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Archives of Clinical Neuropsychology 23 (2008) 521–530

Archives of CLINICAL NEUROPSYCHOLOGY

The relationship of malingering test failure to self-reported symptoms and neuropsychological findings in adults referred for ADHD evaluation

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Accepted 7 May 2008

Abstract

Diagnosis of adult attention-deficit/hyperactivity disorder (ADHD) adults is difficult, as neither symptom report nor neuropsychological findings are specific to ADHD. Few studies address the possibility that noncredible performance influences both symptom report and neuropsychological findings. The present study utilized archival data from young adults referred for concerns about ADHD, divided into three groups: (1) those who failed a measure of noncredible performance (the Word Memory Test; WMT), (2) those who met diagnostic criteria for ADHD, and (3) controls with psychological symptoms but no ADHD. Results showed a 31% failure rate on the WMT. Those who failed the WMT showed clinical levels of self-reported ADHD symptoms and impaired neuropsychological performance. Neither self-report measures nor neuropsychological tests could distinguish ADHD from psychological controls, with the exception of self-reported current hyperactive/impulsive symptoms and Stroop interference. Results underscore the effect of noncredible performance on both self-report and cognitive measures in ADHD.
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Keywords: Malingering; Attention-deficit disorder with hyperactivity; Neuropsychological assessment; Self-report

In increasing numbers, adults are presenting for evaluation with concerns that they have attention-deficit/hyperactivity disorder (ADHD). The diagnosis of ADHD in adults is complicated by several factors, most notably the difficulty establishing evidence for either childhood or current presence of impairing symptoms of the disorder, outside of self-report (Murphy & Schachar, 2000). Further complicating this issue is that neuropsychological assessment is still not broadly accepted as part of a diagnostic evaluation for either children or adults presenting with concerns about ADHD (Stefanatos & Baron, 2007); self-reported symptoms and functioning are still relied upon as major components of diagnosis.

One problem with reliance on self-report in diagnosis of ADHD is the high base rate with which "ADHD" symptoms are reported in the general population. Although only 1–5% of adults are diagnosed with ADHD (Du Paul et al., 2001; Harrison, 2004), a large number of adults report frequently experiencing ADHD-like symptoms, either currently or in childhood. For example, Murphy and Barkley (1996) found that 22% of current ADHD symptoms and 56% of childhood ADHD symptoms were endorsed as occurring "often or very often" by 20% or more of a sample of adults applying

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doi:10.1016/j.acn.2008.05.003

for or renewing their driver's licenses. A series of studies in undergraduate nonclinical samples also found high base rates of endorsement of ADHD symptoms (27.4% of males and 24.6% of females in Du Paul et al., 2001 US sample; 11% in Heiligenstein, Conyers, Berns, Miller & Smith, 1998; 8% in Weyandt, Linterman, & Rice, 1995). Even more compelling data come from a 16-year follow-up of a prospective study (Mannuzza, Klein, Klein, Bessler, & Shrout, 2002), in which structured clinical interviews were administered to adults who were diagnosed with ADHD as children (based on strict research criteria) and adults who showed no evidence of ADHD in childhood. Interviewers, who were unaware of the diagnostic status of participants and the study's purpose, rated the presence of clinically significant childhood symptoms of inattention, hyperactivity, and impulsivity based on the adult interview data. Interviewers then used their ratings to form both probable and definite diagnosis of childhood ADHD. Notably, 32% of childhood ADHD symptoms were recorded as clinically significant in at least 20% of the *control* participants, and 11% of controls were diagnosed with ADHD in adulthood based on their retrospective symptom report, despite having been carefully screened for the *absence* of ADHD when they were children. Such results support the argument that reliance on self-reported symptom data is problematic in the diagnosis of ADHD in adult samples (Murphy, Gordon, & Barkley, 2000).

Not surprisingly, the base rate of reported ADHD symptoms is also high in samples of individuals seeking treatment, even for non-ADHD related concerns. For example, Harrison (2004) asked 224 university undergraduates presenting to university clinics for treatment (180 for medical concerns, 12 for psychiatric concerns, and 21 for counseling) to complete the Brown Attention-Deficit Disorder Scale (BADD; Brown, 1996), a measure of current adult ADHD symptoms commonly used in clinical practice. Although none had a history of ADHD diagnosis, 35% met criteria for probable ADHD using the cutoff score given in the test's manual. Specifically, when broken down by referral source, 27% of the individuals self-referred for medical concerns and over 65% of the psychiatric/counseling referrals scored above the cutoff on the scale. With regard to retrospective childhood symptom report, studies also suggest a high number of false positive scores using the commonly used cutoff on a popular retrospective childhood ADHD scale (the Wender Utah Rating Scale (WURS); Ward, Wender, & Reimherr, 1993). For example, almost half of a sample of individuals who did not meet diagnostic criteria for ADHD but who were seeking treatment for psychiatric concerns fell above this cutoff (McCann & Roy-Byrne, 2004). A similar number of false positives (40–60%) were found in a sample of adults specifically presenting with concerns that they may have ADHD but who did not meet diagnostic criteria for the disorder (Roy-Byrne et al., 1997). The nonspecificity of "ADHD" symptoms to ADHD raises significant concerns about reliance on self-reported current or childhood symptoms for differential diagnosis.

Another potential problem with reliance on self-report measures in ADHD diagnosis is their vulnerability to noncredible symptom reporting, which is not addressed by existing studies. There are ample secondary gain issues in ADHD, including but not limited to receipt of psychostimulant medications and academic/work accommodations (Alfano & Boone, 2007; Sullivan, May, & Galbally, 2007), that may motivate individuals to misrepresent themselves with regard to current or past symptoms (i.e., malingering). The face validity of both current and retrospective symptom report measures makes these instruments easy to exaggerate (Quinn, 2003). Furthermore, the symptoms of ADHD are well known in the general population, due to television advertisements for ADHD medications that list the symptoms, popular press articles and books describing the syndrome, and easily accessed Internet information on ADHD symptoms and the measures used to assess them (Conti, 2004; Murphy, 1994). Of course, there are many potential reasons for high symptom report other than malingering that may be equally noncredible (i.e., not diagnostic of ADHD); for example, high report of any psychological symptoms as a "cry for help" in someone experiencing psychological distress. Although many psychological instruments have subscales to assess the validity of self-report, measures of self-reported ADHD symptoms typically do not (Quinn, 2003).

Given that ADHD is a neurodevelopmental disorder with neuropsychological impairments as core symptoms, another component of many ADHD assessments is a neuropsychological evaluation. However, as mentioned above, neuropsychological test results are not yet a universally accepted part of an ADHD evaluation in either child or adult cases. One reason for this may be that, although reviews show robust differences between ADHD and control groups in many neuropsychological domains, neuropsychological tests are not always sensitive to ADHD and are not specific to the disorder (Nigg, 2005). It is interesting that, despite clear problems with sensitivity and specificity of self-reported symptoms in ADHD diagnosis, clinicians and researchers continue to rely on self-report for diagnosis, but then consider the poor diagnostic "accuracy" in neuropsychological tests to be a fatal flaw. In fact, a factor that may contribute to the poor diagnostic sensitivity of neuropsychological tests in ADHD is the inclusion of false positives

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