



Have We Loosened the Definition of Disability? The Effects of Changes in the Law and Its Interpretation on Clinical Practice

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Abstract

Evolving changes in the law and documentation guidelines since the 1990 Americans with Disabilities Act have led to a loosening of the definition of disability, in which relative weaknesses are now interpreted as evidence of a disability. In this paper, after acknowledging my own shortcomings, I trace the evolution of the law and documentation guidelines from the late 1990s to the present. I discuss how this has led to increased pressure from parents and students on evaluating clinicians to diagnose a disorder and confirm that the student has a disability that requires academic accommodations. Rather than recommending effective interventions and compensatory strategies, many stakeholders (parents, students, psychologists, disability support professionals) now seem to preferentially favor provision of accommodations. I conclude by describing how these changes have affected my own practice and make recommendations for best practices for disability documentation.

Keywords Documentation guidelines · Disability law · Disability definition · Disability evaluation · Neuropsychological evaluation

Prologue: Mea Culpa

From 1992 to 2012, most of my practice involved evaluating teenagers and adults for possible specific learning disorders (SLDs) and attention-deficit/hyperactivity disorder (ADHD). Typically, this included recommendations for accommodations. In addition to initial evaluations and reevaluations, I helped students appeal accommodation denials. Sometimes, the rejected evaluations were outdated, and an update was needed. However, when I did these appeals, I found that testing agencies and universities had turned down accommodation requests usually because reports did not sufficiently document the person's history and the impact of their disability on everyday functioning beyond taking tests. But in some cases, the testing agency had not thoroughly read the report and had overlooked relevant historical information and relevant test scores.

In comparison with brief neuropsychological evaluations written in a medical setting, my evaluations, completed in an

SLD/ADHD-focused, fee-for-service group private practice included a more detailed history and used a more comprehensive battery of tests. The approach that I developed to address what I saw as documentation limitations (Mapou, 2004, 2008a, 2008b, 2009) was frequently successful in helping students obtain accommodations on high-stakes tests (e.g., Medical College Admission Test [MCAT], Law School Admission Test [LSAT], U.S. Medical Licensing Examination [USMLE], state bar examination). Although my approach was generally one of being a “scout” rather than a “soldier” (Lovett, 2022, this issue) because of the medicolegal work I had done, with an emphasis on reviewing academic records, prior test scores, and accommodation history, in looking back to those years, I recognize that I was also functioning as an advocate and likely violating some of the “seven sins of clinicians” (Harrison & Sparks, 2022, this issue) by sometimes making accommodation recommendations based on relative weaknesses rather than deficits.

Some individuals I evaluated clearly had consistently below average academic skills. Although I never made a diagnosis based on one or two low scores in different domains, I did make diagnoses and accommodation recommendations based on a cluster of relative weaknesses (i.e., standard scores of 90 to 95) that were consistent with the research literature on SLDs (e.g., for dyslexia, weaknesses in

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phonological awareness, rapid naming/word retrieval, timed decoding/sight reading, reading fluency, reading comprehension; Fletcher et al., 2019; Pennington et al., 2020) in individuals with IQ scores of 110 and higher. I conceptualized such individuals as being unable to read, write, or do math at the level of their intellect, which, agreeing with Gregg et al. (2007), I considered disabling (Mapou, 2004, 2008a, 2008b). However, over time, because of what I experienced as differing “disability standards” and interpretations of the 1990 Americans with Disabilities Act (ADA, 1990; e.g., many high schools, colleges, and some testing agencies accepted relative weaknesses as sufficient for disability documentation and accommodations, but higher-stakes agencies, such as the Law School Admission Council [LSAC], National Board of Medical Examiners [NBME], or state bar examiners applied more rigorous “average person” standards). When these individuals completed college and opted for careers in law and medicine, they did not meet the more rigorous disability criteria that required “skills below the level of most people.” I was also increasingly influenced by the writings of colleagues, including several who are part of this special issue. Consequently, I decided that I was doing these students a disservice by labeling them as disabled because they would no longer qualify for accommodations to which they had grown accustomed on these higher stakes tests. Because being faced with a test without accommodations would make them very anxious about their career future, I thought that it was better to either improve their reading, study, and test-taking skills (Lovett & Lewandowski, 2015) or suggest a different career path.

Another factor contributed to my reticence about evaluations for accommodations. Until 2018, I was part of a group practice where I did not do my own intakes and where I did not have the opportunity to obtain historical information and the goals for the evaluation. Because I had rethought how I had been conceptualizing disability and changed my approach, I was sometimes faced with parents and adults who were upset when I did not support their view of their child or themselves as disabled. In one instance of a 15-year-old with ADHD who was earning strong grades without accommodations, the school recognized this as well but ultimately agreed to the parents’ pressured insistence on extended time. This was a very unpleasant position for me, and so, for the most part, I stopped doing these evaluations. Also, over the same period of time, I was seeing more autistic individuals whose life struggles and impairments in life skills were obvious, sometimes to everyone but themselves. Testing accommodations were the least of their needs. Finally, I was evaluating individuals needing a Federal Aviation Administration medical certificate for flying or working as an air traffic controller and was frequently seeing adults who had been incorrectly diagnosed with ADHD based on self-report only.

