

# Adult ADHD Assessment: An Integrated Clinical-Forensic Perspective

Benjamin J. Lovett and Karen M. Davis  
State University of New York at Cortland

Initial diagnoses of ADHD in adulthood have increased tremendously in recent years. Making such diagnoses accurately is challenging because ADHD is a childhood-onset disorder and because many adults have an incentive for obtaining a diagnosis (e.g., access to stimulant medication or disability accommodations). Certain elements of a forensic perspective can lead to more accurate ADHD diagnoses in adults and targeted treatment for clients who genuinely need it, and more appropriate alternative clinical responses to those who do not. This article describes the research base for integrating forensic principles into clinical assessments of adults presenting with ADHD-related concerns, and provides a scientific model for such assessments, from referral through conclusions.

### **Public Significance Statement**

This article presents a practical model for increasing the accuracy of ADHD diagnoses in adults. Making more accurate diagnoses not only increases the efficient use of treatment resources, but also reduces unnecessary problems such as medication side effects and stigma from a diagnostic label.

*Keywords:* ADHD, clinical assessment, forensic assessment

Consider a 35-year-old male client who reports symptoms of inattention—being easily distracted by noise, making careless mistakes when completing paperwork—and wonders if he might have attention-deficit/hyperactivity disorder (ADHD). He denies having ever received such a diagnosis before, but he has a friend and a cousin who was both diagnosed recently, and their symptoms sound similar to his. Moreover, his friend and cousin both found medication helpful, and he wonders if he would too. How should a clinician go about assessing him for ADHD?

A situation like the one just described would have been very unusual 30 years ago. In a relatively short amount of time, adult ADHD has gone from a nonentity to an accepted and even common condition (Conrad & Potter, 2000; Paris, Bhat, & Thombs, 2015). Between 1999 and 2010, the proportion of adults' medical office visits because of ADHD more than doubled (Oehrlein,

Burcu, Safer, & Zito, 2016), and between 1994 and 2009, the proportion of adults' office visits that resulted in a prescription for stimulant medication increased by almost 700% (Olfson, Blanco, Wang, & Greenhill, 2013). By 2014, 2.4% of adult patients (aged 20–64) insured by Blue Cross Blue Shield had an active prescription for a stimulant medication (Burcu, Zito, Metcalfe, Underwood, & Safer, 2016).

ADHD is a challenging diagnosis to make in adults, for a variety of reasons. First, ADHD symptoms are common among nondisabled people (e.g., Lewandowski, Lovett, Coddington, & Gordon, 2008), and so clinicians must assess the number, frequency, severity, and chronicity of those symptoms to distinguish pathology from normal variability. In addition, elevated inattention symptoms are present in individuals with many other psychological disorders, making differential diagnosis very difficult. Finally, ADHD by definition begins in childhood (symptoms must be present by age 12; American Psychiatric Association, 2013), and so evidence of early symptoms must be collected. Given this complex situation, it is perhaps not surprising that in a recent review of 100 evaluation reports in which ADHD was diagnosed in young adults, only 1 of the 100 reports documented the presence of the full *Diagnostic and Statistical Manual for Mental Disorders-Fifth Edition (DSM-5)* criteria for the disorder (Nelson, Whipple, Lindstrom, & Foels, 2014). Similarly, it is understandable that health care professionals report being far less comfortable when diagnosing ADHD in adults, compared with diagnosing anxiety or depressive disorders (Adler & Shaw, 2011).

There is an additional factor complicating the diagnosis of adult ADHD: individuals who do not have the disorder may be motivated to obtain a diagnosis anyway. The most obvious motivation relates to access to stimulant medications, which are used illegally (i.e., without a prescription) for cognitive and even mood enhancement by a significant number of people, especially college students

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BENJAMIN J. LOVETT received his PhD in school psychology from Syracuse University. He is currently an associate professor of psychology at the State University of New York (SUNY) at Cortland, and he maintains a private consulting practice focusing on disability documentation and testing accommodations. His research interests include the diagnosis and management of learning disabilities, ADHD, and related disorders.

