

MALINGERED ADHD EVALUATIONS: A FURTHER COMPLICATION FOR ACCOMMODATIONS REVIEWS

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Editor's Note: This article is based on Dr. John D. Ranseen's presentation "How to Identify Malingering in ADHD Evaluations" at the 2011 NCBE Annual Bar Admissions Conference held on April 28–May 1 in San Francisco, California. Dr. Ranseen and Dr. Jasinski have collaborated to produce this article for the Bar Examiner.

Mental health evaluations rely heavily on the patient's report of symptoms and thus assume that the patient is honest, forthcoming, and compliant with the process. Yet many patients come to an evaluation with their own agendas, either conscious or unconscious, which may or may not coincide with the ostensible reason for the evaluation or even be known to the health care professional. In some cases, patients may try to appear more impaired or disabled than they truly are, possibly in hopes of securing a tangible benefit such as disability compensation, medication, financial award from a lawsuit, or the avoidance of prosecution. *Malingering*, as a psychiatric concept, is defined as the "intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives."¹ Realistically, the accuracy of many health care evaluations can be influenced or even voided by the motivation and honesty, or lack thereof, of the person being evaluated.

RECENT DEVELOPMENTS IN THE STUDY OF MALINGERING

There has been an exponential increase in the study of malingering in the last several decades, due pri-

marily to the large increase in neuropsychological evaluations conducted to assess disability eligibility and damages for traumatic brain injury.² This work has focused on the development of techniques to best identify those patients who provide inadequate or suboptimal effort on cognitive tests.

On the other hand, evaluators whose work has primarily focused on the identification and treatment of individuals with learning problems, including Attention Deficit Hyperactivity Disorder (ADHD), have had little reason to consider this issue until recently. For years, much of the ADHD and Learning Disability (LD) literature has focused on children and adolescents who were presumed to have little motivation to feign impairment. Further, adults with learning problems were often embarrassed by their disorder and prone to hide the problem rather than seek identification and potential help.

Increasing recognition that learning problems may persist into adulthood has led to identification of young adults with both LD and ADHD for whom medication and/or specialized programs at the university level are accepted as standard treatment strategies. Many adults with these disorders, when

provided appropriate treatment, are more likely to reach goals that might not have been achievable without such assistance.

Yet some have acknowledged the uncomfortable fact that some individuals with no history of learning difficulty may be motivated to seek a diagnosis of ADHD or LD, primarily in the interest of gaining access to stimulant medication and/or academic accommodations at both the undergraduate³ and postgraduate levels.⁴ Stimulant medications are frequently utilized as a study aid and abused recreationally among college students,⁵ and the academic accommodations afforded to those with a diagnosis of ADHD or LD (e.g., extra time on exams, a private testing room, tutoring services) would potentially benefit any student looking for a competitive edge.⁶ In short, external incentives clearly exist for some students to seek an ADHD diagnosis in order to legally obtain a prescription for stimulant medication and/or access to university disability services, which often include exam accommodations.

MALINGERING IN THE CONTEXT OF BAR EXAM ACCOMMODATIONS REQUESTS

Those who review documentation for accommodations requests on state bar exams are well aware that one of the most common cases is that of the student who seeks his or her first evaluation of ADHD after struggling on initial law school exams. In some cases, evaluation is sought only after bar exam failure. Many other accommodations requests involve updated evaluations where the initial diagnostic evaluation, perhaps conducted during childhood or adolescence, was far from comprehensive.

The most common request for bar exam accommodations is for extended time to alleviate generic problems with “slow” processing of written material

or the inability to organize a response and provide a coherent, well-reasoned written argument quickly and efficiently.⁷ Individuals making such requests likely feel a great deal of stress and may view themselves as having some hidden learning problem that has come to light due to the demands of the environment. Alternatively, they may simply believe that extended time and other accommodations might give them sufficient edge to compete at this level.

