Evaluation of Organic Syndromes for Social Security Disability

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Approximately four million individuals in the United States have been considered by the Social Security Administration as disabled (Social Security Forum, 1989). While the figures have not changed since 1974 (or the inception of the program) the number of applicants claiming mental impairments continues to increase (Dapper, 1987). Most of these are individuals with low income, limited education, and of minority status (U.S. Bureau of the Census, 1983). Additionally, an increasing number of these applicants with mental impairments have organic mental disorders (Puente, 1987). The purpose of this paper will be to review both the disability evaluation procedure as well as the psychological evaluation of organic impairment cases.

SOCIAL SECURITY DISABILITY

The Social Security Administration (1988) has outlined definitions in order to determine disability. First and foremost is the issue that disability is a legal and not a clinical determination and that clinical analysis should yield only information regarding impairment (American Medical Association, 1984). Thus, the role of the psychologist is to provide information regarding functional (and not anatomical) impairment.

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According to Social Security Administration (SSA, 1988) the following is how disability is determined (pages 35519-33520).

1. Consideration of all symptoms and the extent to which objective medical evidence confirms those symptoms.
2. Need for medically determinable impairment that could reasonably produce the symptoms.
3. Both the intensity and persistence are taken into consideration.

The effects of these symptoms, in turn, are analyzed within the constraints of how these symptoms affect Activities of Daily Living (ADL). These include, but are not limited to,

1. Daily activities,
2. Precipitating and aggravating factors,
3. Related factors affecting functional limitations and restriction.

SSA will consider evidence from four sources. These sources include the claimant, Disability Determination Services (state level employees of SSA) personnel, professional health case workers (e.g., psychiatric social workers), and medical professionals (e.g., psychiatrists and psychologists). Evidence from significant others and work evaluations (e.g., vocational evaluations) may also be considered.

In the final analysis, the basic question remains – what is the "residual function capacity" (RFC) of the applicant? From a physical standpoint, SSA will consider the effects of the symptoms on physical demands such as sitting, standing, walking, lifting, carrying, pushing, pulling, reaching, handling, stooping, or crouching. With regards to mental abilities, the SSA will focus on such issues as limitations in understanding and remembering, carrying out instructions, responding to supervisors and to co-workers, and ability to handle stress at work. Physical constraints are considered exertional limitations while mental impairments are defined as non-exertional limitations. Examples of non-exertional limitations include anxiety, depression, and inability to concentrate or remember. These limitations would presumably affect the ability of the claimant to work. Most Disability Determination Sections (DDS) have a list similar to

the one found in Table 1 outlining the basic abilities and aptitudes needed to perform unskilled work.

The question of RFC and employability must be answered prior to being awarded disability benefits. To answer this question a flow chart outlining these questions and categorizing an individual has been formulated by the SSA. Table 2 provides specific information on how that flow chart proceeds.

Of the large number of applicants each year, about 10% are mentally impaired (Rosenberg, 1986). Further, aside from cardiovascular impairment, mental impairments are the most prevalent type of disorders resulting in disability awards (Social Security Administration, 1985). According to Nancy Dapper (1987), previously Acting Executive Program Officer for the SSA, over the fiscal years 1984, 1985, and 1986, an average of 348,151 mental impairment cases were reviewed by SSA per year. This represents about 24.3% of the total workload for SSA. Of the total number of mental impairments cases, 41% were organically related syndromes (i.e., organic mental disorder at 6%, mental retardation at 35%). However, the number of mental retardation cases relative to organic mental disorders is in all likelihood inflated.

ORGANIC MENTAL DISORDERS

In fiscal year 1988, 1,516,873 applications and 318,134 reviews of existing cases were considered by the SSA. Of the initial applicants approximately 36% were allowed while 88% of the reviews were continued. If an individual was denied at this initial stage, they could appeal at three additional levels. Table 3 provides specific information regarding this system of appeals.