What follows is an accounting of the changes in the law and documentation guidelines that, in part, influenced (1) my perception that the definition of disability has been loosened and (2) my decision to stop doing evaluations where the prospective client’s *only goal* is to obtain a disability label and access to accommodations and medication.

Changes in the Law, Documentation Guidelines, and Testing Agency Practices

The Americans with Disabilities Act (ADA, 1990) was passed in the United States (U.S.) to remove barriers and ease access for disabled persons in public settings. It was an extension of the Rehabilitation (RA) Act of 1973 (RA, 1973), which mandated that all facilities receiving U.S. Government funding ensure that persons with disabilities did not face barriers to equal access or equal participation in supports or services offered by those agencies. Both acts were largely focused on removal of barriers for individuals with “visible” (e.g., physical, sensory) disabilities. However, in response to requests for accommodations for SLDs in postsecondary education settings and “the expressed need for guidance related to the documentation of a learning disability in adolescents and adults” (Association on Higher Education and Disability [AHEAD], 1997, p. 1), AHEAD issued guidelines for SLD documentation. In the Introduction, AHEAD (1997) stated, “The information and documentation that establishes a learning disability should be comprehensive in order to make it possible for a student to be served in a postsecondary setting,” adding, “the documentation should indicate that the disability limits some major life activity (p. 1),” as required by both the ADA and the RA. The Educational Testing Service (ETS) issued similar guidelines for SLD (ETS, 1998, January), followed by guidelines for documentation of ADHD (Consortium on ADHD Documentation, 1999). ETS guidelines were subsequently revised for SLDs (ETS, 2007) and for ADHD (ETS, 2016). Both emphasized the requirement for a comprehensive evaluation and the demonstration of a limitation in a major life activity, as defined by disability law. Since then, the ETS guidelines have been expanded to include other disability groups (e.g., psychiatric disabilities, autism, intellectual disabilities, physical and sensory disabilities).

Before the early 2000s, when a student received testing accommodations for a disability, standardized testing agencies flagged tests that had been administered in a non-standardized fashion. This made sense, because when the standardization of a test is changed, one can no longer be sure that the test can be interpreted in the same way as the standardized version (cf., Anastasi & Urbina, 1996; Freedman, 2003; Freedman, 2017, 24 August). However, to avoid going to trial after being sued in 1999, ETS agreed

to stop flagging accommodations on the Graduate Management Admission Test (GMAT), the most frequent accommodation having been extended time (Freedman, 2003). Subsequently, in 2002, likely to avert a threatened lawsuit, the College Board agreed to stop flagging its examinations (PSAT, SAT, SAT Subject Tests, Advanced Placement exams) as administered under accommodated conditions (Lewin, 2002, July 15). About a week later, the ACT did the same (Lewin, 2002, July 28). Interestingly, the CEO of the ACT, Richard Ferguson, did not see the lack of flagging as a problem and commented, “the extensive documentation required should help cut down on abuse of the extended-time provisions by students who do not have legitimate disabilities” (Lewin, 2002, July 28). Shortly thereafter, the College Board tightened up its documentation requirements, adhering more strictly to the ETS guidelines that they were following and accommodated fewer people (Abrams, 2005). As one example of this, in the Washington, DC area, clinicians learned the College Board cracked down on at least one private high school that routinely gave disabled students 100 percent extended time without a sufficient basis. I recall having attended a large meeting at a local private school where parents, students, and even clinicians were incensed about the stricter guidelines.

During this same period, the law showed signs of change. In a landmark court decision, *Bartlett v. New York State Board of Law Examiners* (2001), current Supreme Court Justice Sonia Sotomayor, then a U.S. Circuit Court Judge, ruled that average scores did not negate the possibility of a disability. Rather, it was whether a disabled person differed in the way s/he completed tasks in comparison with most people. As one example, a person could achieve an average score on an “untimed” single-word reading test (e.g., five to 10 s as allowed on most single-word reading measures) but may have used the full time to correctly sound out the words. This is different from most people, for whom reading single words is automatic and quick.

Guidelines also began to change. In 2004, AHEAD replaced their 1997 guidelines with “best practices” for disability documentation (summarized in Lovett, Nelson, & Lindstrom, 2015). According to Lovett et al. (2015), these best practices still “advocated the use of comprehensive reports from objective, external evaluations by credentialed experts when documenting disabilities” (p. 45). Nonetheless, my recollection is that AHEAD no longer wanted to make specific documentation recommendations. The ETS guidelines remained in place, were published on their website, and continued to be followed by many colleges and testing organizations.

