Chapter 40

Mental Disorders

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§ 40.01 Introduction to Mental Disorders—Text of Listings 12.00–12.09

[1] Text of Listings 12.00–12.09

12.00 MENTAL DISORDERS

A. Introduction. The evaluation of disability on the basis of mental disorders requires documentation of a medically determinable impairment(s), consideration of the degree of limitation such impairment(s) may impose on your ability to work, and consideration of whether these limitations have lasted or are expected to last for a continuous period of at least 12 months. The listings for mental...
disorders are arranged in nine diagnostic categories: Organic mental disorders (12.02); schizophrenic, paranoid and other psychotic disorders (12.03); affective disorders (12.04); mental retardation (12.05); anxiety-related disorders (12.06); somatoform disorders (12.07); personality disorders (12.08); substance addiction disorders (12.09); and autistic disorder and other pervasive developmental disorders (12.10). Each listing, except 12.05 and 12.09, consists of a statement describing the disorder(s) addressed by the listing, paragraph A criteria (a set of medical findings), and paragraph B criteria (a set of impairment-related functional limitations). There are additional functional criteria (paragraph C criteria) in 12.02, 12.03, 12.04, and 12.06, discussed herein. We will assess the paragraph B criteria before we apply the paragraph C criteria. We will assess the paragraph C criteria only if we find that the paragraph B criteria are not satisfied. We will find that you have a listed impairment if the diagnostic description in the introductory paragraph and the criteria of both paragraphs A and B (or A and C, when appropriate) of the listed impairment are satisfied.

The criteria in paragraph A substantiate medically the presence of a particular mental disorder. Specific symptoms, signs, and laboratory findings in the paragraph A criteria of any of the listings in this section cannot be considered in isolation from the description of the mental disorder contained at the beginning of each listing category. Impairments should be analyzed or reviewed under the mental category(ies) indicated by the medical findings. However, we may also consider mental impairments under physical body system listings, using the concept of medical equivalence, when the mental disorder results in physical dysfunction. (See, for instance, 12.00D12 regarding the evaluation of anorexia nervosa and other eating disorders.)

The criteria in paragraphs B and C describe impairment-related functional limitations that are incompatible with the ability to do any gainful activity. The functional limitations in paragraphs B and C must be the result of the mental disorder described in the diagnostic description, that is manifested by the medical findings in paragraph A.

The structure of the listing for mental retardation (12.05) is different from that of the other mental disorders listings. Listing 12.05 contains an introductory paragraph with the diagnostic description for mental retardation. It also contains four sets of criteria (paragraphs A through D). If your impairment satisfies the diagnostic description in the introductory paragraph and any one of the four sets of criteria, we will find that your impairment meets the listing. Paragraphs A and B contain criteria that describe disorders we consider severe enough to prevent your doing any
gainful activity without any additional assessment of functional limitations. For paragraph C, we will assess the degree of functional limitation the additional impairment(s) imposes to determine if it significantly limits your physical or mental ability to do basic work activities, i.e., is a “severe” impairment(s), as defined in §§ 404.1520 and 416.920(c). If the additional impairment(s) does not cause limitations that are “severe” as defined in §§ 404.1520 and 416.920(c), we will not find that the additional impairment(s) imposes “an additional and significant work-related limitation of function,” even if you are unable to do your past work because of the unique features of that work. Paragraph D contains the same functional criteria that are required under paragraph B of the other mental disorders listings.

The structure of the listing for substance addiction disorders, 12.09, is also different from that for the other mental disorder listings. Listing 12.09 is structured as a reference listing; that is, it will only serve to indicate which of the other listed mental or physical impairments must be used to evaluate the behavioral or physical changes resulting from regular use of addictive substances.

The listings are so constructed that an individual with an impairment(s) that meets or is equivalent in severity to the criteria of a listing could not reasonably be expected to do any gainful activity. These listings are only examples of common mental disorders that are considered severe enough to prevent an individual from doing any gainful activity. When you have a medically determinable severe mental impairment that does not satisfy the diagnostic description or the requirements of the paragraph A criteria of the relevant listing, the assessment of the paragraph B and C criteria is critical to a determination of equivalence.

If your impairment(s) does not meet or is not equivalent in severity to the criteria of any listing, you may or may not have the residual functional capacity (RFC) to do substantial gainful activity (SGA). The determination of mental RFC is crucial to the evaluation of your capacity to do SGA when your impairment(s) does not meet or equal the criteria of the listings, but is nevertheless severe.

RFC is a multidimensional description of the work-related abilities you retain in spite of your medical impairments. An assessment of your RFC complements the functional evaluation necessary for paragraphs B and C of the listings by requiring consideration of an expanded list of work-related capacities that may be affected by mental disorders when your impairment(s) is severe but neither meets nor is equivalent in severity to a listed mental disorder.

B. Need for medical evidence. We must establish the existence of a medically determinable impairment(s) of the required duration
by medical evidence consisting of symptoms, signs, and laboratory findings (including psychological test findings). Symptoms are your own description of your physical or mental impairment(s). Psychiatric signs are medically demonstrable phenomena that indicate specific psychological abnormalities, e.g., abnormalities of behavior, mood, thought, memory, orientation, development, or perception, as described by an appropriate medical source. Symptoms and signs generally cluster together to constitute recognizable mental disorders described in the listings. The symptoms and signs may be intermittent or continuous depending on the nature of the disorder.

C. Assessment of severity. We measure severity according to the functional limitations imposed by your medically determinable mental impairment(s). We assess functional limitations using the four criteria in paragraph B of the listings: Activities of daily living; social functioning; concentration, persistence, or pace; and episodes of decompensation. Where we use “marked” 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, as long as the degree of limitation is such as to interfere seriously with your ability to function independently, appropriately, effectively, and on a sustained basis. See §§ 404.1520a and 416.920a.

1. Activities of daily living include adaptive activities such as cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring appropriately for your grooming and hygiene, using telephones and directories, and using a post office. In the context of your overall situation, we assess the quality of these activities by their independence, appropriateness, effectiveness, and sustainability. We will determine the extent to which you are capable of initiating and participating in activities independent of supervision or direction.

We do not define “marked” by a specific number of different activities of daily living in which functioning is impaired, but by the nature and overall degree of interference with function. For example, if you do a wide range of activities of daily living, we may still find that you have a marked limitation in your daily activities if you have serious difficulty performing them without direct supervision, or in a suitable manner, or on a consistent, useful, routine basis, or without undue interruptions or distractions.

2. Social functioning refers to your capacity to interact independently, appropriately, effectively, and on a sustained basis with other individuals. Social functioning includes the ability to get
along with others, such as family members, friends, neighbors, grocery clerks, landlords, or bus drivers. You may demonstrate impaired social functioning by, for example, a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, or social isolation. You may exhibit strength in social functioning by such things as your ability to initiate social contacts with others, communicate clearly with others, or interact and actively participate in group activities. We also need to consider cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity. Social functioning in work situations may involve interactions with the public, responding appropriately to persons in authority (e.g., supervisors), or cooperative behaviors involving coworkers.

We do not define “marked” by a specific number of different behaviors in which social functioning is impaired, but by the nature and overall degree of interference with function. For example, if you are highly antagonistic, uncooperative, or hostile but are tolerated by local storekeepers, we may nevertheless find that you have a marked limitation in social functioning because that behavior is not acceptable in other social contexts.

3. Concentration, persistence, or pace refers to the ability to sustain focused attention and concentration sufficiently long to permit the timely and appropriate completion of tasks commonly found in work settings. Limitations in concentration, persistence, or pace are best observed in work settings, but may also be reflected by limitations in other settings. In addition, major limitations in this area can often be assessed through clinical examination or psychological testing. Wherever possible, however, a mental status examination or psychological test data should be supplemented by other available evidence.

On mental status examinations, concentration is assessed by tasks such as having you subtract serial sevens or serial threes from 100. In psychological tests of intelligence or memory, concentration is assessed through tasks requiring short-term memory or through tasks that must be completed within established time limits.

