1. Title: Attention Deficit Hyperactivity Disorder Test (ADHDT)

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3. Publisher: pro-ed, 8700 Shoal Creek Blvd., Austin, TX 78757

4. Forms: Groups to which applicable: The ADHDT is a behavior checklist used to identify persons with Attention Deficit/ Hyperactivity Disorder (AD/HD). It can be completed by parents or teachers and other related professionals to assist in diagnosing clients aged 3-23. The ADHDT is only available in English.

5. Practical features: The ADHDT has 36 items comprising three subscales measuring hyperactivity, impulsivity, and inattentiveness. These three subscales are categories related to the diagnosis of AD/HD in the DSM-IV and professional literature. Most raters require about five minutes to complete the protocol and scoring is easily accomplished.


7. Date of publication: 1995

8. Cost: Complete kit - $74.00; Examiners manual - $42.00; Summary response forms (50) - $34.00

9. Scoring services available: The test is easily scored by hand. No machine or scoring services are available.

10. Generally, a rater can complete the ADHDT in about five minutes and the examiner can score and interpret the protocol in an additional five minutes.

11. Purposes for which evaluated: To identify students with AD/HD; assess persons referred for behavioral problems; document progress of clients with behavioral problems; establish target behaviors for individual Education Plans (IEPs); and collect data for further research regarding AD/HD.

12. Description of test, items, and scoring: Thirty-six items comprise the three subscales. Thirteen items were included to measure hyperactivity, 10 items for impulsivity, and 12 items for inattention. The design of the content is purported to closely resemble DSM-IV criteria. However, DSM-IV no longer views impulsivity as an entity distinct from hyperactivity (e.g. AD/HD - Primarily Hyperactive-Impulsive Type). Scoring of the ADHDT involves computing the simple sum of raw scores for each subtest, entering
each in the appropriate box. These scores are then transferred to the front of the summary form and can be converted into standard scores (M = 10, SD = 3 for subscales and M = 100, SD = 15 for the ADHD Quotient) and percentile ranks. Each derived score is plotted on the front of the summary form to graphically display the subtest and total test results.

13. Author’s Purpose and basis for selecting items: Each item is a behavioral description of the characteristics of AD/HD as defined in DSM-IV. The relationship between items and DSM-IV criteria are readily observed.

14. Adequacy of Directions: training required to administer: The directions are very clear. Any person familiar with the examiner's manual and the psychometric principles governing norm-referenced assessment can easily administer and score the ADHDT.

15. Mental functions or traits represented in each score: The traits measured are hyperactivity, impulsivity, and inattention, as well as global AD/HD.

16. Comments regarding the design of the test: Each behavior/characteristic is clearly identified. The response choices are clearly defined with each response having a quantitative value assigned. There are ten questions for the respondent to answer about the client to better describe circumstances under which the client behaviors are demonstrated, when the symptoms began and any interventions which may have been attempted. The response choices (0 = not a problem; I = mild problem; 2 severe problem) may restrict the accuracy of respondents' subjective observations. For example, the three-response format does not allow a choice for a 'moderate problem.'

17. Validation against criteria: A sample of teachers of 30 children (24 males and six females) with AD/HD aged 5-13 was administered the ADHDT and Conners Teacher Rating Scale - 28 (CTRS-28; Conners, 1989). The ADHDT ADHD Quotient correlated .72, .67, .53, and .59 (p < .01) with standard scores for the CTRS-28 Hyperactivity subscale, ADHD index, Conduct Problems subscale and Inattentive-Passive subscale, respectively. A sample of 66 teachers of individuals (52 males and 14 females) with AD/HD aged 3-23 was administered the ADHDT and Attention Deficit Disorders Evaluation Scale - School Version (ADDES-SV; McCarney, 1989). The ADHDT ADHD Quotient correlated -.88 (p < .01) with the ADDES-SV Sum of Subscale Standard Scores, the ADHDT Inattention subscale correlated -.86 with the ADDES-SV Inattentive subtest, the ADHDT Impulsivity subscale correlated -.81 (p < .01) with the ADDES-SV Impulsive subtest, and the ADHDT Hyperactivity subscale correlated -.82 (p < .01) with the ADDES-SV Hyperactive subtest. A sample of 115 teachers of students (72 males and 43 females) with AD/HD (aged 3-23) was administered the ADD-H Comprehensive Teacher’s Rating Scale (ACTERS; Ullman, Sleator & Sprague, 1984). The ADHDT Inattention subscale correlated -.78 with the ACTERS Attention subtest and the ADHDT Hyperactivity subscale correlated -.71 (p < .01) with the ACTERS Hyperactivity subtest. A diagnostic validity study (n = 530) resulted in 91.9% accurate decisions made, with a false positive rate of only 7.7%.
18. Other empirical evidence indicating what the test measures: The examiner's manual provides the following evidence of the ADHDT's construct validity: strong interrelationship of ADHDT subtest scores, strong item-subtest correlations, and excellent discrimination between diagnosed and normal groups. No exploratory or confirmatory factor analytic studies were reported.