Four years later, the ADA Amendments Act of 2008 (ADAAA, 2008) was passed and ostensibly made it easier for individuals with invisible disabilities to obtain accommodations. This was because new life activities, relevant

to SLD and ADHD, were added: reading, concentrating, thinking, learning, communicating, and working. There were two other important provisions of the ADAAA (2008). First, mitigating factors (e.g., medication, use of assistive devices) could not be considered when diagnosing a disability. A person was disabled regardless of whether medication or an assistive device lessened the disability’s impact. Second, disabilities could be cyclical (e.g., multiple sclerosis, epilepsy) and, at times, might not impair a person’s functioning. The ADAAA (2008) also no longer required having had a history of accommodations, and a disability no longer had to “significantly limit” or “severely restrict” functioning to be considered “substantially limiting.” However, the comparison standard was still most people in the general population or “the average person standard,” as in the ADA.

Over the next few years, the changes in the law affected documentation requirements and the definition of disability. In March 2011, the U.S. Equal Employment Opportunity Commission (USEEOC, 2011) issued regulations regarding implementing the ADAAA. The intent was to cover individuals with less severe disabilities and shift the focus from whether a person had a disability to discriminatory conduct. The regulations stated that an assessment should focus on how a major life activity was substantially limited, not on what a disabled person *can* do and how much time and effort the person needed to accomplish a task. Although the regulations still required an individualized assessment, the regulations stated that the “determination of disability should not require extensive analysis” (USEEOC, 3 May 2011). This left open to interpretation what, exactly, should be included in a disability assessment.

In 2012, AHEAD issued new guidance on supporting documentation requests (AHEAD, 2012), which reflected a substantial change in their recommendations for disability documentation (Lovett & Lindstrom, 2021; Lovett et al., 2015). Based on a review of the ADAAA, AHEAD, with input from disability attorneys, had concluded that no law or regulation specified the *type* of documentation necessary for accommodations (Ashmore, Lissner, Simon, & Funckes, 2012, 24 May). Consequently, in a tiered-list, AHEAD recommended that the primary, and most important source of information for accommodations decisions, should be the student’s self-report, the secondary and next most important source should be observation and interaction with the student by disability support staff, and the tertiary and least important source should be information from external or third parties (e.g., evaluation reports, Individualized Education Programs [IEPs], 504 Plans). This tertiary information was considered desirable when reviewing an accommodation request but not essential. The intent of the guidance was to make the accommodation request process less burdensome for students and disability support professionals, in terms

of the time and financial expense required of students, if an updated evaluation had been required, and the time spent by the disability support professional to review documentation and consider the request.

AHEAD's guidance was very different from the ETS guidelines, which, in my experience, were still being used as a model by most colleges, universities, and testing agencies for their own guidelines and published on their websites. On 24 May 2012, AHEAD held an open "tele-webconference" (phone only, as Zoom did not exist) to explain how the guidance was developed and to answer questions about it (Ashmore et al., 2012, 24 May). I attended the tele-webconference, which included a question and answer (Q&A) session with stakeholders. During the Q&A session, evaluators argued that objective data were needed to document a disability, noting in addition to providing a current assessment, students may be motivated to embellish or fake disabilities in a self-report. Disability support staff stated that they were not "armchair psychologists" and could not make a disability determination without data. At the time, I was a board member of the National Academy of Neuropsychology (NAN), and NAN began receiving emails from clinicians who were concerned about the guidance. These were brought to my attention because of my work with SLD/ADHD disability documentation. I volunteered to speak with the President of AHEAD, Scott Lissner, an attorney and ADA Compliance Officer at Ohio State University, in response to clinician concerns. He told me that the AHEAD guidance was designed for disability support staff to ease the documentation review process for them and to encourage students to self-advocate for themselves and their accommodation needs. He added that many students often did not have a good understanding of their disability. Mr. Lissner told me the guidance was not meant to eliminate the need for evaluations (S. Lissner, personal communication, 2012). Despite the guidance, it was my impression, based on their websites, that many universities and all testing agencies did not change their documentation requirements. More recently, Mr. Lissner has said that the tiered guidance, which he had authored, "was perhaps not the best choice" (as quoted in Greenberg, 3 May 2022).

Shortly after, in October 2012, the U.S. Department of Justice (USDOJ) joined a California-based class action lawsuit against the LSAC on behalf of applicants denied accommodations on the LSAT (USDOJ, 2012, 18 October; Disclosure: One of my clients, for whom I had done an evaluation and written an appeal, became a lead plaintiff in the case).