In work evaluations, concentration, persistence, or pace is assessed by testing your ability to sustain work using appropriate production standards, in either real or simulated work tasks (e.g., filing index cards, locating telephone numbers, or disassembling and reassembling objects). Strengths and weaknesses in areas of concentration and attention can be discussed in terms of your ability to work at a consistent pace for acceptable periods of time and until a task is completed, and your ability to repeat sequences of action to achieve a goal or an objective.
We must exercise great care in reaching conclusions about your ability or inability to complete tasks under the stresses of employment during a normal workday or work week based on a time-limited mental status examination or psychological testing by a clinician, or based on your ability to complete tasks in other settings that are less demanding, highly structured, or more supportive. We must assess your ability to complete tasks by evaluating all the evidence, with an emphasis on how independently, appropriately, and effectively you are able to complete tasks on a sustained basis.

We do not define “marked” by a specific number of tasks that you are unable to complete, but by the nature and overall degree of interference with function. You may be able to sustain attention and persist at simple tasks but may still have difficulty with complicated tasks. Deficiencies that are apparent only in performing complex procedures or tasks would not satisfy the intent of this paragraph B criterion. However, if you can complete many simple tasks, we may nevertheless find that you have a marked limitation in concentration, persistence, or pace if you cannot complete these tasks without extra supervision or assistance, or in accordance with quality and accuracy standards, or at a consistent pace without an unreasonable number and length of rest periods, or without undue interruptions or distractions.

4. Episodes of decompensation are exacerbations or temporary increases in symptoms or signs accompanied by a loss of adaptive functioning, as manifested by difficulties in performing activities of daily living, maintaining social relationships, or maintaining concentration, persistence, or pace. Episodes of decompensation may be demonstrated by an exacerbation in symptoms or signs that would ordinarily require increased treatment or a less stressful situation (or a combination of the two). Episodes of decompensation may be inferred from medical records showing significant alteration in medication; or documentation of the need for a more structured psychological support system (e.g., hospitalizations, placement in a halfway house, or a highly structured and directing household); or other relevant information in the record about the existence, severity, and duration of the episode.

The term repeated episodes of decompensation, each of extended duration in these listings means three episodes within 1 year, or an average of once every 4 months, each lasting for at least 2 weeks. If you have experienced more frequent episodes of shorter duration or less frequent episodes of longer duration, we must use judgment to determine if the duration and functional effects of the episodes are of equal severity and may be used to substitute for the listed finding in a determination of equivalence.
D. Documentation. The evaluation of disability on the basis of a mental disorder requires sufficient evidence to (1) establish the presence of a medically determinable mental impairment(s), (2) assess the degree of functional limitation the impairment(s) imposes, and (3) project the probable duration of the impairment(s). See §§ 404.1512 and 416.912 for a discussion of what we mean by “evidence” and how we will assist you in developing your claim. Medical evidence must be sufficiently complete and detailed as to symptoms, signs, and laboratory findings to permit an independent determination. In addition, we will consider information you provide from other sources when we determine how the established impairment(s) affects your ability to function. We will consider all relevant evidence in your case record.

1. Sources of evidence.

a. Medical evidence. There must be evidence from an acceptable medical source showing that you have a medically determinable mental impairment. See §§ 404.1508, 404.1513, 416.908, and 416.913. We will make every reasonable effort to obtain all relevant and available medical evidence about your mental impairment(s), including its history, and any records of mental status examinations, psychological testing, and hospitalizations and treatment. Whenever possible, and appropriate, medical source evidence should reflect the medical source’s considerations of information from you and other concerned persons who are aware of your activities of daily living; social functioning; concentration, persistence, or pace; or episodes of decompensation. Also, in accordance with standard clinical practice, any medical source assessment of your mental functioning should take into account any sensory, motor, or communication abnormalities, as well as your cultural and ethnic background.

b. Information from the individual. Individuals with mental impairments can often provide accurate descriptions of their limitations. The presence of a mental impairment does not automatically rule you out as a reliable source of information about your own functional limitations. When you have a mental impairment and are willing and able to describe your limitations, we will try to obtain such information from you. However, you may not be willing or able to fully or accurately describe the limitations resulting from your impairment(s). Thus, we will carefully examine the statements you provide to determine if they are consistent with the information about, or general pattern of, the impairment as described by the medical and other evidence, and to determine whether additional information about your functioning is needed from you or other sources.
c. Other information. Other professional health care providers (e.g., psychiatric nurse, psychiatric social worker) can normally provide valuable functional information, which should be obtained when available and needed. If necessary, information should also be obtained from nonmedical sources, such as family members and others who know you, to supplement the record of your functioning in order to establish the consistency of the medical evidence and longitudinality of impairment severity, as discussed in 12.00D2. Other sources of information about functioning include, but are not limited to, records from work evaluations and rehabilitation progress notes.

2. Need for longitudinal evidence. Your level of functioning may vary considerably over time. The level of your functioning at a specific time may seem relatively adequate or, conversely, rather poor. Proper evaluation of your impairment(s) must take into account any variations in the level of your functioning in arriving at a determination of severity over time. Thus, it is vital to obtain evidence from relevant sources over a sufficiently long period prior to the date of adjudication to establish your impairment severity.

3. Work attempts. You may have attempted to work or may actually have worked during the period of time pertinent to the determination of disability. This may have been an independent attempt at work or it may have been in conjunction with a community mental health or sheltered program, and it may have been of either short or long duration. Information concerning your behavior during any attempt to work and the circumstances surrounding termination of your work effort are particularly useful in determining your ability or inability to function in a work setting. In addition, we should also examine the degree to which you require special supports (such as those provided through supported employment or transitional employment programs) in order to work.

4. Mental status examination. The mental status examination is performed in the course of a clinical interview and is often partly assessed while the history is being obtained. A comprehensive mental status examination generally includes a narrative description of your appearance, behavior, and speech; thought process (e.g., loosening of associations); thought content (e.g., delusions); perceptual abnormalities (e.g., hallucinations); mood and affect (e.g., depression, mania); sensorium and cognition (e.g., orientation, recall, memory, concentration, fund of information, and intelligence); and judgment and insight. The individual case facts determine the specific areas of mental status that need to be emphasized during the examination.

5. Psychological testing.
a. Reference to a "standardized psychological test" indicates the use of a psychological test measure that has appropriate validity, reliability, and norms, and is individually administered by a qualified specialist. By "qualified," we mean the specialist must be currently licensed or certified in the State to administer, score, and interpret psychological tests and have the training and experience to perform the test.

b. Psychological tests are best considered as standardized sets of tasks or questions designed to elicit a range of responses. Psychological testing can also provide other useful data, such as the specialist's observations regarding your ability to sustain attention and concentration, relate appropriately to the specialist, and perform tasks independently (without prompts or reminders). Therefore, a report of test results should include both the objective data and any clinical observations.

c. The salient characteristics of a good test are: (1) Validity, i.e., the test measures what it is supposed to measure; (2) reliability, i.e., the consistency of results obtained over time with the same test and the same individual; (3) appropriate normative data, i.e., individual test scores can be compared to test data from other individuals or groups of a similar nature, representative of that population; and (4) wide scope of measurement, i.e., the test should measure a broad range of facets/aspects of the domain being assessed. In considering the validity of a test result, we should note and resolve any discrepancies between formal test results and the individual's customary behavior and daily activities.