In short, there is ample reason for the individual to feign an accepted disorder for which accommodations are now routinely offered in many universities and professional schools. Several researchers have estimated that nearly one-quarter to one-half of students evaluated for ADHD within a university setting may exaggerate or feign symptoms.⁸ Unfortunately, there is little indication that most evaluators who submit reports in support of accommodations requests pay any serious attention to this issue.

As will be explained in this article, most of the techniques used to assess ADHD and other learning problems are extremely susceptible to feigned impairment. Identification of those individuals who are feigning impairment on ADHD evaluations is improving yet remains imperfect. Recommendations will be offered for dealing with this issue in reviewing bar exam accommodations requests based on ADHD diagnostic evaluations.

ADHD EVALUATION: STANDARD PRACTICE

Recommendations for a comprehensive ADHD evaluation involve the following general components:⁹

1. diagnostic interview with behavioral observations

2. psychological testing, including ADHD self-report inventories
3. interviews with and/or symptom ratings from significant others
4. cognitive testing, including IQ tests, academic measures, and tests of specific cognitive functions (e.g., attention, mental flexibility)
5. review of past records: educational records, transcripts, supervisor ratings, etc.

There is no mental health condition, ADHD included, for which a specific, highly reliable biological marker exists. Clinical diagnostic evaluations focusing on ADHD rely heavily on the patient's self-report of past and present symptoms and problems. This is often augmented by psychological testing that includes both self-report inventories and neuropsychological tests to assess cognitive functions. Symptom ratings from a close friend or family member are utilized to corroborate the patient's report of symptoms and may help identify those who seem to be pathologizing normal emotional or academic stressors.

Finally, reviewing past records is recommended in mental health evaluations involving conditions that have been long-standing. ADHD is technically a developmental disorder. Since many of the adult ADHD evaluations involve individuals who were never given the diagnosis in the past, a review of old school records or other information is deemed necessary to establish that the problem is not of recent onset. This is a particular concern in those cases in which a student first finds him- or herself inattentive and distractible under the substantial academic demands of law school. Additionally, inattention is characteristic of a number of psychiatric disorders,

including depression and anxiety, and the lack of a developmental history may lead the clinician to consider alternative explanations for reported symptoms.

Realistically, it should be understood that within the busy clinical environment, many diagnostic evaluations fall short of the recommendations for comprehensive ADHD evaluation. Nevertheless, such evaluations are routinely submitted to support requests for accommodations.¹⁰ Thus, many testing/licensing organizations provide guidelines to encourage evaluators to provide sufficient information by which to conclude that a comprehensive evaluation has been performed. Submitted evaluation reports often indicate that the diagnosis has been made solely based on a psychiatric interview or an interview coupled with an ADHD self-report inventory. Others include brief cognitive testing such as a continuous performance test (CPT) or measures specifically chosen to examine attention, speed of processing, and reading speed in order to provide a rationale for requesting extended time. Research has shown, however, that these diagnostic techniques are quite susceptible to feigned impairment.

FEIGNING ADHD DURING THE ADHD EVALUATION COMPONENTS

Feigning during the Interview

Information regarding typical ADHD symptoms can be readily accessed from countless websites and publications, requiring little effort on the part of an individual motivated to appear to have the disorder. Contrary to television shows such as *Lie to Me*, which depicts a mental health professional with highly scientific methods of determining truth based on subtle verbal and nonverbal cues, studies do not support the myth that mental health professionals have

any ability to detect which patients are presenting a true psychiatric disorder as opposed to a feigned disorder.

In fact, while clinicians often believe themselves to be superior predictors of human behavior, numerous studies have demonstrated that their ability to distinguish between a true disorder and malingering is particularly poor, often no better than random guessing.¹¹ Extensive research and heated debate comparing clinical judgment to statistical prediction models have suggested that clinicians are quite easily fooled when it comes to malingering, and objective data is often better at predicting a feigned disorder.¹² While no study to date has focused specifically on clinician judgment of genuine versus feigned ADHD per se, it is safe to assume that the significant limitations in clinical prediction also apply to this domain.

