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REFLECTIVE PRACTICE

Feigning ADHD: A Necessary Exploration of an Uncomfortable Topic

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This article explored the prevalence of feigning in attention deficit hyperactivity disorder as well as the potential costs when feigning is not identified. A framework for identifying feigning was provided along with clinical examples. In addition, ways to approach discussions of feigning with clients were explored.

Surveys of members of the public suggest that about 15% of people admit to feigning health symptoms (Merten et al., 2023). In terms of mental health, about 37% of people have admitted to lying to their therapist at some point (Martin, 2006). Even professionals are not exempt, with research indicating that 30%–40% of therapists sometimes withhold information from their supervisors (Hantoot, 2000). Doll (2016) found that a majority of therapists believed about one-quarter of their clients had attempted to deceive them, with substance abuse and symptom severity being the most common areas. Although possibly emotive, this issue is not contentious and there is widespread agreement in the literature.

When it comes to attention deficit hyperactivity disorder (ADHD), the research is confronting. For example, a survey found that almost 20% of people who took ADHD medications for recreation or performance enhancement obtained them by deceiving clinicians (Novak et al., 2007). Estimates of the prevalence of feigned ADHD range from about 5% to 50% of people seeking diagnosis (Sadek, 2022). In university settings, a majority of people who have an ADHD diagnosis are asked to share or sell their medications, and 19% are also asked about how to feign ADHD (Advokat et al., 2008). Feigning may also be common in other presentations. For example, studies suggest that over 20% of veterans and around 20%–30% of civilians may feign posttraumatic stress disorder (PTSD) (Taylor et al., 2007). Overall, feigning is estimated at 16% across a range of presentations, with external incentives being an important factor in increasing rates of feigning (Roor et al., 2022). Interestingly, Roor et al. (2022) found feigning was most elevated in private practice contexts, although the socioeconomic environment of this and other studies needs to be considered as it may not translate perfectly to the Aotearoa/New Zealand context.

It is important to be clear about language in this discussion. The terms currently used are ‘performance validity’ and ‘symptom validity’. Performance validity refers to the validity of test scores on tasks, and is typically used in neuropsychological research and practice. Symptom validity refers to the accuracy of a person’s presentation during assessments or on self-report

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measures. The literature suggests that personality traits, the sequencing of tests or items within tests and misinformation about symptoms and disorders may all lead to issues with both performance and symptom validity (Merckelbach et al., 2019). Therefore, validity of performance or symptoms does not directly infer causation. However, 'symptom feigning' generally refers to intentional validity issues and is also commonly called malingering.

It is also important to be clear about my intentions in developing this article. Both ADHD and feigning are complex issues, and the combination necessarily results in a requirement to accept seemingly dichotomous realities. For example, aspects of the construct of ADHD itself remain contentious (Lovett & Harrison, 2021), and some people who experience ADHD encounter significant stigma and service access difficulties (Masuch et al., 2018). There may be three main groups of people who receive an ADHD diagnosis: those who experience ADHD (correctly diagnosed), those who believe they experience ADHD but do not (incorrectly diagnosed) and those who knowingly engage in symptom feigning (incorrectly diagnosed). There is also the possibility of some overlap between these groups. For example, a person experiencing ADHD may exaggerate their symptoms because of fear of not being considered 'bad enough'. Therefore, in focusing on one of the two groups given incorrect diagnoses (those who feign symptoms), I do not intend to minimise or further stigmatise the others. Quite the opposite; given that a primary concern of those experiencing ADHD relates to public doubts about its diagnostic validity (Masuch et al., 2018), it behoves us to ensure that our diagnoses are valid.