6. Intelligence tests.

a. The results of standardized intelligence tests may provide data that help verify the presence of mental retardation or organic mental disorder, as well as the extent of any compromise in cognitive functioning. However, since the results of intelligence tests are only part of the overall assessment, the narrative report that accompanies the test results should comment on whether the IQ scores are considered valid and consistent with the developmental history and the degree of functional limitation.

b. Standardized intelligence test results are essential to the adjudication of all cases of mental retardation that are not covered under the provisions of 12.05A. Listing 12.05A may be the basis for adjudicating cases where the results of standardized intelligence tests are unavailable, e.g., where your condition precludes formal standardized testing.

c. Due to such factors as differing means and standard deviations, identical IQ scores obtained from different tests do not always reflect a similar degree of intellectual functioning. The IQ scores in
12.05 reflect values from tests of general intelligence that have a mean of 100 and a standard deviation of 15; e.g., the Wechsler series. IQs obtained from standardized tests that deviate from a mean of 100 and a standard deviation of 15 require conversion to a percentile rank so that we can determine the actual degree of limitation reflected by the IQ scores. In cases where more than one IQ is customarily derived from the test administered, e.g., where verbal, performance, and full scale IQs are provided in the Wechsler series, we use the lowest of these in conjunction with 12.05.

d. Generally, it is preferable to use IQ measures that are wide in scope and include items that test both verbal and performance abilities. However, in special circumstances, such as the assessment of individuals with sensory, motor, or communication abnormalities, or those whose culture and background are not principally English-speaking, measures such as the Test of Nonverbal Intelligence, Third Edition (TONI-3), Leiter International Performance Scale-Revised (Leiter-R), or Peabody Picture Vocabulary Test—Third Edition (PPVT-III) may be used.

e. We may consider exceptions to formal standardized psychological testing when an individual qualified by training and experience to perform such an evaluation is not available, or in cases where appropriate standardized measures for your social, linguistic, and cultural background are not available. In these cases, the best indicator of severity is often the level of adaptive functioning and how you perform activities of daily living and social functioning.

7. Personality measures and projective testing techniques. Results from standardized personality measures, such as the Minnesota Multiphasic Personality Inventory-Revised (MMPI-II), or from projective types of techniques, such as the Rorschach and the Thematic Apperception Test (TAT), may provide useful data for evaluating several types of mental disorders. Such test results may be useful for disability evaluation when corroborated by other evidence, including results from other psychological tests and information obtained in the course of the clinical evaluation, from treating and other medical sources, other professional health care providers, and nonmedical sources. Any inconsistency between test results and clinical history and observation should be explained in the narrative description.

8. Neuropsychological assessments. Comprehensive neuropsychological examinations may be used to establish the existence and extent of compromise of brain function, particularly in cases involving organic mental disorders. Normally, these examinations include assessment of cerebral dominance, basic sensation and perception, motor speed and coordination, attention
and concentration, visual-motor function, memory across verbal and visual modalities, receptive and expressive speech, higher-order linguistic operations, problem-solving, abstraction ability, and general intelligence. In addition, there should be a clinical interview geared toward evaluating pathological features known to occur frequently in neurological disease and trauma, e.g., emotional lability, abnormality of mood, impaired impulse control, passivity and apathy, or inappropriate social behavior. The specialist performing the examination may administer one of the commercially available comprehensive neuropsychological batteries, such as the Luria-Nebraska or the Halstead-Reitan, or a battery of tests selected as relevant to the suspected brain dysfunction. The specialist performing the examination must be properly trained in this area of neuroscience.

9. Screening tests. In conjunction with clinical examinations, sources may report the results of screening tests; i.e., tests used for gross determination of level of functioning. Screening instruments may be useful in uncovering potentially serious impairments, but often must be supplemented by other data. However, in some cases the results of screening tests may show such obvious abnormalities that further testing will clearly be unnecessary.

10. Traumatic brain injury (TBI). In cases involving TBI, follow the documentation and evaluation guidelines in 11.00F.

11. Anxiety disorders. In cases involving agoraphobia and other phobic disorders, panic disorders, and posttraumatic stress disorders, documentation of the anxiety reaction is essential. At least one detailed description of your typical reaction is required. The description should include the nature, frequency, and duration of any panic attacks or other reactions, the precipitating and exacerbating factors, and the functional effects. If the description is provided by a medical source, the reporting physician or psychologist should indicate the extent to which the description reflects his or her own observations and the source of any ancillary information. Statements of other persons who have observed you may be used for this description if professional observation is not available.

12. Eating disorders. In cases involving anorexia nervosa and other eating disorders, the primary manifestations may be mental or physical, depending upon the nature and extent of the disorder. When the primary functional limitation is physical, e.g., when severe weight loss and associated clinical findings are the chief cause of inability to work, we may evaluate the impairment under the appropriate physical body system listing. Of course, we must also
consider any mental aspects of the impairment, unless we can make a fully favorable determination or decision based on the physical impairment(s) alone.

E. Chronic mental impairments. Particular problems are often involved in evaluating mental impairments in individuals who have long histories of repeated hospitalizations or prolonged outpatient care with supportive therapy and medication. For instance, if you have chronic organic, psychotic, and affective disorders, you may commonly have your life structured in such a way as to minimize your stress and reduce your symptoms and signs. In such a case, you may be much more impaired for work than your symptoms and signs would indicate. The results of a single examination may not adequately describe your sustained ability to function. It is, therefore, vital that we review all pertinent information relative to your condition, especially at times of increased stress. We will attempt to obtain adequate descriptive information from all sources that have treated you in the time period relevant to the determination or decision.

F. Effects of structured settings. Particularly in cases involving chronic mental disorders, overt symptomatology may be controlled or attenuated by psychosocial factors such as placement in a hospital, halfway house, board and care facility, or other environment that provides similar structure. Highly structured and supportive settings may also be found in your home. Such settings may greatly reduce the mental demands placed on you. With lowered mental demands, overt symptoms and signs of the underlying mental disorder may be minimized. At the same time, however, your ability to function outside of such a structured or supportive setting may not have changed. If your symptomatology is controlled or attenuated by psychosocial factors, we must consider your ability to function outside of such highly structured settings. For these reasons, identical paragraph C criteria are included in 12.02, 12.03, and 12.04. The paragraph C criterion of 12.06 reflects the uniqueness of agoraphobia, an anxiety disorder manifested by an overwhelming fear of leaving the home.

G. Effects of medication. We must give attention to the effects of medication on your symptoms, signs, and ability to function. While drugs used to modify psychological functions and mental states may control certain primary manifestations of a mental disorder, e.g., hallucinations, impaired attention, restlessness, or hyperactivity, such treatment may not affect all functional limitations imposed by the mental disorder. In cases where overt symptomatology is attenuated by the use of such drugs, particular attention must be focused on the functional limitations that may persist. We will consider these functional limitations in assessing the severity of
your impairment. See the paragraph C criteria in 12.02, 12.03, 12.04, and 12.06.

Drugs used in the treatment of some mental illnesses may cause drowsiness, blunted effect, or other side effects involving other body systems. We will consider such side effects when we evaluate the overall severity of your impairment. Where adverse effects of medications contribute to the impairment severity and the impairment(s) neither meets nor is equivalent in severity to any listing but is nonetheless severe, we will consider such adverse effects in the RFC assessment.

H. Effects of treatment. With adequate treatment some individuals with chronic mental disorders not only have their symptoms and signs ameliorated, but they also return to a level of function close to the level of function they had before they developed symptoms or signs of their mental disorders. Treatment may or may not assist in the achievement of a level of adaptation adequate to perform sustained SGA. See the paragraph C criteria in 12.02, 12.03, 12.04, and 12.06.

I. Technique for reviewing evidence in mental disorders claims to determine the level of impairment severity. We have developed a special technique to ensure that we obtain, consider, and properly evaluate all the evidence we need to evaluate impairment severity in claims involving mental impairment(s). We explain this technique in §§ 404.1520a and 416.920a.

12.01 Category of Impairments, Mental

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, or when the requirements in C 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 liability (e.g., explosive temper outbursts, sudden crying, etc.) and impairment in impulse control; or
7. Loss of measured intellectual ability of at least 15 I.Q. points from premorbid levels or overall impairment index clearly within the severely impaired range on 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. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of a chronic organic mental disorder of at least 2 years’ duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:
1. Repeated episodes of decompensation, each of extended duration; or
2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
3. Current history of 1 or more years’ inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

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. Marked difficulties in maintaining concentration, persistence, or pace; or
   4. Repeated episodes of decompensation, each of extended duration;
   OR
C. Medically documented history of a chronic schizophrenic, paranoid, or other psychotic disorder of at least 2 years’ duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:
   1. Repeated episodes of decompensation, each of extended duration; or
   2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
   3. Current history of 1 or more years’ inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

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, or when the requirements in C 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 distractibility; 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. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of a chronic affective disorder of at least 2 years’ duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or
2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or

3. Current history of 1 or more years’ inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

12.05 Mental retardation: Mental retardation refers to significantly subaverage general intellectual functioning with deficits in adaptive functioning initially manifested during the developmental period; i.e., the evidence demonstrates or supports onset of the impairment before age 22.

