

Psychological Assessment of Social Security Disability

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Whereas a chapter in a volume of this type is often considered to be practical in nature, this chapter will focus on both the practical and theoretical aspects of psychological assessment of Social Security Disability. As a consequence, some background will be provided as a means of presenting important foundations of psychological issues. Without these foundations, advocates of disability claimants will not be able to fully use psychological information and findings. The foundation will include; difference between a psychologist and a psychiatrist as well as the differences between their reports, brief overview of psychological testing theory, and, finally, a review of the published literature involving the psychological assessment of disability with special focus on Social Security issues. After this section, the listings will be individually considered.

### Theoretical Issues

#### Psychiatric Vs Psychological Approaches

Individuals with emotional and cognitive disorders comprise the largest group of disabled individuals in the Social Security program (Estroff, Patrick, Zimmer, & Lachicotte, 1997). In order to receive disability benefits an evaluation is typically completed by either a psychiatrist or psychologist. However, there are substantial differences in the training and diagnostic approaches by psychiatrists and psychologists. Psychiatrists obtain their psychiatric training after receiving their medical degree. Considering their training is primarily focused in medical schools settings, their orientation has historically been more biological than psychologists. Thus, it is not atypical for psychiatrists to be more interested in medication issues than psychotherapeutic ones. However, psychiatrists are obviously interested in the

diagnostics process albeit primarily in the realm of the mental status exam (see for example, Cain, 1993). Psychologists are also, by definition, doctoral level health-care providers. Some states, such as North Carolina, allow for individuals with training at the Masters-level to be licensed to practice under doctoral-level supervision. The model is similar to that of medicine's Physician Assistant. Psychologists, in contrast to psychiatrists, perform mental status exams but have a greater interest in the use of psychological tests. Hence, psychologists usually do not initiate therapy without the opportunity to complete a battery of psychological tests. Thus, for the last 100 years psychologists have focused on diagnosing through the use of both the mental status exam and psychological tests. As a consequence, the next section will focus on providing an overview of this area.

### Psychological Tests

Depending on what source one would explore, there are thousands of psychological tests available today. In general, they can be divided into two types- projective or objective. Projective tests are typically non-standardized tests whose theoretical underpinnings tend to Freudian or psychoanalytic in nature. Non-standardized implies that the test, while often being administered in a specified fashion, is interpreted according to the clinical context and without reference to a comparison. Indeed, this is the major difference between both types of tests. Objective tests by design are scientifically derived with the purpose of reducing error and bias in the diagnostic process. This approach is comprised of careful and systematic development of the test, specific administration, scoring, and interpretation guidelines, and a comparison or norm-reference sample. Each objective test takes several years to develop as items and scales

have to be empirically. That is one reason why tests are much more expensive than the final byproduct. In other words, one is actually paying for the scientific knowledge that went into the development of the test not just of printing the materials. Each test has very specific guidelines, often with specific wording, that needs to be adhered in the administration as well as the scoring. Interpretation is more flexible allowing the data to be understood in a wider biopsychosocial context. And, finally, each test has one or more comparison groups. These groups, or norms as they are called, provide a reference from which to compare the actual score and are reflective of the intended target group. For example, a group of 100 patients with well-diagnosed schizophrenia residing in a state psychiatric institution could serve as the norms for a test of schizophrenic thinking. In addition, non-schizophrenic patients and normal controls are typically included in the norm references. Tests that are popular tend to be have well developed and multiple group norms. Further, most tests have a life-span of no more than a decade.

Another important aspect of objective tests is the ability of a subtest or test score to be compared to others. Although some tests report  $z$  scores, they are not that common. However, for purposes of clarification a  $z$  score is defined as follows;  $z = (X - \bar{X})/s$  with  $X$  being the raw score,  $\bar{X}$  the mean score, and  $s$  the standard deviation of the scores. More typical than  $z$  scores are  $T$ , percentile and deviation scores. In  $T$  scores, the average or mean score is 50 with each 10 point increment being reflective of one standard deviation (or about 34.13% difference relative to the entire sample). Thus, scores between 40 and 60 represent about 68.26% of the population, scores between 30 and 70 reflect 95.47% of the population, and scores between 20 and 80 represent over 99% of the population. As a rule, psychologists are interested in outliers, primarily those over 2 standard deviations

away from the mean, or outside the 95% confidence level. However, it is important to note that different tests have different T score descriptions for clinical significance.