Feigning on Self-Report Inventories

One of the most commonly used methods for assessing ADHD is the use of self-report ratings, where the individual being evaluated is instructed to rate the severity of various symptoms of the disorder. Inventories such as the Conners' Adult ADHD Rating Scale (CAARS)¹³ and Brown Attention Deficit Disorder Scales (BADDS)¹⁴ are used to identify and quantify current symptom complaints, while the Wender Utah Rating Scale (WURS)¹⁵ is often used to retrospectively assess childhood symptoms.

These measures all purport to be valid and objective measures of ADHD; however, they are

valid only if one assumes that a person has no interest in feigning the disorder. Realistically, these scales derive their validity from "face validity," which means that a person marks obvious symptoms of ADHD along some continuum of severity. The CAARS includes an Inconsistency scale, an indicator of whether the individual read and understood the items, which has little relation to whether the person feigned symptoms. More recently, the development

of an Infrequency, or feigning, scale has been promising on the CAARS but awaits further validation.¹⁶ No other ADHD-specific self-report inventories include a validity scale.

Recent studies have demonstrated significant vulnerability to feigning on the self-report ADHD measures. For example, one study found that up to 95 percent of individuals instructed to fake symptoms of ADHD were easily able to produce an ADHD-like profile on several popular self-report measures of the disorder,¹⁷

and it has been consistently documented that true ADHD and malingered profiles are nearly indistinguishable.¹⁸

In fact, feigning frequently results in extremely high symptom ratings because the feigning individuals indiscriminately endorse all areas of difficulty, whereas individuals with a prior documented diagnosis of ADHD achieve significantly lower scores.¹⁹ This likely occurs because true ADHD involves only some, rather than all, symptoms, and the level of impairment varies greatly between individuals. Additionally, the current diagnostic nomenclature

[F]EIGNING FREQUENTLY RESULTS IN EXTREMELY HIGH SYMPTOM RATINGS BECAUSE THE FEIGNING INDIVIDUALS INDISCRIMINATELY ENDORSE ALL AREAS OF DIFFICULTY, WHEREAS INDIVIDUALS WITH A PRIOR DOCUMENTED DIAGNOSIS OF ADHD ACHIEVE SIGNIFICANTLY LOWER SCORES. THIS LIKELY OCCURS BECAUSE TRUE ADHD INVOLVES ONLY SOME, RATHER THAN ALL, SYMPTOMS, AND THE LEVEL OF IMPAIRMENT VARIES GREATLY BETWEEN INDIVIDUALS.

may apply more to children than to college students or adults.²⁰ Moreover, self-report scales of general psychiatric complaints that do include validity scales (e.g., the Minnesota Multiphasic Personality Inventory-2-RF [MMPI-2-RF] and the Personality Assessment Inventory [PAI]) have not fared well at detecting feigned ADHD symptoms.²¹ Thus, it is well established that self-report inventories, particularly those without validity scales, are easily feigned, and very high symptom ratings should heighten clinician awareness of possible symptom exaggeration.

Feigning on Measures of Observer Symptom Ratings

Current diagnostic criteria for ADHD require the presence of symptoms during childhood; however, adults are poor historians for youth symptoms.²² Thus, Barkley et al.²³ encourage the inclusion of symptom ratings from family members or friends who can speak to the impact of the disorder beginning at an early age. Such ratings are typically done using a variant of the self-report inventories (e.g., the CAARS-Observer Rating Scale), allowing for a direct comparison between self and observer ratings of symptom severity.

As with the self-report scales, the lack of validity scales raises concerns about the possible impact of feigning. There is a general assumption that it is more difficult to get other people to feign a disorder for you, making them potentially less vulnerable, although no studies to date have explored this assumption. Furthermore, clinicians are left with a difficult decision in the face of discrepant self and observer ratings: could the observer be lacking in knowledge or awareness of the patient's true symptoms, or is it possible that the observer ratings are accurate, while the self-report may be exaggerated? At present, there is little reason to assume

that observer ratings are any different from their self-report counterparts, and results should be interpreted as only one piece of the puzzle until their validity can be more firmly established.