KAREN M. DAVIS received her PhD in clinical psychology from Sam Houston State University and completed a postdoctoral fellowship in forensic psychology at Eastern Virginia Medical School. She is currently an assistant professor of psychology at the State University of New York (SUNY) at Cortland. Her research interests include issues related to standards of practice in forensic psychology as well as the assessment of adult ADHD.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Benjamin J. Lovett, Department of Psychology, State University of New York, 132 Old Main, Cortland, NY 13045. E-mail: [benjamin.lovett@cortland.edu](mailto:benjamin.lovett@cortland.edu)

(Flory, Payne, & Benson, 2014). A diagnosis of ADHD can also result in disability accommodations being provided as a client pursues advanced education, takes certification or licensure tests, and navigates employment settings (Gordon, Lewandowski, & Lovett, 2015). A final motivation is less often discussed but causes further problems: an ADHD diagnosis (whether valid or not) can help to soothe an adult client who feels guilt over difficulties that he or she has experienced in life (Fleischmann & Miller, 2013), given the natural human tendency to look for explanations of one's suboptimal performance that protect one's self-esteem.

Given the myriad challenges associated with assessing ADHD in adults, in the present article we suggest borrowing certain approaches from forensic assessment. Although the presence of attorneys and courtroom proceedings is sometimes assumed to be a necessary component of forensic work, this is not the case. The American Psychological Association (APA) Specialty Guidelines for Forensic Psychology apply in any scenario where a psychologist is working with a client before or after "legal, contractual, or administrative proceedings" and "in all matters in which psychologists provide expertise to judicial, administrative, and educational systems" (American Psychological Association, 2013, p. 7).

Although relatively few adults seeking ADHD evaluations are involved in ongoing litigation, clinicians conducting these evaluations are often asked to utilize their clinical knowledge to assist in determining whether a client meets the legal definition of disability and is eligible for accommodations. Additionally, the results of a report may be provided to educational institutions or other administrative entities, which further highlights the relevance of forensic principles to the assessment of adult ADHD. Even when the only goal is treatment, elements of forensic assessment approaches can lead to more accurate diagnoses, which is an aid to effective and efficient use of interventions. In short, best practices for adult ADHD assessment require the use of certain procedures that are associated with the forensic assessment approach.

The remainder of this article consists of two major sections. In the first section, we review several differences between forensic assessment and typical clinical assessment, discussing relevant research that supports the forensic approach with regard to adult ADHD assessment. In the second section, we outline a concrete best-practice model for adult ADHD assessment that integrates clinical and forensic approaches.

### Relevant Forensic Assessment Principles

Forensic psychologists have often noted the differences between clinical and forensic assessment. As the Specialty Guidelines note, "Assessment in forensic contexts differs from assessment in therapeutic contexts in important ways that forensic practitioners strive to take into account when conducting examinations" (American Psychological Association, 2013, p. 15). Below we describe the forensic principles that are most relevant to those conducting adult ADHD evaluations in a traditional clinical setting. (Clinicians asked to evaluate someone who has already entered into litigation may benefit from an even more stringent application of forensic assessment principles.)

### Use of Collateral Sources of Information

As Greenberg and Shuman (1997) observed, clinical and forensic approaches differ in "the degree of scrutiny to which information from the patient-litigant is subjected" (p. 53). When treating a client for depression, for instance, it may not be necessary to verify the accuracy of a client's recollections of a difficult childhood. Even if memories are inaccurate, it may be the client's believing them that gives them significance. In contrast, when diagnosing ADHD in adults, accurate information about the client's childhood is very important, and unfortunately, retrospective recollections of ADHD symptoms in childhood are often not indicative of the disorder (e.g., Suhr, Zimak, Buelow, & Fox, 2009). Of course, even accurate descriptions of childhood symptoms and impairment do not mean that the client still meets the criteria for ADHD. Longitudinal studies of the disorder yield greatly varying rates of persistence from childhood to adulthood, but in all such studies, at least a substantial minority of children with ADHD no longer met the criteria for it in adulthood (for a recent review of the literature, see Caye et al., 2016). Therefore, collateral sources of information from the client's past *and* present should be consulted.