In January 2014, the USDOJ issued a Notice of Proposed Rulemaking (NPRM) to establish USDOJ regulations implementing the ADA (USDOJ, 2014, January 22). The USDOJ regulations were meant to replicate the USEEOC regulations and to focus on local and national examination organizations (e.g., LSAC, Association of American Medical Colleges, NBME, state bar examiners, other professional licensing agencies) likely in response to increased

complaints to the USDOJ from applicants denied testing accommodations. Similar to the USEEOC regulations, the proposed regulations stated that "the question of whether an individual's impairment is a disability under the ADA should not demand extensive analysis" and reduced the standard for demonstrating a "significant limitation" in a major life activity (USDOJ, 2016, 11 August). The regulations also did not distinguish between impairments that may not cause limitations and disabilities that do. Finally, the regulations stated that an updated evaluation should not be required if there was a documented history of accommodations, regardless of the type or quality of that documentation. There were responses from advocacy and testing organizations (cf., AHEAD, Everyone Reading, Inc, 2014, 31 March). However, my experience was that most psychologists did not learn of the NPRM until after the deadline for submitting comments.

In May 2014 and in response to the USDOJ class action lawsuit, the LSAC issued a Consent Decree (USDOJ, 2014, May 20). The LSAC agreed to (1) stop flagging nonstandard LSAT administrations, (2) provide a monetary settlement (Disclosure: Several of my clients benefitted from this), and (3) accept documentation of prior accommodations on any previous entrance exams or the GED® exam (for the equivalent of a high school diploma), provided that the applicant was requesting the same accommodations on the LSAT. The LSAC also agreed to convene a Best Practices committee to review and revise their documentation requirements. The Best Practices committee issued their recommendations in January 2015 (Colker, Golden, Keiser, Mather, & Ofiesh, 2015, January 16). The overall consensus was that documentation requirements should be streamlined and reduced, especially if the applicant had a history of accommodations. More specifically, the panel recommended that any evaluation documenting a disability that was completed at age 13 or older should be accepted by the LSAC as sufficient documentation. However, in a minority report, Keiser (2015, January 26) objected, arguing that it was important to have evidence of current impairment. In another recommendation, the panel wrote, "it is important for individuals with average overall reading abilities to be eligible to receive testing accommodations on the LSAT without excessive documentation requirements if, for example, the manner in which they read is impaired as compared with the general population" (Colker et al., 2015, January 5, p. 5). However, Keiser also objected to this, writing that it did not follow the ADA standard of being "substantially limited or materially restricted in reading ability compared to most other people" (Keiser, 2015, January 26, p. 1).

In September 2015, the USDOJ Civil Rights Division, Disability Rights Section issued their recommendations for

documentation that were to cover standardized tests from the Secondary School Admission Test through professional licensing examinations (USDOJ, 2015 September). Among other recommendations, the USDOJ specified that, “Any documentation if required by a testing entity in support of a request for testing accommodations must be reasonable and limited to the need for the requested accommodations” (p. 5). Acceptable documentation included “recommendations from a qualified professional, proof of past testing accommodations, observations by educators....an applicant’s history of a diagnosis, and an applicant’s statement of his/her history of accommodations” (p. 5). Although a psychoeducational, neuropsychological, or other evaluation was listed as acceptable documentation, it was not required. If a candidate had previously received the requested accommodations, the document stated s/he should be granted the same accommodations on the standardized exam. Furthermore, the USDOJ wrote that a professional’s opinion, no matter how it was communicated, should take precedence over an external review and opinion from a testing agency.

Changes occurred quickly after these recommendations were issued. In the summer of 2016, following continued complaints to the USDOJ that students had been unfairly denied accommodations they were receiving them in school, the ACT streamlined their accommodation application process, which allowed a high school’s test accommodations coordinator to verify the student’s accommodations online (Appleruth, 2017, February/March). In October 2016, the USDOJ put their final regulations into place (USDOJ, 2016, August 11). In December, College Board agreed to waive the need for an updated evaluation if a student had been receiving and using accommodations under an IEP, 504 Plan, or similar accommodation plan (Will, 2016, December 13). According to a staff member at the College Board, with whom I spoke while preparing a workshop presentation, the student had to have been receiving the requested accommodation for four months or more, with verification through the College Board’s electronic portal. However, if there was no electronic verification or if different accommodations were requested than had been provided previously, then an updated evaluation was required (College Board staff, personal communication 2019).

During the COVID-19 pandemic, when in-school classes and standardized testing were suspended, accommodations became less relevant because almost half of U.S. colleges and universities dropped requirements for entrance examinations, with 200 more dropping requirements for the 2021–2022 academic year (Georgetown University, 2020, June 26). This included respected Ivy-league schools and the state of California’s university system. Since then, more than 1800 colleges and universities have dropped or have considered dropping entrance examination requirements (FairTest, 2021, December 7). This was part of an

increasing concern that entrance examinations were accessible mainly to students from higher incomes and were biased against racial and ethnic minorities (Georgetown University, 2020, June 26). There has been a similar criticism that evaluations needed to document a disability and obtain accommodations are typically obtained by those from more affluent backgrounds, with a lack of access to such evaluations in minority and other economically disadvantaged groups (Goldstein & Patel, 2019, July 30). So, some may say that dropping entrance examination requirements (and the associated need for accommodations), relying instead on a student’s grades, extracurricular activities, and personal statement, may be a good thing, in terms of reducing the burden for evaluations on students and parents, and increasing college access to underserved and disadvantaged groups, including disabled people.