To meet a listing, an applicant must (1) directly meet or fit a listing (e.g., organic brain syndrome or mental retardation), (2) have a combination of impairments (e.g., organic brain syndrome and depression), (3) have limited medical improvements related to employment, or (4) not be able to perform a previous or related work. Of these, SSA officials appear to prefer directly meeting a specific.

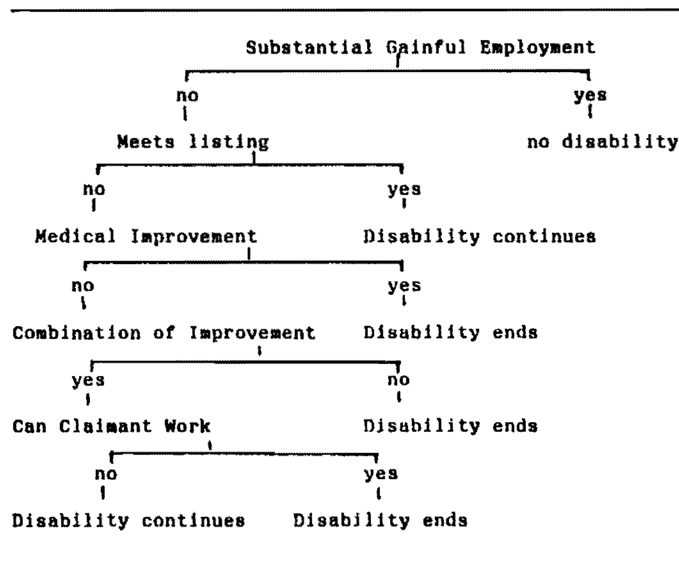
At the present time there are nine separate listings for categorizing mental impairments (Social Security Administration, 1986).

TABLE 1. Mental Abilities and Aptitudes Needed to do Unskilled Work.

1. The ability to remember work-like procedures.
2. The ability to understand and remember very short and simple instructions.
3. The ability to carry out very short and simple instructions.
4. The ability to maintain attention for extended periods of 2-hour segments.
5. The ability to maintain regular attendance and be punctual within customary tolerances.
6. The ability to sustain an ordinary routine without special supervision.
7. The ability to work in coordination with or proximity to others without being (unduly) distracted by them.
8. The ability to make simple work-related decisions.
9. The ability to complete a normal workday and workweek without interruptions from psychologically based symptoms and perform at a consistent pace without an unreasonable number and length of rest periods.
10. The ability to ask simple questions or request assistance.
11. The ability to accept instructions and respond appropriately to criticism from supervisors.
12. The ability to get along with co-workers or peers without (unduly) distracting them or exhibiting behavioral extremes.
13. The ability to respond appropriately to changes in a (routine) work setting.
14. The ability to be aware of normal hazards and take appropriate precautions.

Adopted from: POMS section 24510.085C. In Social Security Forum 10, #11/12, pg. 10, 1988.

TABLE 2. Flow Chart for Disability Determination.



These are organic mental disorders, schizophrenia, paranoid, or other psychotic disorders, affective disorders, mental retardation and autism, anxiety related disorders, somatoform disorders, personality, and substance addiction disorders. Pain has also been recently considered as a possible listing. Of particular relevance for individuals with brain dysfunction is the organic mental disorder listing. Table 4 provides the definition or listing of organic mental disorder encompassing two separate categories, termed Part A and B. Part A contains many of the classical symptoms of "organicity" (e.g., memory impairment), while Part B (Activities of Daily Living) focuses on the effects of the symptoms on or the functional capacity of the person. However, *both* Parts A and B must be considered to qualify under a listing.

A typical problem with organic syndromes is the minimizing of Part B of the listing. It is imperative that the psychologist attempt to translate test findings into everyday functional limitations within the limits of the data gathered. Originally these listings were to be used until August 28, 1988. However, the SSA has extended the

TABLE 3. SSA Decision for Fiscal Year 1988; Total Number by Category with Percentage Appeal.