Forensic psychologists routinely supplement self-reports with historical records and the reports of third-party informants (Melton, Pettila, Poythress, & Slobogin, 2007). Similarly, best practice for ADHD assessment includes reports of clinically high symptom levels from multiple sources in multiple settings. In *adult* ADHD assessment, especially in young adults, recent studies have found that informant reports are actually more accurate than self-reports (Dvorsky, Langberg, Molitor, & Bourchtein, 2016; Sibley et al., 2012). It appears that young adults with genuine ADHD are likely to underreport their symptoms (showing a lack of self-awareness) whereas young adults without ADHD often overreport their symptoms. In short, reports from informants such as parents, siblings, friends, and coworkers should be a standard part of any adult ADHD evaluation.

Of course, informant reports are not infallible. Examinees may prompt collateral informants to corroborate inaccurate self-reports (Rogers, 2008), and knowing the reason for the evaluation may elicit biased reports from the informant before any questions are ever asked (Wood & Brodsky, 2015). To address these problems, forensic psychologists recommend consulting *multiple* informants from different settings in the client's life (Tassé, 2009) and judging informant reports against objective historical records.

Review of such records is particularly helpful in validating self- and informant reports of childhood symptoms of ADHD; for instance, teacher narrative report cards and school discipline records can be invaluable. Objective records are just as critical to the assessment of functional impairment (another *DSM* diagnostic criterion for ADHD). Occasionally, very clear evidence of ADHD-related problems in school was missed in the client's childhood, because the problems were attributed to causes other than ADHD, or because of suboptimal school environments and parents who were not in a strong position to seek assistance for their child. In other cases, a client may recall struggling in school in childhood and adolescence, but the objective records show good and excellent grades. Again, in a therapeutic context, the client's *distress* over his or her past academic performance might be the focus of intervention, but when making an ADHD diagnosis, the objective records are far more important.

A final note: in ADHD assessment, certain collateral sources of information can be more challenging to collect for a variety of reasons. First, given the genetic basis of the disorder (see, e.g., Schachar, 2014), a client's biological family members may have ADHD and struggle with returning phone calls and sending in rating scales. Second, in cases of severe ADHD, a client's own executive functioning deficits may prevent him or her from easily locating and gathering together historical records. Finally, asking an employer or work supervisor about certain core ADHD symptoms (e.g., making careless mistakes) may suggest that the client is not a competent employee, and the client may be understandably concerned about any such implication. These challenges are worth noting, but collateral information is so critical that every effort must be made to obtain such information; as research has repeatedly shown, self-report is an inadequate basis for an ADHD diagnosis.

### Evaluation of Response Validity

Collateral sources of information are one of the two major strategies for addressing the limitations of self-report. The other strategy involves administering specialized measures of response validity—that is, measures of the client's motivation, effort, and honesty during a diagnostic evaluation. Response validity measures assess symptom validity (accuracy in symptom reporting), performance validity (good effort on cognitive tasks), or both; see Larrabee (2012) for further discussion of this distinction. Response validity measures are an integral part of forensic evaluations (Heilbrun & LaDuke, 2015); however, in their review of 100 ADHD evaluation reports, Nelson et al. (2014) found that only three of the reports mentioned specific standalone measures of response validity.

Research from the past decade suggests that inclusion of response validity measures is essential to accurate adult ADHD diagnosis. A significant proportion of adults being evaluated for ADHD (e.g., up to 48% in Sullivan, May, & Galbally, 2007) appear to exaggerate their symptoms, obtaining noncredible scores on specialized performance validity measures. Moreover, those clients with noncredible performance will not be detected without specialized measures, as a recent study by Marshall, Hoelzle, Heyerdahl, and Nelson (2016) showed. These investigators administered comprehensive ADHD diagnostic batteries that included several measures of response validity. Marshall et al. (2016) found that of 115 adults who clearly showed noncredible behavior during the evaluation (as determined by response validity measures), 65% would have been diagnosed with ADHD based solely on a clinical interview and standardized behavior rating scales, and even the addition of cognitive tests (without measures of response validity) would have led to over half of the noncredible adults receiving incorrect ADHD diagnoses.

