

The disability report may fail to demonstrate the connection between the findings of the mental status examination and the observed restriction of functioning. Full descriptions of the content of hallucinations, delusions, phobias or other symptoms and the stated reasons why the claimant has restricted his activities will often provide the needed link between the psychiatric illness and the restricted functioning.

Particular attention must be paid to the writing of reports in which the claimant's illness is currently in remission or in which the claimant is functioning well in a highly supervised or structured environment. The evaluator must fully describe the course of the claimant's illness and the resulting level of functioning and/or any deficits which remain when the individual is not involved in intensive treatment.

[4] Specialized Aspects of the Psychiatric Evaluation

The role of technology remains small at this time in the evaluation of the psychiatrically disabled. Serum levels of medications such as lithium or antidepressants may document the claimant's clinical response in the face of therapeutic levels of medication or may document problems of compliance with a medication regimen. The controversial dexamethasone suppression test may be cited as another indicator that a claimant has a major depression and may be followed to demonstrate the response to anti-depressants. Blood screening of thyroid function, liver and kidney function and complete blood counts as well as a full physical examination are often indicated to rule out medical causes for psychiatric symptoms and would often be done in the general practice of psychiatry as well as during a disability evaluation.

The use of computerized tomography, electroencephalogram and other neurological diagnostic tools is best used by the psychiatrist in conjunction with a full neurologic consultation.²⁴ A neurological or psychoneurological consultation is indicated in any patient with apparent or suspected structural damage to the nervous system.

Teamwork between a psychiatrist and a psychologist often provides invaluable observational and testing data which can be synthesized in the final report.

§ 40.05 The Role of Psychology in Mental Disorders Evaluations

[1] Introduction to the Field of Psychology

Until recently, the evaluation of impairment of mental processes was considered to be a function of solely the psychiatrist. However, psycholo-

²⁴ See *supra* Chapter 39.

gists can and are becoming increasingly involved in the evaluation of mental activity and the assessment of mental impairments.¹

Until World War II, the application of psychological principles was largely limited to the laboratory. With the emergent need to treat war veterans, especially in Veterans Administration Hospitals, the clinical practice of psychology came into its own. Although initially associated with Departments of Psychiatry and directly supervised by psychiatrists, the clinical application of psychology has grown to be the largest segment of psychology today.

In general, all psychological tests can be divided into either projective (*i.e.*, subjective) or objective categories. The projective tests, which include the Rorschach, the Thematic Aperception Test, the Draw-a-Person, and the Incomplete Sentence Test, are open to interpretation and to the biases of the test administrator. As a consequence, it is advised that when accurate information is needed, the psychologist use objective mental tests. These tests differ from the projective in that they have been scientifically developed using widely accepted methods. As a result, the validity and reliability of these tests is not only measurable but also, open to scrutiny. The following are several classes of objective tests and a representative sample of each of these classes of tests:

| <i>Class</i> | <i>Sample</i> |
|---------------------|---|
| Abilities | Minnesota Paper Form Board Test. |
| Affective | Zung Depression Scale. |
| Cognitive | Whitaker Index of Schizophrenic Thinking. |
| Intellectual | Wechsler's Tests (from children to adults). |
| Memory | Wechsler Memory Scale. |
| Motor | Purdue Pegboard. |
| Neuro-Psychological | Luria-Nebraska Neuropsychological Battery. |
| Verbal | Reitan-Indiana Aphasia Test. |
| Visuo-Motor | Trail-Making Test. |
| Vocational | Strong-Campbell Interest Inventory. |

[2] Psychological Aspects of Disability

From the standpoint of psychology, it does not matter whether a disabling impairment is real or imagined. The nature of disability is that it

¹ See Listing 12.00B. For text of this Listing, *see supra* § 40.01[1].

does not reflect the etiology² of the situation but rather the functional outcome in personal, social, and vocational settings and circumstances. Thus, while etiological explanations may assist in a more complete understanding of the client, the ultimate goal of psychology in the disability evaluation is to assess the functional limitations and assets of the client at the present time and (if possible) to make a statement as to the premorbid³ and future levels of functioning.

Complicating the individual's disability is the person's perceived competence, employability, physical beauty or attractiveness, mental ability, and social acceptance. In all cases of disability, whether physical or mental, many of these issues severely affect the client's social interaction. It is important to underscore the close relationship that disability, regardless of its etiology, has with subsequent mental impairments.

While the primary cause of disability may be directly traceable to physical problems or handicaps, secondary psychological deficits may eventually surface as a function of the newly developed handicaps. The most common of these secondary symptoms is depression.⁴ It is not critical whether these handicaps are real or imagined. The consequences of either can be equally debilitating. Conversely, while the primary symptoms of disability may be psychological in nature, secondary physical or organic symptoms may develop and complicate the overall picture of disability.

Secondary psychological symptoms such as depression are often overlooked or minimized by physicians and attorneys alike. The importance of psychological symptoms in determining the vocational ability of an individual dictate special attention. The following table summarizes the commonly observed secondary effects of physical illness:

| <i>Symptom</i> | <i>Description</i> |
|----------------|--|
| Anxiety | Characterized by apprehensive expectation, vigilance as well as physical autonomic discomforts (e.g., ulcers). |
| Anger | Acute, emotional reaction often associated with both behavioral and physiological reaction. |
| Denial | Avoiding, usually in rational fashion, the newly developed limitations. |

² Etymology—The science dealing with the causes of disease; also, the cause of any particular disease.

³ Premorbid—Prior to the onset of a disease.

⁴ Depression—A mood often described as sad, hopeless, discouraged, or an inability to experience pleasure.

| <i>Symptom</i> | <i>Description</i> |
|----------------|---|
| Depression | Psychomotor retardation, diurnal variation, depressed affect, hopelessness, indecision, suicidal ruminations. |
| Psychosis | Altered thinking, mood, and behavior; out of contact with reality. |
| Somatization | Altering psychological problems to numerous diffuse, autonomic symptoms. |

[3] Psychological Reports

The psychological report can be styled as either a letter or a report, but should contain five major sections:

- (1) the reason for referral and date of evaluation must be included with appropriate identifying information;
- (2) a thorough history (including medical and vocational) together with a summary of complaints presented to the interviewer;
- (3) clinical/behavioral observations should be noted to convey how the patient behaved during the evaluation. These observations may be extremely valuable in addressing the issues of attention, social skills, and restriction of daily activities;
- (4) the bulk of the report which should be presented in simple English. Tables, however, may be constructed to present the actual data upon which the conclusions are based;
- (5) a brief, easy to understand summary statement addressing the relationship of findings to residual functional capacity and disability.

The psychologist should be established as an expert witness either in the report or in a secondary statement. The mental health professional may be qualified as an expert and to provide a definite opinion based on prior study or clinical experience.

A psychologist or psychiatrist is significantly aided in adequately diagnosing your client's condition and in rendering a report when you provide information given you by the claimant regarding history, symptoms and social functioning. Use examples from your own interview of the claimant to highlight significant features and ask the clinician to document clinical findings with observations of the client during the interview.⁵

⁵ See also *supra* § 40.04[2][c][iv] concerning the psychiatric report.

§ 40.06 Organic Mental Disorders—Listing 12.02

[1] Text of Listing 12.02

12.02 *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 a 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 lability (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 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).

[2] Description

Organic mental disorders¹ can be considered as disorders of psychological functioning directly attributable to a central nervous system dysfunction.² The myriad of neural cells throughout the body combine to form the nervous system, probably the most complex of the systems. The nervous system is commonly divided into the peripheral (PNS) and central nervous system (CNS).

Dysfunction of behavior (overt or covert) could arise from trauma, cerebrovascular disease (e.g., stroke), convulsive disorders (e.g., epilepsy), toxic states (including alcoholism), tumor, or metabolic (e.g., endocrine), infectious (e.g., syphilis), or degenerative diseases (e.g., Parkinson's). Dysfunctions common to these disorders include memory deficits (both short and long term), lability³ (sudden, often unexpected) and shallowness of affect, impairment of general cognitive abilities (including intellectual, judgment, and insight), confusion, disorientation (to time, place, and/or person), perseverance (inability to terminate a behavior), and aphasia (difficulties with producing or understanding speech).

Although one might expect that traditional methods of neurological diagnosis⁴ including electroencephalographs (EEG) and Computerized Axial Tomography (CAT) and related Scans could and do provide documentation of these deficits, such tests fall short in that they do not address important criterion of the functional limitations encountered by the client. As a consequence, psychological testing has a unique and important role in delineating the behavioral consequences of brain dysfunctions as well as in predicting the likely impact of such deficits on everyday functioning.

[3] Tests

There are numerous tests currently available which allow the psychologist to accurately document the existence and degree of behavioral impairment due to complications of the nervous system. Prior to any psychometric⁵ evaluation, a thorough history should be obtained, both from the

¹ Organic Mental Disorder—A type of organic brain syndrome in which the etiology is known or presumed, involving a psychological or behavioral abnormality associated with transient or permanent dysfunction of the brain.

² Dysfunction—An impairment or abnormality of a function of a part of the body, especially of an organ.

³ Lability—The trait of emotional instability with rapid and wide shifts in mood or affect; e.g., sudden, unexpected crying.

⁴ See *supra* Chapter 39.

⁵ Psychometric—Pertaining to the measurement of the duration, force, precision, etc. of mental processes.

client's perspective as well as from a significant third party including spouse, children, and previous employers, which may differ drastically. A mental status exam should accompany the history.⁵

The backbone of a psychological evaluation for brain dysfunction is psychometric testing. Following is a list of the behavioral variables to be measured and representative tests for each:

| <i>Behavior</i> | <i>Tests</i> |
|-----------------|--|
| Intellectual | All Wechsler Tests; Stanford-Binet; Kaufman's Tests of Intelligence; Wide Range Achievement Test (all tests now have current revisions). |
| Orientation | Mental Status Examination. |
| Memory | Benton's Test; Memory for Designs; Wechsler Memory Scale. |
| Cognitive | Whitaker Index of Schizophrenic Thinking; Raven's Matrices; Wisconsin Card Sorting Test. |
| Personality | Minnesota Multiphasic Personality Inventory; 16 PF. |
| Affect | Minnesota Multiphasic Personality Inventory; Zung Depression Scale; Beck Depression Scale; Spielberger State/Trait Anxiety. |
| Battery | Luria-Nebraska Neuropsychological Battery; Halstead-Reitan Neuropsychological Battery. |
| Visuo-Motor | Trail Making Test. |

Of these tests, the two most often requested by the Social Security Administration for determining disability due to organic syndromes are the Wechsler Adult Intelligence Scale-Revised and the Bender Motor Gestalt Test. In the recently issued recommendations, however, the American Psychiatric Association strongly suggested that these tests are inadequate devices for the measurement of neural impairment. The American Psychiatric Association indicates that a more comprehensive and standardized test developed exclusively for the measurement of brain damage should be used, such as the new Luria-Nebraska Neuropsychological Battery or the Halstead-Reitan.

⁵ See *supra* § 40.04[2][c].

The Halstead-Reitan test involves a lengthy administration time (approximately 8 hours) and until recently lacked well distributed and published norms as well as guidelines for administration. While the Halstead-Reitan and the Luria-Nebraska batteries appear to be equally effective in detecting brain damage, the Luria-Nebraska (with its published norms and 2-3 hour administration time) may be a more practical instrument for disability evaluations at present.

The Bender is a simple test of visual-motor performance in which the client is asked to reproduce nine geometric designs usually on a single, clean, unlined, white sheet of paper. The test administrator not only examines the style of completing the reproductions but also the final product. Specifically, the psychologist examines for the following aberrations:

| <i>Problem</i> | <i>Description</i> |
|----------------|--|
| Angulation | Changes in angles found on original drawings (often related to curvature changes). |
| Overlap | When two or more figures cross or collide (commonly referred to as crossing). |
| Perseveration | Inability to terminate the required task. |
| Simplification | Figures are presented in a simplistic, childish fashion. |
| Reversal | Figures are reversed from that on the original diagrams. |
| Rotation | Figures are not presented parallel to the bottom of the sheet of paper. |
| Embellishment | Inappropriate renditions, often associated with mood elevations or psychosis. |

While the Bender enjoys great acceptance from the Social Security administration, the limitations of this test are extensive. Since this test was not developed for the assessment of brain damage, no adequate norms are available. Furthermore, the simplicity of this test coupled with the fact that it only measures visuo-motor abilities rather than non-organic variables results in an extremely limited and often incorrect test of organicity. Neuropsychologists have developed more appropriate measurement tools such as the Luria-Nebraska Neuropsychological Battery which shows promise in the area of measuring neuropsychological impairment.

It is important to note that the Halstead-Reitan as well as individualized neuropsychological batteries can be used instead of the Luria-Nebraska. Acceptance by Social Security and an ever growing percentage of

psychologists, of the Luria-Nebraska coupled with the availability of norms and short administration time, certainly warrants careful consideration of Luria for neuropsychological assessment of disability.

§ 40.07 Schizophrenic, Paranoid, and Other Psychotic Disorders—Listing 12.03

[1] Text of Listing 12.03

12.03 *Schizophrenic, Paranoid and Other Psychotic Disorders*—Characterized by the onset of psychotic features with deterioration from a previous level of functioning.

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

A. Medically documented persistence, either continuous or intermittent, of one or more of the following:

1. Delusions or hallucinations; or
2. Catatonic or other grossly disorganized behavior; or
3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:

- a. Blunt affect; or
- b. Flat affect; or
- c. Inappropriate affect; OR

4. Emotional withdrawal and/or isolation: 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); OR

C. Medically documented history of one or more episodes of acute symptoms, signs and functional limitations which at the time met the requirements in A and B of this listing, although these symptoms or

signs are currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of deterioration or decompensation in situations which cause the individual to withdraw from that situation or to experience exacerbation of signs or symptoms (which may include deterioration of adaptive behaviors); or
2. Documented current history of two or more years of inability to function outside of a highly supportive living situation.

[2] Description

According to the Social Security Administration, these psychotic disorders are characterized by demonstrable mental abnormalities without specific brain anatomical changes. These typically include thought disorders. According to DSM-III,¹ several disorders from Axis 1 (schizophrenia) and Axis 2 (paranoid) could be considered in this listing.² All types of schizophrenias are included in this category as are the paranoid states (or personalities from Axis 2). In either case, one should expect distortion of reality, alteration of mood, and defects in perception, language, and memory in social and personal functioning. The different schizophrenic disorders are as follows:

| <i>Disorder</i> | <i>Description</i> |
|------------------|--|
| Disorganized | Frequent incoherence, inappropriate/blunted affect, presence of delusions. |
| Catatonic | Stupor, negativism, rigidity of posture (or excitement). |
| Paranoid | Persecutory delusions, grandiose delusions, delusional jealousy. |
| Undifferentiated | Delusions, hallucinations (most common diagnosis). |

[3] Tests

Few objective tests adequately measure schizophrenic disorders, possibly because of the heterogeneity of symptoms. The Minnesota Multiphasic Personality Inventory (MMPI) is one of the most widely used psycho-

¹ All psychiatrists should now be using the *Diagnostic and Statistical Manual of Mental Disorders* (Third Edition, 1980) (DSM-III) to diagnose patients. This is the official classification of mental disorders by the American Psychiatric Association.

² With reference to the DSM-III Multi-Axial System, see *supra* §§ 40.02[3][b][1] and 40.03[2]; see also App. § 40E.

metric tests and can be readily adapted to examine schizophrenic symptoms. Its use in disability determination evaluations is advised because of its acceptance, flexibility, breadth of behaviors measured, and use of validity scales. The 566 items of the MMPI are presented as true-false statements in a forced choice situation. These items are then grouped into 3 validity and 10 clinical scales. There are numerous additional scales which can be scored, although the acceptance of these ancillary scales varies considerably.

§ 40.08 Affective Disorders—Listing 12.04

[1] Text of Listing 12.04

12.04 Affective Disorders—Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

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

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome characterized by at least four of the following:

- a. Anhedonia or pervasive loss of interest in almost all activities; or
- b. Appetite disturbance with change in weight; or
- c. Sleep disturbance; or
- d. Psychomotor agitation or retardation; or
- e. Decreased energy; or
- f. Feelings of guilt or worthlessness; or
- g. Difficulty concentrating or thinking; or
- h. Thoughts of suicide; or
- i. Hallucinations, delusions or paranoid thinking; or

2. Manic syndrome characterized by at least three of the following:

- a. Hyperactivity; or
- b. Pressure of speech; or
- c. Flight of ideas; or
- d. Inflated self-esteem; or
- e. Decreased need for sleep; or

- f. Easy distractability; or
 - g. Involvement in activities that have a high probability of painful consequences which are not recognized; or
 - h. Hallucinations, delusions or paranoid thinking; OR
3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes); 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).

[2] Description

Affective disorders can be categorized into one of three groups. In each case, aberrations of somatic,¹ affective² and cognitive behaviors are noted. The differences between the categories lie in the behaviors found within each of these behavioral constellations.

Of the three types of affective disorders, depression³ is by far the most common. Mania⁴ is often associated with depression in a recurring or circular pattern traditionally known as manic-depression and most recently termed bipolar disorder. The table below presents the major symptoms of depression and mania.

¹ Somatic—Pertaining to the body.

² Affective Disorders—Behavior disturbances characterized principally by increased or decreased activity and thought expressive of a predominating mood of depression or elation. Although at times conspicuous, the behavioral change is seldom bizarre.

³ Depression—A mood often described as sad, hopeless, discouraged, or an inability to experience pleasure.