	First Application	Review of Exiting Benefits
Initial	1,516,873 (36%)	318,134 (88%)
	45% appealed	45% appealed
Reconsideration	438,251 (14%)	16,553 (45%)
	69% appealed	11% appealed
Administrative Law Judge	258,421 (55%)	2,724 (51%)
Appeals Council	57,193 (5%)	481 (2%)
Federal Court	7321 (30%)	

NOTE: () = % approved at each level

Adopted from: POMS section 24510.085C. In National Organization of Social Security Claimants Representatives, Social Security Forum, 10, #11/12, pg. 10, 1988.

TABLE 4. Organic Mental Disorders Listings

Organic Mental Disorders: Psychological or behavioral abnormalities associated with a dysfunction of the brain. History and physical examination or laboratory tests demonstrate the presence of a specific organic factor judged to be etiologically related to the abnormal mental state and loss of previously acquired functional abilities.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Demonstration of loss of specific cognitive abilities or affective changes and the medically documented persistence of at least one of the following;

1. Disorientation to time and place; or
2. Memory impairment, either short-term (inability to learn new information), intermediate, or long-term (inability to remember information that was known sometime in the past); or
3. Perceptual or thinking disturbances (e.g., hallucinations, delusions); or
4. Change in personality; or
5. Disturbance in mood; or
6. Emotional liability (e.g., explosive temper outbursts, sudden crying, etc.) and impairment in impulse control; or
7. Loss of measured intellectual ability of at least 15 I.Q. points from premorbid levels or overall impairment index clearly within the severely impaired range on

TABLE 4 (continued)

neuropsychological testing, e.g., the Luria Nebraska, Halstead-Reitan, etc.; AND

B. Resulting in at least two of the following;

1. Marked restriction of activities of daily living, or;
2. Marked difficulties in maintaining social functioning; or
3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or
4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

From: Disability evaluation under Social Security: A handbook for physicians. Social Security Administration, 1986, Washington, D.C.: Author.

applicability of these listings until August 28, 1990. In all likelihood, they will be reviewed and altered accordingly.

EVALUATION OF ORGANIC SYNDROMES

According to recent guidelines of the SSA (1986), the definition of a "qualified" psychologist has been revised. The new revision, which is based in part on the American Psychological Association's recommendation (see Goodstein, 1986), indicates that an examiner must (1) possess a doctoral degree in psychology (rather than just "clinical psychology" as was stated in earlier guidelines) from an

educational institution accredited by an organization recognized by the Council of Post-Secondary Accreditation, (2) have two years of supervised experience in health services of which one must be post-doctoral, and (3) a license or certification as a psychologist at the independent practice level of psychology by the state in which he or she resides. Applications for consultant status must be made directly to the state SSA or DDS office. Interestingly, psychiatrists are automatically qualified since they are physicians and do not have to submit their specific credentials. Further, in the case where a psychiatrist or "qualified" psychologist is not available, a physician who is not a psychiatrist may assist the SSA in evaluating mental impairments.

Tests and testing are outlined for the evaluation of mental impairments. In their "Final Report" of August, 1985, the SSA stated "The results of *well-standardized* tests such as the WAIS, MMPI, the Rorschach and the TAT may be useful in establishing the existence of a mental disorder" (pp. 36057). They add, "Broad-based neuropsychological assessments using, for example, the Halstead-Reitan or the Luria-Nebraska batteries may be useful in determining brain function deficiencies, particularly in cases involving subtle findings such as may be seen in traumatic brain injuries." However, on May 29, 1986, SSA revised and expanded the original list of acceptable psychological tests to include the following 11 tests; Boston Diagnostic Aphasia Examination, McCarthy Scale of Children's Abilities, the Stanford-Binet Intelligence Scale (3rd ed.), Weschler Intelligence Scale for Children-Revised, Weschler Adult Intelligence Scale-Revised, the Peabody Picture Vocabulary Test-Revised, the Luria-Nebraska Neuropsychological Battery, the Millon Behavioral Health Inventory and Adolescent Personality Survey as well as the Clinical Multiaxial Inventory, and the Kaufman Assessment Battery for Children. According to the SSA, the Luria-Nebraska is "a better technique because it provides a low cost, portable, relatively brief alternative to the Halstead-Rietan Neuropsychological Battery: (pp. 19417). In addition, while not explicitly stated the SSA does not favorably view customized, flexible or non-standardized batteries or tests. Regardless of the tests used, specific symptoms and Activities of Daily Living are reviewed by SSA. The Office of Hearing and Appeals residential staff person, often a psy-