Thankfully, a number of archival and simulation studies have shown that response validity measures are helpful in identifying noncredible presentations of ADHD symptoms (for reviews, see Jasinski & Ranseen, 2011; Tucha, Fuermaier, Koerts, Groen, & Thome, 2015). Currently, the measures with the best sensitivity and specificity tend to be performance tests initially designed for the detection of feigned neurocognitive disorders (such as traumatic brain injury). In simulation studies, some individual measures catch approximately half of feigners while maintaining over

90% specificity (i.e., falsely classifying honest respondents as feigners less than 10% of the time). To raise sensitivity while maintaining such high specificity, multiple measures can be combined (Musso & Gouvier, 2014). Of course, requiring evidence of real-world impairment (in the form of objective records) also greatly aids the detection of exaggeration.

As we discussed above, there are a variety of reasons why adults would exaggerate symptoms to obtain an ADHD diagnosis, especially medication and disability accommodations. With regard to medication, several studies have documented “doctor shopping,” in which adult clients repeatedly seek evaluations, either until they persuade an evaluator that they have ADHD or until they acquire as many prescriptions as they desire (e.g., Cepeda et al., 2015; Stogner, Sanders, & Miller, 2014). Given this phenomenon, it is remarkable that formal consideration of response validity is so rare in ADHD evaluations. Some practitioners may be concerned that measuring response validity conveys a lack of trust or even a bias against the client (Wasserstein, 2005); however, at this point in time, the research evidence favoring the inclusion of response validity measures is overwhelming. Such measures are not foolproof, but they are only rarely triggered by honest clients putting forth their full effort (Tucha et al., 2015), and so their benefits appear to outweigh any risks.

### Relationship Between the Examinee and the Evaluator

In the forensic arena, the client is generally not the examinee but rather a third party (e.g., an attorney or court) that has requested an evaluation (Knapp & VandeCreek, 2012). In such situations, a forensic evaluator's allegiance is to the third party, rather than to the examinee (Knapp & VandeCreek, 2012). Of course, in adult ADHD evaluations, the client and examinee are typically the same individual, and so the forensic perspective might not initially seem relevant here. However, in some ways, the type of relationship that the adult ADHD evaluator establishes with the examinee should be more similar to that of a forensic evaluator and examinee than a therapeutic clinician and client. In particular, diagnosing ADHD in adults calls for an objective, neutral perspective that typifies forensic practice (Greenberg & Shuman, 1997; Zillmer & Green, 2006).

Although it is unrealistic to expect clinicians to be completely devoid of biases when conducting evaluations, forensic psychologists have identified strategies to lessen the potential impact of personal biases on one's evaluation. One such strategy involves continued education in areas related to standards of practice (Neal & Brodsky, 2016; Richards, Geiger, & Tussey, 2015; Robb, 2006). This applies well to adult ADHD assessment; relevant and informative continuing education workshops and texts are widely available. In our experience, even when clinicians are aware of certain research-based principles, it is helpful to be re-exposed to those principles periodically. Such repeated exposure provides “booster shots” of evidence-based reasoning that inoculates against the biases that can fester and flourish in typical clinical practice, where there are a variety of incentives to make a diagnosis when the criteria for ADHD are not actually met.

A second strategy for promoting objectivity involves developing—and testing—plausible alternative explanations for data when conducting evaluations (Heilbrun, 2001; Robb, 2006; Shuman & Zervopoulos, 2010). For instance, when adults report symptoms of

inattention, evaluators should remember that many psychological disorders cause inattention, and most of those disorders are more common than adult ADHD. In an adult, it makes sense to first see if problems such as anxiety, depression, or both, can fully explain the inattention. Other alternative explanations involve cognitive or developmental disorders (such as specific learning disabilities). Still other explanations include feigning or exaggerating symptoms, and so assessment of response validity is critical, as we discussed above. Each alternative explanation for the client's presenting concerns should be tested by explicitly investigating the extent to which available evidence supports or negates it, until the evaluator arrives at the conclusion that best fits the existing information.