Deviation scores are a little harder to understand in that they are a derivative of z scores. In this case, the average score is considered to be 100 with deviations occurring in either direction. In this case, however, each standard deviation equals 15 points. Thus, scores between 85 and 115 represent over 68% of the population while scores between 70 and 130 represent over 95% of the population. As a rule, scores which deviate more than 30 points in either direction are often considered to be of clinical significance. Sometimes a shift of one standard deviation is considered significant although two is most often considered to be a significant shift. Additionally, the further the deviation from the norm the less likely that the claimant will return to a “normal” baseline function. For example, a shift over 30 points on an intelligence test relative to a premorbid level of functioning would suggest that such a shift is due to an underlying organic or emotional problem of significant proportion.

Percentile scores are also often used to describe one person's performance. In many instances, this may be the easiest way to understand the data. In this case, the individual score is compared to the reference sample and a specific percentile is obtained. Percentiles range from 0 to 100 with 50 being the average. Although it varies, most psychological tests like to consider significance when the percentile are anywhere from the lower or higher 2nd percentile.

The usefulness of a test depends on reliability and validity. Reliability is defined as the ability of a test to measure the same thing each time the test is given. Of course, if external variables intervene (e.g., psychological treatment), the test scores would be

expected to change. Validity is defined as the ability of a test to measure what it is intending to measure. There are three kinds of validity; content, criterion, and construct. Content is defined as the ability of the test to measure what it should measure. Criterion validity refers to a reference or related measure. Construct validity is related to understanding the more comprehensive issue in question (e.g., intelligence).

Finally, tests are made of factors. Consider the test a wheel and the factors its spokes. Every test has a variety of factors which are measured directly or indirectly. As in the case of recalling a set of numbers, the test may be measuring attention, language comprehension, mathematical exposure, and so forth. However, it is important to note that, on the surface, most psychological tests or, at least, their subtests are intended to measure primarily one major factor. Secondary factors may be gleaned by more in-depth analysis of the available information.

An understanding of these basic issues in psychological testing will increase an appreciation of the value and limitations of the data presented by psychologists in disability evaluations. The next section presents a brief, scholarly review of the published literature involving the psychological assessment of disability.

Recently, approximately 2,000 members of the American Psychological Association were surveyed (Camara, Nathan, and Puente, 2000). The results provide a further understanding of current patterns of testing. For example, clinical psychologists tended to be more likely to assess for personality and psychopathology (33%) whereas neuropsychologists tended to focus more on organic disorders (approximately 60% of their assessment time). Another interesting contrast is that clinical psychological evaluations tended to be less than four hours in length while neuropsychological

evaluations had an even distribution ranging from a couple of hours to well over 20 hours. In addition, the tests appear similar but are actually quite different, in content and scope. The top ten tests used by each sample are found in the table below.

**Table 1: Top 10 Tests**

Clinical Psychology

Neuropsychology

WAIS

MMPI

MMPI

WAIS

WISC

WMS

Rorschach

F A S

Bender

F A S

TAT

Finger Tapping

WRAT

Halstead-Reitan

House-Tree-Person

Boston Naming

WMS

Category

Millon

WRAT

### Psychological Assessment of Disability

Of the articles published in psychological literature since its inception in 1887, a total of 4347 articles were published on psychological testing. The first known article was by F. N. Freeman, published in 1911 in *Psychological Bulletin*. The article focuses on the work of 12 psychologists between 1909-1910. Interestingly, their primary activity was in the administration of intelligence tests, primarily the Binet scales eventually becoming the foundation for the Stanford-Binet Intelligence Scales. By 1937, psychology had become a rigorous and quantitative science. According to one of the pioneers of psychological testing, L.L. Thurstone, psychology was destined to become a science by having its foundation in mathematics. In many respects, this pattern not only lays the groundwork for psychological testing but provides a framework from which to understand psychological information.