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 through 70 and a physical or other mental impairment imposing an additional and significant work-related limitation of function;

   OR

   D. A valid verbal, performance, or full scale IQ of 60 through 70, 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. Marked difficulties in maintaining concentration, persistence, or pace; or

      4. Repeated episodes of decompensation, each of extended duration.

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. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration.

OR

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

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 at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration.

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 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 at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration.

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.
F. Liver damage. Evaluate under 5.05.
G. Gastritis. Evaluate under 5.00.
H. Pancreatitis. Evaluate under 5.08.
I. Seizures. Evaluate under 11.02 or 11.03.

12.10 Autistic disorder and other pervasive developmental disorders: Characterized by qualitative deficits in the development of reciprocal social interaction, in the development of verbal and nonverbal communication skills, and in imaginative activity. Often, there is a markedly restricted repertoire of activities and interests, which frequently are stereotyped and repetitive.

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

A. Medically documented findings of the following:
   1. For autistic disorder, all of the following:
      a. Qualitative deficits in reciprocal social interaction; and
      b. Qualitative deficits in verbal and nonverbal communication and in imaginative activity; and
      c. Markedly restricted repertoire of activities and interests;
      OR
   2. For other pervasive developmental disorders, both of the following:
      a. Qualitative deficits in reciprocal social interaction; and
      b. Qualitative deficits in verbal and nonverbal communication and in imaginative activity;

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. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration.

[2] Historical Background

No single Social Security Listing has undergone more scrutiny and been the cause of more controversy than the Listings on Mental Disorders.\(^1\) The impetus for the Social Security Administration to critically review and then change these standards came first from the case of Mental Health Ass'n of Minnesota v. Schweiker,\(^2\) and from a General Accounting Office statement in 1983.\(^3\) In the Mental Health Ass'n case it was found that Social Security had engaged in a conscious, systematic attempt to remove thousands of mentally impaired individuals from the disability rolls by denying claims involving individuals under the age of 50 who did not have a mental impairment that met one of the criteria in the mental impairment Listings.\(^4\)

The General Accounting Office statement reported that:

1. the mental impairments Listings were overly restrictive;
2. there was inadequate development of mental impairment cases;
3. state agencies had insufficient psychiatric resources to properly evaluate these cases; and
4. there was an overreliance on consultative examinations.\(^5\)

The most decisive impetus came from the American Psychiatric and Psychological Associations which criticized the mental impairments Listings for being overly restrictive and unrealistic. Responding to this criticism, and looking for a means of correcting this critical problem, the Social Security Administration turned to the American Psychiatric and Psychological Associations to design a new mental impairments Listing.

Congress responded to other criticisms by requiring, in the Disability Benefits

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1 20 C.F.R. Part 404, Subpart P, Appendix 1, Part 1, Listing 12.00 through Listing 12.09. For text of these Listings, see § 40.01[1]; see also Vol. 3, Code of Federal Regulations.
3 General Accounting Office statement by Peter J. McCough, Associate Director, Human Resources Division, to the Special Committee on Aging of the Senate (April 7, 1983).
5 General Accounting Office statement by Peter J. McCough, Associate Director, Human Resources Division, to the Special Committee on Aging of the Senate (April 7, 1983).
Reform Act of 1984,\(^6\) that Social Security rely more heavily on the records of the treating physicians and on records developed over time by other treating sources, and that the state disability determination services, which have the responsibility to evaluate all disability claims at the first two levels of review, hire psychiatrists and psychologists to examine each case involving a mental impairment.

The Listings released in 1985 were adopted almost verbatim from the Diagnostic and Statistical Manual—III (DSM-III). This was a significant improvement over the old Listings, but now the psychiatric community has again revised their diagnostic criteria in the DSM-IV.

\(^{(Text\ continued\ on\ page\ 40-25)}\)

\(^6\) Public Law No. 98–460, 98 Stat. 1794.
INTRODUCTION § 40.01[3]

Considered a major breakthrough for Social Security when introduced in 1985, the current Listings embraced new categories, including affective disorders at Listing 12.04, somatoform disorders at Listing 12.07, personality disorders at Listing 12.08 and substance addiction disorders at Listing 12.09. They continue their “chinese menu” approach used in previous Listings in that the claimant’s mental disorder must be characterized by one or more of the clinical findings listed in paragraph A of the relevant Listing and must produce at least two functional restrictions described in paragraph B of the Listing.

Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner, and repeated episodes of deterioration and decompensation in work or work-like settings that cause the individual to withdraw from the situation or to experience exacerbations of signs or symptoms are some of the key functional limitations described in paragraph B of the Listings produced in 1985 and currently used by Social Security.

Other comparable functional restrictions are discussed in new Rulings issued in July of 1996, which include mental limitations or restrictions that are key to the performance of any form of work, including unskilled sedentary work. If there is a substantial loss of the ability to meet any of the basic work-related mental functions found in that Ruling, the individual is considered disabled. Those limitations are as follows:

1. Understanding, remembering and carrying out simple instructions;
2. Making judgments that are commensurate with the functions of unskilled work—i.e., simple work-related decisions;
3. Responding appropriately to supervision, co-workers and usual work situations;
4. Dealing with changes in a routine work setting.7

[3] Special Rule for Re-opening Cases Involving Mental Incapacity

The Social Security Administration has issued a special ruling on re-opening cases involving mental incapacity. Social Security Ruling 91-5p allows for re-opening of a case involving mental capacity at any time if the claimant can establish that he or she has one of the following factors:8

1. Inability to read or write;
2. Lack of facility with the English language;
3. Limited education;
4. Any mental or physical condition that limits the claimant’s ability to do things for himself or herself.

In determining whether one of these factors exists, the adjudicator is advised to resolve any reasonable doubt in favor of the claimant. If the adjudicator determines that good cause does not exist for re-opening, the adjudicator must dismiss the case and state his or her rationale for not finding good cause for re-opening.9

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7 Social Security Ruling 96-99p (see Ch. 9, App. § 9A[4]) and Social Security POMS DI24510.085.
8 Social Security Ruling 91-5p. See App. § 401[4].
9 See App. § 18C.
§ 40.02 The Social Security Mental Impairment Listings and Diagnostic and Statistical Manual Edition IV (DSM-IV)

[1] Introduction

The need for nomenclature in the classification of mental disorders has culminated in the fourth edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders*, or DSM-IV. The DSM-IV was published officially in May 1994, and is the official text used by mental health professionals to describe a wide variety of mental disorders. It was designed for all mental health clinicians of many different theoretical orientations and in many different settings, i.e., inpatient, outpatient, community populations. It was designed as a tool for collecting and communicating accurate information about mental health disorders across disciplines and settings and allowing a coherent and consistent manner to portray that information. Its predecessors included DSM I, II, III, and III-R since 1952.

The DSM-IV seeks to reduce the dichotomy that exists between mental and physical disorders. It attempts to identify the physical elements in mental diseases and the mental elements in physical diseases. As such many modifiers are used in the descriptive process so that the reader can understand a mental disorder in the context of a potential physical disorder as well.

The DSM-IV is a major departure from its immediate predecessor, the DSM-III-R, in terms of organization. The DSM-III-R followed a dimensional model of classification. In a dimensional model, clinical presentations are given specific descriptions that define clear boundaries from one diagnostic criteria set from another. In the DSM-IV, a categorical classification system was used. In this system, it assumes that no diagnostic category is a discrete entity with absolute boundaries dividing it from other diagnostic categories. In the DSM-IV, there is a basic assumption that all individuals described as having the same mental disorder are not necessarily alike in all important ways. This inherently sets up a conflict with the social security criteria in section 12.00 because these criteria were based on the DSM-III published in 1980 and now are two revisions behind what is used in clinical practice. Therefore, many of the social security criteria are no longer being used by mental health professionals, or have been modified to such an extent that they are no longer relevant in the current DSM-IV context.

When using this chapter, readers should bear in mind that there are vast differences between social security criteria and the current DSM-IV criteria.