19. Fairness: No information regarding procedures for ensuring gender and racial fairness was provided.

20. Comments regarding validity for Particular purposes: The ADHDT appears most useful when used to screen individuals ages 3-23 for symptoms related to AD/HD, both primarily inattentive type and primarily hyperactive-impulsive type. The subscales appear highly related to other tests purporting to measure similar constructs and somewhat useful in discriminating individuals with AD/HD from individuals with other behavioral disorders.

21. Generalizability: Interpretations derived from the ADHDT appear generalizable across age and sex categories. No evidence was provided to substantiate cross-cultural generalizability.

22. Long-term stability: Two test-retest studies were conducted to determine the temporal stability of the ADHDT. In the first study, teachers of 21 students (mean age of 1.0.4 years) were administered the ADHDT on two occasions, two weeks apart. Test-retest correlations were reported to be .89, .91, .85, and .92 for the Hyperactivity, Impulsivity, Inattention, and ADHD Quotient, respectively. In a second study, undergraduate college students majoring in special education served as raters for 21 students (12 with AD/HD, four with an emotional disturbance, and five with a learning disability). Each rater was administered the ADHDT on two occasions one week apart. Test-retest correlations were reported to be .92, .93, .85, and .94 for the Hyperactivity, Impulsivity, Inattention, and ADHD Quotient, respectively. While the sample sizes are small, these are very respectable stability coefficients for a screening test on the given samples.

23. Norms: The ADHDT normative group was comprised of 1,279 children and young adults who had a diagnosis of AD/HD. Age-based norms for the ADHDT were derived for males and females separately. Of the sample, 752 were taking medication in treatment of AD/HD, 273 were not, and missing data was noted for the remaining 254 participants. An attempt was made to stratify the standardization sample according to U.S. population characteristics for race, ethnicity, and geographical region. The sample was not representative according to such variables as sex, urban or rural setting, and socioeconomic status. The raters for the normative group were a mixture of teachers, parents, psychiatrists/diagnosticians, spouses, and a category called 'other'. Interestingly, a single age category (ages 3-23) was derived for the Impulsivity and Inattention subscales while two age categories (ages 3-7 and ages 8-23) were derived for the Hyperactivity subscale. Very few preschoolers (n = 65) and young adults (n =21) comprise the normative
24. Comments regarding adequacy of above for particular purposes: The normative sample is very unusual in that it is comprised totally of individuals previously diagnosed with AD/HD. The sample is likely confounded by collapsing the raters into a single group (teachers, parents, psychiatrists/diagnosticians, spouses, and other) and including individuals concurrently taking medication in treatment of AD/HD (59% of the total sample). For example, nearly all currently published behavior rating scales recognize differences between ratings given by parents and teachers. The author then proceeds to transform the cumulative frequency distribution through nonlinear transformational procedures and convert the resulting percentile ranks into standard scores with $M = 10$ and $SD = 3$. The resulting norms are, thus, based on a sample of children and adolescents with AD/HD, rather than a normal population. However, interpretation of derived standard scores is conducted as if the sample were of normal individuals. For example, an 8-year-old boy attaining a standard score of 10 would be considered average (percentile rank of 50) in comparison with the normative group. But what this means is unclear because his score is the 50th percentile of all those comprising the normative group, each of whom had been previously diagnosed with AD/HD, and more than half of which were medicated when they were rated by a parent or teacher or other respondent. The lack of clarity of these interpretations is a major weakness of the ADHDT. Also, while the sample is adequate for screening children and adolescents, the sample sizes are far too small to lend substantial credibility to interpretations for preschoolers and young adults. Again, for example, nearly all currently published behavior rating scales recognized that the attentional capabilities of preschoolers differ substantially from those of young adults. Collapsing norms across the categories of 3-23 years of age is contrary to currently accepted practice and little justification for this strategy was provided in the manual.

25. Aids to user: Except for a lack of interpretive implications, the ADHDT has clear and precise directions. The manual outlines a sample case for scoring only one section of the test, which is minimally adequate since each subtest follows a similar scoring procedure.

26. Comments from reviewers: No reviews were available.

27. General evaluation: The ADHDT is a potentially valuable tool for screening students with AD/HD and monitoring treatment effects. The forms are easy to complete and respondents comprising the norm sample were diverse with respect to their relationships with the examinee. While the scale items are well defined and have face validity when compared to DSM-IV criteria, it is unclear why the author chose a three subscale format of inattention, impulsivity, and hyperactivity, when the DSM-IV recognizes two dimensions: inattentive and hyperactive-impulsive types. Perhaps more troubling is the issue of interpreting ADHDT norm-referenced scores. Because the normative group was comprised of individuals previously diagnosed with AD/HD, more than half of which were taking medication ostensibly in treatment of AD/HD symptoms, the evaluator is left wondering about the value of the interpretive statistic.
References