A few articles exist that address the application of psychological testing to Social Security Disability. Indeed, of the over 4,000 articles in the literature approximately 100 refer to Social Security Disability. However, most are in passing reference and, hence, will not be reviewed in this chapter. Several articles/chapters by Puente outline specific procedures in greater psychological detail (1986, 1987, 1990, and 1992). However, other articles provide differing approaches to disability evaluation including one by Wiggins (1989) and the first known article on the topic by Nussbaum, Shaffer, and Schneidmuhl (1969). As early as this 1969 article, psychologists were interested in developing “evidentiary needs”. The final section of this chapter will address those particular issues. However, prior to addressing the necessary psychological information, a brief discussion on related matters will be initially presented.



Probably one of the major burdens facing the usefulness of disability evaluations is the “abuse of Social Security income” as dubbed by Rivinus in 1977. In this article, the psychiatrist presents three cases of mental patients that were “incorrectly” receiving SSI income. The premise was these patients were unable or unwilling to get better in part because of the secondary gains associated with having this type of income. The question then becomes how to distinguish between mental disorders and malingering. It is important to note that according to Okpaju, (1985) that psychiatric evaluations of 248 consecutive cases that were in the process of adjudication showed an over-representation of individuals with chronic moderate to severe psychiatric impairments. Hence, the base rate of individuals which are probably being evaluated have a much higher level of psychopathology than typical. However, since the publication of the August 28, 1985 guidelines increasing concerns have been raised, most often implicitly about the validity of psychological test results in determining disability. According to Griffin, Normington, May, and Glassmire (1996), 100 disability applications in Los Angeles seeking disability on psychological grounds were reviewed and was the foundation for the development of a composite malingering index. This index was then applied to 167 applicants, 63 psychologically impaired individual without any need to dissimulate, and 45 disability examiners with instructions to malingering. Based on an empirically-based cutoff score, a total of less than 20% appeared to be malingering.

However, this estimate may be over-inflated. Careful review of the applicants might have revealed that they did not fit into one of the basic diagnostic categories. Secondly, and most importantly, these applicants may have been exaggerating their disorders as a call for help or an actual coping strategy. Thus, this 20% may actually

reflect a composite group of both true malingerers as well as a larger percentage of patients which could have been dually diagnosed- with their original problems (e.g., organic brain syndrome) and a somatoform disorders (e.g., hypochondriasis).

Another point of note relative to psychological evaluations is the issue of providing meaningful reports with appropriate documentation (Kodimer, 1988). Often the issues in question are skirted and documentation is sparse. There are several typical problems found in these reports. These include; 1) limited prior documentation due to no records being sent or provided at the time of the evaluation, 2) limited or no history of the patient including medical, psychological, vocational, social, and personal, 3) misunderstanding of the clinical issues in question, and 4) very limited documentation. If the patient is referred for an evaluation by the Social Security Administration, the chances are high that little or no documentation will be available. As a consequence, little historical evidence will be provided resulting in a limited understanding of the patient's history. This is particularly problematic when the applicant has a severe mental illness and are not accompanied to the evaluation by significant others. A second problem is that evaluations often begin not with a history but with the presenting problems. As a consequence, valuable information is obtained in the interview process and, thus, not reported in the findings. Considering that the ultimate goal is to understand the applicant's current status relative to a premorbid condition, history is critical. Further, some types of disorders (e.g., personality, affective, etc.) are often best understood from an historical perspective. When evaluations are requested, the presenting problem is not often clearly described. Further, most psychological evaluations for the Social Security Administration tend to be based on a brief mental status examination combined with

intellectual assessment. In many cases (e.g., organic disorders) this type of evaluation may serve as a useful screening examination. However, for other situations (e.g., somatoform, affective, etc), an evaluation of this type would not glean enough useful information. Considering that most disability applicants enter the system of disability support due to mood and anxiety disorders (Wagner, Danczyk-Hawley & Reid, 2000), such limited evaluations may be insufficient. Thus, the evaluation should be related to type of mental disorder suspected. In other words, standard evaluations across all mental disorders do not yield the necessary data to understand the applicant's clinical situation. Finally, inappropriate or incomplete documentation is provided. Since psychological tests are the foundation of a psychological report, all scores should be reported. If possible both raw and scaled scores (and, if feasible, age-related) should be included. T, percentile or related scores should also be found. Subtest as well as summary scores should be included if possible. Most likely the most important issue regarding documentation is providing information regarding Part B of the listing. Care should be taken to provide extrapolations from the psychological test data as well as the interview to reflect the issues addressed in Part B- essentially the activities of daily living. For example, continuous and failed attempts to return to gainful employment should be carefully documented and referred to relative to Part B.

