Legal Conceptions of Impairment: Implications for the Assessment of Psychiatric Disabilities

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The measurement of functional impairment is hardly a mere academic enterprise, given the current demand for clinical evaluations of disability status. For instance, witness the recent controversies over US military veterans seeking benefits through certification of psychiatric disability (e.g., McNally & Frueh, 2012) or individuals convicted of murder who may feign intellectual disability to avoid the death penalty (e.g., Chafetz & Biondolillo, 2012). More generally, individuals seeking access to specialized accommodations and services in school or at work are pursuing assessments that establish their qualification as having a disability. To satisfy those requests, clinicians have to understand how the law defines disability and the level of documentation required to establish that an individual has a disability. These legal definitions of disability push clinicians to shift focus from the familiar terrain of symptom counts and psychological test scores to the less traveled path of assessing impairment in actual functioning.

The discrepancies between psychiatric and legal criteria pose challenges for the mental health practitioner. Although many sets of formal diagnostic criteria for psychiatric disorders include an impairment criterion, the standard for meeting this criterion is often very different from the relevant legal standard. In recognition of this reality, the recently revised *Diagnostic and Statistical Manual of Mental Disorders* (the DSM-5; American Psychiatric Association, 2013) clearly states:

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> In most situations, the clinical diagnosis of a DSM-5 mental disorder…does not imply that an individual with such a condition meets the legal criteria for the presence of a mental disorder or a specified legal standard (e.g., for competence, criminal responsibility, or disability). For the latter, additional information is usually required beyond that contained in the DSM-5 diagnosis, which might include information about the individual's functional impairments and how these impairments affect the particular abilities in question. It is precisely because impairments, abilities, and disabilities vary widely within each diagnostic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability. (p. 25)

This chapter is predicated on the premise that, while the transition from clinical to legal criteria for impairment can be jarring, it can also be productive, provoking us to reconsider ideas that are central to the diagnostic enterprise: What constitutes a disorder? What standard should we use to consider someone as having a disability? Should we compare the examinee to the average person, to people of similar educational attainment or aspirations, or to the examinee's own array of strengths and weaknesses? How valid is psychological testing as a source of information about impairment? Should a person be considered to have a disability if the deficit is not so great as to lead to limitations in activities central to daily living? Might the legal method for establishing disability represent a fairer and more practical strategy than what prevails in psychiatry? Does the forensic construal of impairment have something to teach us about how we might reformulate diagnostic protocols?

This chapter reviews the essential elements of establishing impairment within a legal context. Given limitations of space, we focus on conceptions of impairment in disability discrimination law, with some additional consideration of special education law; these arenas have witnessed some of the most nuanced debates over impairment. For readers seeking detailed information about the place of impairment in other legal arenas (e.g., the laws governing someone's competence to stand trial for a crime), we recommend the chapters in a recent edited anthology (Drogin, Dattilio, Sadoff, & Gutheil, 2011).

6.1 Impairment in Special Education Law

The primary law governing special education is the Individuals with Disabilities Education Act (IDEA), most recently reauthorized in 2004. Students who qualify under IDEA receive an individualized education program (IEP), which includes separate educational goals and objectives, based on the students' unique needs. To qualify, students must have a condition that fits into one of 13 enumerated categories (e.g., autism, hearing impairment) *and* their disability condition must lead them to need special education services. It is this latter point that constitutes an impairment criterion under IDEA; if a student has a disability condition but is able to succeed in school without any special services, the student does not qualify. For instance, in one case (*Eric H. ex rel. Gary H. v. Judson Independent School District*; W.D. Tex. 2002), a court found that a student with a diagnosis of Asperger's syndrome did not qualify under IDEA merely because his parents worried that he

would do poorly without special services. As the court noted, "The IDEA not only requires that a disability be shown, but also that the child demonstrate a *present* need for special education services and related services *because* of the disability" (p. 91, emphasis in original). Unfortunately, there are no detailed guidelines available to operationalize "need for special education services." Whether receiving passing grades in classes is sufficient to show a lack of impairment has been debated, but not resolved (Office of Special Education Programs, 1995).

