

# the ADHD REPORT

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## **SPECIAL ISSUE: FOCUS ON ADHD IN ADULTS**

### **Adults Faking ADHD: You Must Be Kidding!**

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#### **ADULT ADHD EPIDEMIC?**

We are witnessing a dramatic increase in the number of adults presenting with symptoms of attention deficit hyperactivity disorder (ADHD) and wondering if they actually have this disorder (Hagar & Goldstein, 2005; Roy-Byrne et al., 1997). The same increase is true at the college and university level (Learning Opportunities Task Force, 2002). Many of these adults have no prior diagnosis of ADHD, and may not be able to provide any information about childhood behavior to corroborate lifetime impairment. In such situations, a clinician not only has to differentiate between the symptoms of ADHD and those of other disorders when making a differential diagnosis, but also must be aware of the possibility that the person may be exaggerating or feigning these symptoms for secondary gain. The idea that individuals could be exaggerating or feigning symptoms of ADHD has only recently become a topic of interest. As Quinn (2003) points out, "malingering may be a potential factor for the difficulty in accurate diagnosis of adult ADHD" (p. 381). Currently, no tests ex-

ist to help psychologists determine the level of motivation or effort being put forth by students being evaluated for ADHD, nor is there a way to determine whether they are exaggerating their degree of impairment. This is troublesome, as recent research clearly suggests that about 50% of the variance in a neuropsychological test battery is explained by effort and cooperation (Green, Rohling, Lees-Haley, & Allen, 2001). Moreover, neuropsychologists such as Iverson (1995) assert that, in any cognitive assessment where financial or other personal gain is at

stake, measures to evaluate effort and honesty must be included.

#### **WHAT IS MALINGERING?**

The term *malingering* refers to a continuum of behaviors ranging from subconscious exaggeration of actual symptoms all the way to outright fabrication of symptoms (American Psychiatric Association, 1994). This definition highlights the fact that a person who is malingering may indeed have genuine symptoms but is exaggerating them for some reason. In all cases, however, the motivation for such behavior is secondary gain: That is, the symptoms either

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Spellacy, 1996) have been developed to help clinicians establish the extent to which an individual was demonstrating genuine impairments in the tests administered. In addition, specific profiles on both the Wechsler Adult Intelligence Scale (WAIS; Wechsler, 1997a) and the Wechsler Memory Scale (WMS; Wechsler, 1997b) have been shown to help determine the authenticity of impairment (Iverson, Slick, & Franzen, 2000; Iverson & Tulskey, 2003). The problem with most of these tests, however, is that they only measure certain types of exaggeration (e.g., memory), but not all people will try to exaggerate memory problems when faking. Similarly, although self-report measures such as the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) contain validity scales, these typically evaluate the extent to which an individual is exaggerating psychiatric symptoms.

#### DIAGNOSIS OF ADHD IN ADULTS

ADHD is typically diagnosed both on the basis of self-reported symptoms and by establishing that the adult met the diagnostic criteria for ADHD in childhood as set out by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV; American Psychiatric Association, 1994). Applying these criteria to adults wondering if they have ADHD, however, is not as easy as it sounds. For example, getting childhood information confirmed by a reliable source is often impossible, and adults are frequently poor historians (Wender, 1997). Self-reports of childhood symptoms without external corroboration are especially problematic, as adults typically have no objective means of determining whether their childhood behaviors were extreme or impairing relative to their peers. Also, we know that recall of past behaviors is not perfect (Loftus, Korf, & Schooler, 1989), especially in terms of level of impaired performance (Dewhurst & Marlborough, 2003). Even when efforts are made to be truthful, retrospective evaluation of childhood behavior is ex-

tremely difficult. For example, Murphy, Gordon, and Barkley (2000) found that adults in general commonly describe their childhood behaviors as ADHD-like, with over 80% of adults reporting experiencing six or more of the DSM-IV symptoms *occasionally* and 25% reporting them *very often*. Furthermore, simply having the required number of symptoms of ADHD is not, in and of itself, sufficient to diagnose the disorder, nor does it necessarily correlate with impaired real-world behavior (Gordon et al., 2005). It is also true that the symptoms of ADHD are somewhat ubiquitous (Goldstein, 2006; Harrison, 2004), and individuals who suffer from other psychiatric conditions that produce similar symptoms may come to believe that the true cause of their symptoms is actually ADHD. Hence, these individuals may be motivated to seek and obtain treatment for ADHD (Goldstein, 2006) instead of dealing with their actual disorder. As a result, they may unconsciously exaggerate or magnify their actual symptoms or fail to recall that their symptoms have not always been as severe as they are at present.