### Psychological Reports

Some of the issues involved in psychological reports have already been addressed in the context of the evaluation. However, a few more comments are in order. First, the report should be comprehensive enough that if another evaluation were to be completed in the same manner at a later date, similar findings would be comparable. Hence,

description of what actually transpired and the tests are required. This would include at a minimum the results of an interview, historical analysis, and testing results. The names of the tests should be included along with their specific tests scores. If possible, it would be useful to have both raw and derived scores included. A summary section should integrate the interview, history, and test results as well as relate them to the mental impairment listings. The most typical flaw is the lack of reporting functional data and integration such data to the test results.

According to Social Security, medical reports (which include psychological ones) should include:

Medical (Psychological) History

Clinical Findings (e.g., Mental status exam)

Laboratory Findings (e.g., Test scores)

Diagnosis

Treatment Prescribed with Response and Prognosis

Estimate of Patient's Abilities

Based on recent recommendations from the American Medical Association and on requirements for documentation from the Health Care Financing Administration, specific suggestions have been developed by the author in order to meet documentation requirements.

If the interview is for a non-organic problem (e.g., depression), the following issues should be addressed;

Reason for Service

History

## Mental Status Exam

### Description of Speech, Thinking, Judgment

If the interview is for an organic problem (e.g., brain-damage), the following issues should be addressed;

Reason for Service

History

Attention

Memory

Visual-spatial abilities

Language Functions

Planning/Organization

Impression/Diagnosis

Documentation for testing, whether it be for organic or functional problems, should include;

Name of Tests Used

Interpretation of Test Results

Impression/Diagnosis

These are basic suggestions that were derived during the development of the American Medical Association's Current Procedural Terminology (CPT) which is the primary coding system used by health-care professionals in the United States.

### Addressing the Listings

There are two essential things that need to be considered in addressing the mental impairment listings. One is to consider Part A and the other Part B. Part A should be

based on careful documentation based on the results of psychological testing. As a consequence, this section will address the major issues involved with each of the different listings and suggestions for types of tests that could be used in assessing for those particular disorders. In each case, it is important to determine whether the condition that is being listed is expected to last “for a continuous period of not less than 12 months”. Furthermore, a “medically determinable impairment” is “an impairment that results from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques” (from the Social Security Disability Professionals Bluebook). Further, medical evidence is based on signs, symptoms and laboratory (test) findings.

#### Organic Disorders

**Description.** Organic disorders involve trauma or disease to the central nervous system resulting in abnormalities of psychological functioning. In younger individuals these problems are most likely to occur as a function of head trauma while in older individuals illness and disease are the most likely causes. In either case, it is important to note that some of the listing of 12.02 are more likely to occur than others. Specifically, in head injury cases memory, thinking, changes in personality, and in mood or emotional lability are more common. In addition, it is not unusual to see a 15 point IQ drop. In older persons, some of these problems may be present but, in addition, difficulties in orientation are sometimes noted.

**Tests.** The two most common batteries to test brain dysfunction are the Luria-Nebraska and the Halstead-Reitan. These batteries represent the fixed approach to testing which indicates that the same tests are administered to each patient in the same fashion.

Gaining in popularity are the flexible batteries which are batteries of singular tests customized to fit the problem in question. Segments of the Halstead-Reitan Battery are very popular including the Finger Tapping, Trail Making, and Category tests. However, these tests do not directly reflect the issues addressed in the 12.02 Part A. As a consequence, the WAIS and WMS which measure intellectual and memory functions, respectively, may be more appropriate. Disturbances of mood and emotion are best understood using history, interview, and the MMPI.

