Comparative study between Conners parent scale and Conners third edition self-report scale in children with Attention Deficit Hyperactivity Disorder

Thesis

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ADHD	Attention deficit hyperactivity disorder
Conners 3–SR	Conners 3rd edition–Self-Report
CBCL	The Child behavioral checklist
CBRS	Conners Comprehensive Behavior Rating Scales
CD	Conduct Disorder
Conners EC	Conners Early Childhood
CGI	Conners' Global Index
CRS	Conners' rating Scales
CPRS	Conners' Parent Rating Scale
CPRS-R:L	The Conners Rating Scale–Revised: Long version
CPRS-R:S	The Conners Rating Scale–Revised: Short version
CASS	the Conners-Wells' Adolescent Self-Report Scale
DSM	Diagnostic and statistical manual of mental disorders
ICD	The International Classification of Diseases
KSAD	The Kiddie Schedule for Affective Disorder and Schizophrenia for School Age Children
ODD	Oppositional Defiant Disorder
VARS	The Vanderbilt ADHD Rating Scales
VADPRS	The Vanderbilt ADHD Parent Rating Scale
VADTRS	The Vanderbilt ADHD Teacher Rating Scale

ABSTRACT

Background: Diagnostic criteria for identifying ADHD are based on behavioral symptoms, because of the lack of reliable biological markers for diagnosing ADHD. Behavior rating scales are the most common ADHD assessment tools because of their uncomplicated administration and high time- and cost-efficiency. While multiple informant reports are useful in providing information observed by different informants in different settings, disagreement appeared between them.

Objective: To study the difference between symptoms reported by the parents and their children and develop and test the Arabic version of the Conners 3 self-scale.

Method: Cross sectional comparative study through correlations between the answers of the children on the Conners 3 self-report after translation of the scale to Arabic language and the answers of their parents on the Conners revised long version parent form.

Results: The only significant correlations we found are between the cognitive subscale of the CPRS and the inattention and learning problems subscale of the SR, the emotional lability subscale and the depression screening items and the social problem subscale of the CPRS and the defiance/aggression subscale of the SR. Low or no agreement between the children and adolescents and their parents as regard different symptoms and subtypes of ADHD.

Conclusions: We found no significant correlation between different subscales of the CPRT and the Conners 3 SR, and

when found it is week. The Arabic version of the Conners 3 self-report has a highly significant interretar reliability which makes it suitable for use in the Arab region with different clinicians and assessors.

Key Words: rating scales, attention-deficit/hyperactivity disorder, informant agreement, Reliability.

Introduction

Attention deficit hyperactivity disorder (ADHD) is a developmental -behavioral disorder mostly diagnosed in childhood. Its prominent features are attention deficit, hyperactivity, and impulsiveness, which can cause poor occupational, academic, and social performance in the future **(*Kalbag and Levin, 2005).***

However, this diagnosis has been controversial because of its high prevalence and the popular conception that it is over diagnosed **(*Sciutto and Eisenberg, 2007*).**

The recognition and treatment of ADHD date from the second half of the 20th century ***(Swanson et al., 1998*)**. Since then, significant advances have been made towards understanding the disorder, resulting in the dissemination of knowledge across societies and in increasing recognition and treatment of affected individuals **(*Timimi and Taylor, 2004)***.

The DSM-IV defined 3 nominal subtypes of ADHD, based on differential elevations on 2 dimensions of inattention symptoms and hyperactivity-impulsivity symptoms. The predominantly inattentive type (ADHD-I) describes individuals with maladaptive levels of inattention, but not hyperactivity impulsivity; the predominantly hyperactive-impulsive type (ADHD-H) is characterized by

maladaptive levels of hyperactivity-impulsivity, but not inattention; and the combined type (ADHD-C) describes individuals who exhibit significant symptoms of both inattention and hyperactivity-impulsivity. Additional DSM-IV criteria required onset of ADHD symptoms prior to age 7 and required that current ADHD symptoms lead to significant impairment in multiple settings. Finally, a diagnosis of ADHD was precluded if the individual met the criteria fora pervasive developmental disorder or psychotic disorder **(*Willcutt, 2012).***

ADHD remains a clinical diagnosis. There is no frog test for ADHD. The diagnosis is made by taking a history and performing an examination and ruling out alternative disorders. The DSM criteria and parent/teacher rating scales are essential elements. The "gold standard" for ADHD diagnosis includes a comprehensive clinical history and examination, rating scales, direct behavioral observations, neuropsychological testing, and objective, comparative analysis of different drug effects. Such an approach is very costly and has economic burden, so that we mostly relay on history/examination and rating scales in diagnosis of ADHD.

ADHD rating scales have been used for almost 50 years. In fact, there is no reason not to use rating scales to

evaluate ADHD symptoms in children. Rating scales are good for delineating symptoms and their perceived severity. Ideally, several informants should fill out a rating scale, including parents, teachers, patient, and spouse. Rating scales are systematic and quantitative, but not objective. They are a necessary component of the diagnostic process, but not sufficient. Many rating scales are used like Vanderbilt rating scale, child behavior checklist, behavior assessment system for children (BASC), Conners parents ,teacher and self rating scale and the Wender Utah Rating Scale, which captures childhood symptoms of ADHD in patients who present as adults**(*Thomas, Gualtieri and Johnson, 2005)***

ADHD frequently persists into adulthood **(*Biederman and Faraone, 2005*)**. The societal economic impact of ADHD is large, with significant costs located both in the health care sector and elsewhere, for example, in education, social services, and productivity losses associated with family members **(*Le et al., 2014).***

Rationale of the study

We depend on rating of ADHD symptoms and subtype in Arab region on parent only because no available valid and reliable tool for children.

Hypothesis

No difference in rating ADHD symptoms and subtypes rated by children and their parents.