[a] Organization

The DSM-IV uses a multi axial system to make a diagnosis, but there have been some significant departures from its predecessors. The five axes are as follows:

Axis I

Clinical Disorders

Other conditions that may be a focus of Clinical Attention

Axis II

Personality Disorders
Mental Retardation

Axis III

General Medical Conditions

Axis IV

Psychosocial and Environmental Problems

Axis V

Global Assessment of Functioning

[i] Axis I

Axis I is for reporting all the various disorders that a person may be suffering from except for the Personality Disorders and Mental Retardation which are reported on Axis II. If an individual is suffering from more than one Axis I disorder, then the disorders are listed sequentially. The major groups of Axis I disorders are as follows:

- Disorders usually first diagnosed in infancy, childhood, or adolescence
- Delirium, Dementia and Amnestic and other cognitive disorders
- Mental Disorders due to a General Medical Condition
- Substance Related Disorders
- Schizophrenia and Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Sexual and Gender Identity Disorders
- Eating Disorders
- Sleep Disorders
- Impulse Control Disorders
- Adjustment Disorders
- Other Conditions that may be a focus of clinical attention

[ii] Axis II

Axis II is for reporting Personality Disorders and Mental Retardation. It can also be used to note maladaptive behaviors or traits without meeting criteria for a specific disorder, i.e., noting narcissistic personality traits. An individual can have more than one Axis II diagnoses and these can also be listed sequentially. The Axis II disorders are as follows:

\[1\] See App. § 40C.
- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder
- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder
- Avoidant Personality Disorder
- Dependent Personality Disorder
- Obsessive Compulsive Personality Disorder
- Personality Disorder Not Otherwise Specified
- Mental Retardation

[iii] **Axis III**

Axis III is for reporting current general medical conditions that are potentially relevant to the understanding of the individual’s mental condition. The general medical conditions are too numerous to list. It should be noted that an individual can have several Axis III diagnoses.

[iv] **Axis IV**

Axis IV is for describing psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of the Axis I and II condition. These psychosocial stressors can be both positive and negative events and are related to the Axis I or II diagnosis. This listing is a departure from DSM-III-R and should be specifically noted. The Axis IV categories are as follows:
- Problems with primary support group
- Problems related to the social environment
- Educational problems
- Occupational problems
- Housing problems
- Economic problems
- Problems with access to health care services
- Problems related to interaction with the legal system/crime
- Other psychosocial and environmental problems

[v] **Axis V**

Axis V is for reporting in the clinician’s judgment the individual’s overall level of
functioning. This is done using the Global Assessment of Functioning (GAF) Scale.\textsuperscript{2}

[2] The Global Assessment of Functioning Scale (GAF) and the Social and Occupational Functioning Assessment Scale (SOFAS)

The GAF can be used in treatment planning and measuring the impact of treatment over time. It is important to note that the GAF rates only psychological, social, and occupational functioning. It does not include impairment in functioning due to physical or environmental limitations. When it is necessary to track social and occupational disability independent of psychological symptoms, it would be better to use the SOFAS.\textsuperscript{3}

A psychiatrist arrives at a GAF score by clinical interview. After the interview, an individual is assigned a numeric score based upon the descriptions given with each value. Generally, a score of 70 and above is an individual who is functioning well. Scores in the 50 to 60 range are transitional, and an individual may or may not be able to work with these scores. Generally, scores below 50 are of individuals with severe impairment both psychologically and occupationally.

An example of the multi axial evaluation may be as follows:

- Axis I
  - Major Depression, single episode
  - Alcohol Abuse
- Axis II
  - Dependent Personality Disorder
- Axis III
  - Hypothyroidism
- Axis IV
  - Victim of Child Abuse
- Axis V
  - 53 current, 80 highest in the past year

[3] The Listings and the DSM-IV Criteria

[a] Organic Mental Disorders—§ 12.02

The general classification “organic mental disorders” no longer exists in the DSM-IV. Instead, the organic mental disorders have been grouped into three sections: (1) Delirium, Dementia, and Amnestic and Other Cognitive Disorders; (2) Mental

\textsuperscript{2} See Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition), The American Psychiatric Association, 1994, pp. 32, 761 (Global Assessment of Functioning Scale (GAF) and Social and Occupational Functioning Assessment Scale (SOFAS)); see also [2], below.

\textsuperscript{3} See Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition), The American Psychiatric Association, 1994, pp. 32, 761 (Global Assessment of Functioning Scale (GAF) and Social and Occupational Functioning Assessment Scale (SOFAS)).
Disorders Due to a General Medical Condition; and (3) Substance Related Disorders.

[i] Delirium

The essential feature of a delirium is a disturbance of consciousness that is accompanied by a change in cognition that cannot be accounted for by a preexisting dementia. In a delirium, the disturbance develops over a short period of time (hours to days) and tends to fluctuate during the course of the day. There is usually evidence from the history, physical or laboratory tests that the delirium is a direct physiologic consequence of a general medical condition, i.e., substance intoxication or withdrawal, toxic exposure, or ingestion. Delirium is most often associated with a disturbance of the sleep-wake cycle. This can include daytime sleepiness and nighttime agitation. The individual manifests an inability to focus or shift attention. Often, there are memory deficits and disorientation.  

[ii] Dementia

A dementia is characterized by the development of multiple cognitive deficits that are the direct result of a general medical condition or substance abuse. Memory impairment is one of several cognitive deficits that also includes the language difficulties, motor difficulties, learning difficulties, and a disturbance in following commands. These deficits must be of sufficient severity to cause impairment in occupational or social functioning and must represent a decline from a previously higher level of functioning. A diagnosis of dementia must not be made if the cognitive deficits occur during the course of a delirium. However, a delirium can occur with a preexisting dementia. Memory impairment is required to make a diagnosis of a dementia and is the major criterion.

In order to accurately assess the degree of memory impairment and other cognitive defects, several informal tests are conducted during the course of a clinical interview. These include assessments of orientation, registration, attention and calculation, recall, language, and visual motor integrity.

More formalized memory testing is possible by a trained clinical psychologist and can more accurately assess specific memory and cognitive deficits. Tests, such as the Boston Naming Test, The Delayed Recognition Span Test, The Wechsler Adult Intelligence Scale—Revised, the Mattis Dementia Rating Scale, The CERAD Figure Copying Test, are just some of the formal tests that can be conducted to assess memory and cognitive functioning.

[iii] Amnestic Disorder

Amnestic disorders are characterized by a disturbance in memory that is either due to the direct physiologic effects of a general medical condition or due to the persisting effects of a substance or medication. The difference from a dementia is the presence of memory impairment alone without the concomitant impairment in other cognitive spheres. Individuals with amnestic disorder are impaired in their ability to learn new

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4 See Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition), The American Psychiatric Association, 1994, p. 129 (Criteria for Delirium, Dementia and Amnesia).
information or are unable to recall previously learned information. The memory impairment is a sufficient severity to cause impairment in social or occupational functioning. Formal neuropsychological testing is usually helpful to objectively quantify

(Text continued on page 40-31)
the nature and extent of the memory impairment. The course of an amnestic disorder can be variable depending on the primary pathological process. Strokes, carbon monoxide poisoning, and mercury exposure can lead to more permanent disabilities, whereas nutritional deficiencies or closed head injuries can sometimes remit over time with treatment.

**PRACTICE GUIDE**

The Listing requires information regarding memory impairment or disorientation to time and place. Delirium and dementia can cause significant memory deficits as well as disorientation, impaired concentration and inability to attend. These are the clinical findings that correspond to the requirements of Listing 12.02.

As an advocate, you must ask the psychiatrist to note whether the disorder meets or equals the requirements of Listing 12.02, and ask whether there are clinical findings that are indicators of a severe impairment which are not mentioned in the Listing but which are of equivalent severity to those found in Listing 12.02.

It is important that the doctor also be asked to do a GAF or SOFA assessment and translate that into Part B criteria at 12.02. If the doctor does a Folstein Mini Mental State Exam or a full examination, there should be some information such as the serial 7’s, that can indicate whether the claimant has difficulty with concentration. It is up to you as the advocate to see that the psychiatrist’s findings are translated into the terms of the appropriate Listing.