chiatrist or psychologist, completes a residual function capacity (RFC) questionnaire. At a higher level, the Office of Health Administration, the RFC may be completed either by an Administrative Law Judge or the Medical Advisor (most often a psychiatrist, but could be a psychologist). Table 5 provides the basic RFC used to quantify the existence and/or extent of brain dysfunction.

One of the most complicated evaluation issues in Social Security work is malingering. Documentation of malingering in Social Security Disability cases poses special difficulties for psychologists since it is commonly an issue. According to Resnick (1984), malingerers of mental illness in general over-react, call attention to their plight, have more difficulty imitating form than content of the disorder, often do not fit a clear diagnostic entitity, and do not show perserveration. While Resnick's observations do provide a foundation for detecting malingering in mental impairment cases, they do not specifically address faking of organic deficits.

An essential initial step in detecting malingering in organic cases is to obtain extensive premorbid history, including information from significant others and employers. This history taking is especially critical since Social Security cases usually present little if any well-documented history or records and the claimants are often poor historians.

Besides extensive history taking, specific patterns of responding on the psychometric tests accepted by SSA must be considered. For example, Heaton, Smith, Lehnan, and Vogt (1978) suggested that an F-K index exceeding a score of 5 was useful for detecting faking. According to Heaton et al. (1978) neuropsychological judges were able to correctly classify between 44-81% of head injured cases and between 25-81% of malingering cases. The authors concluded that an expert's ability to detect malingering in neuropsychological cases ranged from chance to 20%. In a related effort, Green (1978) developed the Carelessness Scale which helps detect poor attention, lack of interest, or simply the inability to complete the MMPI. Nevertheless, caution must be taken in using the MMPI with non-white and low SES-educational attainment groups (Gynther, 1972) which comprise a substantial portion of Social Security claimants. One useful method for detecting faking appears to be the Symptom Validity Testing of Binder and Pankratz (1987). In this test 100 trials

TABLE 5. Residual Functional Capacity Questionnaire for Organic Mental Disorders

_____ No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong in another disorder and are rated in that category.)

_____ Psychological or behavioral abnormalities associated with a dysfunction of the brain . . . as evidenced by at least one of the following:

	Present	Absent	Insufficient Evidence	
1.	____	____	____	Disorientation to time and place
2.	____	____	____	Memory Impairment
3.	____	____	____	Perceptual or thinking disturbances
4.	____	____	____	Change in personality
5.	____	____	____	Disturbance in mood
6.	____	____	____	Emotional lability and impairment in impulse control
7.	____	____	____	Loss of measured intellectual ability of at least 15 I.Q. points from premorbid levels or overall impairment index clearly within the severely impaired on neuropsychological testing, e.g., the Luria-Nebraska, Halstead-Reitan, etc.
8.	____	____	____	Other ____________________

of visual or auditory stimuli with distraction are presented and inconsistent performance is considered a sign of faking. Nevertheless, Binder (1986) suggested that "Malingering can only be detected through the use of clinical judgment, as there are no empirically validated objective criteria for the identification of malingering on neuropsychological testing" (e.g., Heaton et al., 1978) indicating that clinicians could detect protocols "faked" the bad neuropsychologically.

CONCLUSION

Mental impairments comprise a growing number of Social Security Disability applicants. Of these, a large percentage present with organic mental disorders. In this paper several aspects of evaluation of organic syndromes in Social Security cases are presented. These include; Social Security disability, mental impairment listings, and evaluation of organic impairments. Caution should be taken by practitioners not experienced or trained with Social Security process and neuropsychological assessment.

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