There are many external incentives that tempt people to feign symptoms of ADHD (Harrison, 2006). They may be aware of academic or occupational accommodations that will become available, such as increased access to tutoring, educational support, more favourable testing conditions (e.g. more time) and extensions for assignments. In the workplace, people may hope to be given lower workloads, increased break times or more time to reach deadlines, particularly in the context of disability recognition. Socially, people may be able to excuse their errors or mistakes by appealing to their ADHD diagnosis. People may also seek to buffer their self-concept through being able to absolve some or all responsibility for past errors or the current state of their lifestyle via an ADHD diagnosis. In addition, ADHD may be less stigmatising than other diagnoses, such as bipolar disorder or conduct disorder, so it may be more sought after as a potential diagnosis. Fully funded and legal stimulants may be the most potent incentive. Stimulant drugs, including methylphenidate, methamphetamine and cocaine, have fundamentally identical subjective experience profiles as well as clearly established abuse patterns to slow-release formulations of ADHD medications, offering no protection from abuse (Shellenberg et al., 2020). The desire to enhance performance with ADHD medication may be potent, despite research indicating only marginal improvements in specific cognitive domains (Roberts et al., 2022) and no

improvements in academic outcomes (Arria et al., 2017). Use of ADHD medication for sports performance may provide some benefits, but also carries specific health risks and is banned by governing bodies (Berezanskaya et al., 2022). Hyman (2011) argued that people may be caught in a perceived 'arms race', where their competitors are using stimulants as performance enhancers, and they thereby think that they must do so as well. Although much of the research on feigning originates from the US, all of the above incentives are equally relevant in the Aotearoa/New Zealand context.

As with avoiding most things, avoiding the topic of feigning does not make it better. However, anecdotal experience suggests that clinical psychologists do not discuss this topic. From memory, feigning was raised briefly only twice in my training and both times I was advised that it was incredibly rare. The topic does not appear at all in one of my favoured books: *The Handbook of Adult Clinical Psychology* (Carr & McNulty, 2016). Feigning is also not addressed in the ethical guidelines set out in *Professional Practice of Psychology in Aotearoa New Zealand* (Evans et al., 2007). Nor does feigning appear in the (now dated) *New Zealand Guidelines for the Assessment and Treatment of ADHD* (Ministry of Health, 2001) or the new Australian guidelines (Australian ADHD Guideline Development Group, 2022). The only local literature that addresses this issue, albeit in a circumscribed manner, is the New Zealand Psychologists Board (2020) guidelines for the use of psychometric tests. Surely we can do better than this with regards to an issue likely to be present in a significant number of assessments.

I have briefly shown above that feigning is a ubiquitous symptom, and how little it seems to feature in our considerations. In this article, I explore why symptom feigning is important and offer a framework for assessment that aids in identifying symptom feigning. I offer some examples from practice and ideas for how to broach symptom feigning with clients. Although I focus on adults (with whom I have experience), these topics would also apply to adolescents (McCormick-Deaton & Mohiuddin, 2018) and even children (DeRight & Carone, 2015).

Why Symptom Feigning is Important

The costs of an incorrect ADHD diagnosis may be felt by clients, society and health professionals. Although use of prescribed stimulants is relatively safe, it is not without risks, such as psychosis and cardiovascular events as well as high rates of unwanted effects (e.g. headaches, poor sleep, dry mouth, appetite loss, irritability) (Lakhan & Kirchgessner, 2012; Ophir, 2022). In addition, as indicated above, stimulant medications are rewarding and can result in addictive behaviour with escalating frequency and dose of consumption, along with escalating risks and harms (Weyandt et al., 2016). There may also be some psychological risks associated with an incorrect diagnosis when feigned. In particular, the literature raises concerns about people beginning to experience

the difficulties that they express when they feign symptoms as a learned response (Merckelbach et al., 2011). In addition, an incorrect diagnosis may lead people to overlook difficulties that they face or to anchor difficulties to ADHD where other explanations and interventions may be more helpful.

There are also costs of feigned disorders that affect society more broadly. Perhaps chief among these costs is disillusionment with the nature of mental disorders. It may only take one story of a questionable diagnosis before people begin doubting the very disruptive reality of ADHD for those who truly experience it. Of course, ADHD assessments are time-consuming and costly, as are medications (Harrison, 2006). For example, Pharmac spent $8.5 million on ADHD stimulants in 2019 (Pharmac, 2020), and this amount is likely to be significantly higher now. If we take a mid-range estimate of 30% feigned ADHD (assuming this went undetected), the annual cost of unnecessary stimulants would be $2.5 million (not including other incorrect diagnoses). Perhaps if we were better at identifying feigned disorders we would have more time and finances to face other challenges, such as reducing the wait-times that can lead to significant distress for those experiencing ADHD.