#### Schizophrenic, Paranoid, and Other Psychotic Disorders

Description. Schizophrenia is incorrectly considered as split-personality. In reality, these disorders are disorders of perception and of thought. The most common perceptual problem is that of hearing voices. Thinking difficulties included problems of both thought content and style. For example, it is not unusual for certain types of schizophrenics to think they are somebody else (most often Jesus Christ). In addition, their thinking style is plagued with impoverished thoughts, flight of ideas, and illogical or disorganized processes.

Tests. There are several tests that can be used although schizophrenia is often diagnosed by history and clinical interview. Commonly used tests included the MMPI (look for elevations on scale 8) or more specific tests such as the Whitaker Index of Schizophrenic Thinking.

#### Affective Disorders

Description. There are three main types of affective disorders. By far the most common affective disorder is depression, characterized by literally depressed mood, behavior, and thinking. The opposite end of the emotional spectrum is mania although

this problem is most often part of the third type of affective disorder- manic-depression or bipolar disorder. In this scenario, the patient cycles very slowly (over a period of weeks or months) between depression to mania and back.

Tests. History and interview is the best way to diagnose mania. At its peak, it would easily be noted by even untrained individuals. Depression may require more than history and interview and as such tests such as the MMPI is frequently used. Briefer tests are also useful including the Beck and Zung depression scales. Bipolar disorders are almost always diagnosed via history.

### Mental Retardation and Autism

Description. These two disorders are actually quite different in their behavioral and cognitive expression. They do share, however, the idea that there is an organic or physiological component and that their origin is early in the development of the patient. In Autism, the patient has significant problems with communication and socialization. The hallmark of retardation has traditionally been an Intelligence Quotient of 69 or below. However, maladaptive patterns of behavior is now often added for such diagnoses.

Tests. Autism is best understood through history and interview. Indeed, the behavior patterns include easy to identify markers including stereotypical behaviors. Retardation is almost always diagnosed using psychological tests. The Wechsler scales of intelligence are by far the most commonly used. Although the most common tests are the WISC (children) and the WAIS (for adults), other tests are sometimes used (e.g., Stanford-Binet, Kaufman, etc.). Sometimes tests such as the Raven might serve as a good



alternative for patients with communication difficulties and/or illiteracy. It might also be valuable to document academic abilities with achievement tests such as the WRAT.

### Anxiety Related Disorders

**Description.** Anxiety disorders are comprised of generalized anxiety, phobias, and obsession-compulsion. Each of these three are quite different from each other. For example, generalized anxiety is marked by increased psycho-physiological function (e.g., heart rate) as well as hypervigilance and a sense that the future holds only problems. Phobia is fear-mediated avoidance. Obsession is the mental aspect while compulsion is the behavioral expression of an illogical but “required” stereotypical behavior (e.g., cleanliness to an extreme such as constant hand washing).

**Tests.** Probably the most commonly used tests to diagnose these disorders is the MMPI. However, other tests such as the Millon and the Spielberger are often used, especially for the generalized anxiety problems.

### Somatoform Disorders

**Description.** Somatoform disorders are psychological disorders that involve or reflect physiological dysfunction- sometimes real, sometimes perceived. Hypochondriasis is usually reflected in an over-concern of physiological dysfunction, especially in light of evidence to the contrary. Somatization implies a large number of physical problems related to psychological distress. Finally, conversion hysteria implies the existence of a physiological dysfunction but without clear evidence of an underlying medical condition.

**Tests.** Several tests can be used in conjunction with the interview and a well-documented history (with medical records). The tests include the MMPI, especially of the

ancillary scales, and the Millon. Several other lesser known tests have also proven to be valuable for specific types of this disorder.

### Personality Disorders

**Description.** By definition, personality disorders comprise Axis II of the DSM diagnostic system. All other forms of mental illness are part of Axis I. Although there are over 12 different kinds, they all have several things in common; difficulties with societal adaptation, limited insight into their problems, development of the problems often in childhood, and a resistance to psychotherapy.

**Tests.** The best way to diagnose these disorders is by the development of a very comprehensive history. Collateral interviews may also be valuable. In contrast, tests have not proven to be that useful in diagnosing these mental disorders.