There have been similar developments for the entrance examination required by law schools. In February 2016, the University of Arizona College of Law became the first to accept the GRE in place of the LSAT, after the ETS had determined that the GRE was an equally reliable and valid predictor for law school success (University of Arizona, 2016, February 20). In March 2017, Harvard Law became the second law school to accept the GRE (Harvard University Harvard Law, 2017, March 10), with a goal of expanding law school access both in the U.S. and internationally. Other law schools followed suit. From a clinical standpoint, my experience, at least before 2014, was that obtaining accommodations on the GRE was easier and more streamlined than on the LSAT. So, this potentially opened up the possibility of more law school candidates receiving accommodations on entrance exams. In March 2018, the LSAC was held in contempt of the 2014 Consent Decree by a federal magistrate judge for failure to consistently follow the Best Practices panel’s recommendations (Weiss, 2018, March 6). One charge was related to the failure of the LSAC to provide accommodations when an applicant did not respond to an email granting him/her a partial accommodation of 50 percent time. The judge’s ruling extended the Consent Decree for additional time, as some components were originally to be in place for only three years, once the Best Practices panel’s recommendations had been put into place (USDOJ, 2014, May 20). However, the LSAC responded that by then, they were adhering fully to the panel’s recommendations and would continue to do so (Weiss, 2018, March 6). According to U.S. News and World Report, by June 2021, more than 70 law schools were accepting the GRE in place of the LSAT (Kuris, 2017, June 7). Subsequently, in November 2021, the American Bar Association’s Section of Legal Education and Admissions to the Bar voted to allow all law schools to accept the GRE in place of the LSAT (Ward, 2021, November 30).

In summary, the evolution of the law since inception of the ADA (1990), the changes implemented by the ADAAA (2008), recommended changes in interpretation of the ADAAA by the USDOJ, and associated changes in requirements for documentation of disabilities, have, in my view, resulted in a lessening of what is considered a disability (i.e., relative weaknesses rather than frank deficits). Perhaps this is due to what has been described as “concept creep” (Haslam, 2016, as cited and summarized by Harrison & Sparks, 2022, this issue), in which what was once seen as normal (i.e., normal variability in human skills) is now viewed as deviant from normal and disabling. This is even more concerning, given that the DSM-5 criteria for SLD and ADHD require clear evidence of impairment (American Psychiatric Association, 2013) beyond symptoms and/or weaknesses found on an evaluation. Often, documentation of impairment in real life settings is missing from evaluations (cf., Harrison & Sparks, 2022, this issue).

So Why Is This a Problem?

These changes imply that older evaluations, evaluations without data consistent with the requested accommodations, recommendations that are not supported by the growing evidence base on accommodations, or sources of information other than data-based evaluations, should be accepted as disability documentation. However, this is not consistent with research and good clinical practice (Lovett & Lewandowski, 2015; Lovett & Lindstrom, 2021). Early identification and intervention for reading disorders can eliminate or substantially ameliorate the problem (Fletcher et al., 2019). Early identification and treatment of ADHD with medication can make a child more available for learning and prevent deleterious effects on academic performance as the child goes on in school (Barkley, 2014). Consequently, an evaluation of a young child may reflect a problem that no longer exists in a young adult. Also, poorly done evaluations may have led to a child being granted accommodations unfairly or inappropriately. However, if accommodations are simply carried through in an IEP or 504 Plan every year without an updated evaluation, the most recent IEP or 504 Plan may not accurately reflect a student’s need for accommodations.

Furthermore, people and brains change. The young teenage brain is not the 24-year-old brain—the frontal lobes mature, and associated executive functions improve from the teens to the early to late twenties (Barkley, 1997; Eslinger, Marlowe, & Biddle, 2022). Not only does this result in improved executive functioning, it can also result in improved academic skills that rely on executive functioning (e.g., Cutting & Denckla, 2003; Denckla et al., 2013; Locascio, Mahone, Eason, & Cutting, L. E. 2010). In my

own practice, over the course of two or more evaluations, I have seen high school students improve reading speed and comprehension and writing skills as their brains mature. College demands and repeated practice of reading and writing in college can also lead to improvements (e.g., reading regularly improves fluency, Fletcher et al., 2019; editing help from professors improves writing). Without an updated evaluation, there is no information about a person’s *current* functioning. Current functioning, not past functioning or just a disability label, should be the standard for disability determination.