### **Purpose of the Evaluation and Competence of the Evaluator**

In the clinical arena, the goal of a diagnostic evaluation is to assist in developing a treatment plan that is likely to benefit the individual being assessed (Heilbrun, DeMatteo, Holliday, & LaDuke, 2014). From this perspective, clinicians evaluating adults for the presence of ADHD would have the end goal of developing a treatment plan or recommendations that would benefit the examinee. Forensic evaluators are instead tasked with addressing a "psycholegal question" (Greenberg & Shuman, 1997)—that is, a legal question that psychological expert opinion can help answer.

Those assessing for the presence of adult ADHD typically make recommendations for treatment (Ramsay, 2015), but they often also must make a legal judgment of disability (e.g., when recommending accommodations). In the latter task, evaluators are, therefore, bound by the legal definitions included in the Americans with Disabilities Act (ADA; Americans with Disabilities Act of 1990, 1990) regarding the circumstances under which a diagnosis constitutes a disability that could require accommodations. A clinical diagnosis of ADHD is not the same as a legal judgment of disability, a fact acknowledged by the *DSM-5* (American Psychiatric Association, 2013): "In most situations, the clinical diagnosis of a *DSM-5* mental disorder . . . does not imply that an individual with such a condition meets legal criteria for the presence of a mental disorder or a specified legal standard (e.g., for competence, criminal responsibility, or *disability*)" (p. 25, emphasis added). Indeed, as part of its regulations for enforcing ADA, the United States Department of Justice (2016) recently declined requests to add ADHD to a list of conditions (such as blindness) that would "in virtually all cases" meet the threshold for legal disability.

Competent evaluators of ADHD must, therefore, be familiar with legal standards, especially those related to disability. Briefly, the ADA and its associated regulations define a disability as a mental or physical impairment that substantially limits a major life activity relative to most people in the general population (Gordon et al., 2015). High-achieving adults who compare their accomplishments to similar peers (e.g., medical students) may be distressed by functional levels that are well within the average range for the general population, precluding a determination of disability, even if high levels of ADHD symptoms are present. The ADA was amended in significant ways in 2008 and recent case law (*Blackard v. Livingston Parish Sewer District*, 2013; *Healy v. National Board of Osteopathic Medical Examiners*, 2010) has further informed the standard for documenting ADHD as a legally

protected disability condition. Knowledge of such developments is very helpful when conducting ADHD evaluations. Unfortunately, several surveys of clinicians have shown very poor knowledge of relevant disability law (Gordon, Lewandowski, Murphy, & Dempsey, 2002; Harrison, Lovett, & Gordon, 2013; Hernandez, Keys, & Balcazar, 2003).

### **An Integrated Model of ADHD Assessment: From Referral to Conclusion**

Below we present an integrated clinical-forensic model for assessing adults who present with ADHD-related concerns. A comprehensive discussion of appropriate adult ADHD assessment procedures is beyond the scope of this article, but we will outline important elements of such procedures, and readers are referred to other sources (Mapou, 2009; Murphy & Gordon, 2006; Ramsay, 2015) for more detailed discussions of assessment procedures.

#### **The Initial Referral Meeting**

Either in person (preferred), or over the phone, the clinician explains to the prospective client the purposes of the evaluation and the importance of honesty and good effort throughout the evaluation. In addition, the clinician asks the client about the latter's goals for the evaluation; why is he or she interested in being evaluated, and what outcomes (not just in terms of a diagnosis) is the client hoping for? Improvement of the quality of a marriage? A better score on an admissions test? Is the client already considering the potential value of particular treatments or accommodations?

