treatment planning (e.g., IDEA 2004)
- Multiple ratings in multiple settings with easily integrated results

Conners EC:

- Comprehensive coverage of issues that occur in young children
- Developmentally sensitive items
- Strong statistical foundation and diagnostic utility
- Support early identification and intervention
- Multiple ratings in multiple settings with easily integrated results

extension of the Conners 3 and Conners CBRS. We again brainstormed, considered clinical cases, and reviewed relevant research and publications about young children. We agreed that it was critical to include items reflecting important research on early indicators of certain disorders. We considered whether to represent symptoms of DSM-IV-TR disorders, but we ultimately decided that the more important job for the Conners EC was to capture functional issues that are usually first observed in young children. As such, a set of developmental milestone items was added, requiring a departure from the traditional 0 to 3 Likert scale used in all previous versions of the Conners rating scales. All of this labor and deliberation delivered a robust tool with behavioral, emotional, social, and cognitive components, as well as norm-referenced

markers for key developmental skills across a range of domains. See Rapid Reference 1.6 for a summary of the key development goals for the Conners 3, Conners CBRS, and Conners EC. See Rapid Reference 1.7 for an overview of changes made to the CRS–R and Rapid References 1.8 through 1.9 for a scale-by-scale comparison.

Rapid Reference 1.7

Key Changes from the CRS–R to the Conners 3 and Conners CBRS

- Updated normative sample and normative groups.
  - Ensures that the norms reflect current levels of behaviors.
  - Separate norms for each age, by year (CRS–R norms were grouped by 3-year age bins)—this reflects findings that the scores were age sensitive, and that different areas changed at different ages. Using 1-year age groups provides more accurate and precise results.
  - Optional combined gender norms for boys and girls. As with the CRS–R, data were gender specific for many scales, with changes occurring at different ages for boys versus girls. Because some settings require combined-gender norms, combined-gender norms are provided for the Conners assessments (see Rapid Reference 1.24 for additional information).
- Expanded clinical samples. Data were collected about a much wider range of clinical diagnoses than for the CRS–R (see Rapid References 1.25 and 1.26). [a]
- Modified age range. Conners 3 and Conners CBRS norms begin at 6 years, 0 months and extend through 18 years, 11 months to capture the range of ages present in school-aged youth (CRS–R norms ranged from 3 years through 17 years, 11 months). Self-report forms can be completed by youth who are 8 to 18 years old.
  - Young children need different items to accurately capture important issues. Ages 2 to 6 years are now represented on the Conners EC. The Conners 3 and Conners CBRS begin at 6 years old, the age at which most children enter an academic setting in the first grade.[b]
  - Many youth turn 18 years old before they complete high school. The upward extension of the age range helps describe these students before they transition to instruments designed for use with adults, such as the Conners Adult ADHD Rating Scale™ (CAARS™).
  - Based on data supporting the accuracy of self-report by children as young as 8 years old, norms are provided for the self-report forms when completed by 8- to 18-year-olds.