Some students who have disability conditions but who are found to not need special education still qualify for certain protections at school, through Section 504 of the Rehabilitation Act of 1973. Schools must consider this potential eligibility after determining that IDEA does not apply (Yell, 2012). Section 504 does not typically provide special education per se, but it ensures that *public* schools do not discriminate against individuals with disabilities. Many students receive accommodations such as preferential seating in classrooms, scheduling adjustments, and testing accommodations under Section 504, without receiving any special education services (Lovett & Lewandowski, 2015). Section 504 has an impairment criterion as well. The student's disability must substantially limit one or more "major life activities," just as under the Americans with Disabilities Act (ADA). We will discuss the specifics of this definition in more detail below.

6.2 The Americans with Disabilities Act

The most important legislation that currently establishes the bounds of disability is the Americans with Disabilities Act (ADA). It encompasses the institutions that IDEA and Section 504 apply to, as well as other institutions. This law, designed to combat discrimination against individuals with disabilities, contains five sections, three of which impact daily life. Title I requires employers to treat qualified individuals with and without disabilities equally with regard to hiring, salary, promotion, and training opportunities. It also requires that "reasonable accommodations" be made so as to allow individuals with disabilities to perform their jobs. Title II deals with public services, requiring (for instance) public transportation authorities to ensure that individuals with disabilities have comparable access to the transit system. Finally, Title III requires that any facility open to the public (designated under the law as a "public accommodation") be accessible to individuals with disabilities. As proclaimed by the General Rule for this section: "No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation."

Anti-discrimination laws do not guarantee success in life for individuals of groups that the laws combat discriminate against. In the same way that a law prohibiting racial discrimination in employment would not guarantee that any minority applicant applying for a particular job would be hired, the ADA does not guarantee that an individual with a disability will be hired or admitted to a particular educational program.

By definition, an anti-discrimination law such as the ADA is "outcome-neutral." While it establishes procedures for making certain decisions around hiring and test accommodations, it does not impose constraints on the decision itself. For instance, the ADA does not dictate that a student qualified as having a disability must succeed in every course or examination. It only guarantees that the student not be discriminated against because of limitations that are irrelevant to the essential functions inherent in being a student. The ADA would protect someone who was visually impaired from failing an examination because he could not see the text. It would not assure that that student received a high score on a version of the test he could access. Therefore, a clinician who writes, in a report supporting accommodations, that the student "must be allowed extra time so that he can pass the licensure examination for his profession" misreads the intent of the law and ensuing regulations. The ADA ensures that individuals who are otherwise qualified for jobs or educational programs are not denied participation *simply because they have disabilities*. The law therefore guarantees *access*, not *success*.

In educational settings, advocates for students with disabilities may be surprised to learn about ADA's outcome-neutral nature, especially if they are using special education laws (e.g., The Individuals with Disabilities Education Act and its revisions) as a model. Typically, these special education laws have aimed at improving performance of students with disabilities, rather than merely protecting students from discrimination (Yell, 2012). Even though these laws do not guarantee high achievement (or any *particular* outcome; Latham, Latham, & Mandlawitz, 2008), they are designed to promote it. The No Child Left Behind Act reinforces this goal by setting clear academic expectations for students and insisting that all students (including almost all students with disabilities) meet those expectations (Hess & Petrilli, 2006). These laws consider outcomes, while the ADA, again, only examines the *procedures* followed by institutions. This distinction may cause confusion when students transition from high school to college, since special education laws do not apply in the latter setting.

Evaluators charged with making objective decisions about disability status may also misconstrue the intent of the law. In a survey of 147 clinicians who prepared disability documentation to support testing accommodations on the Law School Admissions Test (LSAT), Gordon, Lewandowski, Murphy, and Dempsey (2002) found marked disagreement over the purpose of the ADA. Over 30 % of the clinicians (incorrectly) endorsed the statement that the ADA was intended to increase test scores and the academic performance of individuals with disabilities. Over 35 % of the clinicians (again, incorrectly) endorsed the statement that the ADA is violated if a testing organization or academic institution "fails to provide accommodations guaranteeing that the individual with a disability will perform at his or her best." A more recent study showed many of the same confusions present in Canada, where clinicians failed to appreciate the similar distinctions between education and human rights laws there (Harrison, Lovett, & Gordon, 2013).

