TEST REVIEW:
Conners’ Parent Rating Scales – Revised: Short Form
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1. Title: Conners' Parent Rating Scales-Revised: Short Form (CPRS-R:S)

2. Author: C. Keith Conners, Ph.D.


4. Forms: groups to which applicable: There is one English version used with parents or guardians of children aged 3-17 years who may exhibit symptoms of ADHD, hyperactivity, cognitive problems, or oppositional behavior. The CPRS-R:S is currently being normed for several other languages as well.

5. Practical features: There are twenty-seven items to which respondents indicate the frequency of behaviors observed in their child during the previous month. Frequency of behavior is determined according to the following descriptors: NOT TRUE AT ALL (Never, Seldom); JUST A LITTLE TRUE (Occasionally), (PRETTY MUCH TRUE (Often, Quite a Bit); VERY MUCH TRUE (Very Often, Very Frequent). A tenth grade reading level is required of respondents. The CPRS-R:S generally requires only 10-15 minutes to complete, but may take longer for respondents whose native language is not English, or those with psychiatric or reading problems. The CPRS-R:S is most practical when time is limited or if respondents will be given multiple retests over time. A long version of the CPRS-R (80 items) is available as well.

6. General type: Behavior rating scale which assesses ADHD and comorbid conditions.

7. Date of Publication: 1997


9. Scoring services available and cost: The CPRS-R:S can be hand-scored by administrators with QuickScore forms (no additional cost). It can also be scored within 148 hours (+ mail delivery) through a 'mail-in scoring service, or within a few minutes through a fax-back system that operates 24 hours/day. An available personal computer program will score and provide interpretive statistics within seconds.

10. Time required to score: Approximately 10-15 minutes.

11. Purpose for which evaluated- Behavior rating inventory for use with parents or guardians of school-aged children.
12. Description of test, items, and scoring: The CPRS-R:S assesses ADHD and comorbid conditions (problems with conduct, emotion, anger control and anxiety). It contains an Oppositional subscale (6 items), a Hyperactivity subscale (6 items), a Cognitive Problems subscale (6 items), and an ADHD Index (12 items). These items assess the frequency of behaviors as observed by a parent or guardian during the past month. CPRS-R:S feedback forms allow for summarization of scores as 'low' 'typical' or "problem" and provide room for intervention suggestions, remediation strategies, and advice. The CPRS-R:S Profile Form automatically transforms raw scores into T-scores, which can easily be converted to percentile ranks. Treatment Progress ColorPlot forms can be used to plot changes in scores over time. Up to seven administrations can be plotted on one form.

13. Author’s purpose and basis for selecting items: Items were developed to assess ADHD and comorbid conditions in children and adolescents as observed by parents or guardians. This rating scale can be used in conjunction with the short versions of the Conners’ Teacher Rating Scale-Revised and the Conners-Wells’ Self-Report Scale-Revised (for adolescents aged 12-17). The CPRS-R:S was intended to be used as part of a comprehensive assessment, not as the sole diagnostic tool. This revision of the CPRS now includes a new, extensive normative database, and test items that incorporate DSM-IV criteria for ADHD. The developers created items derived from prior CRS forms, DSM-IV criteria, and other clinically relevant information. The initial item pool was pilot tested and revised prior to use with the normative sample.

14. Adequacy of directions and training required to administer: The instructions are clear and easy to follow. Administrators need very little training, if any, beyond proper procedures to obtain informed consent, avoid bias, and debrief clients. Results of the CPRS-R:S should only be interpreted by professionals with at least a Master’s degree who have proper education, training and competence in test interpretation.

15. Mental functions or traits represented in each score: Each item on the CPRS-R:S assesses the frequency of behavior in one or more categories, as observed by a parent or guardian, that a school-aged child exhibits. The categories are: Oppositional (6 items), Hyperactivity (6 items), Cognitive Problems (6 items), and ADHD (12 items).

16. Comments regarding design of test: Instructions are very easy to follow. Response indicators (NOT TRUE AT ALL (Never, Seldom); JUST A LITTLE TRUE (Occasionally); PRETTY MUCH TRUE (Often, Quite a Bit); VERY MUCH TRUE (Very Often, Very Frequent)) are effective changes from the previous CPRS version, except that the placement of "Seldom" in the NOT TRUE AT ALL category is contradictory. Some of the items also contain words that may cause confusion. For example, one item contains the word 'attends', which in this case means “pays attention”, rather than "is present". Overall, however, the items are clear and easy to understand for anyone reading at or beyond the 10th grade level.

17. Validation against criteria: Factorial validity for the three subscales (Oppositional, Cognitive Problems, Hyperactivity) was tested from two approaches: exploratory and confirmatory factor analysis, and subscale intercorrelations. All items from subscales on
the CPRS-R:S also appear on the long version (CPRS- R:L). Correlations between the two versions range from .97 to .98 for males and .96 to .97 for females. The CRS- R also offers a short-version teacher rating scale (CTRS- R:S). Though both have an ADHD Index and Hyperactivity, Cognitive Problems, and Oppositional subscales, they do not share all the same items. The CRS-R also offers a short-version adolescent self-rating scale for 12 to 17 year-olds (CASS:S). Low to nonsignificant correlations were found between most of the CPHS-R:S and CASS:S ratings. The only moderate correlations were found on the Cognitive Problems subscale (.53 for males and .42 for females). No correlational information was provided for the CPRS-R:S and other tests commonly used to screen and diagnose children with ADHD.

18. Other empirical evidence indicating what the test measures: Validity of the ADHD Index was assessed using a sample separate from the normative sample. Parents of ADHD and 'normal" children and adolescents rated their children on items that assessed problematic behaviors. Results indicated that the ADHD Index can be used as an effective screening measure to identify children and adolescents meeting ADHD diagnostic criteria.