During this initial meeting, clinicians should mention the importance of multiple, independent perspectives on the client's symptoms, necessitating the client's permission for the clinician to send questionnaires and rating scales to others who know the client well. The client's own perspective on his or her problems is described as extremely valuable but necessarily limited. Whereas some clients are eager to solicit perspectives of third parties (e.g., "Just ask my wife; she'll tell you all about my problems!"), others will be surprised and even resistant. Such resistance can stem from a variety of factors, including impatience at resulting delays in diagnosis, annoyance over perceived distrust by the clinician, and fears of humiliation in front of the additional parties now involved in the evaluation. When faced with resistance, the clinician should reassure the client that soliciting third-party reports is a typical practice and an important one.

After the initial meeting, the clinician takes a moment to reflect on his or her own feelings about the case. To the extent possible, personal sources of biases (e.g., affinity for the client and his or her situation) are identified, along with the consequences of those biases that can be guarded against. Based on the client's initial description of problems, the clinician notes a number of alternative explanations, which typically go beyond ADHD.

#### **Collection of Data Before the Formal Evaluation Meeting**

The evaluator distributes questionnaires and rating scales to the client and directly to relevant third parties: family, friends, co-workers, and so forth. A cover sheet clearly explains the impor-

tance of honest, accurate ratings. The questionnaires and rating scales assess symptoms as well as real-world functional impairment, two separable phenomena that must both be present for an accurate diagnosis (Lewandowski, Lovett, & Gordon, 2016). Norm-referenced scales allow for a clearer interpretation of normal versus abnormal functioning, and this is suggested by the *DSM-5* diagnostic criteria, which note that the symptoms must be atypical for the person's age. Norm-referenced scales also help to address the high base rate of ADHD symptoms in the general population, which limits the utility of simple checklists of *DSM* items. The symptoms assessed should include those of ADHD as well as other psychiatric disorders for the purpose of differential diagnosis. ("Broadband" symptom rating scales assessing a variety of symptom areas are especially helpful in this regard.) As the questionnaires and rating scales are returned, they are reviewed, and normed scales are scored.

Based on this initial data collection, the alternative explanations for the client's problems are revisited and refined, and any additional explanations that could fit the data are identified as well. Each of the explanations serves as a hypothesis to be tested at the formal evaluation meeting, and so the clinician contemplates an ideal assessment battery tailored to testing those hypotheses.

### The Formal Evaluation Meeting

After receipt of the mailed data, the formal evaluation meeting can be scheduled. The client is asked to bring records of real-world functioning: report cards from childhood, job performance reviews, copies of discipline referrals, reports of accidents or injuries caused by inattention, and so forth. Clinicians should also obtain releases to speak to relevant third parties and to obtain the records directly should there be any indications that the client chose unrepresentative records to exaggerate the severity of impairment (e.g., "sour cherry picking"; see Gordon, 2009). Additionally, clinicians should note in their report whether they relied solely on records that were provided by the client so that subsequent evaluators or administrative bodies have a full understanding of the information utilized by the evaluator.

At the formal evaluation meeting, the clinical interview is the central activity. Clinicians should push for very specific examples illustrating any reported symptoms and impairment. Questions should be directed toward the alternative hypotheses; for instance, questions might focus on whether inattention symptoms were present in childhood without the mood symptoms that the client currently has. Questions can also be focused on topics where discrepancies appear to exist between different informants, or between an informant and objective records. Discrepancies often have explanations other than dishonesty, but should still be resolved whenever possible.

Along with the clinical interview comes direct observation of the client. The clinician notes whether the client appears restless or impulsive, or easily distracted by minor noises and visual stimuli. Sometimes, the form of the client's responses to interview questions actually suggests the presence of disorder: can the client provide an integrated narrative in response to wide, open-ended questions, or does the client quickly lose sight of the question and does the response quickly veer into irrelevant information and lengthy tangents? Admittedly, the structured, one-to-one nature of the evaluation meeting can attenuate ADHD symptoms in the moment, but some individuals with

ADHD will nonetheless show easily observable distractibility or impulsive responses to questions.