Feigning on Cognitive Measures

ADHD evaluations may also include tests of intelligence, academic skills, processing speed, memory, attention, and executive functioning to aid in confirming the diagnosis, as well as to direct appropriate interventions based on the individual's personal strengths and weaknesses. These cognitive tests are no less susceptible to feigned symptoms, however, and clinicians who fail to consider effort as part of their evaluations run the risk of using very low scores on cognitive tests to further justify a questionable diagnosis. Several recent studies have documented exceptionally low scores on a wide range of cognitive tests among individuals instructed to feign ADHD, while those with a prior diagnosis of the disorder tended to show significantly fewer cognitive deficits.

Feigning on Tests of Processing Speed and Reading Fluency

The score disparity between feigning subjects and ADHD subjects has been most evident on tests of processing speed and reading fluency, where individuals who attempt to fake attention problems overestimate the impact of the disorder and perform exceptionally poorly. For instance, individuals instructed to fake having ADHD suppressed their scores on a processing speed index and digit recall subtest far below those of individuals with a well-documented history of ADHD. In fact, ADHD subjects often scored in the average range or higher on such measures, while feigning subjects varied somewhat but typically scored well below average.²⁴

Similar results were found on a test of reading fluency, or how quickly a person is able to read short sentences. Again, mean scores for the ADHD sample group typically fell in the average range, while the faking group's mean score fell below average.²⁵

Feigning on Tests of Memory, Executive Function, and Attention

Other studies have found evidence of significantly suppressed scores among malingerers on tests of memory, executive function, and attention, with no evidence of problematic scores among the ADHD comparison groups.²⁶ Anecdotal reports confirm that individuals who fake ADHD utilize a number of strategies to appear impaired by over-reporting typical symptoms of the disorder, completing tasks very slowly, responding incorrectly, or performing carelessly or too quickly.²⁷

Overall, while ADHD subjects do not generally show large deficits on many neuropsychological tests, and the tests therefore may not be particularly diagnostic of the disorder, concern should be raised when scores fall well below the average range, particularly among individuals who have successfully navigated a higher education system for several years.

THE USE OF SYMPTOM VALIDITY TESTS TO IDENTIFY MALINGERING

In an attempt to address the issue of feigned symptom presentations on cognitive tests, several authors have suggested using the widely accepted and well-validated symptom validity tests (SVTs) developed for traumatic brain injury (TBI) and other neurological insults. SVTs have gained substantial attention in recent decades and are able to accurately detect suboptimal effort using tests that appear to rely heavily on complex tasks (e.g., memory). These

tests, however, are actually quite simple, and even severely neurologically impaired patients can pass the tests with very good scores.

Research and Development of Symptom Validity Tests

Research about and development of SVTs utilize two primary study methodologies: *simulation studies* and *known-groups design studies*. Simulation studies include a group of participants who are instructed to fake symptoms of the disorder and are often provided an incentive for doing so "successfully" (i.e., avoiding being caught by not feigning too obviously). This simulation group is then compared to a group whose members were previously diagnosed with the disorder of interest (e.g., TBI, ADHD), or to a group without any prior diagnoses or conditions.

In a known-groups design study, individuals are selected for inclusion in a group because they are thought to be malingering based on their failure of one or more SVTs. The suspected feigning group is then also compared to a group known to have a history of the condition of interest, or to a group with no prior diagnoses.

Simulation studies are often used because they are easy to conduct and allow the researcher more experimental control. However, they are limited in that they may not capture the "real world" incentives at stake for a person who is motivated to feign symptoms of a disorder.