19. Fairness: On all subscales of the CPRS-R:S, males scored higher than females. Significant age group differences were found on the Hyperactivity and Cognitive Problems subscales. As such, norms for the CPRS-R:S are age and gender dependent. The rationale behind the use of 3-year age categories (ages 3-5,6-819- 11, 12-14,15-17) was not provided. Also, problems may arise for children being assessed near their sixth, ninth, twelfth, and fifteenth birthdays. For example, a child assessed one week after her ninth birthday likely exhibits no significant behavior differences from one week prior to her birthday, yet she would be scored against a different 3-year age group.

20. Comments regarding validity for Particular purposes: The ADHD Index is an effective screener to identify children and adolescents meeting ADHD diagnostic criteria. The CPRS-R:S offers good factorial (Oppositional, Cognitive Problems, Hyperactivity) validity. Substantial cross-loading of items was observed and has been shown to lead to high interscale correlations. Some items could have been rewritten to reduce cross-loading. No convergent or divergent validity information with respect to tests outside of the CRS-R is provided. No discriminant validity information for the subscales of the CPRS-R:S is provided although information is provided for the CPRS- R:L and the manual suggests that results would be very similar for the CPRS- R:L.

21. Generalizability: Norms are age and, gender dependent, and only take into account behaviors observed by a parent or guardian within the past month. Also, correlations between the CPRS-R:S and the short- version Conners' Teacher Rating Scale-Revised (CTRS- R:S) reveal -considerable variability. Though this may be due to differences in the two scales or differential perceptions between teachers and parents, it also might reveal actual differences in behavior at school and home.

22. Long-term stability: Internal reliability of the CPRS- R:S was tested by gender and age group with total reliability coefficients ranging from 0.857 to 0.938. Test- retest reliability, examined using an interval of 6 to 8 weeks, produced coefficients ranging
from .62 to .85 on the three subscales and ADHD Index. The manual suggests that, due to statistical regression effects, practitioners should acquire at least two baseline ratings prior to providing treatment.

23. Norms: All items and all subscales in the CPRS-R:S are also found in the CPRS-R:L, and most of the normative data for the CPRS-R:S was derived from CPRS-R:L data. This is an unusual practice and most certainly accounts for the exceedingly high correlations between subscales for the long and short forms. Data was collected from 2,426 parents or guardians from all areas of the United States and Canada who had a child in one of the following age categories: 3-5, 6-8, 9-11, 12-14, and 15-17. Norms were constructed to account for age and gender differences. Eighty-four percent of respondents classified themselves as Caucasian/White.

24. Comments regarding adequacy of above for Particular purpose: The source of the database is questionable. Every subscales and item on the CPRS-R:S can also be found on the CPRS-R:L. Most of the CPRS-R:S data was derived from information gathered for the CPRS-R:L. This means that the sample was not actually given the CPRS-R:S to complete. As a result, time to complete the form could be a confounding variable. Also, responses to a particular item might differ depending on the number and content of items answered previously. In sum, had the sample actually completed the CPRS-R:S, the norms might be somewhat different. Focusing on the characteristics of the normative database, representativeness becomes an issue. The database is representative in terms of data collection sites, age groups, and gender. It is not adequately representative in terms of ethnicity, however. Also, significant differences were found on the Oppositional subscale between the Native American group and the other ethnic groups, yet separate norms were not created. Children and adolescents designated as special education were excluded from the sample, and no explanation for this was provided. The rationale behind the use of 3-year age categories (ages 3-5, 6-8, 9-11, 12-14, 15-17) was also not provided.

25. Aids to user: The CPRS-R:S can be used for research, screening, or monitoring treatment effects overtime. It can also be used as a diagnostic tool in conjunction with other information. The CPRS-R:S is potentially useful in numerous settings, including schools, residential treatment centers, and private practices.

26. Comments of reviewers. Because of the CPRS-R:S's recent publication date, no published comments were available.

27. General evaluation: As part of a multimodal, assessment, the CPRS-R:S can provide valuable information regarding behavior indicative of ADHD and comorbid conditions, as observed by a child's parent or guardian. It can be used in conjunction with the Conners- Wells' Adolescent Self Report Scale (CASS:S) for adolescents aged 12-17, and the short-version Conners' Teacher Rating Scale-Revised (CTRS-R:S). The short version of each scale is recommended when time is a factor, or if multiple retests are anticipated. There are long versions of each scale as well. The CPRS-R:S is easy to administer, score, and interpret. The directions are easy to follow and the items, in general, are clearly written and easy to understand for anyone reading at or beyond the
tenth grade level. Hand-scoring is easy using QuickScore forms, and additional scoring services are provided. Feedback forms and ColorPlot forms are additional, helpful aids for interpretation and reporting of results. Detailed User's and Technical Manuals are also provided. Validity data for the CPRS-R:S is limited. More convergent, divergent, discriminant, and efficiency data would be helpful, particularly correlations with other commonly used screening tests. Internal consistency of the CPRS-R:S subscales for the standardization sample was adequate for screening purposes. In general, higher test-retest coefficients are desirable to insure consistency of decisions made using the CPRS-R:S over time. Norms for the CPRS-R:S are representative in terms of data collection sites, age, and gender, but not for ethnicity. Also, the normative sample was not actually given the CPRS-R:S to complete. Rather, data was derived from responses to the CPRS-R-L, since all items on the CPRS-R:S are also found on the CPRS-R:L. To avoid confounding variables, the CPRS-R:S norms should be based on responses to the CPRS-R:S items alone.

Reference