### Addiction Disorders

**Description.** As with personality disorders, there are numerous types of addictive disorders. All have in common several basic things; tolerance will eventually build resulting in a higher amount of behavior/substance to maintain equilibrium, withdrawal occurs when the behavior/substance is stopped, and the behavior/substance will invariably affect social, vocational, and personal functioning.

**Tests.** Some tests have been developed specifically for certain types of addictions (e.g., alcoholism). However, the MMPI ancillary scales are very useful in this regard.

### Part B of the Listings

As previously stated, Part B is often misunderstood or ignored in psychological evaluations. Restrictions of daily living, difficulties in maintain social functioning, deficiencies in concentration, persistence, or pace, and repeated episodes of deterioration

or decompensation in work or work-like settings need to be individually addressed. These activities of daily living can best be understood by careful history-taking as well as collateral interviews of accompanying significant others.

### Summary

Mental disorders pose one of the most difficult problems for those representing Social Security disability claimants. For many, mental disorders are disorders of volition. That is, one chooses to be mentally ill as a means of profiting from avoidance of societal demands, including work productivity. Indeed, research and clinical evidence would support otherwise. In addition, these disorders are hard to understand as they are often “gray” in nature. In other words, psychopathology is abstract. As a consequence, diagnosing and later documenting, these disorders is difficult. Careful documentation of history, clinical interview, and psychological testing together with an understanding of both Parts A and B of these listings will go a long ways into solving the difficulties posed by mental impairment claimants.

### Case Examples

The following cases represent recent examples of individuals who were referred for the psychological assessment of disability. The sample of presented cases reflects referrals from three separate sources: Legal Services, private legal representatives, and Social Social Security. These cases represent typical, rather than unusual or clear cases of mental impairment. In order to reflect this approach, these three cases were drawn from the last six cases seen by the author for psychological assessment of disability.

Organic Brain Syndrome- Epilepsy. General History and Status: Born with epilepsy. Was able to complete the 8<sup>th</sup> grade with significant difficulties. Terminated

school with an average grade of F. He has been in prison approximately ten times. Seizures are treated aggressively by neurologist but poor medication compliance has occurred. He has been employed only once, by his uncle for 1.5 days. Was terminated due to a seizure on the job. He does not have a driver's license, nor a checking account, and relies on family for assistance in these and related matters. He presents as poorly groomed and hygiened with over one dozen tattoos and related clothing. Testing: Unable to complete the WAIS due to its level of difficulty and instead the Peabody Picture Vocabulary was administered. The score places him in the mildly retarded range. The Wide Range Achievement Test verified that he is functionally illiterate. Summary: Meets Part A of the 12.02 as well as Part B.

Organic Brain Syndrome- Head Injury. Prior Records: A Masters level psychological associate diagnosed this individual with a personality disorder and chronic pain syndrome. Unfortunately, this conclusion did not include information regarding a hospitalization for a head injury including a CT scan showing general brain atrophy together with atrophy in the frontal and temporal lobes. General History and Status: Born and raised in intact and successful nuclear family. Head injury as adolescent with resulting academic problems. Obtained a GED and a series of unskilled laborer positions. At present, he lives with a friend, has no job, no transportation, no social support, nor any direction. He presents as depressed and dishelved. Testing: Finger tapping, grip strength, Trail Making, Category Test, as well as other components of the Halstead-Reitan Neuropsychological Battery are all in the moderately impaired range. Summary: Meets 12.02 Parts A and B.

Depression, Organic Brain Syndrome and Retardation. General History and Status: Limited historian but dysfunctional and poorly educated family. She dropped out during middle school years. Unable to complete GED and maintain any form of regular employment. All social unions have terminated quickly. Lives by self in a boarding home with support from the "house parent". Has no checking account, does not do shopping, has no means of transportation. Symptoms range from a host of psychophysiological problems to inability to understand and follow simple directions. In addition, numerous medical problems exist including obesity, diabetes, and hypertension. Testing: All aspects of neuropsychological test results are in the mild to moderately impaired range. Intellectual test scores are approximately around an IQ of 60 or about the lowest one percentile. Beck Depression Scale, which was read to the patient, revealed significant depression as well. Summary: Whereas patient meets a variety of listings (individually), a combination 12.02, 12.04, and 12.05 Part A and B appears to be more appropriate.

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