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# Detection of malingering in assessment of adult ADHD

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## Abstract

Comparisons of two assessment measures for ADHD: the ADHD Behavior Checklist and the Integrated Visual and Auditory Continuous Performance Test (IVA CPT) were examined using undergraduates ( $n = 44$ ) randomly assigned to a control or a simulated malingering condition and undergraduates with a valid diagnosis of ADHD ( $n = 16$ ). It was predicted that malingerers would successfully fake ADHD on the rating scale but not on the CPT for which they would overcompensate, scoring lower than all other groups. Analyses indicated that the ADHD Behavior Rating Scale was successfully faked for childhood and current symptoms. IVA CPT could not be faked on 81% of its scales. The CPT's impairment index results revealed: sensitivity 94%, specificity 91%, PPP 88%, NPP 95%. Results provide support for the inclusion of a CPT in assessment of adult ADHD.

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*Keywords:* Malingering; Adult ADHD; Continuous Performance Test; Assessment; ADHD rating scale

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## 1. Introduction

The Diagnostic and Statistical Manual of Mental Disorders IV, DSM-IV ([American Psychiatric Association, 1994](#)) recognizes that Attention Deficit Hyperactivity Disorder (ADHD), can continue into adulthood. In recent years, general awareness that ADHD may persist into adulthood has increased. This may be due to many best-selling books ([Hallowell & Ratey, 1993](#); [Nadeau, 1994](#)), and increased media coverage. Public awareness has led to a dramatic influx of adults seeking evaluation and treatment for this condition ([Roy-Byrne et al., 1997](#)). The purpose of this study is to examine diagnostic tools used in the assessment of adult

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ADHD and to determine whether differences can be found to alert clinicians to the possibility of malingering.

### 1.1. Adult ADHD

ADHD is typified by three primary characteristics—inattentiveness, hyperactivity, and impulsiveness, according to the DSM-IV. For a diagnosis to be valid, symptoms must be pervasive with significant impairment to individual functioning across settings and symptoms must be evident early in life, before age 7 (Toone & Van Der Linden, 1997). However, past research recommends slight modifications in symptomatology for adults. In young adults, the salient characteristics of the disorder are inattention, impulsivity, personal disorganization (Toone & Van Der Linden, 1997) poor task persistence, poor time-management, and lack of goal-directed behavior (Murphy & Barkley, 1996a).

A comprehensive assessment of ADHD in adults should employ multiple strategies, including a structured clinical interview, medical examination, self-report rating scales, rating scales from other reporters, structured tasks of attention, and structured tasks of impulsivity (Roy-Byrne et al., 1997). A clinical interview with informant history should always guide the assessment protocol. However, most adults do not invite a parent or sibling along to the evaluation who can document the client's prior history. Moreover, most adults lack developmental documentation, such as report cards, teacher evaluations or past psychological testing results (Roy-Byrne et al., 1997). Poor recollection on the part of many adults further weakens the reliability of their report (Wender, 1997). A medical examination is often warranted to rule out conditions (e.g., Reye's syndrome, CNS infection, cerebral-vascular disease, hypothyroidism) in which lack of attention may be just one symptom (Barkley, 1990).

Some structured tasks of attention and/or impulsivity typically used in assessment of ADHD include the Matching Familiar Figures Test (MFFT), Wisconsin Card Sort, Stroop Word-Color Association Test, and Continuous Performance Tests (CPTs). However, the MFFT, and Wisconsin Card Sort fail to reliably discriminate those with ADHD from controls and are therefore not recommended for use in assessing this disorder (Barkley, 1990). Stroop Word-Color Association can reliably predict impulsive responding (Barkley, 1990). CPTs provide scores for both inattention and impulsivity (Ricco, Cohen, Hynd, & Keith, 1996).

### 1.2. Rating scales

Typically, rating scales have been a key component to most assessment procedures. Many self-report scales are derived from DSM criteria, which require the presence of six out of nine possible symptoms (Johnson, 1996). These types of scales show the greatest criterion-related validity for both adults and children (Doyle, Ostranser, Skare, Crosby, & August, 1997). When scales are used in childhood assessment, a parent and teacher present distinct observations from separate contexts (Roy-Byrne et al., 1997). Although data suggest that adults are reliable self-reporters (Biederman et al., 1993), an adult seeking diagnosis is often the only one to report on the scales. Moreover, most rating scales may be improperly worded for adults with diagnostic thresholds that are too stringent and/or restrictive in this population (Murphy &

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