#### HOW EASY IS IT TO FAKE ADHD ON SELF-REPORT INVENTORIES?

Recent studies demonstrate that it is very easy to fake symptoms of ADHD, especially when filling out self-report checklists (e.g., Jachimowicz & Geiselman, 2004; Quinn, 2003). Because symptom checklists do not include any scales to identify malingering or exaggeration of symptoms, these studies have shown that it is easy for adults to simply read over the DSM-IV criteria for ADHD and give answers that easily satisfy the diagnostic criteria.

Quinn (2003) also found that responses to ADHD symptom checklists could be successfully faked for both childhood (retrospective) and current symptoms and that malingerers could not be differentiated from those with bona fide ADHD on the basis of checklist data alone. The Quinn study also suggested that it is harder to fake on continuous performance tasks (CPTs).

The problem, however, is that CPTs are also less able to discriminate between ADHD and other clinical groups (Homack & Reynolds, 2005) and in fact may not even be reasonably accurate at discriminating between normal children and those with ADHD (Corkum & Siegel, 1993, as cited in Homack & Reynolds).

Jachimowicz and Geiselman (2004) showed that college students who had merely read over the DSM-IV diagnostic criteria for ADHD could easily fake most of the commonly used ADHD symptom checklists, producing elevated profiles consistent with ADHD. Indeed, 75% of participants could convincingly fake the ADHD Rating Scale (ARS-IV; DuPaul, Power, Anastopoulos & Reid, 1998), 95% could fake the Brown Adult ADHD Scale (BAAS; Brown, 1996), 90% could successfully malingering on the Connors Adult ADHD Rating Scale (CAARS; Connors et al., 1999), and 65% on the Wender Utah Rating Scale (WURS; Ward, Wender & Reimherr, 1993). Of note is the fact that students were more likely to overendorse symptoms of hyperactivity on these measures, perhaps because those are the ones most typically associated with ADHD. The authors concluded that their results clearly demonstrate a need to improve the diagnostic accuracy and reliability of adult symptom checklists and perhaps include other objective measures in the evaluation of ADHD.

Symptom checklists for ADHD are not specific and are prone to overidentifying both students at the post-secondary level (Harrison, 2004) and adults in the general population (McCann & Roy-Byrne, 2004) as having ADHD when they do not. Given that it is much easier to exaggerate symptoms you already have rather than producing them de novo, these studies demonstrate that without investing too much effort, both adolescents and adults can easily over-report symptoms they currently experience and potentially fake the symptoms of ADHD.

## WHY WOULD PEOPLE FAKE ADHD?

There are a number of potential reasons why people would consciously or unconsciously choose to feign or exaggerate the symptoms of ADHD.

### Access to Disability Status

Being identified with a disability may allow individuals access to special services, concessions, or academic supports. For instance, in the post-secondary school setting, students can obtain academic accommodations. Jachimowicz and Geiselman (2004) discuss how students would see access to academic accommodations as desirable, especially in terms of extra time for tests. In Ontario, Canada, students with diagnosed disabilities can access a government-sponsored bursary program that will allow them to purchase computers, laptops, assistive devices, and tutoring services, up to \$10,000 per school year. For cash-strapped students, this is certainly a tempting opportunity. In addition, a diagnosis of ADHD may make a student eligible for better, individual-room campus housing (Burt, 2004). Concern has been raised that students will fake having ADHD or a learning disability (LD) in order to receive extra time on high-stakes testing, in the belief that this will improve their scores and give them a competitive edge over fellow students when applying to graduate school or other specialized programs (Mullis, 2003).

Outside the academic arena, a diagnosis of ADHD may allow individuals to access government funding allotted for persons with disabilities. Cassar, Hales, Longhurst, and Weiss (1996) recently reported on a case of malingering for the purpose of accessing disability benefits. In Canada, persons with disabilities can receive income replacement benefits and also money to support academic upgrading and retraining. Such individuals can also obtain disability tax credits and even have their student loans excused with proof of a severe disability. Clearly, these are potent incentives to malingering.