⁴ Manic Syndrome (Mania)—Characterized by a predominant mood which is either elevated, expansive or irritable. Includes symptoms such as hyperactivity, pressure of speech, decreased need for sleep, inflated self-esteem, distractibility, and excessive involvement in activities that have a high potential for painful consequences, which is not recognized.

| <i>Behavioral Constellation</i> | <i>Depression</i> | <i>Mania</i> |
|---------------------------------|-------------------------|--------------------------------|
| Somatic | Psychomotor Retardation | Psychomotor Agitation |
| | Diurnal Variation | Decreased Sleep |
| | Decreased Libido | Increased Libido |
| Affective | Depressed Affect | Irritability |
| | Hopelessness | Flight of Ideas |
| | Emptiness | Pressure of Speech |
| Cognitive | Indecision | Delusions |
| | Suicidal Ruminations | Grandiosity Loose Associations |

[3] Tests

Even though depression is commonly observed in psychopathological behavior, few specific tests for affect⁵ have been accepted by the psychological community. In part this could be due to the limitations of the behaviors sampled in these tests. As a rule, these tests have traditionally not considered somatic aspects of the disorder.

Another potential reason for the paucity of accepted tests could be that for the most part these disorders can often be diagnosed using clinical and historical information to the exclusion of any psychometric data. Regardless, there are several acceptable tests including the Minnesota Multiphasic Personality Inventory (MMPI),⁶ the Beck Depression Scale, and the Zung Depression Scale.

It is important to note that the MMPI is the only widely accepted test which specifically tests for mania (*i.e.*, it has a scale which purports to measure manic behavior). In many cases, psychologists prefer to determine the existence and extent of this type of disorder using clinical, historical, and, if possible, observational data. For reasons dealing with the nature of the disorder, a combination of test as well as clinical, historical, and observation information is the best manner in which to chronicle bipolar disorders.

⁵ Affect—An immediately expressed and observed emotion. A feeling state becomes an affect when it is observable, for example, as overall demeanor or tone and modulation of voice. Affect is to be distinguished from mood, which refers to a pervasive and sustained emotion. Common examples of affect are euphoria, anger, and sadness. *See also* further description in Glossary, App. § 40A *infra*.

⁶ Minnesota Multiphasic Personality Inventory (MMPI)—A verbal response test concerning behavior, feelings, social attitudes and symptoms of psychopathology. Used to establish diagnostic groups and personality types.

§ 40.09 Mental Retardation and Autism—Listing 12.05

[1] Text of Listing 12.05

12.05 *Mental Retardation and Autism*—Mental retardation refers to a significantly subaverage general intellectual functioning with deficits in adaptive behavior initially manifested during the developmental period (before age 22). (Note: The scores specified below refer to those obtained on the WAIS, and are used only for reference purposes. Scores obtained on other standardized and individually administered tests are acceptable, but the numerical values obtained must indicate a similar level of intellectual functioning.) Autism is a pervasive developmental disorder characterized by social and significant communication deficits originating in the developmental period.

The required level of severity for this disorder is met when the requirements in A, B, C, or D are satisfied.

A. Mental incapacity evidenced by dependence upon others for personal needs (e.g., toileting, eating, dressing, or bathing) and inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded; OR

B. A valid verbal, performance, or full scale IQ of 59 or less; OR

C. A valid verbal, performance, or full scale IQ of 60 to 69 inclusive and a physical or other mental impairment imposing additional and significant work-related limitation of function; OR

D. A valid verbal performance, or full scale IQ of 60 to 69 inclusive or in the case of autism, gross deficits of social and communicative skills with 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).

[2] Description

Traditionally, mental retardation was considered simply the attainment of an IQ lower than 70 which represents a score in the lower 2% of the population. This limited perspective has been superseded by a more com-

prehensive definition. Together with an IQ score comes an analysis of the individual's ability to interact with others and take care of personal needs.

Mental retardation still denotes a lifelong situation. Unlike braindamage which is acquired during later development or adulthood, the mentally retarded individual acquires or inherits limited intellectual abilities *in utero*, during birth, or during infancy. The causes of this retardation can be traced to genetic factors (both chromosomal and recessive gene), prenatal involvement (including maternal infections, blood incompatibilities, drugs, and possibly excessive stress), birth complications (e.g., prematurity and asphyxiation), and immediate postnatal complications (such as infections, head injuries, and lead poisoning).

[3] Tests

There are numerous tests of intelligence which are used to assist in diagnosing retardation. Wechsler Adult Intelligence Scale-Revised (WAIS-R)¹ and the Wechsler Intelligence Scale for Children-Revised (WISC-R) are most widely used. Other tests are presented in the following table:

| <i>Test</i> | <i>Description</i> |
|----------------|---|
| Stanford-Binet | Measures IQ from 2 to adult, loaded with verbal material, reflects scholastics. |
| Arthur Point | Nonverbal test of intelligence which uses manipulation of objects. |
| Raven Matrices | Designs with a piece missing, nonverbal general intelligence test. |
| Army Alpha | A simple, easy to administer and widely used non-verbal test of intelligence with stronger norms and more accurate development; very promising since variations of this test are often used in service (e.g., Army) evaluation. |

The WAIS-R is the test most often requested by SSA. The first adult intelligence scale developed by the late David Wechsler was published in 1939 as the Wechsler-Bellevue Intelligence Scale. A revision of this instrument was completed in 1955 (and published by the Psychological Corporation) and revised again in 1981. The newest version of Wechsler's test in the Wechsler Adult Intelligence Scale-Revised (WAIS-R). The tests included in the WAIS-R are presented in the table below:

¹ Wechsler Adult Intelligence Scale (WAIS)—A verbal and performance test of several parts which measures IQ MA in three different scoring yields. Copyrighted 1955. WAIS-R is an updated (copyright 1981) revised version of the WAIS.

| <i>Test</i> | <i>Description</i> |
|---------------------|---|
| Verbal | |
| Information | Knowledge of cultural information, alertness, remote/long-term memory (influenced by home, cultural and educational experiences). |
| Similarities | Ability to perceive logical relations and perform abstract thinking, verbal concept. |
| Arithmetic | Evaluates concentration and numerical reasoning abilities, verbal ability (often reflective of educational attainment). |
| Vocabulary | Deals with functional understanding and use (good premorbid index). |
| Comprehension | Judgement of everyday situations, general understanding, verbal ability, social knowledge (could relate to an individual's ability to function in social situations). |
| Digit Span | Memory, reflective of attentional abilities. |
| Performance | |
| Picture Completion | Visual alertness test, deals with detail and visual memory (work habits). |
| Digit Symbol | Attentiveness and persistence in simple visuo-motor task, visual-association memory (probably most reflective of vocational habits and performance). |
| Picture Arrangement | Ordering and sequencing of visual stimuli, persistence, visual recognition. |
| Block Design | Ability to analyze and perceive visual patterns, work skills, attitudes about self. |
| Object Assembly | Visual organization and speed, thinking, work habits, attention, and persistence. |

Each of the subtest raw scores are added and converted into scaled scores according to Wechsler. These scaled scores are added to yield a total scaled score for Verbal and Performance sections, which in turn, are converted into Verbal and Performance Intelligence Quotients. The Intelligence Quotients combine to yield a total IQ referred to as the Full Scale

(Rel.3-12/86 Pub.637)

Intelligence Quotient. The mean score for all Wechsler scales is 100 with a standard deviation of 15.

§ 40.10 Anxiety Related Disorders—Listing 12.06

[1] Text of Listing 12.06

12.06 *Anxiety Related Disorders*—In these disorders, anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders.

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

A. Medically documented findings of at least one of the following:

1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:

- a. Motor tension; or
- b. Autonomic hyperactivity; or
- c. Apprehensive expectation; or
- d. Vigilance and scanning; or

2. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or

3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or

4. Recurrent obsessions or compulsions which are a source of marked distress; or

5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress; 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); OR

C. Resulting in complete inability to function independently outside the area of one's home.

[2] Description

Traditionally, anxiety has evoked a diffuse concept of psychopathology. This is probably due in large part to the Freudian concepts of unconscious anxiety which resulted from the imbalance of the Id and Super Ego within the structure of an individual's personality. Today, this concept has been narrowed and operationally defined, and even altered to accept more current theories of functioning. The table below depicts the most significant behaviors noted in anxiety disorders.

It is important to note that anxiety disorders for the purposes of the new listings are different from DSM-III criteria. Specifically, this general category contains the categories of generalized anxiety, obsessive/compulsive behavior, and phobias (including anorexia nervosa and bulimia). For disability criteria, only the first of these three disorders is actually considered. The table below provides the four major behaviors associated with generalized anxiety and examples of each.

| <i>Behavior</i> | <i>Examples</i> |
|---------------------------|---|
| Motor Tension | Shakiness, tension |
| Autonomic Hyperactivity | Sweating, heart pounding, GI problems |
| Apprehensive Expectations | Anxiety, fear, rumination |
| Vigilance/Scanning | Hyperalertness, decreased concentration, impatience |

[3] Tests

Although there are numerous tests of generalized anxiety, few have been widely accepted by psychologists, especially those involved in research in this area. The MMPI and the Spielberger are two of the tests currently being used to measure behaviors observed in generalized anxiety.

| <i>Test</i> | <i>Description</i> |
|-------------|--|
| MMPI | A verbal response test concerning behavior, feelings, social attitudes and symptoms of psychopathology. Used to establish diagnostic groups and personality types. |
| Spielberger | Both a state and trait assessment of anxiety. |

§ 40.11 Somatoform Disorders—Listing 12.07**[1] Text of Listing 12.07**

12.07 *Somatoform Disorders*—Physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms.

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

A. Medically documented by evidence of one of the following:

1. A history of multiple physical symptoms of several years duration, beginning before age 30, that have caused the individual to take medicine frequently, see a physician often and alter life patterns significantly; or
2. Persistent nonorganic disturbance of one of the following:
 - a. Vision; or
 - b. Speech; or
 - c. Hearing; or
 - d. Use of a limb; or
 - e. Movement and its control (e.g., coordination disturbance, psychogenic seizures, akinesia, dyskinesia; or
 - f. Sensation (e.g., diminished or heightened).
3. Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury; AND

B. Resulting in three 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 behavior).

[2] Description

The somatoform disorders are considered one of the three major neurotic states in the DSM-III classifications. Its history stems from the psychodynamic concept that a physical symptom could develop from a psychological cause. In a more specific sense, the notion was that loss of the use of a limb, for example, could be due to a psychological and not a physical trauma. These concepts were the basis for one of the three somatoform disorders, that of conversion¹ hysteria.

Somatization is defined as existence of a lengthy and complex history of physical symptoms, which could be due to both psychological and physical factors. Hypochondriasis² is another of the related neurotic behaviors. In this case, the individual incorrectly interprets physical symptoms despite medical assurances. As a result, hypochondriacs often seek medical assistance from numerous health professionals usually as a result of the lack of verification of their problems.

Of the three, probably the most common in the general population is somatization disorder. Furthermore, the existence of numerous physical symptoms often results in the development of secondary complications, most notably anxiety and depression. This is especially seen in individuals with chronic medical problems (e.g., cancer, arthritis). The following table depicts some physical problems which may have psychological etiology.³

| <i>Category</i> | <i>Description</i> |
|-----------------|---|
| Cardiovascular | High blood pressure, migraine headaches, Raynaud's disease ⁴ |

¹ Conversion—A loss or alteration of physical functioning that suggests a physical disorder but is actually a direct expression of a psychological conflict or need. The disturbance is not under voluntary control and true physical disease has been ruled out by medical investigation.

² Hypochondriasis—Unrealistic interpretation of physical signs or sensations as abnormal, leading to preoccupation with the fear or belief of having a disease or view that one is "sickly."

³ Etiology—The science dealing with the cause of disease; also, the cause of any particular disease.

⁴ Raynaud's Disease—A disease marked by spasms of the blood vessels in the limbs, especially in the legs, and more often in the toes. During an attack, the affected part aches and feels cold. The spasms are usually initiated by exposure to cold and by emotional strain.

| <i>Category</i> | <i>Description</i> |
|--------------------------|--|
| Musculoskeletal | Tension headaches, muscle cramps, muscular tics |
| Gastrointestinal | Ulcers, gastritis, colitis, obesity, anorexia nervosa, ⁵ bulimia ⁶ |
| Dermal (Skin) | Neurodermatitis, ⁷ hives, hyperhidrosis ⁸ |
| Respiratory | Asthma, allergy, hyperventilation ⁹ |
| Genito-urinary | Dysmenorrhea, ¹⁰ premenstrual syndrome (implication is that mental stress manifests itself in diffuse autonomic ¹¹ symptoms) |
| Somatoform ¹² | Somatization, conversion hysteria, hyperchondriasis |

⁵ Anorexia Nervosa—An emotional disorder marked by a keen concern about obesity and by loss of appetite. The condition affects mostly young women and leads to a serious, often life-threatening, loss of weight and malnutrition.

⁶ Bulimia—An excessive, almost insatiable appetite, often a symptom of mental or physical disease. It often alternates with anorexia.

⁷ Neurodermatitis—A chronic skin disorder marked by the appearance of itching eruptions, especially on the neck and in the armpits. It is seen in persons of nervous temperament.

⁸ Hyperhidrosis (Psychogenic Hyperhidrosis)—Excessive sweating caused by psychogenic or emotional factors, such as fear, embarrassment, etc. It involves mainly the axillae (armpits), forehead, and the palms.

⁹ Hyperventilation—Abnormally rapid and deep breathing, and the condition resulting from it, which includes a reduction in the normal amount of carbon dioxide present in the blood. The condition occurs in nervous and anxious persons, especially females, and is precipitated by an episode of acute emotional tension.

¹⁰ Dysmenorrhea—Menstruation which is accompanied by pain. Emotional factors are often responsible.

¹¹ Autonomic—Having self-controlling functions, especially in reference to the part of the nervous system known as the autonomic nervous system which controls certain organs.

¹² Somatoform Disorder—Physical symptoms, of several years duration, of psychic, mental or emotional origin, which have no known demonstrable organic basis but which have caused the individual to take medicine frequently, seek medical treatment and alter life patterns. In DSM-III, a group of disorders which includes physical symptoms suggesting physical illness for which there are no demonstrable organic findings but for which there is positive evidence, or a strong presumption, that the symptoms are linked to psychological factors. This group includes soma-

[3] Tests

There are several relatively new tests available which do an acceptable job of relating physical to psychological disorders. These are found in the following table:

| <i>Test</i> | <i>Description</i> |
|--------------------------------|--|
| Millon | Uses medical norms to relate physical to psychological symptoms. |
| Type A/Jenkins Activity Survey | Developed to predict psychological problems associated with cardiovascular disease. |
| Life Experience Survey | Weights assigned to specific experiences, predictive of future physical illness. |
| General Health Questionnaire | Similar to Millon, English norms. |
| MMPI | A verbal response test concerning behavior, feelings, social attitudes and symptoms of psychopathology. Used to establish diagnostic groups and personality types. |

Although the Type A test (*i.e.*, Jenkins Activity Survey) has received much attention, the most promising of this group, relative to its breadth of application and scientific development, is the Millon Behavioral Health Inventory. This instrument contains 150 items grouped into 20 different scales. This is the first psychometric instrument specifically developed to measure psychopathology¹³ in the physically ill. The following table summarizes the four major areas of assessment on the Millon Inventory:

| <i>Area of Assessment</i> | <i>Description</i> |
|---------------------------|--|
| Personality; coping style | General personality, relationship to health personnel. |

tization disorder, conversion disorder, psychogenic pain disorder, and hypochondriasis.

¹³ Psychopathology—The branch of medicine investigating and dealing with the nature and causes of mental disease.

| <i>Area of Assessment</i> | <i>Description</i> |
|-------------------------------------|---|
| Psychogenic ¹⁴ attitudes | Reflect psychological stressors which exacerbate illness. |
| Psychosomatic correlates | Degree of emotional factors affecting physical disease. |
| Prognostic Scale | Predicts psychological complications. |

The area of somatoform or psychophysiologic disorders remains to be explored as the new discipline of behavior medicine develops. Until the interface between physical disease and psychological problems can be adequately measured and understood, this area should be closely monitored especially in clients with chronic physical problems.

§ 40.12 Personality Disorders—Listing 12.08

[1] Text of Listing 12.08

12.08 Personality Disorders—A personality disorder exists when personality traits are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or a subjective distress. Characteristic features are typical of the individual's long-term functioning and are not limited to discrete episodes of illness.

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

A. Deeply ingrained, maladaptive patterns of behavior associated with one of the following:

1. Seclusiveness or autistic thinking; or
2. Pathologically inappropriate suspiciousness or hostility; or
3. Oddities of thought, perception, speech and behavior; or
4. Persistent disturbances of mood or affect; or
5. Pathological dependence, passivity, or aggressivity; or
6. Intense and unstable interpersonal relationships and impulsive and damaging behavior; AND

B. Resulting in three of the following:

1. Marked restriction of activities of daily living; or

¹⁴ Psychogenic—Of emotional or mental origin; used to describe the etiology of symptoms that cannot be traced through examination and testing to any physical abnormality.

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).

[2] Description

The inclusion of personality disorders into the Social Security listings poses new challenges for both the mental health and legal professions. The paucity of research and the proliferation of myths regarding these disorders pose a threat to their understanding and diagnoses. Additionally, since the hallmark of these disorders are longstanding patterns of behaviors, the diagnosis of personality often focuses on traits and not on observable behaviors. This is especially critical in that verification of observable behaviors, historical or current, decreases the margin of diagnostic error.