6.2.1 ADA and the Average Person Standard

At the heart of the ADA is a fundamental question: "What defines a disability?" The law defines disability as follows: *The term disability means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual, a record of such an impairment; or being regarded as having such an impairment* (P.L. 101–336, 1990). We note that the use of "impairment" here does *not* refer to functional impairment; instead, it refers to the disability condition (e.g., diabetes, ADHD). Throughout the rest of the chapter, we return to using "impairment" to mean functional impairment.

One governmental entity responsible for setting forth regulations regarding the ADA, the Equal Employment Opportunity Commission (EEOC), has noted that a substantial limitation must be gauged by determining if someone is limited "*compared with the abilities of the average person* [italics added]." The regulations illustrate this principle by stating that "an individual who had once been able to walk at an extraordinary speed would not be substantially limited in the major life activity of walking if, as a result of a physical impairment, he or she were only able to walk at an average speed, or even at moderately below average speed." This statutory language was intended to ensure that the ADA covered serious disabilities but not those that were minor or trivial.

Establishing the general population as the norm against which to judge impairment has profound implications for determinations of disabilities in both postsecondary education and the workplace. By setting "average abilities of most persons" as the standard, Congress adopted a benchmark that departs from the educational tradition embodied by special education laws. For determining learning disabilities in elementary and secondary school students, many states use a discrepancy between aptitude and achievement as one way of establishing abnormality (Zirkel & Thomas, 2010). However, for ADA-type determinations, the government and courts have indicated that a discrepancy alone is not sufficient to warrant test accommodations and that impairment also must be considered. The obvious significance for clinicians is that one cannot justify someone as having a *legal* disability based on relative discrepancies or presumptions of "potential" based on scores from psychological testing. Furthermore, the law discourages the practice of using norms based on other than the general population (e.g., college graduates or students in professional programs). According to the ADA, a student cannot be considered to have a disability simply because he or she is not quite as talented as other very talented individuals.

Several concrete implications for the assessment of impairment follow from these points. First, assessment measures with population norms should be strongly preferred to criterion-referenced test scores. Norm-referenced scores are calculated by comparing each examinee's performance to that of other examinees. IQ scores, T-scores from rating scales, and percentile scores are common examples of scores that show a relative comparison to the average person. Criterion-referenced scores are calculated by comparing the examinee's performance to an absolute standard, rather than to other examinees' performance. For instance, many state exams in

K-12 education classify students using terms such as "proficient" and "advanced" depending on what percentage of items they answer correctly. These scores do not gauge an individual's scores to the performance of most people (Sax, 1997).

Second, these norms should be based on the general population (typically, age-norms are appropriate here) rather than being based on "clinical groups" (e.g., samples of students with ADHD) or high functioning groups (e.g., college graduates, law students). As Hopkins (1998) points out, the key to making confident norm-referenced score interpretations is a representative norm group. Individually administered tests of ability and achievement are known for their careful selection of participants for standardization samples, stratified by relevant demographic variables, and consequently representative of the population at large. A new trend has been the creation of norms for certain population subgroups (e.g., performance of medical school students on the Nelson Denny Reading Test). However, while these norms may serve certain clinical goals well, they cannot be used for disability determinations because they directly violate the average person standard.

Finally, the assessment of impairment should not be based solely on self-reported comparisons to others in a particular peer group since those peers often function much better than the average person in the general population. For example, a professor at Harvard Law School who describes a student as having academic trouble might be tantamount to an Olympics coach describing an athlete as "the worst on the team." It is unlikely that a Harvard Law School student or an Olympian would function poorly when compared to the average person. Evaluators should be aware that high-functioning individuals frequently report that they perform less well than peers. Lewandowski, Lovett, Codding, and Goddon (2008) found that a sizable proportion of typical college students perceived themselves as slower readers and poorer test takers than other students. Thus, there is something inherently natural, albeit inaccurate, about reporting relative deficiencies, even among groups of individuals who perform better than most people.