## Drug Seeking

Through the years, there have been a number of concerns that use of stimulant medications to treat children with genuine ADHD would either lead to addiction or to potential abuse of other non-prescription drugs (Breggin & Breggin, 1995), but these fears have not been supported by clinical research (Mannuzza, Klein, & Moulton, 2003; Weiss and Hechtman, 1993). Indeed, when taken orally as prescribed for persons with ADHD, stimulants are not particularly addictive (Barkley, 2006) and do not necessarily lead children with ADHD to experiment with other, more addictive substances (Weiss & Hechtman, 1993). It is true, however, that these stimulants improve blood flow to the frontal and parietal lobes and thus improve attention and alertness (Mehta et al., 2000). Therefore, it is not surprising that stimulants are being overused by students as a study aid (Barrett, Darredeau, Bordy & Pihl, 2005).

More worrisome, however, is the fact that stimulants are also being used for recreational purposes—with individuals injecting or inhaling them as an inexpensive, prescription-based alternative to cocaine. Ziegler (2000, as cited in Jachimowicz & Geiselman, 2004) noted that methylphenidate is used recreationally by 7% of high school students at least once a year and that 2.5% admit to using it monthly, mainly for the sense of euphoria it creates. Other studies have estimated that almost 7% of non-ADHD college students have used prescription stimulants at some time in their lives, with 4.1% reporting use within the last month (McCabe, Knight, Teter, and Wechsler, 2005). Teter, McCabe, Boyd & Guthrie (2003) reported that approximately 3% of undergraduate students abuse methylphenidate and other stimulants, and these authors warn that this is a serious public health risk on college campuses. Of greater concern are the findings of Barrett and colleagues (2005), who present a sobering report on methylphenidate misuse in a Canadian university population that included

mixing it with other psychoactive substances, intranasal use, and intravenous injection. These results mirror the findings of a survey by Babcock and Byrne (2000), who found that 16% of students at a small public liberal arts college reported having tried methylphenidate recreationally, with 12.7% admitting to having taken it intranasally. When snorted or injected intravenously, methylphenidate produces effects similar to cocaine and is quite addictive (Swanson & Volkow, 2003). When taken along with large quantities of alcohol, methylphenidate produces a unique metabolite, ethylphenidate (Markowitz et al., 2000), and there are reports that this combined alcohol-methylphenidate can enhance euphoria but diminish the sense of drunkenness, which could then lead to dose escalation (Barrett & Pihl, 2002).

### SAY IT ISN'T SO

Clinicians may be wondering how common malingering activities are and may find it difficult to believe that exaggeration of symptoms is actually occurring. Some sobering data from our office may therefore be of interest. Over the past two years, we evaluated 127 students referred for an assessment to determine a) whether they had ADHD, and b) what academic accommodations and supports might be appropriate for them. Referrals came either from physicians or disability services personnel, and they included both college and university students suspected of having ADHD or needing updated verification of their ADHD. Of these 127 referrals, we estimate that approximately 20% significantly exaggerated their symptoms or in fact willfully malingered concerning ADHD in order to receive some secondary gain. Indeed, using the criteria set out by Mittenberg and colleagues (2002), we identified 24 students whose self report, symptom severity and/or performance on objective tests were highly suspicious, and we had 2 confirmed cases of outright malingering. None of these students had previously received a diagnosis of ADHD. Given that students could

score positive on more than one of the indicators, we found that 7 students returned scores above published cut-offs (e.g., Iverson & Tulskey, 2003) on tests said to identify malingered performance on neurocognitive tests, 21 had a pattern of test performance that was completely inconsistent with their history (e.g., performance on tests of processing speed less than the first percentile in someone who had been an accomplished high school goalie and first violinist in his high school orchestra), and 25 had symptom complaints that were completely inconsistent with their prior history (e.g., symptom complaints on the CAARS falling at the 95th percentile or higher in someone with a history of working as a summer camp director, achieving marks in the 80–90 range in high school while also holding down a part-time job, etc.). It was also interesting to examine the reasons why these 26 students wanted an assessment. Seven students (26.9%) came expressly for the purpose of obtaining medication; eight (30.7%) came because they had failed their year and wanted a letter verifying that their previously undiagnosed ADHD had been the reason for their failure; fourteen (53.8%) came wanting to be given extra time on tests; and three (11.5%) came specifically wanting accommodations on high-stakes testing (such as the LSAT). In fact, one student even arrived for his first appointment with the LSAT accommodation form in hand. He was outraged when told that this form could not be completed until he underwent a full assessment and that he might not qualify for accommodations. In all these cases, the motivation of the students to accurately report symptoms or perform optimally in testing was questionable.