Personality dysfunctions are numerous and are classified by the DSM-III¹ into three clusters. Their classification and brief descriptions are found in the following table.

| <i>Cluster</i> | <i>Disorder</i> | <i>Description</i> |
|----------------|-----------------|---|
| I | Paranoid | Chronic and unwarranted mistrust of people. |
| | Schizoid | Inability to develop social relations. |
| | Schizotypal | Similar but less severe than schizophrenia. |
| II | Histrionic | Intense, dramatic patterns of relating. |
| | Narcissistic | Extreme self-centeredness. |
| | Antisocial | Sociopath; violation of rights of others. |
| | Borderline | Instability of behavior. |

¹ All psychiatrists should now be using the *Diagnostic and Statistical Manual of Mental Disorders* (Third Edition, 1980) (DSM-III) to diagnose patients. This is the official classification of mental disorders by the American Psychiatric Association.

| <i>Cluster</i> | <i>Disorder</i> | <i>Description</i> |
|----------------|--------------------|---|
| III | Avoidant | Need for overwhelming approval. |
| | Dependent | Lets others assume major responsibility for self. |
| | Compulsive | Perfectionistic, reductionistic. |
| | Passive-Aggressive | Indirect resistance to demands. |

Common to all personality disorders appear to be three major factors. First, individuals with these diagnoses are at odds with society, in general, and individuals, in particular. As a rule, while these individuals do exhibit inappropriate behavior patterns they tend to affect, in essence hurt, others more than they do themselves. To complement this, there is a pattern of inability to understand or appreciate the consequences of their behavior (*i.e.*, poor insight). Secondly, these behaviors often originate early in childhood.

Nevertheless, while the etiology for personality disorders is not well understood, genetic predisposition and learning (*e.g.*, modeling at home) are most often cited as primary causes. Finally, most personality disorders are extremely resistant to change. There are no currently acceptable treatments for personality dysfunctions and such individuals do not view this personality as maladaptive.

[3] Tests

Assessment of these disorders may be difficult for the non-trained observer. History may provide the first sign of these disorders. Current vocational, financial, and interpersonal activities are also useful in diagnosing these disorders. The following table describes the most commonly used tests to assess personality disorders:

| <i>Tests</i> | <i>Description/Application</i> |
|------------------------------------|--|
| MMPI | Specific scales have been recently developed; Machiavellianism, Sociopathy, etc. |
| Eysenck Personality | Developed to measure wide variety of normal and abnormal personality patterns. |
| California Psychological Inventory | Focuses on assessing wide variety of "normal" personality patterns. |

§ 40.13 Substance Addiction Disorders—Listing 12.09

[1] Text of Listing 12.09

12.09 *Substance Addiction Disorders*—Behavioral changes or physical changes associated with the regular use of substances that affect the central nervous system.

The required level of severity for these disorders is met when the requirements in any of the following (A through I) are satisfied.

- A. Organic mental disorders. Evaluate under 12.02.
- B. Depressive syndrome. Evaluate under 12.04
- C. Anxiety disorders. Evaluate under 12.06.
- D. Personality disorders. Evaluate under 12.08.
- E. Peripheral neuropathies. Evaluate under 11.14.
- F. Liver damage. Evaluate under 5.05.
- G. Gastritis. Evaluate under 5.04.
- H. Pancreatitis. Evaluate under 5.08.
- I. Seizures. Evaluate under 11.02 or 11.03.

[2] Description

Drug use is a commonly accepted behavior pattern in most societies including the United States. Whether it be caffeine, nicotine or more serious drugs such as cocaine or alcohol, the use of drugs for recreation, escape, or inappropriate and illegal medical use is clearly on the rise. The problem, from the standpoint of disability, lies in distinguishing use from abuse and dependence.

Abuse is generally considered to reflect a need for the drug in order to perform daily, vocational, or social activities. Concomitantly, the development of impairment in one or more spheres of the abuser's life will occur. Dependence, often considered only a physiological phenomenon, is measured by examining tolerance and withdrawal variables. These variables are broadly defined as the need for increased amounts of a drug for desired effects and the development of symptoms (including psychological ones) in response to discontinued drug use.

It is important to realize that many drugs, such as cocaine, tend to produce extremely subtle, yet powerful, psychological addictions. As a conse-

quence, the variables which need to be measured in order to gauge the likelihood of disability may be more psychological than physiological in nature.

The following table briefly presents the three major classes of drugs which produces significant psychological changes as well as examples of each of these classes:

| <i>Class</i> | <i>Drug</i> | <i>Examples</i> | <i>Effect</i> |
|--------------|---------------|--|---|
| Stimulants | Caffeine | Colas; coffee; No-Doz | Withdrawal anxiety, irritability, etc. |
| | Nicotine | Cigarette | Withdrawal anxiety, irritability, etc. |
| | Amphetamine | Speed; Methedrine | Paranoia, hallucination, depression |
| Depressants | Barbiturates | Seconal; Qualude | Irritability, nervousness, depression |
| | Tranquilizers | Valium; Thorazine | wide range of effects including a decrease in motivation |
| | Alcohol | Methyl; ethyl | Brain damage, deterioration in all spheres of functioning |
| Recreational | Cannabis | Marijuana; THC; hash | Decrease in motivation unclear |
| | Hallucinogens | LSD; Mushrooms | Unclear |
| | Cocaine | Coke, rocks | Anorexia, irritability, paranoia |
| | Opiates | Heroin; morphine | Deterioration of all aspects of functioning |
| | Others | Volatile solvent inhalants, steroids, analgesics, designer drugs | Varied effects depending on type of drug |

[3] Tests

Few tests exist which adequately measure drug use, abuse, or dependence since assessment of such behaviors is usually based on historical and currently observable behaviors rather than on test results. However, since few chronic drug users reveal the extent of consumption, it is often difficult to base conclusions on histories provided by them. Thus, information from objective, significant others as well as from available psychological tests should be used to accurately determine the extent of the problem. The following psychological tests have proven to be of value.

| <i>Test</i> | <i>Description</i> |
|------------------------------------|---|
| MMPI | Psychopathic, Depression, Psychasthenia, ¹ and MacAndrews scales |
| Locus of Control | Drinking-Related |
| Michigan Alcoholism Screening Test | Self-report questionnaire of drinking behavior |

§ 40.14 Pain Disorders**[1] Description**

Even though pain has not been introduced as part of the Social Security mental disability rules, many individuals seeking disability assistance will have, either directly or indirectly, experienced pain. A brief introduction to pain and its measurement is presented to assist the representative in serving the claimant incapacitated by pain.

Both organic and psychogenic¹ pain are extensively affected by cultural determinants, pain threshold, psychological experiences, suggestibility, body/gender image, and secondary gains. Considering the diffuse nature of pain as well as its potential vocational and personal impact, careful attention should be paid to these variables. For many individuals, pain is a means to control or punish. Careful analysis of potential social reinforcers is usually dictated. Pain patients are often categorically viewed as malingerers, however, only a portion of all patients actually fall into this category.

¹ Psychasthenia—A mental disorder of the neurosis type marked by compulsions to perform senseless acts which the subject recognizes as silly or irrational; obsessions with haunting ideas, anxieties, abnormal fears, etc.

¹ Psychogenic—Of emotional or mental origin. Used to describe the etiology of symptoms that cannot be traced thorough examination and testing to any physical abnormality.

Pain is a complicated psychophysiological phenomena, often diagnosed and treated by the neurologist, neurosurgeon, psychiatrist, oncologist² and psychologist. Pain can be categorized into one of two groups; organic (or real) pain, psychogenic (or imagined) pain. Organic pain is, generally, although not exclusively, handled by medical specialists while psychogenic pain, as a rule, falls into the domain of mental health professionals. Psychogenic pain can be further subdivided into three sections: delusional (as in persecutory pain); hallucinatory (perceptual aberration); and neurotic pain (such as somatoform disorders).³

[2] Tests

Despite the difficulty of measuring physical pain, the psychological dimension has been measured with a good degree of success. There are several tests which directly measure pain behavior while several more are commonly used to measure the byproduct of the experience of pain. The following table provides an introduction to these tests.

| <i>Test</i> | <i>Description</i> |
|---------------------------|--|
| McGill Pain Questionnaire | Both a structured interview and questionnaire available; widely respected. |
| Pain Apperception | Semi-projective test with long history of use in the field. |
| Zung Pain Scale | Brief, easy to administer and score pain screening instrument. |
| Hendler's Questionnaire | Used for low back pain patients. |
| Related tests | MMPI; ⁴ Zung Depression Scale; Millon; State-Trait Anxiety. |

² Oncologist—A physician specializing in the study and treatment of tumors and new growths (cancer).

³ Somatoform Disorder—Physical symptoms, of several years duration, of psychic, mental or emotional origin, which have no known demonstrable organic basis but which have caused the individual to take medicine frequently, seek medical treatment and alter life patterns.

⁴ Minnesota Multiphasic Personality Inventory (MMPI)—A verbal response test concerning behavior, feelings, social attitudes and symptoms of psychopathology. Used to establish diagnostic groups and personality types.

§ 40.15 Establishing a Mental Impairment—Listings
12.00–12.09

[1] Introduction

At the time of the initial interview with the mental impairment claimant,¹ the representative should ascertain the medical information that is available directly from the claimant about the mental impairment, as well as what existing evidence might be obtained from the claimant's Social Security disability case file, and from medical practitioners, hospitals and other sources.²

The representative should also begin thinking about what other laboratory tests or medical evidence might be helpful in proving the claimant's mental impairment. The representative should always take an open approach to the possibilities of each case, keeping an eye open for any as yet undiscovered impairments, or relationships among impairments, that might establish disability even if the claimant's mental impairment does not meet or equal a listed impairment.³

The three main types of medical evidence are symptoms (the claimant's personal observations of his impairment and the restrictions it imposes), signs (the observations of medical professionals respecting the impairment), and laboratory findings (obtained by the use of medically acceptable laboratory diagnostic techniques).⁴ The representative should assemble all three of these categories of medical evidence.

[2] The Important Role of Listing 12.00

In any mental impairment case the representative must closely consider the provisions of Listing 12.00.⁵ This listing contains important instructions concerning the need for medical evidence;⁶ the assessment of sever-

¹ For an overview of the initial interview, *see supra* § 28.03[1][a][i], [ii] and [iii].

² For an overview of the process of obtaining records from Social Security case files and from other sources, *see supra* § 28.03[1][a][iv].

³ For further discussion of the representative's approach to the case, *see supra* § 28.03[1][a][i].

⁴ 20 C.F.R. § 404.1528. *See supra* § 14.01[1].

⁵ Listing of Impairments, 20 C.F.R. pt. 404, subpt. P, app. 1, pt. A § 12.00.

⁶ *Id.* § 12.00B.

ity;⁷ documentation;⁸ chronic mental impairments;⁹ effects of structured settings;¹⁰ the effects of medication;¹¹ and the effect of treatment.¹² It should be noted that Listing 12.00C is particularly important as it provides the analytical framework for assessing severity in activities of daily living;¹³ in social functioning;¹⁴ with respect to concentration, persistence and pace;¹⁵ and regarding deterioration or decompensation in work or work-like settings.¹⁶

[3] New Regulations for the Evaluation of Mental Impairments

In addition, Listing 12.00I provides for a new technique for Social Security review of the evidence in mental disorders claims to determine the level of impairment severity. This technique, which is used in connection with the sequential evaluation process,¹⁷ is contained in new Social Security regulations effective August 28, 1985.¹⁸

According to the statement issued by Social Security promulgating these new regulations:

We are introducing a procedure to assist in the evaluation of mental impairments. This procedure is to be followed by us at each administrative level of review. The procedure will assist us in (1) identifying the additional evidence necessary for the determination of impairment severity, (2) considering and evaluating aspects of the mental disorder(s) relevant to your ability to work, and (3) organizing and presenting the findings in a clear, concise, and consistent manner.¹⁹

It should be noted that at the time of promulgating these regulations, Social Security also published a copy of the psychiatric review technique form which it will use in applying the regulations.²⁰

⁷ *Id.* § 12.00C.

⁸ *Id.* § 12.00D.

⁹ *Id.* § 12.00E.

¹⁰ *Id.* § 12.00F.

¹¹ *Id.* § 12.00G.

¹² *Id.* § 12.00H.

¹³ *Id.* § 12.00C1.

¹⁴ *Id.* § 12.00C2.

¹⁵ *Id.* § 12.00C3.

¹⁶ *Id.* § 12.00C4.

¹⁷ *See supra* § 13.01[2].

¹⁸ 20 C.F.R. § 404.1520a. For the text of these regulations, *see infra* App. § 40C.

¹⁹ 50 Fed. Reg. 35,039 (August 28, 1985).

²⁰ *Id.* at 35,054.

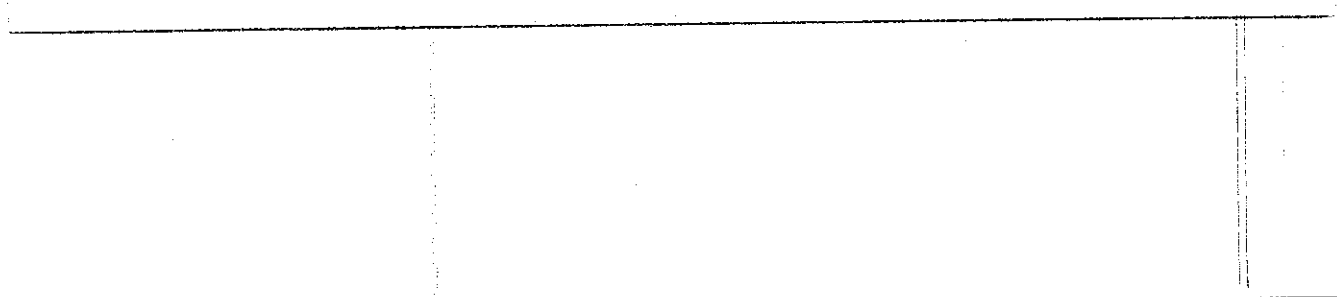
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Appendix

Synopsis

- App. § 40A Glossary
- App. § 40B Mental Disorders Cases Listed by Circuit
- App. § 40C Code of Federal Regulations Provisions: Evaluation of Mental Impairments (20 C.F.R. § 404.1520a)
- App. § 40D Questions and Answers on the New Mental Evaluation Guidelines: Legislative Implementation Update No. 85-2 (September 1985), Issued by the Office of Disability, Social Security Administration
- App. § 40E DSM-III Multi-Axial System
- App. § 40F Questions for Family Members of the Mentally Impaired Individual
- App. § 40G Mental Status Examination
- App. § 40H Bibliography
- App. § 40I Social Security Administration Form for Mental Residual Functional Capacity Assessment by Medical Consultant
- App. § 40J Social Security Rulings
Ruling 85-16 Residual Functional Capacity for Mental Impairments

App. § 40A Glossary

Adaptive Behavior—Ability to conduct one's total activity in accordance with one's environment.

Affect—An immediately expressed and observed emotion. A feeling state becomes an affect when it is observable, for example, as overall demeanor or tone and modulation of voice. Affect is to be distinguished from mood, which refers to a pervasive and sustained emotion. Common examples of affect are euphoria, anger, and sadness.

A range of affect may be described as broad (normal), restricted (constricted), blunted, or flat. The normal expression of affect involves variability in facial expression, pitch of voice, and the use of hand and body movements. Restricted affect is characterized by a clear reduction in the expressive range and intensity of affects. Blunted affect is marked by a severe reduction in the intensity of affective expression. In flat affect there is a lack of signs of affective expression; the voice may be monotonous and face, immobile.

Affect is inappropriate when it is clearly discordant with the content of the person's speech or ideation. Affect is labile when it is characterized by repeated, rapid, and abrupt shifts. Example: An elderly man is tearful one moment and combative the next.

Affective disorders—Behavior disturbances characterized principally by increased or decreased activity and thought expressive of a predominating mood of depression or elation. Although at times conspicuous, the behavioral change is seldom bizarre.

Agitation—*See infra* Psychomotor Agitation.

Agoraphobia—Marked fear of leaving the familiar setting of the home.

Akinesia—Loss or absence of motor function, *i.e.*, loss of the ability to move a part of the body or to move around; impairment, rather than total absence, of such function; immobility.

Ambivalence—The presence of strong, conflicting emotions or ideas about a person, object or goal.

Amnesia—A partial or total inability to recall past experiences which were once known.

Anhedonia—Inability to experience pleasure.

Anorexia Nervosa—An emotional disorder marked by a keen concern about obesity and by loss of appetite. The condition affects mostly young women and leads to a serious, often life-threatening, loss of weight and malnutrition.

Anxiety—Apprehension, tension, or uneasiness that stems from the anticipation of danger, which may be internal or external. Anxiety may be focused on an object, situation, or activity which is avoided (phobia), or may be unfocused (free-floating anxiety). It may be experienced in discrete periods of sudden onset and be accompanied by physical symptoms (panic attacks). When anxiety is focused on physical signs or symptoms and causes preoccupation with the fear or belief of having disease, it is termed hypochondriasis.

Arthur Adaptation of the Letter—Non-verbal test suitable for testing children between the ages of 3 and 8 or adults at those mental ages. Scores yield mental age (MA) and intelligence quotient (IQ).

Attention—Ability to focus in a sustained manner on one task or activity. A disturbance in attention may be manifested by difficulty in finishing tasks that have been started, easy distractibility, and/or difficulty concentrating on work.

Autistic Behavior—Extremely self-involved behavior leading to a lack of responsiveness to other people.