Symptom Validity Tests as Applied to ADHD Evaluations

Only recently have these SVTs been applied to ADHD evaluations, in the hope of gaining a repertoire of tests able to detect feigned attention problems. To date, three studies have provided initial support for the inclusion of SVTs in a standard

ADHD test battery. Sollman et al.²⁸ were among the first to examine SVTs and found good support for use of the Test of Memory Malingering (TOMM),²⁹ Letter Memory Test (LMT),³⁰ Digit Memory Test (DMT),³¹ and Nonverbal Medical Symptom Validity Test (NV-MSVT).³²

The NV-MSVT is a computerized test that requires an individual to remember pairs of objects, and it takes approximately 5 to 10 minutes to administer. The TOMM, DMT, and LMT are card forms of memory tests and require a person to recall pictures, a series of digits, or a series of letters, respectively. Each test requires 20 to 30 minutes of administration time and manipulates the apparent level of difficulty by adding more items to recall or extending the length of time before the recognition task. Jasinski et al.³³ provide additional validation for these tests and suggest that failure of two or more of these SVTs provides the best overall prediction of feigning among college students claiming to have ADHD.

In general, these tests demonstrate strong specificity (e.g., the percentage of individuals without ADHD that are correctly identified as honest by the test) and moderate sensitivity (e.g., the percentage of individuals who are feigning ADHD that are correctly “caught” by the test). The statistical properties of the SVTs when used to detect feigned ADHD are very similar to those found when detecting malin-

gered TBI, suggesting that these tests should be routinely used in ADHD evaluations.

Two other validity tests, the b Test³⁴ and the Dot Counting Test (DCT),³⁵ are promising for detecting feigned ADHD but await further validation.³⁶ Additionally, indices embedded within cognitive tests (e.g., the Reliable Digit Span³⁷ and the Rey Auditory Verbal Learning Test Exaggeration Index³⁸) may be useful in examining feigning, although these indices are less powerful in detecting suboptimal effort than the SVTs.³⁹

In general, SVTs can be applied to ADHD evaluations with increasing confidence, despite being developed for the assessment of feigned memory impairment. What remains unclear is whether individuals who feign ADHD believe memory impairment to be part of the syndrome, or if they perform poorly on all measures of cognitive ability. In either case, tests developed for malingered TBI are currently the best option for use in detecting suboptimal effort in ADHD evaluations.

MALINGERING AND THE ACCOMMODATIONS REVIEW PROCESS

Challenges Posed by the Amended Americans with Disabilities Act

Reviewing requests for accommodations on licensing exams based on mental disorders such as ADHD has always been complicated by the fact that clinicians submitting evaluations on behalf of individuals requesting accommodations often have

limited understanding of the legal basis for their advocacy.⁴⁰ State boards are currently struggling to interpret the implications of the amended Americans with Disabilities Act (ADAAA) and the recent regulations provided by the Department of Justice interpreting this law as it currently applies to test accommodations.⁴¹

Recognition that some, perhaps many, evaluations submitted to state law boards may be tainted by exaggerated symptom reports and feigned impairment on cognitive tests comes at a problematic time. The ADAAA regulations seem to uphold the previous standard of disability (i.e., substantial limitation in a major life activity) while also advising that this standard be applied by testing organizations in a less stringent manner.⁴² Thus, these regulations indicate that a history of accommodations should be taken quite seriously when reviewing current requests and that state boards should not make onerous requests for additional diagnostic information. It is presumably not onerous or unreasonable to request a valid evaluation if one does not believe the primary findings upon which the diagnosis of the disabling condition is based.

Evaluator Awareness of Malingering

In past years, it was unusual to review an ADHD evaluation that made any attempt to address the issue of malingering. Currently, some evaluations will address this issue by reporting performance on either a symptom validity measure or a validity scale on a self-report inventory such as the MMPI-2. As previously discussed, there is no adequate self-report validity scale for ADHD measures that has undergone sufficient study to address feigned self-report of symptoms.