Many clinicians are unaware of the ADA's basic tenets on these points. For example, the survey by Gordon et al. (2002) documented that 43 % of clinicians wrongly endorsed the practice of determining impairment by comparing a student to others at "similar educational levels," and 36 % wrongly endorsed examining "students in a similar college or professional program" to establish a standard. Even more surprisingly, over 50 % of clinicians wrongly endorsed making a diagnosis of "reading disability" for a hypothetical student with an IQ of 135 and a reading score of 100 (perfectly average) under the ADA. Clearly, to the extent that clinicians examine impairment, many compare examinees with standards other than the "average person" standard of the ADA.

6.2.2 Significant Impairment and Major Life Activities Under the ADA

To be qualified as disabled under the ADA, an individual must be substantially limited in one or more "major life activities." To justify accommodations for

individuals in higher education, clinicians often claim that the substantial limitations are present, but latent. Typically, the evaluator accounts for high academic or occupational functioning by claiming that the individual was only successful because of hard work or high intelligence. For example, a clinician might write, "Susan was able to adjust because she was so motivated to achieve and worked much harder than her classmates. Now that she is in graduate school, she requires accommodations because the work is becoming so demanding, and her learning disability/ADHD is causing her to perform below average in the class."

Claiming that a person can become disabled because of heightened academic demands is problematic. First, both LD and ADHD are developmental problems which should surface and cause impairment during childhood (12–14 years of age, at the latest). Generally, if an individual is able to cope with the academic and social demands of a high school education without substantial assistance, he or she is neuropsychologically intact and therefore unimpaired relative to most people. While the person may encounter future academic difficulties, those shortcomings are often better understood as the consequences of a mismatch between individual aptitude and the requirements of a challenging educational program or career choice. A reading disability, then, should not be first identified when a law student begins to struggle with comprehension of a law textbook. By stretching the age of onset for symptom presentation until young adulthood or later, clinicians risk distorting the concept of disability to include anyone who reaches an academic level that outstrips his or her particular array of talents. Conceivably, people can "develop" a disability simply by matriculating in educational programs for which they are poorly suited. Thus, clinical impairment resulting from a developmental disorder should be documented early and throughout one's educational life.

A second problem with the clinician's report on Susan is that "being a graduate student" is not likely to be considered a major life activity. "School" may be a major life activity in elementary and even high school, but in postsecondary settings, the classification is less obvious. In graduate or professional school, the "major life activity" designation is incorrect, considering how many individuals discontinue formal education by this point. Similarly, an assistant district attorney who develops problems concentrating and other symptoms of inattention after taking a job directing the homicide division of a large city's district attorney's office is unlikely to be considered to have a disability under the ADA since success in that particular position is not a major life activity.

A third problem often seen in evaluation reports involves the clinician's use of "hard work" as an explanation for successful function in spite of a disability. In truth, most of us have to work hard to succeed, especially as expectations and demands mount over time. Lewandowski et al. (2008) found that over 40% of a large sample of nondisabled students at a private university felt they worked harder than peers to get good grades. Over half of the students reported having to read material over and over again to understand it. Finding life's challenges to be challenging makes no sense as a marker of disability. Using that metric would result in classifying most individuals as having a disability in some area of life.

Yet another problem with the report on Susan involves identifying her high intelligence as an explanation for the late onset of her symptoms. Clinicians often make the argument that a particular student warrants a disability classification because he or she does not perform as one would expect given his or her IQ score. The logic behind this assertion seems to require that IQ is a perfect predictor of academic outcome. Actually, research indicates that, although IQ is a moderately strong predictor of academic or occupational achievement (Mackintosh, 2011), the prediction is far from perfect. A high IQ is simply not a precise indicator of how well someone should perform on the job or in higher education. A bright person can underperform for a universe of reasons unrelated to disability, from poor educational experiences to uneven motivation. The evidence is clear that a diagnosis of a learning problem based on a discrepancy between IQ and achievement should not be sufficient to document a learning disability (as indicated in the revised diagnostic guidelines in DSM-5; American Psychiatric Association, 2013).

6.2.3 Reasonable Accommodations Under the ADA

If it is determined that an individual is indeed qualified as having a disability under the ADA, the next step is to identify reasonable accommodations. Those accommodations must be justified based upon two considerations: (a) the specific nature of the person's functional impairment; and (b) the educational, occupational, or testing environment in which that individual will be functioning. The evaluator must provide a rationale for any recommended accommodations by explaining how those adjustments or technological aids would cancel or ease the impact of the impairment on the task in question.