Autonomic—Having self-controlling functions, as certain organs, especially the part of the nervous system known as the autonomic nervous system.

Autonomic Hyperactivity—Disturbance of that part of the nervous system that functions outside of consciousness and that is not caused by external stimuli. Symptoms may include sweatiness, goosebumps, palpitations, flushing, rapid heart rate, abdominal cramping and diarrhea as well as light-headedness.

Bipolar Syndrome—A major affective disorder. The individual shifts between manic and depressive symptoms. Similar to a cyclothymic disorder (*see infra*), but more intense.

Blocking—An interruption of a train of thought and speech before a thought or idea has been completed, evidenced by a person stopping in the middle of speaking and later remarking that he or she cannot recall what he or she had intended to say.

Bulimia—An excessive, almost insatiable appetite, often a symptom of mental or physical disease. It often alternates with anorexia (*see supra*).

Catatonic behavior—Marked motor anomalies, generally limited to disturbances in the context of a diagnosis of a non-organic psychotic disorder. Motor anomalies include excitement, negativism, rigidity, posturing, stupor, and "waxy flexibility."

Circumstantiality—A term used to describe a disturbance of thought and speech that is indirect and delayed in reaching the point or main idea because of digression into unnecessary, tedious irrelevant details, and parenthetic remarks.

Cognitive abilities—Refers to the mental abilities of comprehension, judgment, memory and reasoning as contrasted to emotional and volitional processes.

Compulsion—Repetitive and seemingly purposeful behavior that is performed with a sense of inner compulsion according to certain rules or in a stereotyped fashion. The behavior is not an end in itself, but is designed and believed to produce or prevent some particular condition or some future state of affairs; the activity, however, either is not connected in a realistic way with the state of affairs it is designed to produce or prevent, or it may be clearly excessive. For example, a person feels compelled to wash his hands each time he touches another object due to a fear of germ contamination recognized by the individual to be excessive. The act is performed with a sense of subjective compulsion coupled with a desire to resist it (at least initially); performing the particular act may not be pleasurable, although it may afford some relief of tension. Seen in obsessive compulsive disorder and schizophrenia.

Confabulation—The unconscious fabrication of "facts" by an individual with a severe memory impairment.

Conversion—A loss or alteration of physical functioning that suggests a physical disorder but is actually a direct expression of a psychological conflict or need. The disturbance is not under voluntary control and true physical disease has been ruled out by medical investigation.

Conversion Hysteria—*See also supra.* A form of neurosis causing alterations in the patient's personality, which may take the form of multiple personality, sleep walking, aimless running, etc.

Cyclothymia—A personality disorder of chronic mood disturbance characterized by periods of alternating moods of cheerfulness, vivacity and mild depression and hypomania. The mood swings are not of sufficient severity or duration to be called either a major depression or a manic episode.

Decompensation—Exacerbation of signs and symptoms following an individual's unsuccessful attempt to adapt to stressful circumstances.

Delerium—An organic mental disorder marked by a clouded state of consciousness. Disorientation, memory impairment, agitation and hallucinations are commonly seen in this acute condition.

Delusion—A false personal belief about the real world based on incorrect inference about external reality and firmly sustained in spite of what almost everyone else believes and in spite of what constitutes definite incontrovertible and obvious proof of evidence to the contrary.

Delusion of reference—A delusion whose theme is that events, objects, or the people in the person's immediate environment have a particular and unusual significance, usually of a negative or pejorative nature.

Dementia—A chronic deterioration (due to organic brain syndrome) from a previous level of intellectual functioning and abilities involving personality change and resulting in impairment of memory, abstract thinking, judgment and impulse control. Clouding of consciousness does not occur, although its severity will interfere with social and occupational functioning occurring in a normal state of alertness. May be chronic or acute and reversible or irreversible.

Depersonalization—An alteration in the perception or experience of the self so that the feeling of one's own reality is temporarily lost. Manifested by a sense of being outside one's own body, or that parts of the body are very large, very small, or not under one's control, etc. Seen in various psychiatric disorders and also in the absence of any mental disorder in the presence of overwhelming anxiety, stress or fatigue.

Depression—A mood, often described as sad, hopeless, discouraged or an inability to experience pleasure.

Depressive Neurosis—A chronic mood disturbance characterized either by moderate depression or loss of interest or pleasure in all, or nearly all, usual activities and pastimes. Not of sufficient severity or intensity to be called a major depression.

Diagnostic and Statistical Manual of Mental Disorders—All psychiatrists should now be using the *Diagnostic and Statistical Manual of Mental Disorders* (Third Edition, 1980) (DSM-III) to diagnose patients. This is the official classification of mental disorders by the American Psychiatric Association.

Disorientation—Confusion about the date or time of day, where one is (place), or who one is (identity).

Dissociative Disorders—Sudden and temporary changes in either consciousness, sense of identity or voluntary motor movement.

Distractibility—Attention drawn too frequently to unimportant or irrelevant external stimuli. Example: While being interviewed, a subject's attention is repeatedly drawn to noise from an adjoining office, a book that is on a shelf or the interviewer's school ring.

DSM-III—(*See supra* Diagnostic and Statistical Manual of Mental Disorders).

Dyskinesia—Impairment of the power to execute satisfactorily voluntary movements, especially with the arms or legs.

Dysmenorrhea—Menstruation which is accompanied by pain. Emotional factors are sometimes responsible.

Dysthymic disorder—*See* Depressive neurosis.

Etiology—The science dealing with the cause of disease; also, the cause of any particular disease.

Euphoria—An exaggerated feeling of well-being.

Flight of Ideas—A nearly continuous flow of accelerated speech with abrupt changes from topic to topic, usually based on understandable associations, distracting stimuli, or plays on words. When severe, the speech may be disorganized and incoherent.

Functional disorder—A broad class of mental impairments that cannot be traced to an organic or physical origin.

Grandiosity—An inflated appraisal of one's worth, power, knowledge, importance, or identity. When extreme, grandiosity may be of delusional proportions. Example: A professor who frequently put his students to sleep with his boring lectures is convinced that he is one of the more dynamic and exciting teachers at the university.

Hallucination—A false sensory perception which may occur in any of the five sensory channels without external stimulation of the relevant sensory organ.

Hallucination, auditory—A hallucination of sound, most commonly of voices, but sometimes of clicks, rushing noises, music, etc.

Hallucination, visual—A hallucination involving sight, which may consist of formed images, such as of people, or of unformed images, such as flashes of light. Visual hallucinations should be distinguished from illusions, which are misperceptions of real external stimuli.

Halstead-Reitan—A comprehensive battery of psychological tests which demonstrate cognitive and motor abilities.

Histrionics—A personality trait or disorder characterized by dramatic and intensely expressed behavior and emotions as characteristic disturbances in interpersonal relationships.

Hyperhidrosis (psychogenic hyperhidrosis)—excessive sweating caused by psychogenic or emotional factors, as fear, embarrassment, etc. It involves mainly the axillae (armpits), forehead, and the palms.

Hyperventilation—Abnormally rapid and deep breathing, and the condition resulting from it, which includes a reduction in the normal amount of carbon dioxide present in the blood. The condition occurs in nervous and anxious persons, especially females, and is precipitated by an episode of acute emotional tension.

Hypochondriasis—Unrealistic interpretation of physical signs or sensations as abnormal, leading to preoccupation with the fear or belief of having a disease or view that one is "sickly."

Idea of reference—An idea, held less firmly than a delusion, that events, objects, or other people in the person's immediate environment have a particular and unusual interest or meaning specifically for him or her. *See also supra* Delusion of Reference.

Illogical thinking—Thinking that contains clear internal contradictions in which conclusions are reached that are clearly erroneous, given the initial premises.

Insight—Refers to the extent to which the patient is aware he is ill, recognizes the nature of the illness and understands the dynamic factor involved in producing the illness.

Insomnia—Difficulty falling or staying asleep.

Judgment—The ability to compare facts and ideas, understand their relations and draw correct conclusions from them. This ability is evaluated during psychiatric examination for evidence of impairment.

Lability (see also Affect)—Trait of emotional instability with rapid and wide shifts in mood or affect; e.g., sudden, unexpected crying.

Leiter International Performance Scale (LIPS/LIS)—A non-verbal matching or grouping test which is arranged in levels to indicate years of accomplishment. Scores yield mental age (MA) and IQ.

Loosening of Associations—Thinking characterized by speech in which ideas shift from one subject or topic to another that is completely unrelated or only obliquely related without the speaker's showing any awareness that the topics are unconnected.

Luria-Nebraska—A comprehensive battery of psychological tests which demonstrate cognitive and motor abilities.

Malingering—The production or exaggeration of psychological or physical symptoms in pursuit of a goal.

Manic Syndrome (Mania)—Characterized by a predominant mood which is either elevated, expansive or irritable. Includes symptoms such as hyperactivity, pressure of speech, decreased need for sleep, inflated self-es-

teem, distractibility, and excessive involvement in activities that have a high potential for painful consequences, which is not recognized.

Marked—Where “marked” is used as a standard for measuring the degree of limitation, it means more than moderate, but less than extreme. A marked limitation may arise when several activities or functions are impaired or even when only one is impaired, so long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately and effectively. See Listing 12.00C in § 40.01[1] *supra*.

Mental Disorder—In DSM-III, a mental disorder is a clinically significant behavioral or psychological syndrome or pattern associated either with distress or impairment in one or more areas of functioning.

Mental Retardation—Insufficient intellectual capacity (due to genetic endowment, disease or injury) to cope with environmental demands resulting in the inability to establish an independent social existence.

Minnesota Multiphasic Personality Inventory (MMPI).—A verbal response test concerning behavior, feelings, social attitudes and symptoms of psychopathology. Used to establish diagnostic groups and personality types.

Mood—A pervasive and sustained emotion that, in the extreme, markedly colors the person’s perception of the world. Mood is to affect as climate is to weather.

Morbid—(1) Diseased; disordered; abnormal. (2) Pertaining to, or involving, diseased organs or tissues; pertaining to a disease; pathologic.

Neurotic Disorder—A mental disorder in which the predominant disturbance is a symptom or group of symptoms that is distressing to the individual and is recognized by him or her as unacceptable and alien; reality testing is grossly intact. Behavior does not violate gross social norms. The disturbance is relatively enduring or recurrent without treatment, and is not limited to a transitory reaction to stressors.

Neurodermatitis—A chronic skin disorder marked by the appearance of itching eruptions, especially on the neck and in the armpits. It is seen in persons of nervous temperament.

Neuroleptics—A class of psychotropic drugs which modify psychotic behavior in general. They have become the major therapeutic agents in treating schizophrenia with the capacity to modify affective states without seriously impairing cognitive functioning.

Obsessions—Recurrent, persistent ideas, thoughts, images, or impulses that are ego-dystonic, that is, they are not experienced as voluntarily produced, but rather as ideas that invade consciousness.

Organic Mental Disorder—A type of organic brain syndrome in which the etiology is known or presumed involving a psychological or behavioral abnormality associated with transient or permanent dysfunction of the brain.

Panic Attacks—Discrete periods of sudden and intense apprehension or fearfulness. There may also be symptoms of shortness of breath, chest pain, choking, or fears of going crazy.

Paranoid Disorders—A group of psychotic disorders characterized by delusions of grandeur and persecution, suspiciousness, hypersensitivity, hyperalertness, jealousy, guardedness, resentment, humorlessness, litigiousness (tending to engage in lawsuits) and sullenness.

Paranoid Ideation—Ideation, of less than delusional proportions, involving suspiciousness or the belief that one is being harassed, persecuted, or unfairly treated.

Perservation—Persistent repetition of words, ideas or topics.

Personality disorder—Implies inflexible and maladaptive patterns of sufficient severity to cause either significant impairment in adaptive functioning or subjective distress.

Phobia—A persistent, irrational fear of a specific object, activity, or situation that results in a compelling desire to avoid the dreaded object, activity, or situation (the phobic stimulus).

Poverty of Content of Speech—Speech that is adequate in amount but conveys little information because of vagueness, empty repetitions, or use of stereotyped or obscure phrases.

Poverty of Speech—Restriction in the amount of speech, so that spontaneous speech and replies to questions are brief and unelaborated. When the condition is marked, replies may be monosyllabic and some questions may be unanswered.

Pressure of Speech—Speech that is increased in amount, accelerated, and difficult or impossible to interrupt. Usually it is also loud and emphatic. Frequently, the individual talks without any social stimulation and may continue to talk even though no one is listening.

Psychasthenia—A mental disorder of the neurosis type marked by compulsions to perform senseless acts which the subject recognizes as silly or irrational, obsessions with haunting ideas, anxieties, abnormal fears, etc.

Psychogenic—Of emotional or mental origin. Used to describe the etiology of symptoms that cannot be traced through examination and testing to any physical abnormality.

Psychogenic Pain Disorder—Characterized by complaints of pain, not associated with signs of physical illness and with evidence of psychological disturbance.

Psychometric—(1) Pertaining to or involving the measurement of intelligence, as by intelligence (or psychometric) tests. (2) The measurement of the duration and/or intensity of a mental activity.

Psychomotor Agitation—Excessive motor activity associated with a feeling of inner tension; the activity is usually nonproductive and repetitious. When the agitation is severe it may be accompanied by shouting or loud complaining. Examples: Inability to sit still, pacing, wringing of hands, pulling at clothes.

Psychomotor Retardation—Visible generalized slowing down of physical reactions, movements, and speech.

Psychopathology—The branch of medicine investigating and dealing with the nature and causes of mental disease.

Psychosis—A term indicating gross impairment in reality testing including hallucinations, delusions or severe disorganization of thought. It may be used to describe the behavior of an individual at a given time, or a mental disorder in which at some time during its course all individuals with the disorder have grossly impaired reality testing.

Psychotropic—Having an effect on the psyche or mind.

Raven Progressive Matrices—A non-verbal intelligence test. It uses abstract designs which must be completed by the participants; yields IQ only.

Raynaud's Disease—A disease marked by spasms of the blood vessels in the limbs, especially in the legs, and more often in the toes. During an attack, the affected part aches and feels cold. The spasms are usually initiated by exposure to cold and by emotional strain.

Rorschach—A verbal response test of ten inkblots used to obtain a picture of the participant's personality to aid psychiatric diagnosis and prognosis.

Schizoid Personality Disorder—A personality disorder characterized by an inability to form relationships with others.

Schizophrenia—A group of disorders of differing etiologies with certain psychotic features during the active phase of the illness such as delusions, hallucinations and incoherence. Onset is usually before age 45, a deterioration.

ration from a previous level of social and occupational functioning is noted, and duration continues for at least six months.

Sensorium—The functional state of the special senses, especially as related to the condition of consciousness.

Sign—An objective manifestation of a pathological condition. Signs are seen by the examiner. *See* Listing 12.00B in § 40.01[1] *supra*.

Somatic—Pertaining to the body. The word is used in two senses: pertaining to the body as distinguished from the mind, and pertaining to the body framework and walls as distinguished from the organs contained inside the body.

Somatoform disorder—Physical symptoms of several years duration of psychic, mental or emotional origin, which have no known demonstrable organic basis but which have caused the individual to take medicine frequently, seek medical treatment and alter life patterns. In DSM-III (*see supra*), a group of disorders which includes physical symptoms suggesting physical illness for which there are no demonstrable organic findings but for which there is positive evidence or a strong presumption, that the symptoms are linked to psychological factors. This group includes somatization disorder, conversion disorder, psychogenic pain disorder, and hypochondriasis.

Symptoms—A subjective complaint reported by the patient. *See* Listing 12.00B in § 40.01[1] *supra*.

Syndrome—A grouping of symptoms that occur together and that constitute a recognizable condition.

Thematic Apperception Test (TAT)—A verbal response test wherein the participants tell stories of pictures shown to them. It focuses primarily on interpersonal relationships and is a diagnostic tool.

Thought Disorder—Any disturbance of thinking that affects language, communication, thought content or thought process. In DSM-III, a disturbance in the form of thought as distinguished from the content of thought. This may include loosening of associations, neologism (newly invented words), perseveration or blocking.

Vigilance and Scanning—Increased watchfulness with visual examining of a small or isolated area with attention to the environment for signs of threat.

Wechsler Adult Intelligence Scale (WAIS)—A verbal and performance test of several parts which measures IQ mental age (MA) in three different scoring yields. Copyrighted 1955.

WAIS-R—An updated (copyright 1981) revised version of the WAIS. See also the American Psychiatric Association *Psychiatric Glossary*, American Psychiatric Press, 1400 K Street N.W., Wash., D.C. 20000.

App. § 40B Mental Disorders Cases Listed by Circuit*Supreme Court*

Richardson v. Perales, 402 U.S. 389, 28 L. Ed. 2d 842, 91 S. Ct. 1420 (1971) (a landmark case involving a man with paranoid personality; deals with due process rights of claimants at hearings).

First Circuit

Nieves v. Secretary of Health and Human Services, 775 F.2d 12 (1st Cir. 1985) (claimant with IQ in the 60s and myositis and depression was awarded benefits from 1978).

Lopez-Cardona v. Secretary of Health and Human Services, 747 F.2d 1081 (1st Cir. 1984) (pain and nervousness are two factors which must be considered as vocationally relevant in determining whether the claimant can engage in forms of substantial gainful activity).

Lebron v. Secretary of Health and Human Services, 747 F.2d 818 (1st Cir. 1984) (the cumulative impact of mental and physical impairments must be weighed in determining whether a claimant is capable of gainful employment).

Goodermote v. Secretary of Health and Human Services, 690 F.2d 5 (1st Cir. 1982).