Feigned ADHD may also cost health professionals. Importantly, it may have a significant impact on our knowledge base through research. For example, when research is population-based, having 5%–50% of participants that are not actually experiencing the disorder is a significant confounding factor. It may also impact on our own internal working models of disorders and our role in ameliorating them. For example, diagnoses may become anchor points from which we make decisions and also cause us to attribute symptoms to an existing diagnosis rather than considering alternatives more broadly (Carr & McNulty, 2016). If such diagnoses are based on feigned symptoms, then these issues become even more challenging.

Symptom Feigning in Clinical Examples

It may be useful here to briefly describe a standard assessment for ADHD in adults. Before an ADHD diagnosis is considered, this assessment must show that: symptoms exist across contexts and cause significant functional impairment across contexts; there is a consistent pattern of these symptoms and functional impairments going back to at least early adolescence; and other possible causes of symptoms are excluded (Barkley, 2018). To achieve these goals, clinicians need to seek collateral information from numerous sources, including other people and records, both current and historical (Barkley, 2018). I cover this here to provide context for the examples I describe below. I do not assess in this manner because of suspecting feigning everywhere, but because this is the correct way to undertake assessment.

To diagnose ADHD correctly and detect feigning (if present), clinicians should conduct assessment as above while also being aware of frameworks for identifying feigning. Perhaps the most authoritative framework for detecting feigning is that developed by Sherman et al. (2020). However, the work of others, such as Sagar et al. (2017), that is specific to ADHD, can also be considered. In their framework, Sherman et al. (2020) recommended four criteria for determining feigning: A) presence of an external incentive, B) invalid presentation on examination indicative of feigning or exaggeration, C) marked discrepancies and D) behaviours meeting criterion B that are not fully accounted for by another developmental, medical or psychiatric condition. In the below exploration, I go through each of these criteria as it relates to ADHD assessment. I provide clinical examples in an attempt to show how these criteria sometimes play out.

A) Presence of an external incentive. The reality is that external incentives, as explored above, are normally only able to be assumed by the clinician and there is little use in pressing the matter with people. Of the assessments I have completed where feigning became an identified issue, the person's goals (when asked) were expressed in terms of getting a specific diagnosis rather than more broadly understanding and addressing their difficulties. I want to be clear that I have seen some people who experience ADHD who also use such language, so this alone is not a predictive indication of feigning. My point is that *all* of the ADHD assessments I have undertaken where feigning was identified involved such clear motives. Sometimes, the information is more directly concerning. For example, good general practitioners may be concerned that people with an existing ADHD diagnosis give urine drug screens not showing prescribed amphetamines (indicating possible diversion) or are consistently asking for dose increases above guidelines or for early scripts.

B) Invalid presentation on examination indicative of feigning or exaggeration. Sherman et al. (2020) accounted for invalid neurocognitive, somatic and psychiatric presentations (or a combination of these) under this criterion. This criterion suggests that marked inconsistencies between presentation and self-report, or evidence from psychometric tests of performance or symptom validity issues should lead to increased consideration of feigning. The somatic identifier largely accounts for feigning of pain and other physiological issues, so I will not explore this further here. In addition, cognitive assessments are not always warranted in ADHD assessment, so the more objective performance validity tasks may not be undertaken.

In terms of cognitive assessments, there are a range of imbedded and stand-alone tests for performance validity. For psychiatric assessment, there are also a range of available psychometric tests that have embedded symptom validity tests; chief among these are the major multi-axial or broad-band questionnaires. Stand-alone ADHD questionnaires and structured interviews that specifically aim to evaluate symptom validity are beginning to emerge in

research. I have chosen not to name these tests here to reduce the proliferation of their online profiles in accordance with the expressed wishes of many of their authors. They are easy enough for practitioners to find, they come with detailed instructions and interpretive aids and they should be used routinely when external incentives are elevated (Sagar et al., 2017). Importantly, it should be noted that none of the common ADHD screening measures are useful in identifying feigning, and they produce unacceptably high rates of false positives when baseline probabilities are accounted (Sagar et al., 2017).