Finally, in addition to the interview and observation, many clinicians will conduct formal psychological testing of some sort: neuropsychological testing of attention and related functions, personality testing related to potential comorbid disorders, achievement testing to examine academic skills and potential learning disabilities, and so forth. Although these kinds of tests can make an evaluation lengthier and more expensive, and the test results are generally not primary sources of evidence of core ADHD symptoms (Gordon, Barkley, & Lovett, 2006), such testing is an important strategy for ruling out alternative explanations of real-world impairment (e.g., the presence of other disorders). In addition, such testing can be very useful in assessing motivation, honesty, and effort; many neuropsychological and personality tests have validity indices embedded in them, and standalone formal tests of response validity (e.g., the Word Memory Test; Green, 2003) are recommended as well.

### Diagnostic Conclusions and Feedback

After the evaluation is complete, the clinician scores any formal tests, integrates information, makes a final consideration of various explanations of the evidence, and prepares a written report detailing the results of the assessment tools, diagnostic conclusions, and recommendations for treatment and management. If at all possible, rather than merely sending the report to the client, a session is scheduled for verbal feedback, and the written report is provided at the end of the verbal feedback. Starting feedback by summarizing the data, including the client's self-report, helps to lay the foundation for the conclusions and, thus, prepares the client for the clinician's recommendations. Discrepancies between information sources are presented in a nonconfrontational manner, and the clinician emphasizes that discrepancies are common (see, e.g., Zucker, Morris, Ingram, Morris, & Bakeman, 2002). If the conclusions include that ADHD is present, appropriate recommendations follow. If the data suggest a lack of response validity, such that no diagnostic conclusions can be drawn, that is shared in a nonaccusatory manner, with the clinician sharing a variety of reasons why response validity may be insufficient (see Carone, Iverson, & Bush, 2010 for more details). Finally, if the conclusion is that ADHD is not present, this should be presented in a positive light, along with alternative explanations of data (especially self-reports) that might have initially appeared to the client to be evidence of ADHD. Time is reserved for questions from the client, to ensure adequate comprehension and trust. Given that, in many cases, the results of the evaluation may be surprising to the client, care is taken to present the results sensitively, but nonetheless firmly (when the diagnostic conclusions are unequivocal).

### A Note on Evaluating Current Therapy Clients

Our model of the evaluation process has assumed that the client is a new referral, as is often the case. However, at times, psychologists complete an ADHD evaluation for a current therapy client. If the client is seeking an evaluation for a specific purpose (e.g., the possibility of medication or disability accommodations), we recommend that the psychologist refer the client to a colleague who can conduct the evaluation with more objectivity. If this is not possible, the

psychologist should explain to the client the importance of a thorough, objective assessment and should proceed cautiously through the model we discussed above. Additionally, clinicians should consult with colleagues during the course of evaluating someone with whom they have a prior relationship as another way to guard against biases that could influence the outcome of the evaluation.

### Conclusions

Diagnosing ADHD in adults is a complex matter, as we have discussed. The need for informant reports and childhood records, the problem of response invalidity, and the difficulties of differential diagnosis are features not commonly addressed in “business as usual” clinical assessments of the sort that many practitioners are used to conducting before beginning therapy. Even psychologists who focus on assessment often fail to adequately address those issues, at least in our own experience, and emerging empirical studies (e.g., Nelson et al., 2014) show this as well. We routinely see individuals who are diagnosed with ADHD for the first time in adulthood, based solely on self-reported data, often from narrowband questionnaires that do not even assess for other disorders. Such practices likely contribute to the tremendous increase in adult ADHD diagnoses and stimulant prescriptions in recent years.

As we have shown, borrowing certain forensic assessment principles—including a general forensic mindset—can be helpful in addressing the complexities of adult ADHD assessment. This does not mean that diagnosticians should treat their clients like criminal defendants or that clinical empathy must be discarded before entering the evaluation room. It only means that adult ADHD assessment requires highly structured, planned evaluations that take the limitations of self-report seriously and review objective evidence concerning each of the *DSM* diagnostic criteria for the disorder. Multimodal assessment has long been recognized as best practice in child ADHD assessment (e.g., DuPaul & Stoner, 2014), and although such assessment is more challenging in adults, it is no less needed, and forensic strategies provide assistance in conducting it.

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