Deblois v. Secretary of Health and Human Services, 686 F.2d 76 (1st Cir. 1982).

Lizotte v. Secretary of Health and Human Services, 654 F.2d 127 (1st Cir. 1981) (severe depression with anxiety combined with poor intelligence can create disability).

Guzman Diaz v. Secretary of Health, Education and Welfare, 613 F.2d 1194 (1st Cir. 1980).

Second Circuit

City of New York v. Heckler, 742 F.2d 729 (2d Cir. 1984) (a class comprised of 50,000 mentally impaired New York residents successfully challenged Social Security's procedures for evaluating the claims of mentally impaired individuals; interim benefits were awarded to those whose benefits were terminated).

Berry v. Schwieker, 675 F.2d 465 (2d Cir. 1982) (a 36-year-old former carnival ride operator was denied disability for insufficient clinical evidence to support his claim that he was disabled due to retardation, chronic brain syndrome and functional nonpsychotic disorders).

Rutherford v. Schwieker, 685 F.2d 60 (2d Cir. 1982) (alcoholism).

Carter v. Schweiker, 649 F.2d 937 (2d Cir. 1981) (alcoholism).

McAndrew v. Heckler, 562 F. Supp. 1227 (S.D.N.Y. 1983) (severe reactive depression suffered by claimant had disabling consequences).

Bradford v. Secretary of Health and Human Services, 532 F. Supp. 1025 (E.D.N.Y. 1982).

Third Circuit

Caffee v. Schweiker, 752 F.2d 63 (3d Cir. 1985) (Caffee, a 46-year-old former male attendant in a state mental hospital, suffered from paranoid schizophrenia with depression which rendered him unable to deal with the stress of his job. His IQ was measured at 85. Testifying as to the relationship of stress to employment, a vocational expert stated that all forms of employment carry with them a certain amount of stress. It was held that Caffee's limited stress tolerance brought about by his severe mental condition prevented him from engaging in competitive employment).

Van Horn v. Schweiker, 717 F.2d 871 (3d Cir. 1983) (alcoholism).

Torres v. Schweiker, 682 F.2d 109 (3d Cir. 1982).

Hall v. Schweiker, 567 F. Supp. 213 (E.D. Pa. 1983) (hysterical personality causes disability).

Simons v. Heckler, 567 F. Supp. 440 (E.D. Pa. 1983) (a personality disorder precluded the performance of gainful activity).

Fourth Circuit

Branham v. Heckler, 775 F.2d 1271 (4th Cir. 1985) (mental retardation).

Smith v. Schweiker, 719 F.2d 723 (4th Cir. 1984).

McLain v. Schewiker, 715 F.2d 866 (4th Cir. 1983) (psychiatric impairments, such as a long-standing nervous disorder with inadequate personality, are nonexertional impairments).

Grant v. Schweiker, 699 F.2d 189 (4th Cir. 1983) (limited intelligence is a nonexertional impairment which requires vocational testimony).

Mitchell v. Schweiker, 699 F.2d 185 (4th Cir. 1983) (a low IQ is a life-long problem which could be the basis of a finding of disability based on the listing governing mental retardation).

Schrader v. Harris, 631 F.2d 297 (4th Cir. 1980) (creates exception for cases involving the mentally impaired to the standards on res judicata set out in *Califano v. Saunders*, 430 U.S. 90, 51 L. Ed. 2d 1972, 97 S. Ct. 980 (1977)).

Wilson v. Califano, 617 F.2d 1050 (4th Cir. 1980) (effects of severe anxiety and depression must be weighed in determining the claimant's entitlement).

Hicks v. Califano, 600 F.2d 1048 (4th Cir. 1979) (alcoholism).

Swaim v. Califano, 599 F.2d 1309 (4th Cir. 1979) (alcoholism).

Stawls v. Califano, 596 F.2d 1209 (4th Cir. 1979).

Lewis v. Weinberger, 541 F.2d 417 (4th Cir. 1976) (a claimant afflicted with anxiety and hypochondriacal neurosis was found to be totally disabled).

Wyatt v. Weinberger, 519 F.2d 1285 (4th Cir. 1975) (nervousness).

Finney v. Schweiker, 566 F. Supp. 1541 (W.D.N.C. 1983) (the ALJ should have ordered IQ tests after the claimant's limited intelligence became apparent during the hearing).

Fifth Circuit

Green v. Schweiker, 694 F.2d 108 (5th Cir. 1982), *reh'g denied*, 699 F.2d 1163, *cert. denied*, 460 U.S. 1091, 103 S. Ct. 1790, 76 L. Ed. 2d 357 (1983).

McGee v. Weinberger, 518 F.2d 330 (5th Cir. 1975).

Dixon v. Weinberger, 495 F.2d 202 (5th Cir. 1974) (claimant suffering from a number of other physical and mental problems was awarded benefits).

DePaepe v. Richardson, 464 F.2d 92 (5th Cir. 1972) (multiform psychiatric problems with physical disorders created disability).

Sixth Circuit

Sherrill v. Secretary of Health and Human Services, 757 F.2d 803 (6th Cir. 1985) (a widow suffering from depression, fibrositis and osteoarthritis was awarded benefits).

Branham v. Gardner, 383 F.2d 614 (6th Cir. 1967) (well-informed discussion on the role of psychiatry in disability proceedings).

Seventh Circuit

Orlando v. Heckler, 776 F.2d 209 (7th Cir. 1985).

Hassler v. Weinberger, 502 F.2d 172 (7th Cir. 1974) (paranoid personality with depression can form basis for award of benefits).

Eighth Circuit

Benson v. Heckler, 780 F.2d 16 (8th Cir. 1985) (it was error for the Administrative Law Judge to discount allegations of pain because of lack of objective evidence; the court noted that, under the new Mental Impair-

ment Listing, somatization disorder is listed as a disabling impairment; on remand, the Secretary should evaluate the claimant's case in light of the standards set out in the Listing).

Steele v. Heckler, 748 F.2d 492 (8th Cir. 1984) (a medical improvement case involving moderate to severe anxiety, nervousness, irritability and panic was remanded because there was no evidence to support the Secretary's claim that the claimant's condition had improved).

Miller v. Heckler, 747 F.2d 475 (8th Cir. 1984).

Smith v. Heckler, 735 F.2d 312 (8th Cir. 1984).

Van Horn v. Heckler, 717 F.2d 1196 (8th Cir. 1983) (chronic undifferentiated schizophrenia, a passive aggressive dependent personality, and a probable organic learning disorder cause disability).

Brenner v. Schweiker, 711 F.2d 96 (8th Cir. 1983) (a 41-year-old woman with seven years of special education alleged disability due in part to her low IQ which was 65 on the verbal component of the WAIS; she could not tolerate social interactions and could work only in a sheltered environment; as a result, her claim was approved).

Burns v. Schweiker, 708 F.2d 351 (8th Cir. 1983).

Woodard v. Schweiker, 668 F.2d 370 (8th Cir. 1981).

Bailey v. Califano, 614 F.2d 146 (8th Cir. 1980).

Veal v. Califano, 610 F.2d 495 (8th Cir. 1979) (alcoholism).

Behnen v. Califano, 588 F.2d 252 (8th Cir. 1978) (a psychoneurosis with conversion features can contribute to disability).

Adams v. Weinberger, 548 F.2d 239 (8th Cir. 1977) (alcoholism).

Ninth Circuit

Brown v. Heckler, 713 F.2d 441 (9th Cir. 1983) (alcoholism).

Hall v. Secretary of Health, Education and Welfare, 602 F.2d 1372 (9th Cir. 1979) (depressive neurosis and mental deficiency of claimant must be considered in determination of disability).

Griffis v. Weinberger, 509 F.2d 837 (9th Cir. 1975) (alcoholism).

Eleventh Circuit

Powell v. Heckler, 773 F.2d 1572 (11th Cir. 1985) (a 44-year-old chronic schizophrenic with intermittent employment was awarded benefits during the time of unemployment from 1978 through 1981).

Pendley v. Heckler, 767 F.2d 1561 (11th Cir. 1985) (it was error to exclude consideration of the claimant's anxiety disorder in a hypothetical question to vocational expert).

App. 40-17

MENTAL DISORDERS CASES

App. § 40B

Edwards v. Heckler, 755 F.2d 1513 (11th Cir. 1985)

Ambers v. Heckler, 736 F.2d 1467 (11th Cir. 1984).

Freeman v. Schweiker, 681 F.2d 727 (11th Cir. 1982) (IQ of 62 with physical disorders qualifies claimant for disability under § 200.00(h) of the Medical-Vocational Guidelines).

**App. § 40C Code of Federal Regulations Provisions: Evaluation
of Mental Impairments (20 C.F.R. § 404.1520a)**

(a) *General.* The steps outlined in § 404.1520 apply to the evaluation of physical and mental impairments. In addition, in evaluating the severity of mental impairments, a special procedure must be followed by us at each administrative level of review. Following this procedure will assist us in:

- (1) Identifying additional evidence necessary for the determination of impairment severity;
- (2) Considering and evaluating aspects of the mental disorder(s) relevant to your ability to work; and
- (3) Organizing and presenting the findings in a clear, concise, and consistent manner.

(b) *Use of the procedure to record pertinent findings and rate the degree of functional loss.*

(1) This procedure requires us to record the pertinent signs, symptoms, findings, functional limitations, and effects of treatment contained in your case record. This will assist us in determining if a mental impairment(s) exists. Whether or not a mental impairment(s) exists is decided in the same way the question of a physical impairment is decided, i.e., the evidence must be carefully reviewed and conclusions supported by it. The mental status examination and psychiatric history will ordinarily provide the needed information. (See § 404.1508) for further information about what is needed to show an impairment.

(2) If we determine that a mental impairment(s) exists, this procedure then requires us to indicate whether certain medical findings which have been found especially relevant to the ability to work are present or absent.

(3) The procedure then requires us to rate the degree of functional loss resulting from the impairment(s). Four areas of function considered by us as essential to work have been identified, and the degree of functional loss in those areas must be rated on a scale that ranges from no limitation to a level of severity which is incompatible with the ability to perform those work-related functions. For the first two areas (activities of daily living and social functioning), the rating of limitation must be done based upon the following five point scale: none, slight, moderate, marked, and extreme. For the third area (concentration, persistence, or pace) the following five point scale must be used: never, seldom, often, frequent, and constant. For the fourth area (deterioration or decompensation in work or work-like settings), the following four point scale

must be used: never, once or twice, repeated (three or more), and continual. The last two points for each of these scales represent a degree of limitation which is incompatible with the ability to perform the work-related function.

(c) *Use of the procedure to evaluate mental impairments.* Following the rating of the degree of functional loss resulting from the impairment, we must then determine the severity of the mental impairment(s).

(1) If the four areas considered by us as essential to work have been rated to indicate a degree of limitation as "none" or "slight" in the first and second areas, "never" or "seldom" in the third area, and "never" in the fourth area, we can generally conclude that the impairment is not severe, unless the evidence otherwise indicates there is significant limitation of your mental ability to do basic work activities (see § 404.1521).

(2) If your mental impairment(s) is severe, we must then determine if it meets or equals a listed mental disorder. This is done by comparing our prior conclusions based on this procedure (i.e., the presence of certain medical findings considered by us as especially relevant to your ability to work and our rating of functional loss resulting from the mental impairment(s)) against the paragraph A and B criteria of the appropriate listed mental disorder(s). If we determine that paragraph C criteria will be used in lieu of paragraph B criteria (see listings 12.03 and 12.06), we will, by following this procedure, indicate on the document whether the evidence is sufficient to establish the presence or absence of the criteria. (See paragraph (d) of this section).

(3) If you have a severe impairment(s), but the impairment(s) neither meets nor equals the listings, we must then do a residual functional capacity assessment, unless you are claiming benefits as a disabled widow(er) or surviving divorced spouse.

(4) At all adjudicative levels we must, in each case, incorporate the pertinent findings and conclusions based on this procedure in our decision rationale. Our rationale must show the significant history, including examination, laboratory findings, and functional limitations that we considered in reaching conclusions about the severity of the mental impairments(s).

(d) *Preparation of the document.* A standard document outlining the steps of this procedure must be completed by us in each case at the initial, reconsideration, administrative law judge hearing, and Appeals Council levels (when the Appeals Council issues a decision).

(1) At the initial and reconsideration levels the standard document must be completed and signed by our medical consultant. At the administrative law judge hearing level, several options are available:

(i) The administrative law judge may complete the document without the assistance of a medical advisor.

(ii) The administrative law judge may call a medical advisor for assistance in preparing the document; or

(iii) Where new evidence is received that is not merely cumulative of evidence already in your case file or where the issue of a mental impairment arises for the first time at the administrative law judge hearing level, the administrative law judge may decide to remand the case to the State agency for completion of the document and a new determination. Remand may also be made in situations where the services of a medical advisor are determined necessary but unavailable to the administrative law judge. In such circumstances, however, a remand may ordinarily be made only once.

(2) For all cases involving mental disorders at the administrative law judge hearing or Appeals Council levels, the standard document will be appended to the decision.

**App. § 40D Questions and Answers on the New Mental
Evaluation Guidelines: Legislative Implementation
Update No. 85-2 (September 1985), Issued by the
Office of Disability, Social Security Administration**

Questions and Answers on the New Mental Evaluation Guidelines

The purpose of this second Legislative Implementation Update (LIU) is to share with you questions and answers (Qs & As) concerning the new mental evaluation guidelines. This LIU is composed of questions raised during the mental evaluation training sessions in several regions, and the corresponding Office of Disability answers.

Attached to this page are 21 pages of Qs & As arranged in the following four categories.

- Section A 67 Qs & As on the mental listings
- Section B 19 Qs & As on the Psychiatric Review Technique Form (PRTF)
- Section C 16 Qs & As on mental residual functional capacity (RFC).
- Section D 2 Qs & As on district office (DO) issues

In keeping with our commitment to publish Qs&As resulting from the Hot Line and other sources, we will continue to provide additional Qs&As as they are received and resolved. Information about the mental evaluation Hot Line contact points is contained in Section IX of LIU Number 85-1.

A. Listing Questions

Question 1: How can we document and adjudicate cases involving Asian immigrants who do not believe in western medicine?

Answer: The program does not evaluate claimant's beliefs but rather their mental status, psychiatric history and functional limitations (if any). Claimants who are new to U.S. culture are often difficult to evaluate. However, even newly arrived immigrants with mental impairments perform activities of daily living; have social relationships; show deficiencies in concentration, persistence and pace; and have episodes of deterioration and decompensation, all in an historic and longitudinal context. These, of course, must be carefully developed, detailed, and assessed. If possible, mental status data should be obtained from psychiatrists or psychologists familiar with the claimant's culture or language. Social workers or psychiatric nurses who are familiar with culture or language at hand can be very helpful. Under certain circumstances, a disability determination services

(DDS) may wish to hire such social workers or nurses on a consultant or contractual basis.

Question 2: We need more guidelines for part "C" decisions. What kinds of evidence are acceptable?

Answer: Part C of 12.03 applies to claimants with chronic psychotic disorders who may have been in treatment for several years. Their histories may include multiple hospitalizations, out-patient treatment and psychosocial support (e.g., day care centers, sheltered workshops, boarding houses, etc.). In addition to medical reports from hospitals and clinics, adequate descriptions of functional limitations should be obtained from these and other sources, such as programs and facilities where the individual has been observed over a considerable period of time. Information from both medical and nonmedical sources may be used to obtain detailed descriptions of the individual's activities of daily living, social functioning, ability to concentrate and persist, or ability to tolerate increased mental demands (stress). Such information can be provided by family members and other caretakers who have knowledge of the individual's functioning. (See Program Operations Manual System (POMS) DI 00401.595C.6C).

Question 3: How can two isolated episodes of psychosis, widely separated by remission be differentiated from 12.03C1 criteria? What does "repeated" mean?

Answer: The concept of "repeated episodes of deterioration or decompensation" as outlined in 12.03C1 implies a remission of symptomatology under the effects of treatment or treatment equivalence (neuroleptics and psychosocial support) but with no significant improvement in the claimant's capacity to function independently or autonomously on a sustained basis. An individual who has two episodes of psychosis widely separated by remission, but whose residual functional capacity (RFC) improves significantly during remission to a level of capacity for substantial gainful activity (SGA), does not fit the 12.03C1 criteria. In fact, individuals with a chronic schizophrenic disorder often experience a progressive deterioration in their functioning with each episode of active psychosis. These are precisely the chronically psychotic individuals whose psychopathology and level of functioning should be evaluated under listing 12.03C1. If the question implies two widely separated discrete episodes with no evidence of any severe mental disorder in between episodes, e.g., two episodes of brief reactive psychosis separated by months or years with no intervening mental disorder, listing 12.03C would not ordinarily apply.

Question 4: How is "intermittent persistence" defined?

Answer: The key issue here is the fact that schizophrenic disorders (listing 12.03) and affective disorders (listing 12.04) are usually chronic.

Their clinical manifestations may remit to a level where residual symptoms are minimal or even nonexistent, for variable periods of time, usually under treatment (ongoing or otherwise). In the case of affective disorders such as bipolar disorder, their cyclic (and thus intermittent) nature is even more evidence. Therefore, their clinical manifestations can be either continuous, or, the same manifestations ("persistence") can be reactivated following a period of quiescence ("intermittent"). "Persistence" of clinical manifestations refers to the chronic nature of the mental disorders at issue. "Intermittent" refers to their cyclic or episodic course.

Question 5: How do we deal with treating source opinion that an individual will decompensate when there is no evidence one way or the other?