Accommodations are task-specific and intended to eliminate or reduce the impact of the impairment on a particular activity. Thus, an individual who must dictate test answers to a scribe because of a limitation in the ability to write would not require that accommodation on an oral examination. Likewise, an individual who, because of problems walking, requires a ramp to enter a building would not need additional time to complete assignments or examinations, at least based on that disability. In essence, there must be a demonstrated match between the disability and task requirements.

Assignment of a diagnostic label does not mean that the individual is automatically entitled to accommodations, even though students (and their advocates) sometimes request accommodations that are not directly related to the impairment. To give an example: Roger submits documentation to a testing agency certifying that he suffers from ulcerative colitis. First, he wants to be seated near the restroom because he may need to use it often during the course of the day. The test organization has no problem granting this request. But Roger also wants double the allotted time to take the examination. Here, the ADA administrator balks. What are the functional impairments associated with ulcerative colitis that would require extra time to work on the test? While off-the-clock breaks may be justified, it is hard to provide a rationale for extended time working on the test itself.

Another key concept in justifying accommodations relates back to the outcome-neutral nature of these anti-discrimination laws. Under the ADA, the explanation that someone "would benefit from" a particular accommodation is not sufficient. As we have repeatedly indicated, the intent of the law is not to help people succeed. This stance is eloquently described in an opinion by the Office of Civil Rights (OCR) in the Golden Gate University (CA) case in 1996. In this instance, a student claimed to have the right to accommodations so that he could achieve a certain grade. OCR responded thus:

> "[The student] appears to be of the misapprehension that the duty to provide academic adjustments includes a responsibility to provide such adjustments until a certain outcome is achieved, e.g., a grade of A. This is not what was contemplated by the OCR regulations. The objective is to create equal opportunity, not equal outcomes. Tests are modified to achieve greater validity, not higher grades. Indeed, the regulation implementing Section 504 explicitly states that services provided by recipients, 'to be equally effective, are not required to produce the identical result or level of achievement for disabled and nondisabled persons, but must afford disabled persons equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement.'" (National Disability Law Reporter, 1996, §12)

The focus of an accommodation request should therefore not be on what would help the individual to do better or to pass the exam or course requirements. Instead, the focus should be on which accommodations would correct or circumvent functional impairments that might otherwise preclude a fair opportunity to access a course or a test.

By implication, an ADA-based accommodation, because it is designed to correct a deficit, should not represent a general benefit to anyone in the same situation. Such an accommodation would constitute an unfair advantage rather than an accommodation specifically aimed at reducing the impact of a disability. For example, a handicapped-accessible door allows someone in a wheelchair to gain access to that building. The accommodation would neither help nor hinder most individuals who did not use wheelchairs. Even if individuals who fell outside of ADA's protection benefited from it, they are, importantly, not excluded from using it. Similarly, while large print on a paper exam would be an appropriate accommodation for an individual with poor eyesight, it would not be of substantial benefit to most nondisabled individuals. It might actually slow such individuals down because it would require extra page turning. These accommodations lead to what has been described as a "differential boost" (Fuchs & Fuchs, 2001) for the individual with a disability since in each case, the accommodation provides more of a "boost" to the test scores of individuals with the disability than to nondisabled examinees.

Strictly speaking, accommodations for ADHD should also meet the "differential boost" criterion. Most examinees who apply for accommodations based on this disorder request extra time. However, because most high stakes examinations are at least in part speeded, additional time would likely help anyone (see Lovett, 2010, for a review of evidence on this point). There are a variety of reasons why extra time may not be particularly helpful for ADHD, some of which follow from the impulsiveness that is the hallmark of this disorder (Barkley, 1997). For instance, many

individuals with ADHD report that extra time would be of little use because they tend to complete tests too quickly, failing to make wise use of the allotted time for checking answers and ensuring accuracy (Murphy & Gordon, 1997).

That reasonable accommodations are designed to correct for impairment rather than to increase performance is often a difficult distinction to make in practice. Indeed, many clinicians may not even be aware of the principle, as evidenced by the survey by Gordon et al. (2002). In this survey, 29 % of clinicians agreed with the statement that the "purpose of accommodations is to allow an individual with a disability to perform at his or her best," which presumes that all performance (and testing) environments should be *optimal* environments.