**SPECIAL NOTE**

Neuropsychological testing is a better mechanism for determining memory loss.  

[vi]  Mental Conditions Due to a General Medical Condition

Mental disorders due to a general medical condition are characterized by the presence of mental symptoms that are thought to be the direct physiological consequence of a general medical condition usually coded on Axis III. The criteria for these conditions are as follows:

1. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition.

2. The disturbance is not better accounted for by another mental disorder.

3. The disturbance does not occur exclusively during the course of a delirium.

These disorders were previously part of the organic mental disorders in the DSM-III-R. The dichotomy between mental and physical is eliminated in the DSM-IV and, therefore, these criteria should be considered in all of the diagnostic categories to be discussed.

[vii]  Substance Related Disorders

The substances in this section include 11 classes of drugs: alcohol, amphetamine or similarly acting sympathomimetics, caffeine, cannabis, cocaine, hallucinogens, inhalants,

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5 20 C.F.R. § 404, Appendix 1, § 12.00C(3), which states in part “On mental status examinations, concentration is assessed by such tasks as having the individual subtract serial 7’s from 100.”

6 See § 40.06[3].
nicotine, opiates, phencyclidine or similarly acting arylcyclohexylamincs, and sedative, hypnotics or anxiolytics. Many prescription and over the counter medications, such as anesthetics, analgesics, antihistamines, and cardiovascular medications can cause substance related disorders, as can exposure to a wide range of chemical substances, such as heavy metals (i.e., lead, bromine, mercury, aluminum), poisons, pesticides, nerve gases, carbon monoxide, paint thinners and antifreeze.

The Substance Related Disorders are divided into the following categories:

1. Substance Use Disorders
   Substance Dependence and
   Substance Abuse

2. Substance Induced Disorders
   Substance Intoxication
   Substance Withdrawal
   Substance Induced Delirium
   Substance Induced Persisting Dementia
   Substance Induced Persisting Amnestic Disorder
   Substance Induced Psychotic Disorder
   Substance Induced Mood Disorder
   Substance Induced Anxiety Disorder
   Substance Induced Sexual Dysfunction
   Substance Induced Sleep Disorder

[b] Schizophrenic, Delusional (Paranoid), Schizoaffective and Other Psychotic Disorders—§ 12.03

The disorders in this section have psychotic symptoms as the defining feature. However, the nature of the psychotic symptoms for each of the diagnoses is different. Although classified within the same family, the diagnostic criteria, duration of illness and course and outcome are different for each of the diagnoses.

[i] Schizophrenia

The hallmark of schizophrenia is the presence of hallucinations or delusions of at least one month duration. The full diagnosis calls for a duration of the illness for at least six months. Schizophrenia typically has its onset between the late teens and mid-thirties. The lifetime prevalence of schizophrenia is between 0.5 to 1 percent. The course of the illness is one of a chronic disease with frequent exacerbations and remissions. There are no laboratory tests to aid in the diagnosis, but there are a number of functional imaging studies currently under investigation. However, they are not readily available to use by the ordinary clinician. There does appear to be a genetic element to schizophrenia in that first degree biological relatives of individuals with schizophrenia have a 10 times greater risk of schizophrenia than the general population.
Pharmacotherapy is the mainstay of treatment, and there has been an explosion of newer pharmacological agents to help keep this disorder in remission. There are several subtypes of Schizophrenia, including Paranoid, Disorganized, Catatonic, Undifferentiated, and Residual Type.\(^7\)

A Schizoaffective Disorder includes the Criterion A of Schizophrenia, but also includes a major disturbance in mood such as a major depressive or manic episode, as discussed in [c][I], below.

**[ii] Delusional (Paranoid) Disorder**

The essential feature of a Delusional Disorder is the presence of one or more non-bizarre delusions that persist for at least one month. Psychosocial functioning is variable during this illness with some individuals relatively unimpaired and others completely impaired. There are several subtypes, including:

- Erotomania—This usually involves idealized love of another individual
- Grandiose—This usually involves some great talent or insight
- Jealous—This type usually involves the unfaithfulness of a spouse or lover
- Persecutory—This involves the individual believing that he or she is being followed or poisoned
- Somatic—This usually involves the belief that one’s body is infected, malodorous, or misspelled
- Mixed—This is when no one theme predominates

The age of onset for a Delusional Disorder is generally middle or late adult life. The Persecutory type is the most common subtype, and the prognosis is generally poor.

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The DSM-IV criteria for schizophrenia are virtually identical to those found in Listing 12.03. There is a “social/occupational dysfunction” category under the DSM-IV diagnostic criteria that states that, “an individual with this diagnosis suffers marked dysfunction in the areas of work, interpersonal relations or self-care for a significant portion of the time since the onset of the disturbance.”\(^8\)

A diagnosis of schizophrenia under the DSM-IV criteria should establish that the claimant’s condition is significant enough to meet both the Part A and the Part B criteria of Listing 12.03. That should be made clear, though, in the report from a psychiatrist or psychologist.\(^9\)

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\(^7\) See *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition), The American Psychiatric Association, 1994, pp. 285-286 (Criteria on Schizophrenia and Delusional Disorder).

\(^8\) See *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition), The American Psychiatric Association, 1994, pp. 285-286 (Criteria on Schizophrenia and Delusional Disorder).

Psychotic illnesses often go into periods of remission; such remissions do not mean that the disability has ceased.\textsuperscript{10}

[c] Mood Disorders—§ 12.04

The mood disorders section is perhaps the most complex of all. It is subdivided into the following categories:

- Major Depressive Disorders
- Dysthymic Disorders
- Bipolar I Disorders
- Bipolar II Disorders
- Cyclothymic Disorders

The following modifiers describe the most recent episode:

- Mild, Moderate, Severe without psychotic features
- Severe with psychotic features
- In Partial Remission
- In Full Remission
  - Chronic
  - With Catatonic Features
  - With Atypical Features
  - With Postpartum Onset
  - With Seasonal Pattern
  - With Rapid Cycling

[i] Major Depressive Disorders

The essential feature of a Major Depressive Disorder is the presence of a persistent and sad mood daily, or nearly every day for at least two consecutive weeks and at least five out of nine symptoms as described below. The degree of impairment varies, but usually there is some significant interference on social, occupational, or other areas of functioning. No laboratory findings that are diagnostic of a Major Depressive Episode have been identified, although some tests such as the Dexamethasone Suppression Test and the TRH Stimulation Test have shown to be abnormal, but not completely diagnostic. Sleep EEG abnormalities are evident in 40 to 60 percent of outpatients and include: prolonged sleep latency (time to fall asleep), increased intermittent wakefulness, and early morning awakenings, reduced non-rapid eye movement sleep, decreased rapid eye movement latency, and increased duration of rapid eye movement sleep early in the night. Sleep studies are not easily obtainable for diagnostic purposes. The incidence is about 20 percent, and the present symptoms are the same for children and adolescents, although they may have more somatic complaints, increased irritability, and social withdrawal.

\textsuperscript{10} Andler v. Chater, 100 F.3d 1389, 1393 (8th Cir. 1996) and Miller v. Heckler, 756 F.2d 679, 681 (8th Cir. 1985); see App. § 40G, Sample Declaration Involving A Patient With Diagnosis Of Chronic Schizophrenia.
The risk of suicide is about 15 percent in individuals with depression and needs to be carefully screened. Approximately 50 to 60 percent of individuals who have a single episode will experience a second episode at some point in their lives. Individuals who have had two episodes have a 70 percent chance of a third, and those with three episodes have a 90 percent chance of a fourth.\(^\text{11}\)

[ii] Dysthymic Disorder

The essential feature of a dysthymic disorder is a chronically depressed mood that occurs for most of the day for at least two years. In children, the mood may be irritable rather than depressed, and the required minimum duration is only one year. Individuals with dysthymic disorder generally present with low interest and self criticism and often see themselves as uninteresting or incompetent. This disorder can coexist with a Major Depression and often progress to a Major Depression. There are no specific tests to diagnose this disorder, but it can be chronic and disabling to people.