Answer: Opinion evidence in isolation has little programmatic value when not substantiated by clinical signs, symptoms and findings. The assertion by a treating psychiatrist that a claimant's functioning *will* decompensate should be supported with a clinical precedent and/or a clear explanation of the interaction between the possible precipitating and exacerbating factors with the relevant historic documentation and the resulting clinical manifestations.

While treating source opinions should always be given serious considerations, they are not, in and of themselves, determinative. What is determinative is the evidence as a whole, taken particularly in the context of sustainability and longitudinality. It is the DDS physician/examiner team which ultimately makes the decision as to the likelihood of decompensation.

Question 6: Is there an educational level at which a person is expected to do serial 7's?

Answer: Most claimants who have successfully completed 6th grade will have the educational background to complete serial 7's. Of course, no conclusion about the claimant's overall mental status should be based solely on a single item, e.g., serial 7's.

Question 7: To what degree should "cardiac neurosis" and "cancer neurosis" be developed? Do we need a consultative examination (CE)? (These are common findings post myocardial infarction (MI) or open heart surgery.)

Answer: "Cardiac neurosis" denotes a psychiatric syndrome with significant anxiety, phobic, depressive or somatoform components in the absence of (an appropriate degree) cardiovascular pathophysiology. As such, it requires the appropriate evaluation by a psychiatrist. The emotional reactions observed during recovery from MI and open heart surgery are usually of a short duration (2-4 months) and fall in the category of ad-

justment disorders with anxiety and/or a depressive mood. When its duration persists and interferes with functional recovery, the nature and prognosis should be evaluated through a psychiatric CE.

Question 8: What is the definition of "frequent"?

Answer: "Frequent" is more than "often" and less than "constant." Item "B3" requires more than an evaluation of frequency, however. Duration and effect must be developed, detailed, and considered as well.

Question 9: Can the new listings be used for supplemental security income (SSI) dependent child (DC) claims?

Answer: Yes, as the current regulations provide, in evaluating disability for a person under age 18, Part B will be used first. If the medical criteria in Part B do not apply, then the medical criteria in Part A will be used.

Question 10: How do the diary categories apply to the new listings? For example, the 2-year duration is already established, can we still diary for 1 year based on prognosis?

Answer: The diary categories are currently being revised. However, POMS DI 00401.790 states that a medical judgment must be made by the reviewing physician based upon the facts of the individual case, as to whether a diary is appropriate. A diary should be established in any case in which there is a reasonable expectation that the individual will regain the ability to work.

Question 11: Does a mental impairment have to be established by medical evidence from a psychiatrist or is medical evidence from a nonpsychiatrist sufficient? Some agoraphobics may have seen only their attending physician.

Answer: The existence of a medically determinable impairment must be established by medical evidence consisting of clinical signs, symptoms and/or laboratory or psychological test findings regardless of whether the impairment is physical or mental. Clinical signs are medical demonstrable phenomena which reflect specific abnormalities of behavior, affect, thought, memory, orientation, or contact with reality. Symptoms are complaints presented by the individual. Signs and symptoms generally cluster together to constitute recognizable syndromes (mental disorders). If a physician, who is not a psychiatrist or psychologist, can supply the necessary detailed information to establish a medically determinable mental impairment, then that evidence will be sufficient. However, most nonpsychiatric physicians cannot provide adequate psychiatrically relevant evidence in psychiatric cases.

Question 12: Is lay evidence sufficient to set the onset?

(Rel.3-12/86 Pub.637)

Answer: In disabilities of non-traumatic origin, the determination of onset involves consideration of the applicant's allegations, work history, if any, and the medical and other evidence concerning impairment severity. The weight to be given any of the relevant evidence depends on the individual case. With slowly progressive impairments it may be necessary to infer the onset date based on all relevant evidence. (For a complete discussion of onset of non-traumatic disabilities refer to POMS DI 00401.725.)

Question 13: When development is by report of contact (RC), must it be signed by the contact?

Answer: Please refer to POMS DI 00401.120 which discusses signature requirements for medical evidence received over the telephone. However, for nonmedical evidence, a signature is not required on an RC.

Question 14: Is the permanent impairment list to be updated?

Answer: Yes, we are working on it now.

Question 15: Based on the examples, we can evidently make assumptions about premorbid IQ level. Is this correct? Does it require some kind of documentation?

Answer: Documentation is always required to establish the existence of a medically determinable impairment. If previous IQ scores do not exist, there may still be instances when the documentation in the file would indicate that there has been a drop of 15 points in a claimant's IQ. Such a situation might occur if there is documentation describing a claimant who has graduated from college and functioned well in an intellectually demanding job who is found to have an IQ of 85 following brain injury. From a clinical standpoint, however, it is difficult to envision a case in which the diagnosis of an organic mental disorder would depend solely on a drop in IQ with no other findings as described in the "A" criteria of 12.02.

Question 16: If 12.02C2 is met and the person therefore has not worked for 2 years, will the onset be set 2 years back?

Answer: Presumably this refers to listing 12.03C. Onset would be when the claimant could not work because of a medically determinable impairment. If the claimant has not been able to function outside of a highly structured setting, onset would be when the claimant could no longer function outside that setting.

Question 17: Can the minor affective disorders mentioned by Dr. Goldman (cyclothymic, dysthmic, atypical bipolar and atypical depression) also meet listing 12.04? Sometimes they are as severe or more so than the major affective disorders.

Answer: They will rarely meet 12.04 because the "A" criteria describes major affective disorders. They may equal 12.04 if the requisite restrictions described in the "B" criteria are satisfied.

Question 18: Does "gross deficits of social and communicative skills" refer only to diagnosed autism? With the word "or" in the listing it would seem autism could also *meet* 12.05D even if the IQ were above 69. Why does the tape say you would *equate* the listing in that instance?

Answer: Yes, "gross deficits . . ." does refer only to autism. Autism can meet 12.05D even if the IQ were above 69. The tape is in error. A claimant with autism, irrespective of IQ, who shows the gross deficits will *meet* the listing.

Question 19: How frequent must manic-depressive illness "cycle"? How long can "well periods" last?

Answer: There is no minimal number of cycles that must be established. However, the 12 month duration requirement for initial claims must be met. The court of major affective disorders is variable. There may be many years of normal functioning between episodes of illness. Rarely, is there an alternation of manic and depressive episodes over a long period of time without an intervening period of near normal mood.

Question 20: Under which listing should anorexia and bulimia be evaluated?

Answer: There are at least three possibilities, depending on the details of the case, i.e., 12.06A4, 12.08A3, and 12.04. Eating disorders are more frequent in adolescents and young adults. Because of the involvement of other body systems, the assessment of severity sometimes involves more than one listing.

Question 21: Has the policy about noncompliance with medical treatment changed?

Answer: No, there has been no policy change regarding failure to follow prescribed treatment (see POMS DI 00401.575ff). However, it must be kept in mind that individuals with chronic mental disorders may not be able to make sound judgments about following prescribed treatment because of the nature of their impairments, and thus may have "good cause" for failure to comply.

Question 22: How can we avoid the CE "snapshot" approach on continuing disability review cases where there have been no treating sources?

Answer: Prior medical and nonmedical evidence in file fill help establish a longitudinal picture of the impairment. Third party reports and the current CE will help fill the gaps to present an adequate picture. In some

cases, it may be appropriate to obtain a second CE. (POMS DI T00401.821)

Question 23: Should we use medical deferral when onset is recent in order to obtain more longitudinal data?

Answer: In some cases this may be appropriate.

Question 24: In considering deterioration under work-like conditions, is there a timeframe to show that stress caused the deterioration?

Answer: No. Timeframe, per se, does not establish causality.

Question 25: If the person does deteriorate under work conditions, who does the work development, this district/branch office (DO/BO) or DDS?

Answer: Usually the DDS will develop work activity since the DDS will know what specific information is required to adjudicate the case. (POMS DI 00401.003B, DI 004011.035B and DI 00401.125.)

Question 26: Can we really obtain a mental status exam that contains enough information for the new listings?

Answer: A mental status exam is only one part of a psychiatric exam and in and of itself would ordinarily not provide sufficient documentation to permit evaluation under the new listings.

Question 27: Where does the term "significant" fit in?

Answer: We cannot determine the point of this question.

Question 28: Do we need permission to use DO observations as lay evidence?

Answer: No, we do not need permission to use DO observations as lay evidence. (POMS DI 00401.080 and DI 00403.015E.)

Question 29: Will there be a rationale form for obtaining information about activities of daily living (ADL)?

Answer: Yes, a supplemental form has been developed for the DOs to use in documenting ADLs. Shortly, the draft form will be released for comments to the regional commissioners.

Question 30: Will the emphasis on obtaining longitudinal information from all sources replace purchasing CEs?

Answer: No. Obtaining longitudinal evidence will help present a complete picture of the claimant's impairment. It may help reduce the number of CEs required. However, CEs will still be needed to supplement the longitudinal picture when that picture is incomplete or lacking in sufficient detail.

Question 31: Do the new evaluation guidelines really provide a more precise measure of severity?

Answer: Yes, they do. Besides documenting the presence of a mental disorder, the "B" criteria assess functional limitations in areas related to work activities. The PRTF further assists in determining the degree of functional limitation and the new MRFC form much more precisely aids in determining RFC.

Question 32: What if a claimant fails to cooperate due to his condition?

Answer: In many cases of mental impairment, the claimant's failure to cooperate may well be due to his/her impairment. In such cases the DDS must take extra steps to get the full range of necessary information. This may include a psychiatrist contacting the claimant directly for the additional information. (POMS DI 00401.110E3 and DI 00401.005A.5.)

Question 33: When longitudinal evidence is in conflict with a CE, is the longitudinal evidence given more weight, since the CE is a "snapshot"?

Answer: This varies from case to case. Each case must be evaluated based on the total evidence. If there are clear conflicts in the evidence, it is sometimes necessary to obtain additional evidence, e.g., a second mental status CE.

Question 34: Have new processing time goals been established?

Answer: No, although case processing time may increase for the first 3 to 6 months as adjudicators and reviewers familiarize themselves with the new materials.

Question 35: Will the DO/BO be spending more time to obtain extra information about sources of evidence, daily activities, etc.?

Answer: Some increase in time may be necessary.

Question 36: What if there are no IQ tests prior to the impairment for comparison?

Answer: Prior IQ testing will not be necessary in most cases. There will be other bases for evaluating the case, including premorbid levels of vocational and social functioning, gross disparities in PIQ and VIQ, as well as non-IQ related data which will obviate any need for reference to IQ.

Question 37: Can the difference between performance and verbal scores be an IQ change?

Answer: Yes, the case as a whole, however, must be fully developed and evaluated.

Question 38: Does "persistent" mean all the time or over a longitudinal history?

Answer: It can be intermittent as opposed to continuous and still be persistent. In either case, longitudinal development is necessary.

Question 39: The Halstead-Teitan and Luria Nebraska are expensive tests. Has this been cleared with the Office of Management and Budget (OMB)?

Answer: The regulations have been approved by the OMB. The Luria Nebraska and Halstead-Reitan are only cited as examples of neuropsychological tests that can be used in 12.02A7. Other neuropsychological tests may also be useful in connection with 12.02A7. However, if these tests have been completed by the claimant, they certainly should be obtained from the treating sources.

Question 40: What are "work-like settings" and how do we identify and develop these?

Answer: This is broadly interpreted to be any setting or situation likely, in any way, to challenge or stress the claimant.

Question 41: Regarding 12.03C, what if the person has never tried to live outside a sheltered or supportive environment?

Answer: Attempts to live outside a sheltered environment are not necessary to establish a meeting of listing 12.03C. Such claimants have considerable anecdotal data to indicate that they are, in general, incapable of sustained and independent functioning outside of a sheltered, supportive, structured or supervised setting.

Question 42: Can living at home be a supportive living situation?

Answer: Yes, living at home could be considered a supportive living situation in some cases. However, it would be necessary to have sufficiently detailed evidence to conclude that the family situation does provide the highly structured and supportive setting referred to in section F of the preamble to the listings. We will not presume that a family setting is structured unless certain situations are present, e.g., the family setting greatly reduces the mental demands on the impaired individual through setting a routine, giving medication at specified times, and providing crisis intervention when required.

Question 43: How can we determine restrictions when someone has always lived in the family home?

Answer: It is usually necessary to obtain detailed anecdotal material, in addition to mental status evidence, reviewed on a longitudinal basis, particularly in the context of the claimant's ability to function independently (e.g., autonomously, on a self-generated, self-directed basis), noting the degree of supervision, support, structure and shelter the claimant requires

to function. The claimant's response to changes in stress, even in the home setting, is relevant. In a very small number of cases, a workshop evaluation may be necessary.

Question 44: Will the "C" criteria apply only to schizophrenics and not manic depressives?

Answer: No. The 12.03C criteria can apply where clinically relevant and appropriate to other diagnostic categories on an equivalent basis.

Question 45: Can a schizoaffective disorder be evaluated under "C"?

Answer: Yes.

Question 46: Must we obtain more than 12 months of documentation for 12.03C?

Answer: More than 12 months documentation does not necessarily have to be obtained, especially when using listing 12.03C1. In many cases, 12 months of actual documentation may be sufficiently clear as to reasonably predict the equivalent of 3 or more episodes in a year, of 2 weeks or more duration. However, at least 24 months of documentation is required to demonstrate that the claimant will be unable to function outside a structured setting for a 2-year period, and thus meet the requirements in listing 12.03C2.

Question 47: Do the 2 years have to be continuous or can there be "in and out" periods?

Answer: There can be "in and out" periods. For example, if the claimant deteriorates or decompensates when out of a sheltered or supportive setting even for 3 to 4 months at a time, this would meet/equal the intent of the listing if it occurred over a 2-year period.

Question 48: Does "repeated episodes" mean three or more in a year?

Answer: Yes.

Question 49: Why is 2 years required when the duration requirement is only 12 months?

Answer: These are two different subjects. The 2-year requirement is present to establish a requisite level of severity, likely to be descriptive of listing level severity.

Question 50: The criminally insane may be institutionalized by the court. How do we determine their need to be there?

Answer: A mental status, psychiatric history, and a longitudinal review of functional limitations will allow us to evaluate these cases.

Question 51: Since 12.04 does not have a "C", doesn't it penalize the claimant to use 12.04 rather than 12.03?

Answer: No. In cases involving 12.04 type diagnostic categories which include the presence of "C" type functional limitations, equalling the listings can typically be found under listing 12.03C.

Question 52: What about a person who appears to meet but is not under treatment? Someone who has improved with treatment in the past?

Answer: There are no practical treatment requirements for mental impairments. Treatment is often not accessible or sometimes may not be efficacious. Noncompliance with treatment for mental impairments would frequently be found to be "good cause" given the claimant's mental status and psychiatric history. Significant numbers, if not a clear majority of mental impairment claimants, either do not or can not comply because of the signs or symptoms of their impairment, and/or there is no immediately accessible, efficacious treating source. The fact that someone has improved with treatment in the past does not prove or establish that current non-compliance is without "good cause."

Question 53: How can the validity of IQ scores be determined?

Answer: Validity of IQ scores can be determined by establishing a longitudinal view of the claimant's overall ability to sustain independent function as based on activities, social relations, etc., in the context of the claimant's psychiatric history.

Question 54: What constitutes a second significant impairment under 12.05C?

Answer: A second impairment under listing 12.05C would be any severe mental or physical impairment other than the retardation itself which imposes additional and significant work-related limitations of function.

Question 55: What do we look for when autism is not accompanied by a decreased IQ?

Answer: If an autistic individual does not have a decreased IQ, then he/she must have gross deficits of social and communicative skills with two of the four "B" criteria.

Question 56: How are autistics tested?

Answer: Mental status exam and psychiatric history is critical to the evaluation of autism. A very wide range of psychological tests may show autism. However, autistics often have extreme difficulty even taking tests. In such cases, formal psychological testing is clearly irrelevant. A complete and detailed review of social functioning and other daily activities, particularly in the context of independence and appropriateness of performance, is usually necessary.

Question 57: What does "maintaining social functioning" mean in relation to someone with an IQ of 60? Do we mean the same social functioning as a normal person?

Answer: "Marked difficulties in maintaining social functioning" is the same as referred to in "B2" of the listing. This is substantively similar to the old "B" listing which referred to "seriously impaired ability to relate to other people."

Question 58: The listing refers to "scores obtained on other tests." Aren't we going to use the same tests as in the past?

Answer: Yes, in general, but we are not precluding other tests as appropriate.

Question 59: If a person is currently in treatment, would they meet the duration requirement?

Answer: Treatment, per se, is no indication whatsoever of severity (minimal and maximal), and this, in and of itself, does not suggest for or against satisfying the duration requirement.

Question 60: Some people may not be observed when having a panic attack. How can this be documented?

Answer: Corroborative data from medical or non-medical sources will satisfy the intent of the requirements, if in sufficient detail.

Question 61: Haven't there been significant recent developments in treatment for panic attacks so that duration would not be met?

Answer: Isolated individual panic attacks would usually not satisfy the duration requirements. The frequency and duration of the attacks and the length of history of the attacks would be considered in determining the overall duration.

Question 62: Isn't 12.07 easy to fake?

Answer: No, listing 12.07 is not easy to fake if full documentation is present, i.e., mental status, psychiatric history, a detailed long-term review of functional limitations, and where necessary, psychological tests.

Question 63: Does "pathological dependence" mean drug or alcohol dependence?

Answer: It can in some circumstances. However, the primary listing for substance dependence is 12.09. Listing 12.08A5, in general, refers to dependent personalities irrespective of drug or alcohol dependence.