6.2.4 A Note on the 2008 ADA Amendments

Our coverage of the ADA has reflected the current version of the law, which involves significant changes from when we wrote the corresponding chapter for the first edition of this book (Lovett, Gordon, & Lewandowski, 2009). In 2008, the U.S. Congress passed the ADA Amendments Act (ADAAA; also known as the ADA Restoration Act). The ADAAA was passed in response to the conservative interpretation of the original ADA of 1990 on the part of the U.S. Supreme Court and the Equal Employment Opportunity Commission (EEOC). For instance, the Supreme Court had ruled that if "mitigating factors" such as medications and technology aids kept someone from being substantially limited, that person was no longer disabled under the law. The ADAAA explicitly takes issue with these interpretations and designates different standards, among its other changes (Joiner, 2010; Rozalski, Katsiyannis, Ryan, Collins, & Stewart, 2010; Scott, 2010). However, the changes should not be overstated; key features of the original ADA, such as the average person and general population standards, are still intact. Again, the foregoing discussion of the ADA was revised to make it consistent with the current ADA, as amended in 2008. Still, readers may find it useful to be aware of the changes, especially if they examine documentation—or case law—from before the ADAAA was passed.

6.3 A Special Legal Issue in Assessment: Malingered Impairment

One additional legal issue in the assessment of impairment concerns malingering, defined in the DSM-5 as "the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs" (APA, 2013, p. 726). Malingering has long been recognized as a problem in medical assessment (e.g., Jones & Llewellyn, 1918). Its import in psychological assessment is seen in the "validity scales" of personality tests and the "effort tests" developed by neuropsychologists. In assessing impairment, clinicians must be alert to the possibility of malingering whenever an external incentive exists. Individuals seeking evaluations to justify

accommodations based on high-incidence disorders (such as LD and ADHD) may want to look impaired because they would like to benefit from extra time on tests, the availability of academic support services, accommodations on the job, medications that act as performance boosters, etc.

Technically, malingering is only one of a set of related threats to validity. Some clients may exaggerate their symptoms without consciously malingering (as when a client seeks attention). They may also simply put forth poor effort on cognitive and achievement measures due to apathy, boredom, or noncompliance. They may similarly exaggerate symptoms for a variety of reasons. Indeed, the DSM conceptualization of malingering is problematically narrow (Berry & Nelson, 2010). We use "malingering" as shorthand for this set of problems although we acknowledge that malingering, symptom exaggeration, and poor effort are distinct (if related) issues (Iverson, 2006).

Of the non-forensic subspecialties within the clinical realm, clinical neuropsychology has been most aware of the threat of malingering. In 2005, the National Academy of Neuropsychology issued a position paper (Bush et al., 2005) acknowledging that "Symptom exaggeration or fabrication occurs in a sizeable minority of neuropsychological examinations" (p. 419). The position paper insists that, "In order to place maximal confidence in the ability to interpret accurately results from cognitive measures and/or tests of personality or mood, a determination must be made that the examinee put forth appropriate effort on tasks and responded honestly to questions" (p. 421). Two years later, the American Academy of Clinical Neuropsychology, in their Practice Guidelines for Neuropsychological Assessment and Consultation (Board of Directors, 2007), were more specific. They recommended that "Clinicians utilize multiple indicators of effort, including *tasks and paradigms validated for this purpose*" (p. 222, emphasis added). Unfortunately, in other areas of clinical, counseling, and school psychology, these issues are not given much attention. The default assumption seems to be that clients are putting forth adequate effort and honestly reporting their symptoms and impairment under all circumstances. Clinicians even assert that they can use their clinical judgment to detect malingering and low motivation, despite research suggesting otherwise (e.g., Faust, Hart, Guilmette, & Arkes, 1988).