As noted above, we discovered two students who had actively been attempting to malingere. One was not savvy enough to realize that his performance had to be believable and consistent with past school and parental reports. He confessed to his counselor after being told by our office that he did not demonstrate a clear childhood his-

tory consistent with the diagnosis. It was later discovered that he had been abusing methylphenidate since high school, obtaining it from a classmate who had a prescription, and using it intranasally on a regular basis. He was now at university, and needed a constant supply.

The second student was discovered when his roommate (a student with genuine ADHD) came to our office and advised us of his roommate's plan to dupe the system and obtain academic accommodations and free computers. The roommate with ADHD was worried that his own condition might not be taken as seriously if people such as this malingerer could easily fake the symptoms and obtain services.

### RECOMMENDATIONS

Clinicians need to be cautious when diagnosing ADHD in adults and should not base their diagnosis mainly on results of symptom checklist data. Studies show that these have poor discriminate validity, and are easy to fake. In addition, simply endorsing a sufficient number of symptoms only satisfies one of the DSM-IV criteria for diagnosis; just as important is the establishment of real world impairment (Gordon et al., 2005). We would also urge clinicians to be suspicious of students or young adults presenting for first-time diagnoses who rate themselves as significantly symptomatic, yet have managed to achieve well in school and other life activities.

In determining whether a previously undiagnosed adult has ADHD, it is essential to get collateral confirmation of impairment in two or more settings and to obtain objective evidence of significant impairments in childhood. McGough and Barkley (2004) provide good counsel when they admonish clinicians to insist on reasonable evidence of retrospectively determined ADHD symptoms and to establish that these symptoms actually impaired the individual during his or her childhood. Since the 7 years age-of-onset criteria has been criticized (McGough & Barkley, 2004), one can use the more le-

nient criteria that symptoms must have been present and impairing before the ages of 12 to 15.

Finally, psychologists must begin researching ways to discriminate symptom exaggerators from true positives. Currently, we are in the process of trying to develop a pool of self-report items that might serve as a "validity check" in adult evaluations. The difficulty, however, is that one has to find items that look like symptoms that persons with ADHD would endorse but which, in fact, are not endorsed by people with genuine ADHD. As the field of neuropsychology quickly discovered, we too must work to develop tests to ensure that individuals are providing us with accurate information, so that we may be more confident in the diagnoses we render, especially when there is no one medical test or specific neuropsychological profile upon which we can rely to objectively make this diagnosis.

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## Identifying New Symptoms for Diagnosing ADHD in Adulthood

Russell A. Barkley, Ph.D., and Kevin R. Murphy, Ph.D.

The current symptom list for ADHD in the DSM–IV (American Psychiatric Association, 2000) was developed on children and was only field tested using children (Lahey, Applegate, McBurnett, Biederman, Greenhill et al., 1994; Spitzer, Davies, & Barkley, 1989). The utility of extending that list to adults with ADHD is therefore an open question. This article addresses the important issue of whether or not better symptoms could be identified for the adult stage of this disorder than those 18 childhood symptoms currently represented in the DSM–IV.

We began by making a list of the most common complaints that we had heard from adults presenting at the Adult ADHD clinic at the University of Massachusetts Medical Center where more than 100 adults were evaluated each

year. We also went back through previous charts of adults seen at this clinic to identify such symptom items. We also used the theory of executive functioning developed by Barkley (1997) and extended to understanding ADHD in order to generate potential symptoms that deal with each of the five executive components of his model: response inhibition, nonverbal working memory and sense of time, verbal working memory, emotional/motivation self–regulation, and planning (generativity or reconstitution). The results of our work on this new symptom list will appear early next year in a new book presenting the results of an original research project. This project constitutes one of the most comprehensive evaluations of adults with ADHD. In this project, we extensively evaluated 146

adults with ADHD on numerous measures of adaptive functioning across many domains of major life activities. We compared them to both a community control group of 109 adults and a clinical control group of 97 adults seen at the same ADHD Clinic but not diagnosed with the disorder. These adults had a mean age of 32–37 years, depending on the group, with 47–68% of each group being male.

### A NEW ITEM POOL OF POTENTIAL SYMPTOMS FOR ADHD IN ADULTS

We developed a list of 91 new items that might have some potential for being associated with and predictive of ADHD at the adult stage of its development. We included items that further elaborated on the problems with behavioral