Inconsistencies between self-report and presentation can vary greatly. With ADHD, I have often found great variance in the difficulties reported by people who feign and their observed behaviours. For example, people have claimed that they struggled to remain seated for any length of time or fidget and squirm when they have to sit still, but get through multiple assessment sessions of over 2-hours without difficulty. Or they may claim that they constantly interrupt people and struggle to follow conversations, but this is not observed at all during their interview. At times when other indicators of feigning are present, I have observed people in the waiting room before appointments to explore the feigning hypothesis. Of course, I am aware that context and environment play a role in behavioural expression, so I am not claiming such observations can be used to confirm feigning in isolation, but wish to note that they play a role in building clinical understanding.

What I have also found is that people who feign ADHD often seek multiple diagnoses with a large range of extreme symptoms. Again, this may also occur in those legitimately experiencing ADHD and should not be used in isolation. Perhaps this is an attempt to confuse the assessor and make professionals abandon in-depth assessment in favour of brief screening. Regardless, there are typically large discrepancies between self-report and observed presentation with these symptoms. For example, those that claim obsessive compulsive disorder resulting in extreme fear of stepping on cracks, but are observed to be doing so calmly when walking to and from my building. At times, these self-reports may be completely contradictory when assessed carefully, such as claims of being both extremely tidy, clean and timid (due to PTSD) and a reckless and disorganised mess (due to ADHD).

C) Marked discrepancies. This criterion encompasses discrepancies between self-report and the natural history or professional understanding of the condition, records and other media and collateral reports (Sherman et al., 2020). Such reports are vital for establishing symptoms and functional impacts, both currently and in childhood. However, people may sometimes be either unable or unwilling to provide collateral sources. If I have significant concerns based on Criteria A and B, I tend to stop my ADHD assessments at this point. I simply state that as I cannot confirm impact on functioning or the presence of symptoms in childhood, I am quite unable to make a diagnosis of ADHD, which is in keeping with general practice in the ADHD field (Barkley,

2018). I offer to continue assessment and formulation of difficulties so that we can consider interventions. However, most people in this situation either decline this offer or are subsequently able to find someone to offer collateral, both indicating potential singular interest in an ADHD diagnosis and related incentives.

When people who feign ADHD provide access to collateral information, there are typically inconsistencies. For example, being allowed to contact parents but numbers not connecting and people being unwilling to discuss their hesitancy to provide a correct number. I have also had people consent to my contacting others but wanting to check with them first. I typically ask them to call and check while I am in the room because I have followed up with people who admitted to stressful conversations where the client attempted to coach them in exaggerating symptoms. At times collateral information (when made available) has vastly differed from self-report. For example, claiming to have been highly dysfunctional at home and school and to have left school at an early age, but normal reports from both parents as well as statements of having finished school.

People have also been hesitant with regards to contacting employers, even when they claimed that they were undergoing performance management or about to be dismissed. It is useful to ask if a formal performance process has begun or how the employer has expressed concerns. Such records (emails, documents, messages) will be present if the self-report is valid. Other records may also cast doubt on the accuracy of self-report. For example, a person claiming to have been in multiple serious car crashes (because of ADHD) requiring emergency department visits, but there being no medical history available of this. I have also had people claim to have 'flunked out' of university, but a quick Internet search was able to show that they graduated (most universities have online graduate rolls going back decades). Current students can also check and display their grades online, even those at most secondary schools. Again, such information is critical in both establishing an ADHD diagnosis and understanding individual strengths and weaknesses, and so can be valuable in assessment even when feigning is not indicated.