Yet, defining skills that are average (but weak relative to other skills) may now be used to establish a disability rather than being recognized as simply a relative weakness. This has been a “sin” of clinicians who advocate for students rather than providing an objective evaluation (Harrison & Sparks, 2022, this issue). As others in this special issue have noted, this makes no sense because *everyone* has strengths and weaknesses across different cognitive and life domains. Research has definitively shown substantial variability among standardized test performances in normal individuals who have no brain disorders (Binder et al., 2009; Schretlen et al., 2003; Schretlen et al., 2008).

Finally, relying on self-report, which the AHEAD (2012) guidance recommends, is poor practice because students may be motivated by a desire for unjustified accommodations or medication (Harrison & Sparks, 2022; Lovett, 2022, both in this issue). This is why evaluators must include measures of performance and symptom validity, which are standard in neuropsychological practice (cf., Boone, 2021; Sweet et al., 2021) but less so in other psychological specialties. These measures help determine, respectively, whether performances on cognitive and academic measures and whether symptom reports on psychological inventories and rating scales are valid and credible, given the history of the client.

Pressures on Parents, Students, Clinicians, and Disability Support Professionals

In my group practice, which I believe is representative of metropolitan areas with a large affluent population, my colleagues and I have seen students feeling increased pressure to make straight As, regardless of their cognitive abilities, so that they can get into the “right” college, medical school, law school, etc. Parents often agree and believe their child is not performing “up to his/her potential.” With a looser definition of disability, more parents and students are seeking a disability label to explain grades with which they are unhappy and accommodations to improve their grades. Parents then pressure clinicians to diagnose SLD or ADHD and to recommend accommodations, usually extended time but

sometimes much more, that may not be warranted. Parents complain that other students with invisible disabilities and without obvious problems are receiving accommodations and believe that their child should have this, too. Otherwise, they fear their child's marks will not be competitive.

Yet, one does not see increased pressure to diagnose physical disabilities, perhaps because these are obvious. Based on data from the National Health Interview Survey, Houtrow, Larsen, Olson, Newacheck, and Halfon (2014) found that the prevalence of a neurodevelopmental or mental health disorder diagnosis increased 21 percent from 2001 to 2011, but the prevalence of a physical disability diagnosis decreased by 11 percent during the same period. They also noted that prevalence of diagnosed invisible disabilities was far more common in affluent students than those in poverty. Based on the Student Experience in the Research University Survey, McGregor, Langenfeld, Van Horne, Oleson, Anson, and Jacobson (2016) found a tripling of self-reported SLD over 12 years, for a prevalence of six percent. They noted that both affluent and lower income students had the highest rates of disabilities, but affluent students were more likely to be receiving accommodations.

A good illustration of the advantages of affluence on disability determination is seen in the 2019 Varsity Blues scandal, in which, among other abuses, parents paid for children to be “diagnosed” with a disability that would lead to accommodations (Anderson, 2019, 29 March). In the criminal complaint, college placement “specialist” William “Rick” Singer was caught on a recording advising parents as follows:

We need to get your daughter tested for a learning difference. Here's why. If she gets tested for a learning difference, and let's say it's my person that does it, or whoever you want to do it, I need that person to get her 100% extended time over multiple days. So what that means is, we'll have to show that there's some discrepancies in her learning, which there's gotta be anyways. . . . I also need to tell [your daughter] when she gets tested, to be as, to be stupid, not to be as smart as she is. The goal is to be slow, to be not as bright, all that, so we show discrepancies. And she knows that she's getting all this extra time, everywhere that she is right now. At the Academy kids are getting extra time all the time.“ (from the criminal complaint, as cited by Oreskes, 2019, March 14 in the *Los Angeles Times*).

This illustrates the belief that relative weaknesses define a disability, and that an SLD diagnosis may be obtained easily simply by slowing down and not performing in a valid manner. This is clearly an abuse of the system, illustrating the need for performance and symptom validity measures as part of an evaluation, and has increased skepticism about legitimate disabilities that require accommodation (Anderson, 2019, 20 March; Harrison, 2019, 13 May).

In my own practice, I have found that parents believe that extended time and/or medication will result in better test/exam scores and higher grades, which makes them eager to obtain a disability diagnosis for their child. However, the lower test/exam scores may be due to a deficit in study skills or a failure to be diligent with studying and assignment completion, which requires a student to do the work and a parent to oversee the student. Even then, this may not be enough to improve a grade. Students also believe that extended time and/or medication will solve the problem and will make them less anxious during exams. However, performance anxiety, which most people experience, is not a disability (Lovett & Nelson, 2017). Other students without a significant problem may want to gain an edge and be more competitive by getting accommodations, typically extended time, and/or psychostimulant medication. They assume medication would help them focus attention more effectively when taking tests and when studying, which would lead to higher grades. I have found that some students seeking a diagnosis do not want to do the harder work required to improve relatively weaker skills. They want an easy out, and a disability label is becoming the route to this. This view may be supported by their parents. In my opinion, relying only on accommodations and medication is like wanting to lose weight or build muscle without eating a healthy diet and exercising. But when clinicians explain to parents and students that there is no disability, that the problem is due, for example, to a lack of study skills and follow-through, and that intervention (e.g., study skills and test-taking skills tutoring, executive function coaching) rather than accommodation is a better approach in the long run, parents may become angry, complain that they paid a lot of money for the evaluation, and put pressure on the clinician to make a disability diagnosis, which is not a pleasant experience for the clinician. As a result, some clinicians may make a diagnosis and recommend accommodations simply to avoid negative consequences such as conflict, a complaint to a licensing board, or litigation.