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The diagnostic criteria for major depressive disorder and dysthymic disorder found in the DSM-IV are truly identical to the criteria of Listing 12.04A[1], except that the DSM-IV criteria do not contain the criterion of hallucinations or delusions.

Again, the diagnostic criteria for major depressive disorder and dysthymia state that when this diagnosis is assigned to a patient, “symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of function.”\(^\text{12}\)

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Major depression can have a very definite impact on a claimant’s capacity for work. The following represent some of the problems that can arise from this condition with very definite vocational implications:\(^\text{13}\)

1. Low motivation;
2. Increased error rates;
3. Decline in the rate performance, reliability and conscientiousness of the claimant;
4. Increased irritability and withdrawn behavior that can have an impact on co-workers and supervisors;
5. Hypersensitivity to supervisory criticism and latent sense of rejection with reduced stress tolerance.

\(^{11}\) See Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition), The American Psychiatric Association, 1994, pp. 327, 349 (Criteria on Major Depressive and Dysthymic Disorders).

\(^{12}\) See Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition), The American Psychiatric Association, 1994, pp. 327, 349 (Criteria on Major Depressive and Dysthymic Disorders).

[iii] Bipolar Disorders

There are six separate sets of criteria for a Bipolar Disorder. In bipolar disorders, the clinical course is characterized by the occurrence of one or more Manic Episodes or Mixed Episodes. A *manic episode* is defined as an abnormally elevated or expansive mood for at least one week duration. A manic individual’s mood can be euphoric, irritable, labile, hypersexual, grandiose, or cheerful with clarity of vision and thought. They may talk for hours and have a markedly decreased need for sleep. Their thoughts are described as racing, and ideas flood their consciousness. They tend to be over involved in activities including occupational, political, and religious activities.

If left untreated, these individuals can exhaust family fortunes through gifts and expensive purchases and poor judgment with decision making. They frequently require hospitalization in order to bring their disease under control. They frequently do not recognize that they are ill, and this impairs the ability of the clinician to treat them.

The cycles experienced by a bipolar patient can be to a normal or depressed mood and vary from individual to individual. A depressive episode immediately follows a manic episode in 50 percent of cases.

The mean age of onset is in the early twenties, but there are cases that occur in adolescence and as late as fifty years old. There are no laboratory tests currently available that aid in the diagnosis of the manic states.

Bipolar disorders have various subtypes:

- Bipolar I—one or more manic episodes usually accompanied by Major Depressive Episodes
- Bipolar II—one or more depressive episodes usually accompanied by at least one hypomanic episode
- Cyclothymic—two years of numerous periods of hypomanic episodes alternative with depressed episodes

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Bipolar disorders are described in virtually the same terms as the criteria at Listing 12.04A(2), except that hyperactivity is not a part of the new criteria. Pressure of speech is expanded to include talkativeness. In Part g of Listing § 12.04A(2), involvement in activities with a high probability of painful consequence is described in DSM-IV as “excessive involvement in pleasurable activities that have a high potential for a painful consequence.” For instance, these folks will often go on buying sprees during which they will buy a new car they cannot afford or spend up to or beyond the limit of their credit cards.

The DSM-IV criteria for bipolar disorder (manic episode) states that “the mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or usual social activities or relationships with others. . .”

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14 See Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition), The American Psychiatric Association, 1994, p. 332 (Criteria on Bipolar/Manic Disorder).

15 See Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition), The American Psychiatric Association, 1994, p. 332 (Criteria on Bipolar/Manic Disorder).

16 See Rohan v. Chater, 98 F.3d 966 (7th Cir. 1996).
A diagnosis of bipolar disorder should easily fulfill the requirements of Listing 12.04 Parts A and B, but this should be clearly set out in the doctor’s report.17

[iiv] Cyclothymic Disorder

Cyclothymic is a chronic change in mood characterized by periods of hypomanic symptoms and depressive symptoms for a two year period (one year in children and adolescents). The symptoms of cyclothymia are of insufficient number and severity to meet criteria for either a major depression or a manic episode. The disability that results from a cyclothymic disorder is a result of prolonged periods of cyclical and often unpredictable mood changes, making the person temperamentally, moody, unpredictable, and inconsistent.

[d] Anxiety Disorders—§ 12.06

This group of disorders includes: Panic Disorder with and without Agoraphobia; Agoraphobia without a history of Panic Disorder; Specific Phobia; Social Phobia; Obsessive Compulsive Disorder; Post-Traumatic Stress Disorder; Acute Stress Disorder; and Generalized Anxiety Disorder. Each of these disorders has separate criteria and could be disabling in and of themselves by virtue of their criteria. There are, however, no corresponding criteria in the social security manual for each of these disorders individually. Unfortunately, this is a real deficiency in the assessment of anxiety disorders for disability purposes.

The hallmark of an anxiety disorder is a panic attack. A panic attack is a discrete period in which there is the sudden onset of intense apprehension, fearfulness, or terror, often associated with the feeling of impending doom.

During an attack an individual usually experiences at least four of the following: palpitations; sweating; trembling or shaking; shortness of breath; feeling of choking; chest pain or discomfort; nausea or abdominal distress; feeling dizzy; feelings of unreality; fear of losing control; fear of dying; numbness or tingling sensations; and chills or hot flushes. The various anxiety disorders incorporate the panic attack symptoms into their criteria. The more disabling anxiety disorders are described below.

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The Listings do discuss panic disorders at 12.06A(1)(3). The elements of the DSM-IV criteria are found in this Listing.

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Generalized anxiety can cause the following problems with very definite vocational implications:18

1. Excessive worry;
2. Oversensitivity;

17 See Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition), The American Psychiatric Association, 1994, p. 332 (Criteria on Bipolar/Manic Disorder); see also App. § 40C, Sample Report of Psychiatrist Using DSM-IV Nomenclature and Format.
3. Excessive willingness to make concessions to avoid confrontations;
4. Diminished concentration;
5. Sleep disturbance;
6. Tension and irritability;
7. Increased absenteeism due to the need to avoid interpersonal stress and performance expectations;
8. Slow pace and poor concentration;
9. Risk aversion; excessive support of co-workers and supervisors to maintain motivation.

[i] **Panic Disorder With Agoraphobia**

Panic disorder can occur with and without agoraphobia. Ninety-five percent of the time, agoraphobia occurs in the presence of a panic disorder. Because of the anxiety, an individual begins to avoid a variety of situations that he or she believes will precipitate a panic attack. These typically involve being unable to leave one’s home, driving on an interstate, fear of flying or a fear of crossing bridges. When an individual tries to expose himself or herself to these feared situations, he or she experiences a sense of dread and impending doom and the onset of the panic occurs. This is disabling for an individual, because his or her world becomes restrictive and his or her activities narrow. Perhaps the most famous individual with panic disorder and a specific phobia is John Madden, the former football coach. He was unable to fly with his team for the football season. Normally, this would have precluded him from remaining a football coach; however, he was able to buy his own bus and travel by ground. Most individuals would not have the resources to accommodate their phobia and as such would lose their job.

The onset for a panic disorder is typically between late adolescence and mid-thirties. Some individuals have episodic outbreaks while others have continuous symptoms. Agoraphobia usually develops within the first year of a panic disorder as an individual attempts to control his or her symptoms by controlling his or her environment. Individuals without treatment tend to develop a chronic and unremitting course.  

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The criteria for agoraphobia corresponds to Listing 12.06(1)(2).

[ii] **Obsessive Compulsive Disorder**

In an obsessive compulsive disorder, the essential feature is recurrent obsessions or compulsions that are severe enough to be time consuming (more than one hour a day), and to cause significant distress and impairment. Obsessions are persistent or repeated thoughts that interfere with the daily life of an individual. Compulsions are persistent or repeated acts that also interfere with the daily life of an individual. By definition, at some point an individual with obsessive compulsive disorder recognizes that his obsession or compulsion is unreasonable, but is powerless to stop it. Because obsessions and

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19 See *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition), The American Psychiatric Association, 1994, pp. 402-403 (Criteria on Panic Disorder With Agoraphobia).
compulsions are distracting, they can impair cognitive performance, and social activities, as well as impair overall academic or occupational functioning. The Yale Brown Obsessive Compulsive Scale (YBOC) is a list of the most common obsessions and compulsions. The YBOC also has a rating scale to assess the severity of an individual’s symptoms.