D) Behaviours meeting criterion B are not fully accounted for by another developmental, medical, or psychiatric condition. Sherman et al. (2020) made it clear that other explanations need to be considered in determining if inconsistencies and discrepancies relate to feigning. It is also important to note that feigning of one disorder does not mean that the person does not experience another disorder or significant distress. In is again important to note that the ADHD assessment process and content suggested by Barkley (2018) stresses the comprehensive nature of adequate assessments. Such a process will offer alternative diagnostic hypotheses that need to be addressed along the way to an ADHD diagnosis.

Discussing Concerns with People

I want to repeat here that the above techniques and information sources are either vital or useful in the assessment of ADHD, whether or not feigning is present (Barkley, 2018). They should not be taken as my pre-determination of feigning. In addition, there is no suggestion that any of the above issues or criteria should be used in isolation. Sherman et al. (2020) encouraged the determination of feigning be based on multiple instances of inconsistency and discrepancy. At times there may be some indication of feigning, but limited confidence (e.g. failing of some validity tests but not all). Sherman et al. (2020) described a process for working through such presentations in a structured manner. The decision is typically obvious when there is significant discrepancy between self-report *and* observed behaviour *and* collateral information.

It is important to approach these discussions with people in a balanced and non-judgemental manner, even when feigning has been established with a high level of certainty. The approach that I normally take is to first state that the person does not meet criteria for an ADHD diagnosis. I then ask if they would like to know why not. Most, but not all, people tend to want to hear the explanation. Those that do not want an explanation tend to make their motivations clear by showing no interest in any further assessment or discussion (once ADHD is removed as an option). I have had people get up and walk out almost immediately in these situations.

When I am explaining my thoughts about not meeting criteria, I am careful to state the findings without my interpretation of them. For example, for validity measure issues I may say that 'some of the questionnaires have methods for figuring out if people might not be reporting things accurately. All of those you completed suggested that accuracy might be an issue. What do you make of this?' For inconsistency between self-report and observations, I will simply state something like 'I am a little confused as you said that you could never sit still but were able to sit perfectly through two really long assessment sessions. What should I think about this?' For discrepancy between self-report and collateral, I may simply state 'As you know, for diagnosis of ADHD I need to clarify that you experienced significant symptoms in childhood and I have not been able to do that'. When there is discrepancy between self- and other-report, I tend not to go into detail about these as there is no purpose in potentially causing friction within these relationships.

What I have found using the above style is that the majority of people accept the results of the assessment without any upset. People appear flushed, stressed and perhaps embarrassed and quickly leave the office. Only a couple of people have stayed and engaged in further discussion of their difficulties and how these may be addressed, and these interventions have been remarkably successful. However, I am honest in my conclusions after discussion (when I have very high certainty) that I believe the person is feigning and that I will note this

on the assessment. I should say that these conversations are stressful for the clinician and there is the prospect of aggression from people. These assessments also leave the clinician exposed to potential complaints, although I am yet to face one. Therefore, clinicians may want to have another professional present when these topics are broached, both for immediate safety and for collateral in terms of what was said by whom.

Conclusions

I want to acknowledge again that feigning may be emotive. It is not easy to talk about feigning, and it is even harder to write about it. However, research consistently finds that a significant minority of people seeking an ADHD diagnosis do feign symptoms. As I have shown, a properly comprehensive assessment will generally identify legitimate ADHD as well as signs of feigning, and will be more likely to do so when specific content, measures and processes are used. Again, I am expressly focusing on those people who feign symptoms, and do not intend for this to affect perceptions of those people who actually experience ADHD. I assume, given the costs of feigning, that those who experience ADHD and their allies would be aggrieved by people who feign and not the clinicians who identify them. As health professionals, we want to assume the best in people, help them, and hold them in unconditional positive regard. However, I do not believe that we achieve any of these goals through turning away from reality. Quite the opposite; ignoring feigning comes at significant cost to people, society and professionals themselves.

Implications for Practice

- Research consistently shows that a minority of people seeking a diagnosis of ADHD (as well as other diagnoses) will feign symptoms.
- Clinicians may be best placed to offer a valid ADHD diagnosis if they follow guidelines for comprehensive assessment and are aware of frameworks for detecting feigning.
- Feigning is an emotive topic that can be difficult to manage in the clinical environment, and supervision is essential.

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