Finally, as a reviewer of disability documentation for disability support services at several universities for more than ten years, I have seen disability support staff faced with an increasing number of students requesting accommodations for SLD, ADHD, and mental health disorders, in line with the increases reported by Houtrow et al. (2014) and McGregor et al. (2016). Although in some instances, the disability and associated impairment are clear, in many others, diagnoses have been based on evaluations that fail to show impairment. I have also seen long lists of accommodations recommended in these reports, some of which were never required before college and others of which have no relationship to the diagnosed disability. Consistent with my observations, studies of documentation submitted to colleges, universities, and testing agencies have frequently found a failure

to document disorders using the DSM-5 (American Psychiatric Association, 2013), especially in terms of the requirement for impairment and a limited or absent relationship of test data to accommodations (Harrison & Sparks, 2022, this issue; Joy, Julius, Akter, & Baron, 2010; Weis et al., 2016; Weis, Erickson, & Till, 2017; Weis, Speridakos, & Ludwig, 2014). However, disability staff may feel pressured to accept the diagnosis and recommended accommodations to avoid anger on the part of parents and students. They may also fear the threat of litigation due to recent changes in the law and feel compelled to accept a poorly done or outdated evaluation because the student has a history of accommodations.

This is not to say that SLD and ADHD do not exist—indeed they do, are real, and can have a significant impact on academic performance and life functioning (cf., Barkley, 2014; Fletcher et al., 2019; Pennington, et al., 2020; Waber, 2010). But I believe that the environment of the last 20 years has increasingly fostered a belief that relative weaknesses caused by normal variation in test scores and/or skill deficits unrelated to biology are disabilities. This, in turn, has led to an increase in students who are requesting and ultimately receive accommodations.

Academic Pressure and Mental Health

Although parents want their children to succeed, the cost of pressure to excel in school has resulted in students who are increasingly stressed about school and getting into “the right” college, graduate school, or professional program (Lythcott-Haims, 2015; Marano, 2008). This is especially true in affluent areas of the country but is likely to be less the case in economically disadvantaged areas, where there are other more significant life stressors. More broadly, there has been a massive increase in children and teens with mental health issues, including anxiety disorders, depressive disorders, and suicidal ideation over the past ten to 15 years (Editor, 2021). Although the COVID-19 pandemic has contributed, the increase in mental health problems and requests for testing accommodations was noticed in the early 2000s and attributed to “helicopter” parents and the associated failure to develop resilience in their children (Marano, 2004, 2008). The increase in mental health disorders also predated the pandemic and is not fully explained by the pandemic (Blake, 2022, 1 April). Students today seem less resilient and less able to cope with adversity—those in older generations know that adversity can foster problem-solving, which builds coping skills. However, relying only on accommodations and medication does not give students a chance to build these skills. I heard an analogy from a physically disabled man making a comment to a speaker at a conference I attended several years ago: disabled kids who do not learn to pick themselves up after they fall do not learn to be mobile.

He attributed his success to his parents allowing him to fall and then learn how to get himself up.

Best Practices: What I Do Now

Since 2018, I have had the option of doing my own intake interviews, which enables me to inquire about the purpose of the evaluation. During the intake, I ascertain whether the person’s *only* goal is receiving accommodations by asking a series of questions. These include the person’s goal for the evaluation and asking what their response would be if I do not diagnose an SLD or ADHD or, even if I make a diagnosis, determine that they are not disabled by the diagnosis and do not qualify for accommodations. For those seeking an SLD or ADHD diagnosis for the first time, I tell them that in my approach, the goal of the evaluation is to determine the cause of the problem and what to do about it. This may or may not include recommendations for accommodations and/or medication. For those who have a well-documented history of SLD or ADHD and have received accommodations (some are my own clients returning for reevaluation), I still remind them that the purpose of the evaluation is to obtain an updated assessment, and there could be some changes in what I recommend. It is certainly important to have a collaborative approach with the client when discussing the evaluation process during the intake, to be sure that the evaluation will meet their needs and goals. However, if the patient states that a diagnosis and accommodations are *all* that they want, I will not work with them, as there is no longer a collaboration. In essence, they are asking for my diagnostic opinion, but telling me ahead of time what the result must be in order for them to be satisfied. In my experience, I have effectively screened out individuals who would not be happy with results that do not support a disability or accommodations.