Question 64: What does "subjective distress" mean?

Answer: Subjective distress is distress as noted by the claimant (him or herself), not necessarily dependent on or correlated with the social environment.

Question 65: How do we evaluate a somatoform disorder if they are not being treated?

Answer: The same way we evaluate any other mental impairment when there is no current treatment, which is probably the case in 30 to 50 percent of mental impairment cases. In such cases CE data will probably be necessary, including the possibility of more than one purchased mental status or psychological test review.

Question 66: Why can't the "C" criteria be used with the other listings?

Answer: The "C" criteria were developed to meet the circumstances most often encountered in the case of the individual with chronic schizophrenia whose symptoms are largely attenuated but whose functioning remains marginal. Under the concept of equivalency, presumably the "C" criteria could be applicable in other disorders based on medical judgment.

Question 67: How can part "B" of the listings be completed for a street person?

Answer: Part "B" of the listings can only be completed by full development for such factors as to appropriateness, independence of performance, overall quality (e.g., consistency, usefulness, routineness and effectiveness of activities, and social relations), sustainability, and longitudinality of function. Where there are deficiencies in concentration, persistence, and pace, or where there are episodes of deterioration, these must be evaluated in the context of their frequency, duration, intensity, and effect. In some cases, this data may need to be obtained by a face-to-face visit by a social worker or nurse.

B. PRTF Questions

Question 1: Should we use a separate PRTF for both alleged onset of disability (AOD) and established onset of disability (EOD) when they are significantly different?

Answer: No, do not use a separate PRTF. Explain the disparity under part II.

Question 2: Where should the PRTF be filed in the folder?

Answer: The PRTF should be filed on the left hand side of the folder.

Question 3: How is the PRTF completed for mental retardation with IQ 70-84? Should "other" be checked on page 6 and nothing on page 11? Then check "RFC Necessary" on the medical summary?

Answer: Section IIID (listing 12.05) item 5 "(Other)" can be used for IQs 70-84. Functional restrictions, assuming there are some, should be noted under section IVA of the PRTF. An RFC assessment would be necessary if section IVA substantiates the existence of a severe impairment.

Question 4: There is no provision for disabled widow(er)s benefit (DWB) cases on the medical summary page.

Answer: DWB cases can be listed under any of the medical dispositions specified in Part IA. However, if the disabled widow(er) has a severe impairment which does not meet or equal a listed impairment, it is necessary to modify item IA6 to fit that situation by crossing out the words "RFC ASSESSMENT NECESSARY."

Question 5: Shouldn't IA6 read ". . . severe mental imp. . .?"

Answer: No, the PRTF is only used for mental impairments. If no mental impairment was present, a PRTF would generally not be used. If there is a severe physical impairment and a not severe mental impairment present, a mental RFC must still be completed.

Question 6: Shouldn't IA8 read "Insufficient medical evidence to rate severity?"

Answer: Section IA8 notes within itself "(i.e., a programmatic documentation deficiency is present)."

Question 7: Does zero have to be entered in IVB of the PRTF or can it be left blank?

Answer: A zero must be entered in section IVB.

Question 8: Does the PRTF have to be completed by a psychiatrist or psychologist?

Answer: Yes. At the initial and reconsideration levels, the reviewer who completes and signs the PRTF must either be a psychiatrist or psychologist as defined in POMS DI 00401.562.

Question 9: Is a new PRTF completed at the recon level?

Answer: Yes. See above.

Question 10: Will the review component's medical consultant staff complete the PRTF?

Answer: Yes, the review component's medical consultant will complete a PRTF. However, we are considering if the need exists for the consultant to complete an entirely new PRTF at the regional office (RO) and central office (CO) (i.e., should the consultant only review the DDS completed

PRTF or should the consultant complete a new PRTF). For the present moment, RO consultants must complete a PRTF.

Question 11: What should examiners say to the consultant on the discussion sheet?

Answer: Examiners should not write on section II of the PRTF. The PRTF is to be prepared *exclusively* by the psychiatrist or psychologist. Examiner messages, questions, and issues can be conveyed to the medical staff via other methods.

Question 12: Can examiners complete the summary page of the PRTF?

Answer: No, the PRTF is to be completed in its entirety by a psychiatrist or psychologist.

Question 13: When more than one PRTF is needed, can we complete only part of the subsequent PRTF?

Answer: The DDS should place only one PRTF in file for each level of review, i.e., one for initial claims and another for reconsiderations. Preliminary or tentative PRTFs should be discarded once a final one is completed.

Question 14: Is it possible to have more than one PRTF at the same level of adjudication?

Answer: Yes. If the disposition of a the first PRTF was "insufficient evidence," a second PRTF would be completed when sufficient evidence was obtained. However, the preliminary PRTF should be discarded once a final one is completed.

Question 15: Has the PRTF been studied for consistency?

Answer: We are doing this now. This is one of the purposes of the case bank study.

Question 16: If emotional/mental problems are simply alleged or mentioned in other evidence, does the PRTF have to be completed?

Answer: Yes, in general, development of the mental disorder should be undertaken and a PRTF should be completed.

Question 17: Does a PRTF need to be completed if a pain clinic is involved?

Answer: Yes, if a medically determinable mental impairment is likely to be present, which may be the case with claimants who attend pain clinics.

Question 18: Is the PRTF necessary if a psychiatric CE shows no impairment?

Answer: A PRTF should be completed since it will aid in deciding if there is or is not a medically determinable mental impairment.

Question 19: Should the face sheet of the PRTF show the listing which is met or equalled and all subsections of that listing which apply?

Answer: Yes; section IA3 and IA4 should show the appropriate listing and subsections.

C. RFC Questions

Question 1: Why does the tape so strongly emphasize the RFC statement be only in positive terms? In many instances the adjudicator needs to know specific limitations as well as capabilities in order to determine the occupational base or cite appropriate jobs.

Answer: RFC refers to capacities, i.e., what the claimant can do, not what he/she cannot do. This does not preclude the noting of specific limitations.

Question 2: What is the difference for vocational purposes between "moderate" and "marked" limitation? If any of the basic mental demands of work are checked markedly limited, wouldn't this preclude all work?

Answer: "Marked" implies there is no practical, useful, sustained capacity for that item. "Moderate" is more than "not significantly limited" but not as limited as "marked." More importantly the boxes and columns of part I of the MRFC constitute only a work sheet or scratch sheet from which the physician later describes the RFC in the narrative under part III of the MRFC. The narrative itself is the MRFC, not the boxes with checks.

Question 3: How do you translate symptoms into work activities?

Answer: Symptoms themselves should not be translated into work activities. Signs, symptoms, findings, functional limitations and effects of treatment, all evaluated on a longitudinal basis, provide a context and data base for evaluating "B3," "B4," and RFC.

Question 4: Is it the DDS psychiatrist who decides to order a workshop evaluation?

Answer: In general, the DDS medical consultant should, in collaboration with the DDS examiner, make a team decision in requesting work evaluations. Based upon comments received following publication in the *Federal Register* of proposed work evaluation policy guidelines, refinements to these guidelines are being developed. These will indicate the circumstances under which work evaluations should be obtained.

Question 5: We need more guidelines for workshop evaluations. How long should they be? What kind of information should they provide?

Answer: In general, workshop evaluations should not be more than 5 days in length. They should provide the kind of data necessary to evaluate the "B" criteria of the listings and to complete section IVA of the PRTF and the MRFC. These specific issues should be explicitly raised with the workshop provider prior to ordering it. (See POMS DI 00401.125.C.)

Question 6: Whose responsibility is the conclusive RFC?

Answer: The RFC is the responsibility of the psychiatrist or psychologist in terms of completion and signature. Examiners, however, must be able to apply the functional statement provided by the physician to job requirements to determine the capacity to work.

Question 7: Will there be more training for proper interpretation of the RFC and deciding what jobs a person can and cannot do?

Answer: A workgroup of CO, RO and DDS participants is currently at work on this.

Question 8: Can a file have more than one RFC form?

Answer: Yes. If evidence in file is insufficient to permit the psychiatrist/psychologist to make an assessment of the critical functional capacities, he/she will record the medical development to be undertaken in section II of the MRFC. When the additional development is obtained, a new MRFC must be completed.

Question 9: If one item in part A of the RFC is checked "markedly limited," would you still need to check the other two?

Answer: Yes, all items must be completed.

Question 10: Shouldn't the PRTF and RFC be consistent on functional items?

Answer: The PRTF measures impairment severity (i.e., functional limitations). The RFC measures functional capacity. Therefore, what the PRTF and RFC measure are different sequentially and conceptually, thus different terms are appropriate.

Question 11: Wouldn't you need two RFCs for different time periods if the case is concurrent and there is a date of last insured (DLI) issue?

Answer: Probably.

Question 12: The RFC form has many more categories. Doesn't this make it more difficult to allow a case?

Answer: No, the RFC form will allow a more comprehensive evaluation of RFC and will enhance well documented decisions.

Question 13: What about the person who simply can't produce?

Answer: Claimants who can't minimally function because of a medically determinable mental impairment are usually allowable.

Question 14: Can we send a list of the RFC criteria to CE providers?

Answer: Yes.

Question 15: Will the regional medical consultant staff use the same RFC form?

Answer: The regional medical consultant will complete his/her own SSA-4734-F4-Sup at this time. The SSA-392-F4 is currently being revised to correlate with the new MRFC.

Question 16: Should the physician give guidance in the vocational end of a case?

Answer: The physician should only supply the RFC assessemnt. It is the examiner's responsibility, see POMS DI 00401.001 and ID 401.003F, to determine what degree the individual's RFC compromises his or her occupational base.

D. Questions on DO Issues

Question 1: Will a supplemental form be developed for the DOs to use in documenting activities of daily living?

Answer: Yes, shortly a draft form will be released for comments to the regional commissioners.

Question 2: Does the DO have liability with respect to third party contacts?

Answer: Under the Privacy Act, SSA can make contact with third party sources without any liability to DO personnel. Such contacts are permissible if the third party has, or is expected to have, information relating to the claimant's eligibility for or entitlement to benefits under the Social Security Program, when the data is needed to establish the validity of evidence or to verify the accuracy of information presented by the individual. (See GN00305.025B and DI 00601.055C.2.) Therefore, the DO personnel will incur no liability in connection with the acquisition of third party evidence.

App. § 40E DSM-III Multi-Axial System**DSM-III Multi-Axial System for Evaluating Mental Impairments**

DSM-III (Diagnostic and Statistical Manual of Mental Disorders (3rd ed. 1980)) requires that each case be assessed on each of several 'axes' each of which refers to a different class of information. The first three axes provide the official diagnostic assessment.

- | | |
|----------|--|
| Axis I | -clinical syndromes |
| | -conditions not attributable to a Mental Disorder that are a focus of attention or treatment (e.g., marital problem) |
| Axis II | -Personality Disorders |
| | -Specific Development Disorders (e.g., reading or arithmetic disorder) |
| Axis III | -Physical Disorders and Conditions |
| Axis IV | -Severity of Psychosocial Stressors |
| Axis V | -Highest Level of Adaptive Functioning in the Past Year |

App. § 40F Questions for Family Members of the Mentally Impaired Individual

Please be honest in your responses as the more complete, detailed and honest your statements are, the more helpful they will be to us in our efforts to assist _____. Please provide examples from your observations of the individual which can show what you mean. This information will not be shared with any other individual nor with _____. If you have questions regarding any of the following questions, please feel free to call us at _____.

1. What is your name and where do you live?

2. How are you related to the claimant?

3. Does the claimant live with you? If yes, for how long?

4. How often do you visit with the claimant each day or week?

5. How long do you spend with the claimant each visit?

6. How does the claimant spend an average day?

7. How much time does (s)he spend alone?

8. Did (s)he once enjoy hobbies? Is (s)he interested in them now? Give examples.

9. Does the claimant go out with friends to social activities, such as ball games, movies, etc.? Is this a change from his/her past activities?

10. How does the claimant act when (s)he meets new people? Give example.

11. Does (s)he go shopping? Does (s)he encounter any difficulties? If yes, please explain.

12. Does (s)he participate in any outside activities such as attending church? How often?

13. Does (s)he carry on understandable conversations with family members? What about others?

14. Does (s)he communicate thoughts in an understandable manner?

15. Does (s)he change subjects often and rapidly?

16. Does (s)he repeat (her)himself often?

17. Does (s)he speak in a rapid fire manner (very fast)?

18. What does (s)he generally talk about? Give examples.

19. What has (s)he told you that causes the voice or visions?

20. What do the people in the visions look like, do, say, etc.?

21. How often is (s)he experiencing voice/visions?

22. Does the claimant take medication?

23. Does this help control seeing vision and hearing voices? Does the medication control the visions/voices completely?

24. Does (s)he communicate feelings to you or others?

25. What sort of feelings does (s)he talk about? Give examples.

26. Is (s)he easily upset by ordinary conversation or events?

27. Does (s)he anger easily or is (s)he easily irritated? If yes, please give example.

28. Does (s)he perform household chores? Any problems in performing these chores?

29. Can (s)he finish these chores without you or other family members being with them or returning often?

30. Does (s)he require a lot of repeated instructions on what you want done?

31. Have you noticed any problem with memory? If yes, please give examples.

32. How long does (s)he take in doing a simple household chore? Is it longer than an average person would take? Please give example.

33. Does (s)he generally successfully complete the household chore or do you have to redo it? Please give examples.

34. Finally, in doing a household chore, does (s)he have to rest frequently? Does (s)he tell you why (s)he has to rest?

35. Is (s)he able to dress appropriately without your help or the help of another family member? Please explain.

36. Does (s)he bathe and groom himself(herself) regularly without coaxing from a family member? Please explain.

37. Does (s)he drive a car?

38. Can (s)he use public transportation without becoming nervous or having other problems? Please give example or explain.

39. Does (s)he prepare food? How often? Any problems?

40. Does (s)he cooperate with the family members? If no, please give examples.

41. Does (s)he argue with family members often or is (s)he abusive in his or her language? If yes, please give examples.

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QUESTIONS: MEMBERS

App. § 40F

42. Does (s)he perform errands for your? If yes, please give examples.
If no, why not?

43. Is (s)he able to follow instructions on what you want him or her
to do on the errand? Please give example.

44. Can you trust him or her to purchase what you want him or her to
purchase?

45. Has (s)he been fired from a job? How many times?

46. Does (s)he read the newspaper? For how long?

47. Does (s)he watch television? For how long?

48. Does (s)he eat meals with the family on a regular basis?

49. Does (s)he have a normal appetite?

50. Does (s)he sleep at night or is (s)he up all night?

51. Have you noticed any changes in his or her personality? Please
share how his or her personality has changed.

SIGNATURE

App. § 40G Mental Status Examination

The Mental Status Examination

General Observations

Appearance

Behavior

Mood-Affect

Speech

Content of Thought

Cognitive Exam

Orientation

Memory

Attention

Concentration

Abstraction

Insight

General Knowledge

Judgment

App. § 40H Bibliography

General References

Diagnostic and Statistical Manual of Mental Disorders (Third Edition), The American Psychiatric Association, 1980.

"Guidelines for Psychiatric Evaluation of Social Security Disability Claimants," 34 *Hospital and Community Psychiatry* 1044-1051 (November 1983).

Specific References

These references are intended to serve as representative samples of published works describing Social Security mental impairments as well as of the basic issues involved in the psychological assessment of Social Security disability.

Abnormal Psychology

Coleman J.C., Butcher, J.N., Carson, R.C.: *Abnormal Psychology and Everyday Life* (7th ed.), Scott, Foresman, & Co., Glenview, IL (1984).

Affective Disorders

Beck, A.T.: *Depression: Causes and Treatment*, University of Pennsylvania Press, Philadelphia, 1976.

Anxiety Disorders

Hine, F.R., Larson, R.C., Maddox, G.L., Thompson, R.J., Williams R.: *Introduction to Behavioral Science in Medicine*, Springer-Verlag, New York, 1983.

Behavioral Medicine

Pinkerton, S., Hughes, H., Wenrich, W.W.: *Behavioral Medicine*, John Wiley, New York, 1982.

Clinical Neuropsychology

Golden, C.: *Diagnosis and Rehabilitation in Clinical Neuropsychology*, C.C. Thomas, Springfield, IL, 1981.

Clinical Psychology

Sundberg, N.D., Taplin, J.R., Tyler, L.E.: *Introduction to Clinical Psychology*, Prentice-Hall, Englewood Cliffs, NJ, 1983.

Disability Evaluation

Bolles, F.: *Mental Evaluation of the Disability Claimant*, C.C. Thomas, Springfield, IL, 1973.

Drugs

Bassuk, E.L., Schoonover, S.C., Gelenberg, A.J.: *The Practitioners Guide to Psychoactive Drugs* (2d ed.), Plenum, New York, 1983.

Forensic Psychology

Shapiro, D.L., *Psychological Evaluation and Expert Testimony*, Van Nostrand Reinhold, New York, 1984.

Introduction to Psychology

Atkinson, R.L., Atkinson, R.C., Hilgard, E.R.: *Introduction to Psychology* (8th ed.), Harcourt Brace Jovanovich, New York, 1983.

Mental Retardation

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Organic Brain Syndromes

Golden, C.: *Diagnosis and Rehabilitation in Clinical Neuropsychology*, C.C. Thomas, Springfield, IL, 1981.

Pain Disorders

Melzack, R.: *The Puzzle of Pain*, Basic Books, New York, 1983

Personality Disorders

Millon, T., Everly, G.S.: *Personality and Its Disorders*, John Wiley, New York, 1985.