Additionally, many evaluators continue to employ outdated symptom validity measures, such as the Rey 15-Item Memory Test, that have limited sensitivity to detecting malingering in TBI populations.⁴³ This limited sensitivity undoubtedly extends to the ADHD population. Nevertheless, given that so few evaluators provide any discussion of effort in their reports submitted to support requests for accommodations based on ADHD, credit must be given to the fact that an evaluator at least shows some awareness of this concern.

Current Research and Conclusions

The state of current research regarding feigned symptom reports and cognitive test results within ADHD evaluations can be summarized as follows:

1. Studies indicate that some evaluations conducted primarily with college students include a substantial number who do, in fact, feign impairment in order to achieve a desired goal usually involving access to stimulant medication and/or provision of accommodations.
2. ADHD evaluations based solely on symptom reports cannot be reliably considered valid. Particular concern should be noted in evaluations indicating extremely high levels of symptoms that show little or no correspondence to impaired functioning in life.
3. Neuropsychological testing that reveals unusual degrees of cognitive impairment more consistent with severe TBI than with mild deficits in attention or speed of processing cannot be considered valid, particularly if the evaluation has not included any symptom validity testing. ADHD is not characteristically associated with extremely low levels of reading fluency.

4. Evaluations that employ symptom validity testing designed to detect suboptimal effort on memory tests provide some assurance of validity yet do not completely ensure that the impairment on other measures has not been feigned.

The implications of these findings are, in fact, consistent with previous recommendations for comprehensive ADHD evaluation. Although many practitioners seem to rely solely on self-report of symptoms, this has never been considered acceptable practice for comprehensive diagnosis of ADHD, particularly as it applies to supporting accommodations requests.⁴⁴ Given that such evaluations are completely susceptible to malingering, they should not be accepted.

Similarly, impaired performance on a continuous performance test or other cognitive measure without other credible indications of impairment in the actual life of the person is not diagnostic of ADHD. Particular importance has always been given to providing a clear developmental history of symptoms and the impairment caused by these symptoms across environments over time. ADHD is not conceived to be either a disorder that first arises under the demands of a challenging academic environment or one that only causes an isolated problem focusing on difficult exams. An individual can feign impairment on all aspects of an ADHD evaluation except for the previous history of problems. For this reason, past performance has always been a better indication of limitation than an isolated weakness on a neuropsychological evaluation.

The implications of the ADA^{AAA} notwithstanding, documentation submitted on behalf of an individual requesting accommodations for ADHD needs to include a comprehensive diagnostic evaluation that provides credible evidence of impairment. Some state documentation requirements request that the evaluator address how it was determined that malingering was ruled out. Other states should consider adding this to their documentation requirements. At a minimum, this signals to an evaluator a need to take this issue seriously.

Those providing consultation to state boards should question evaluations that display unusual levels of impairment with no symptom validity testing and no credible evidence of past difficulty on exams. For instance, there is no coherent explanation for a law student claiming a disability in processing speed due to ADHD having a measured reading fluency at the fourth-grade level even though the student achieved an average LSAT score without accommodations. Put simply, the LSAT score is a better indication of limitation in reading fluency than an isolated low score on a test whose validity is completely dependent upon effort.

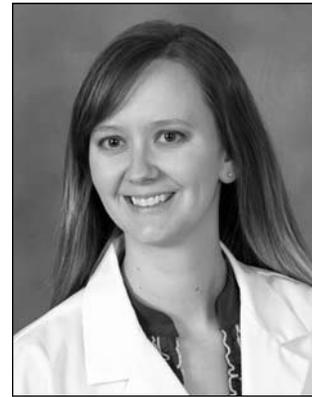
This is not to imply that all low scores on cognitive tests should be routinely dismissed. Every accommodations request has to be taken on its full merits. Realistically, there is no way to completely ensure that test findings are valid in terms of providing an accurate reflection of the person's full effort. Nevertheless, ongoing research in this area is

improving and will eventually provide a sounder basis for determining which ADHD evaluations truly reflect a person's actual functioning. 

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