Several examples illustrate my current approach. A few years ago, I was contacted by a medical student preparing to take the USMLE. She had been granted accommodations in medical school but did not have a recent evaluation. She was only interested in accommodations. After a discussion, it was clear that she would not accept anything other than a disability label, and I told her that I was unwilling to do the evaluation. About a year ago, I evaluated a student from the same medical school who had been granted accommodations there for the first time. She was interested in applying for accommodations on the USMLE but said she was open to accepting my diagnostic opinion and recommendations. The results, which were valid based on performance validity measures, suggested dyslexia and ADHD, which had been her concerns. However, the data were not entirely consistent, and there was some magnification of ADHD symptoms, with rating scale scores that were higher than

typical of individuals with ADHD. Consequently, without records from earlier history, I was unable to make a definitive diagnosis. I asked the student to provide her earlier academic records, which she had agreed to do. However, after numerous reminders without a response, I finished the report without a definitive diagnosis and with recommendations for improving her test taking skills. Finally, more recently, I received a call from a woman working with a government agency. She said she had excelled in school, had never been diagnosed with a disability, and had never had accommodations. She insisted that she was an excellent worker, had advanced to a high level, and was valued by supervisors and coworkers. However, she insisted, equally strongly, that she had dyslexia, which was now interfering with the increased demands of her work, and needed an “official diagnosis” so that she could obtain accommodations. In our discussion, it was clear that she would accept nothing but a dyslexia diagnosis. Knowing that this would be a losing battle, I politely said that I would not see her. There were likely other clinicians who would have diagnosed these individuals with a disability and would have recommended accommodations. Of course, whether they would have received accommodations, especially the two medical students on the USMLE, is open to question and, I suspect, unlikely.

That being said, I continue to believe that accommodations are valuable and warranted for individuals who are impaired by SLD or ADHD. So, what should be included in a comprehensive evaluation? I have outlined my approach elsewhere (Mapou, 2009; Mapou, *in press*), which I continue to follow and which continues to evolve. I believe that the guidelines established initially by AHEAD (1997) and continued by ETS (2007, 2016) are still applicable. A best-practices evaluation should include an interview with the patient and with parents whenever possible, an interview with a spouse or partner if relevant, a review of as many academic records as can be obtained, including the results of standardized tests (without and with accommodations if that has been done), and selection of tests appropriate to the referral question. Tests should include at least two stand-alone measures of performance validity (Boone, 2021) to ensure that the patient’s performance is credible and consistent with reported difficulties. A comprehensive psychological inventory (e.g., Minnesota Multiphasic Inventory-3, Personality Assessment Inventory), and not just a brief rating scale (e.g., Beck Depression Inventory-II, Beck Anxiety Inventory) should be used to determine whether a mental health issue is the primary cause of the problem or is exacerbating SLD or ADHD because most individuals with ADHD have co-occurring mental health issues (Barkley et al., 2008). The psychological measure should include one or more symptom validity indices (Boone, 2021) to ensure that the patient’s self-report is credible. Finally, behavioral rating scales with symptom validity indices should be used to quantify self-reported

ADHD symptoms and problems with everyday attention and executive functioning, supplemented by an informant report (parent for past history; partner, spouse, roommate, close friend, or parent for current functioning). Results from all measures should be interpreted based on current research about SLD and ADHD (cf., Harrison & Sparks, 2022; Lovett, 2022; both this issue; Lovett & Lewandowski, 2015; Mapou, 2009). Cognitive deficits should be interpreted as disabling only when they cluster within a consistent domain and lead to academic deficits that are consistently below average (i.e., not just a single score). To the extent possible given the limited research, accommodation recommendations should be evidence-based (Lovett & Lewandowski, 2015).

As noted earlier, as students progress through increasingly challenging entrance and professional examinations, obtaining accommodations becomes more difficult. If a clinician concludes that there are only relative weaknesses in a previous evaluation that led to a disability label and accommodations, s/he should advise students who have a goal of attending law school or medical school about the difficulty of obtaining accommodations on the bar examination, USMLE, or other professional examinations. Intervention recommendations to improve test-taking and study skills are essential for these students if they want to pursue these careers successfully, as accommodations will be highly unlikely. Clinicians should also be realistic if a student does not have the “right stuff” for an advanced professional degree and advise them accordingly. Such students may not be happy about these recommendations, but it is better to help them avoid an expensive investment and possible failure.

In summary, SLD and ADHD are real disorders and can impair life functioning significantly. Accommodations can help students with the essential skills needed for an academic program or work succeed even with the challenges of SLD, ADHD, or mental health disorders. However, we should stop recommending accommodations and medication for students who have relative weaknesses and are not truly disabled. Helping students without disabilities gain a competitive advantage is unfair to disabled students, especially those who have not had the resources that more privileged students have had.

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