In the case of ADHD, only in the past decade or so has research established that many individuals being assessed for possible ADHD may be exaggerating their symptoms to some degree (e.g., Sullivan, May, & Galbally, 2007). Most ADHD rating scales make it easy to malinger for anyone with even a passing acquaintance with the symptoms of the disorder (Jachimowicz & Geiselman, 2004). In one recent study, Harrison, Edwards, and Parker (2007) compared university students who were asked to put forth full effort on a battery of tests with students who were asked to try to simulate symptoms of ADHD in an attempt to obtain a variety of accommodations. Both groups were then compared with a sample of students from the same university who had validated diagnoses of ADHD. The simulators exhibited performances closer to the legitimate ADHD group than to the other nondisabled students. A discriminant function analysis incorrectly classified over one third of the simulators as being in the ADHD group.

Until recently, most of the malingering literature has focused on more severe neuropsychological problems, especially traumatic brain injury (TBI; see e.g., Green, Rohling, Lees-Haley, & Allen, 2001). However, the concept clearly applies in any test or evaluative situation in which less than optimal effort can produce a desirable outcome. Recent research on learning disability assessments suggest that they exhibit a vulnerability to malingering similar to that of ADHD assessments although fewer examinees may attempt to malinger. Sullivan et al. (2007) used the Word Memory Test (WMT) to examine possible malingering in a sample of college students being assessed for LD/ADHD conditions. The WMT is a measure designed to detect malingering. It uses recognition measures of memory for paired-associate stimuli (e.g., dog/cat) that almost all cognitively intact, literate adults could manage quite well. Based on the number of students who "failed" the WMT, Sullivan and colleagues estimated that 25 % of students being assessed for comorbid LD-ADHD were exaggerating symptoms. A remarkable 48 % of students assessed solely for ADHD were found to exaggerate their symptoms.

To assess for possible malingering when examining impairment, clinicians should consider administering tests that have been shown to be easier for individuals with actual impairment than for those feigning impairment. The WMT meets this criterion for neuropsychological problems. For dyslexia, an even more specific test, the Word Reading Test, has been shown to effectively detect malingering (Osmon, Plambeck, Klein, & Mano, 2006). For schizophrenia and other psychiatric problems, a variety of personality test indices that have been shown detect malingering (Berry, Baer, Rinaldo, & Wetter, 2002). There are even effort tests to detect low effort in individuals being assessed for chronic pain disorders (Suhr & Spickard, 2007).

Finally, we note that a growing body of research is emerging on malingering and poor effort in children and adolescents, and on the utility of special tests to assess effort and symptom validity in this population (DeRight & Carone, 2015). In sum, psychologists and other professionals should be aware of these threats to validity when assessing impairment in both children and adults, and at least outside of neuropsychology, there is certainly a need for more education and training regarding this issue.

6.4 Conclusions

In this chapter, we have reviewed issues pertinent to the evaluation of disability status within a legal context. We have emphasized how laws such as the ADA have set standards that can be at odds with practices common to clinical and educational settings. At the heart of that tension are contrasting conceptions for what constitutes a disability or disorder. The legal standard hinges on the notion that an individual is disabled only if he or she is substantially impaired in a major life activity relative to the average person. Also, the ADA and its predecessors were designed to combat discrimination, not ensure a successful outcome. Clinicians, on the other hand, operate in a world where the lines are drawn less boldly. It is more common in such

circumstances to identify a disorder even in the absence of absolute abnormality relative to most people. Clinicians are more apt to make diagnoses and recommend accommodations to help a client on the path to *success*, rather than to gain mere *access*.

While legal and clinical approaches to the identification of disability/disorder can collide, we conclude by wondering if clinicians might learn something from the standards of the legal world. The legal emphasis on impairment is consistent with the spirit of the frequently mentioned clinical criteria of dysfunction and disability when defining psychopathology (e.g., Maddux, Gosselin, & Winstead, 2012). Similarly, the educational reform movement known as Response-to-Intervention (RTI; Hughes & Dexter, 2011) also implicitly defines abnormality as impairment—a failure to acquire appropriate levels of important academic and social–behavioral skills (despite exposure to appropriate instruction and intervention)—rather than focusing on within-person discrepancies and skill profiles. One cannot help but wonder whether the clear lines established in a legal context are not appropriate for clinical settings. In refusing to lower thresholds for what constitutes a disability, courts aim to limit special protections to those who are truly impaired. That stance, while disheartening to some, has a basis in much clinical literature, and represents a reasonable effort at defining disability in ways that are most protective of those who are most in need.

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