Psychological Tests

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Sweetland, R.C., Keyser, D.S.: *Tests: A Comprehensive Reference for Assessment in Psychology, Education, and Business*, Test Corporation of America, Kansas City, 1983.

Schizophrenic Disorders

Strauss, J.S., Carpenter, W.T.: *Schizophrenia*, Plenum, New York, 1981.

Somatoform Disorders

Pinkerton, S., Hughes, H., Wenrich, W.W.: *Behavioral Medicine*, John Wiley, New York, 1982.

Testing Issues

Standards for Educational and Psychological Tests, American Psychological Association, Washington, D.C., 1974.

Representative Journals

General Psychology

American Psychologist, American Psychological Association, Washington, D.C. 20036.

Psychology Today, American Psychological Association, Washington, D.C. 20036.

Clinical Psychology

Journal of Clinical Psychology, Clinical Psychology Publishing Co., Brandon, VT 05733.

Journal of Consulting and Clinical Psychology, American Psychological Association, Washington, D.C. 20036.

Clinical Neuropsychology

Archives of Clinical Neuropsychology, Pergamon Press, New York, NY.

Journal of Clinical Neuropsychology, Swets Publishing Co., The Netherlands.

Behavioral Medicine

Health Psychology, American Psychological Association, Washington, D.C. 20036.

Journal of Behavioral Medicine, Plenum Publishing, New York, NY 10013.

Professional Psychology

Professional Psychology, American Psychological Association, Washington, D.C. 20036.

**App. § 40I Social Security Administration Form for Mental
Residual Functional Capacity Assessment by Medical
Consultant**

**Mental Residual Functional Capacity Assessment
(Social Security Form SSA-4734-F4-SUP)**

Name _____ Social Security Number _____

Categories (From IB of the PRTF)

Assessment is for:

- ☐ Current Evaluation
☐ 12 Months After Onset
☐ Date Last Insured: _____
☐ Other: _____ (Date) to _____ (Date)

1. Summary Conclusions

This section is for recording summary conclusions derived from the evidence in file. Each mental activity is to be evaluated within the context of the individual's capacity to sustain that activity over a normal workday and workweek, on an ongoing basis. Detailed explanation of the degree of limitation for each category (A through D), as well as any other assessment information you deem appropriate, is to be recorded in Section III (Functional Capacity Assessment).

If rating category 5 [No Rateable Available Evidence] is checked for any of the following items, you must specify in Section II the evidence that is needed to make the assessment. If you conclude that the record is so inadequately documented that no accurate functional capacity assessment can be made, indicate in Section II what development is necessary, but do not complete section III.

A. Understanding and Memory

1. The ability to remember locations and work-like procedures.
Not Significantly Limited ☐ Moderately Limited ☐
Markedly Limited ☐ No Evidence of Limitation in this
Category ☐ No Rateable Available Evidence ☐
2. The ability to understand and remember very short and simple
instructions.
Not Significantly Limited ☐ Moderately Limited ☐

Markedly Limited ☐ No Evidence of Limitation in this
Category ☐ No Rateable Available Evidence ☐

3. The ability to understand and remember detailed instructions.
Not Significantly Limited ☐ Moderately Limited ☐
Markedly Limited ☐ No Evidence of Limitation in this
Category ☐ No Rateable Available Evidence ☐

B. Sustained Concentration and Persistence

4. The ability to carry out very short and simple instructions.
Not Significantly Limited ☐ Moderately Limited ☐
Markedly Limited ☐ No Evidence of Limitation in this
Category ☐ No Rateable Available Evidence ☐
5. The ability to carry out detailed instructions.
Not Significantly Limited ☐ Moderately Limited ☐
Markedly Limited ☐ No Evidence of Limitation in this
Category ☐ No Rateable Available Evidence ☐
6. The ability to maintain attention and concentration for extended
periods.
Not Significantly Limited ☐ Moderately Limited ☐
Markedly Limited ☐ No Evidence of Limitation in this
Category ☐ No Rateable Available Evidence ☐
7. The ability to perform activities within a schedule, maintain regu-
lar attendance, and be punctual within customary tolerances.
Not Significantly Limited ☐ Moderately Limited ☐
Markedly Limited ☐ No Evidence of Limitation in this
Category ☐ No Rateable Available Evidence ☐
8. The ability to sustain an ordinary routine without special supervi-
sion.
Not Significantly Limited ☐ Moderately Limited ☐
Markedly Limited ☐ No Evidence of Limitation in this
Category ☐ No Rateable Available Evidence ☐
9. The ability to work in coordination with or proximity to others
without being distracted by them.
Not Significantly Limited ☐ Moderately Limited ☐
Markedly Limited ☐ No Evidence of Limitation in this
Category ☐ No Rateable Available Evidence ☐
10. The ability to make simple work-related decisions.
Not Significantly Limited ☐ Moderately Limited ☐
Markedly Limited ☐ No Evidence of Limitation in this
Category ☐ No Rateable Available Evidence ☐

11. The ability to complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods.
- Not Significantly Limited ☐ Moderately Limited ☐
Markedly Limited ☐ No Evidence of Limitation in this Category ☐ No Rateable Available Evidence ☐

C. Social Interaction

12. The ability to interact appropriately with the general public.
- Not Significantly Limited ☐ Moderately Limited ☐
Markedly Limited ☐ No Evidence of Limitation in this Category ☐ No Rateable Available Evidence ☐
13. The ability to ask simple questions or request assistance.
- Not Significantly Limited ☐ Moderately Limited ☐
Markedly Limited ☐ No Evidence of Limitation in this Category ☐ No Rateable Available Evidence ☐
14. The ability to accept instructions and respond appropriately to criticism from supervisors.
- Not Significantly Limited ☐ Moderately Limited ☐
Markedly Limited ☐ No Evidence of Limitation in this Category ☐ No Rateable Available Evidence ☐
15. The ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes.
- Not Significantly Limited ☐ Moderately Limited ☐
Markedly Limited ☐ No Evidence of Limitation in this Category ☐ No Rateable Available Evidence ☐
16. The ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness.
- Not Significantly Limited ☐ Moderately Limited ☐
Markedly Limited ☐ No Evidence of Limitation in this Category ☐ No Rateable Available Evidence ☐

D. Adaptation

17. The ability to respond appropriately to changes in the work setting.
- Not Significantly Limited ☐ Moderately Limited ☐
Markedly Limited ☐ No Evidence of Limitation in this Category ☐ No Rateable Available Evidence ☐
18. The ability to be aware of normal hazards and take appropriate precautions.
- Not Significantly Limited ☐ Moderately Limited ☐

Markedly Limited ☐ No Evidence of Limitation in this
Category ☐ No Rateable Available Evidence ☐

19. The ability to travel in unfamiliar places or use public transportation.

Not Significantly Limited ☐ Moderately Limited ☐
Markedly Limited ☐ No Evidence of Limitation in this
Category ☐ No Rateable Available Evidence ☐

20. The ability to set realistic goals or make plans independently of others.

Not Significantly Limited ☐ Moderately Limited ☐
Markedly Limited ☐ No Evidence of Limitation in this
Category ☐ No Rateable Available Evidence ☐

II. Remarks: If you checked box 5 [No Rateable Available Evidence] for any of the preceding items or if any other documentation deficiencies were identified you MUST specify what additional documentation is needed. Cite the item number(s), as well as any other specific deficiencies and indicate the development to be undertaken.

III. Functional Capacity Assessment: Record in this section the elaborations on the preceding capacities. Complete this section ONLY after the SUMMARY CONCLUSIONS section has been completed. Explain your summary conclusions in narrative form, include any information which clarifies limitation or function. Be especially careful to explain conclusions that differ from those of treating medical sources or from the individual's allegations.

MEDICAL CONSULTANT'S
SIGNATURE

DATE

App. § 40J Social Security Rulings

Ruling 85-16

Residual Functional Capacity for Mental Impairments

TITLES II AND XVI; RESIDUAL FUNCTIONAL CAPACITY FOR MENTAL IMPAIRMENTS

This supersedes Program Policy Statement (PPS) No. 117 (Social Security Ruling (SSR) 85-8), Titles II and XVI: Residual Functional Capacity (RFC) for Mental Impairments (which superseded PPS No. 97 (SSR 83-16) with the same title).

PURPOSE: To state the policy and describe the issues to be considered when an individual with a mental impairment requires an assessment of the residual functional capacity (RFC) in order to determine the individual's capacity to engage in basic work-related activities.

CITATIONS (AUTHORITY): Sections 223(d), 216(i) and 1614(a) of the Social Security Act, as amended; Regulations No. 4, Subpart P, sections 404.1545, 404.1546, and Appendix 1, Part A, section 12.00, and Regulations No. 16, Subpart I, sections 416.945, 416.946.

INTRODUCTION: An individual whose impairment(s) meets, or is medically equivalent to, the requirements of an impairment(s) contained in the Listing of Impairments is considered unable to function adequately in work-related activities. On the other hand, an individual whose impairment is found to be not severe is considered not to be significantly restricted in the ability to engage in basic work-related activities. An individual whose impairment(s) falls between these two levels has a significant restriction in the ability to engage in some basic work-related activities. It is, therefore, necessary to determine the RFC for these individuals. This policy statement provides guides for the determination of RFC for individuals whose mental impairment(s) does not meet or equal the listing, but is more than not severe.

POLICY STATEMENT:

Importance of RFC Assessments in Mental Disorders

Medically determinable mental disorders present a variable continuum of symptoms and effects, from minor emotional problems to bizarre and dangerous behavior. However, in determining the impact of a mental disorder on an individual's capacities, essentially the same impairment-related medical and nonmedical information is considered to determine

(Rel.3-12/86 Pub.637)

whether the mental disorder meets listing severity as is considered to determine whether the mental impairment is of lesser severity, yet diminishes the individual's RFC. For impairments of listing severity, inability to perform substantial gainful activity (SGA) is presumed from prescribed findings. However, with mental impairments of lesser severity, such inability must be demonstrated through a detailed assessment of the individual's capacity to perform and sustain mental activities which are critical to work performance. Conclusions of ability to engage in SGA are not to be inferred merely from the fact that the mental disorder is not of listing severity.

Regulation No. 4, sections 404.1545(c)/416.945(c), presents the broad issues to be considered in the evaluation of RFC in mental disorders. It states that this evaluation includes consideration of the ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers, customary work pressures in a work setting. Consideration of these factors, which are contained in section 12.00 of the Listing of Impairments in Appendix 1, is required for the proper evaluation of the severity of mental impairments.

The determination of mental RFC involves the consideration of evidence, such as:

- History, findings, and observations from medical sources (including psychological test results), regarding the presence, frequency, and intensity of hallucinations, delusions or paranoid tendencies; depression or elation; confusion or disorientation; conversion symptoms or phobias; psychophysiological symptoms; withdrawn or bizarre behavior; anxiety or tension.
- Reports of the individual's activities of daily living and work activity, as well as testimony of third parties about the individual's performance and behavior.
- Reports from workshops, group homes, or similar assistive entities.

In analyzing the evidence, it is necessary to draw meaningful inferences and allow reasonable conclusions about the individual's strengths and weaknesses. Consideration should be given to factors such as:

- Quality of daily activities, both in occupational and social spheres (see Listing 12.00, Introduction), as well as of the individual's actions with respect to a medical examination.
- Ability to sustain activities, interests, and relate to others *over a period of time*. The frequency, appropriateness, and independence of the activities must also be considered (see PPS No. 96, SSR

83-15, Titles II and XVI: Evaluation of Chronic Mental Impairments).

- Level of intellectual functioning.
- Ability to function in a work-like situation.

When a case involves an individual (except disabled widow(ers) and title XVI children under 18) who has a severe impairment(s), which does not meet or equal the criteria in the Listing of Impairments, the individual's RFC must be considered in conjunction with the individual's age, education, and work experience. While some individuals will have a significant restriction of the ability to perform some work-related activities, not all such activities will be precluded by the mental impairment. However, all limits on work-related activities resulting from the mental impairment must be described in the mental RFC assessment.

It is the responsibility of the program physician or psychologist, the disability hearing officer (DHO), the administrative law judge (ALJ), or the Appeals Council (AC) member to identify the pertinent evidence from medical and nonmedical reports and to make findings as to the individual's ability to perform work-related activities (RFC). The determination of impairment severity and the resulting RFC constitute the medical evaluation of the mental disorder. The determination of "disability," however, depends upon the extent to which the individual has the vocational qualifications to perform work, in light of the restrictions described in the RFC assessment.

Evaluation of Medical and Other Evidence

Medical evidence is critical to determinations of disability. It provides medical history, test results, examination findings, and observations, as well as conclusions of medical sources trained and knowledgeable in the diagnosis and treatment of diseases and disorders.

Reports from psychiatrists and other physicians, psychologists, and other professionals working in the field of mental health should contain the individual's medical history, mental status evaluation, psychological testing, diagnosis, treatment prescribed and response, prognosis, a description of the individual's daily activities, and a medical assessment describing ability to do work-related activities. These reports may also contain other observations and opinions or conclusions on such matters as the individual's ability to cope with stress, the ability to relate to other people, and the ability to function in a group or work situations.

Medical documentation can often give clues as to functional limitation. For example, evidence that an individual is markedly withdrawn or seclu-

(Rel.3-12/86 Pub.637)

sive suggests a greatly reduced capacity for close contact and interaction with other people. The conclusion of reduced RFC in this area can then be applied to all steps of vocational assessment. For example, when the vocational assessment establishes that the claimant's past work has been limited to work requiring close contact and interaction with other people, that preceding assessment would indicate that the claimant would be unable to fulfill the requirements of his or her past work. Therefore, the determination of disability in this instance would depend on the individual's vocational capacity for other work.

Similarly, individuals with paranoid tendencies may be expected to experience moderate to moderately severe difficulties in relating to coworkers or supervisors, or in tolerating normal work pressures. The ability to respond appropriately to supervision and to coworkers under customary work pressure is a function of a number of different factors, some of which may be unique to a specific work situation.

The evaluation of intellectual functioning by a program physician, psychologist, ALJ, or AC member provides information necessary to determine the individual's ability to understand, to remember instructions, and to carry out instructions. Thus, an individual, in whom the only finding in intellectual testing is an IQ between 60 and 69, is ordinarily expected to be able to understand simple oral instructions and to be able to carry out these instructions under somewhat closer supervision than required of an individual with a higher IQ. Similarly, an individual who has an IQ between 70 and 79 should ordinarily be able to carry out these instructions under somewhat less close supervision.

Since treating medical sources often have considerable information about the development and progress of an individual's impairment, as well as information about the individual's response to treatment, evidence from treating sources should be given appropriate consideration. On occasion, the report of a current treating source may disclose other sources of medical evidence not previously reported. If so, these sources should be contacted, since it is essential that the medical documentation reflect all available sources, particularly in instances of questionable severity of impairment or inconclusive RFC. When medical source notes appear to be incomplete, recontact with the source should be made to attempt to obtain more detailed information. Every reasonable effort should be made to obtain all medical evidence from the treating source necessary to make a determination of impairment severity and RFC before obtaining evidence from any other source on a consultative basis. However, when treating medical sources cannot provide essential information, consultative examination by a treating or nontreating source may resolve the impairment or

RFC issue. Similarly, when the reports from these sources appear to be incomplete, the source should be recontacted to clarify the issues.

Other evidence also may play a vital role in the determination of the effects of impairment. To arrive at an overall assessment of the effects of mental impairment, relevant, reliable information, obtained from third party sources such as social worker, previous employers, family members, and staff members of halfway houses, mental health centers, and community centers, may be valuable in assessing an individual's level of activities of daily living. Information concerning an individual's performance in any work setting (including sheltered work and volunteer or competitive work), as well as the circumstances surrounding the termination of the work effort, may be pertinent in assessing the individual's ability to function in a competitive work environment.

Reports of workshop evaluation may also be of value in assessing the individual's ability to understand, to carry out and remember instructions, and to respond appropriately to supervisors, coworkers, and customary work pressures in a work setting. Consequently, wherever the record shows that a workshop evaluation has been performed, the report should be requested from the source. If no workshop evaluation has been done, but after complete and comprehensive documentation, genuine doubt remains as to the individual's functional capacity, consideration should be given to obtaining one. Information derived from workshop evaluations must be used in conjunction with the clinical evidence of impairment, but all conflicts between workshop evaluation evidence and the conclusions based on objective medical findings must be resolved.

Descriptions and observations of the individual's restrictions by medical and other sources (including Social Security Administration representatives, such as district office representatives and ALJ's), in addition to those made during formal medical examinations, must also be considered in the determination of RFC. However, care must be taken not to give duplicate weight to certain findings. For example, a competent psychometric assessment of intellectual functioning provides a sample referenced to established norms, or the workshop situation. Such a psychometric assessment, therefore, usually provides the same impairment-related information about functional capacity that might also be disclosed in the course of a workshop evaluation. Since the effects of the same underlying impairment(s) may be revealed in both assessment approaches, it would be incorrect to consider this duplicate representation of the same impairment to reflect separate and independent impairments. Such an approach would give the same impairment(s) double weight.

(Rel.3-12/86 Pub.637)

Observations and findings from a workshop evaluation may supplement the psychometric assessment or may raise some questions concerning the accuracy of the psychometric assessment. Whenever a significant discrepancy in conclusions between the two arises, an explanation must be given by the program physician, psychologist, ALJ, or AC member for rejecting or modifying the conclusions of the psychometric assessment or the workshop evaluation.

EFFECTIVE DATE: On publication.

CROSS-REFERENCES: Program Operations Manual System, section DI00401.592.