[iii] Post-Traumatic Stress Disorder

In Post Traumatic Stress Disorder (PTSD), an individual develops a characteristic set of symptoms. The development of the symptoms can be acute (duration of less than three months), chronic (duration of three months or longer), or with delayed onset (onset of symptoms occur at least six months after the event). Individuals with PTSD describe a host of symptoms that generally impair interpersonal relationships and lead to marital conflict, divorce, or loss of a job.\(^{20}\)

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The listing of criteria on post-traumatic stress disorders are woefully deficient when compared to the new criteria in DSM-IV, but it is generally discussed, very briefly, at Listing 12.06. When discussing the claimant’s post-traumatic stress disorder with the claimant and the psychiatrist, use the DSM-IV criteria, as there are many elements contained in the criteria that, if present, would preclude the performance of any gainful employment such as:\(^{21}\)

1. Markedly diminished interest or participation in significant activities;
2. Feeling of detachment or estrangement from others;
3. Difficulty concentrating.
4. Reduced stress tolerance, especially for events associated with trauma (verbal aggressiveness by a supervisor could trigger such stress)
5. Increased error rate due to cognitive difficulty

[e] Somatoform Disorders—§ 12.07

The Somatoform Disorders are a group of disorders in which the presence of a physical symptom suggests the presence of a general medical condition. However, on closer examination, the physical condition does not fully explain all of the symptoms. The disorder causes significant distress and impairment in social, occupational, and other areas of functioning and, therefore, is thought to have a psychological base as well. The Somatoform Disorders include: Somatization Disorder; Conversion Disorder; Pain Disorder; Hypochondriasis; and Body Dysmorphic Disorder. The hallmark of all of these conditions is that there is no diagnosable general medical condition to fully account for the physical symptoms.\(^{22}\)

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\(^{21}\) See *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition), The American Psychiatric Association, 1994, pp. 427-429 (Criteria on Post-Traumatic Stress Disorders).

\(^{22}\) See *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition), The American Psychiatric Association, 1994, pp. 449-450 (Criteria on Somatoform Disorder).
[f] Personality Disorders

Personality disorders must be distinguished from personality traits. A personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture. The pattern is inflexible and pervasive across a broad range of personal and social situations. The pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

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Individuals afflicted with personality disorders tend to have unstable relationships, less empathy, and poor ability to establish and maintain relationships on and off the job. They also tend to tolerate stress poorly.23

§ 40.03 Evaluative Techniques for Mental Disorders

[1] Introduction

The listings describe the complexities of evaluating the chronically ill. For example, the role of medication in either enhancing or limiting functioning is discussed at Listing 12.00G. The possible presence of drowsiness or other adverse side effects as a complication of the use of antipsychotic medication, thereby causing further functional impairment, is raised.

The requirement of psychiatric evidence consisting of demonstrable clinical signs and laboratory findings as well as the individual’s reported symptoms (Listing 12.00B) places enormous emphasis on the psychiatrist’s reporting of a thorough mental status examination and the possible use of psychological testing. Both the mental status examination1 and psychological testing2 will yield data relevant to Part A (signs) and Part B (functional restrictions).

For example, a claimant may laugh while discussing his mother’s death or other serious matters, demonstrating inappropriate affect3 under Listing 12.03A. This inappropriate affect may be noted by the interviewer to impair the establishment of rapport between the physician and the claimant during the interview and, therefore, be an example of a marked difficulty in maintaining social functioning under Listing 12.03B.


1 See § 40.04[2][c].

2 See § 40.05.

3 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] Importance of Documenting Functional Restrictions

In writing a disability report, it is essential that the consultant note the degree and examples of restriction in each of these areas. For example, the consultant might inquire what the patient's "housecleaning" consists of, including the type of tasks, their frequency and the methods used by the patient to accomplish them. Family members, neighbors or landlords would be asked independently about the patient's housekeeping. Professional staff such as social workers making home visits could document over time the patient's abilities in this area. Some signs and symptoms have an obvious and profound effect on a task such as housecleaning.

An individual with an obsessive-compulsive disorder which often includes a fear of germs may, for example, refuse to pick up a sponge or other cleaning utensils because of the dread of contamination, leading to a marked restriction of functioning. Other symptoms such as profound disorganization of thinking due to schizophrenia or extreme lethargy due to a major depression can lead to a similar level of impairment.

Similar inquiry should be made about food preparation, personal hygiene, social activities and hobbies of all types. A typical "good" day and a typical "bad" day should be described by the patient and confirmed by other family members, treatment personnel and/or records. Additional data can be obtained from requested autobiographical accounts or office questionnaires. Patients can obtain a printout of their work history with names of employers, and inclusive dates from the Social Security Administration. School records can also be helpful to document level of functioning.

The representative should also request that the consultants describe their assessment of the claimant's remaining ability to comprehend, recall and carry out instructions, and the claimant's ability to respond to supervision, to relate to co-workers, and to tolerate work pressures. These are skills which make up the patient's residual functional capacity.4

An individual will ultimately be judged to be disabled if there is sufficient evidence to establish that either s/he has a "marked" impairment as described in the listings, or s/he does not have sufficient "residual functional capacity" to perform work done in the past or to do other work that exists in substantial numbers in the national economy.

Factors such as the claimant's age, education, and full work history are taken into consideration by Social Security and should be noted in the report. The consultant's descriptions of the claimant's ability or inability to perform specific functions of daily living and work-related skills will permit an accurate assessment of the degree of impairment and/or any residual functional capacity.

Social Security requires that the illness be expected to be disabling for at least 12 months. Sufficient data must be included to describe the course of the illness, including exacerbations and remission. Reports should describe the claimant during periods of good and poor functioning. The effects of medication and need for supports to maintain functioning should also be detailed. It is also appropriate to describe the claimant's level of functioning while under stress or when treatment is interrupted.

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4 For discussion of residual functional capacity, see ch. 11, § 11.05.
The representative should provide a psychiatric consultant with the new listings and thoroughly discuss the concepts within them when requesting an examination for a client.

[b] Initiating the Examination

The attorney should seek medical reports from either the treating physician and/or a psychiatrist experienced in the preparation of medico-legal reports. The treating physician has the best data because of knowing the patient and his illness over a period of time as well as having established a relationship with the patient which maximizes information gathering. The request for the evaluation is best initiated by the attorney by telephone contact in order to establish the physician's availability, fees, and method of payment. A subsequent letter from the attorney should confirm the request. Most mental health professionals then request the patient to call to arrange their own appointment. Some physicians will also do the consultation while the patient is hospitalized if the patient’s ability to follow through on outpatient appointments is unlikely.

A thorough disability examination takes between 3 and 6 hours, usually divided over at least two appointments. The consultant’s time is best used if the attorney supplies her/him with all available past hospital and treatment records as well as past disability reports prior to the initial appointment. Consultants also often request separate appointments with family members to seek confirmation for reported symptoms or observed signs.

A psychiatrist frequently works with a psychologist to obtain psychological testing after the initial interview. Your client should be informed that additional requests for release of information may be required to gather all relevant data. Instruct your client to be thorough and honest in reporting history and symptoms. A false representation of one set of facts will destroy their credibility with the consultant and the disability determination personnel.

[c] Mental Status Examination

[i] Purpose of the Examination

It is the consultant’s job to fully describe behavior, its relationship to a mental disorder, and how the mental disorder directly impacts upon the claimant’s daily activities. The mental status examination is the most significant part of the psychiatric evaluation. The purpose of the mental status examination is to observe and record information that the evaluator has obtained from the patient in order to clearly establish the presence or absence of mental illness. This systematic procedure assists the evaluator in diagnosing the nature of the patient’s mental disorder and permits disability determination personnel in appreciating both the claimant’s signs and symptoms (Part A of the listings) and their effect on the claimant’s daily activities (Part B of the listings).

The mental status examination is divided into two major parts: (1) General Observations and Report of Signs and Symptoms;⁵ and (2) The Cognitive Exam.⁶ The mental status examination is a shorthand way of fully describing the claimant. Both major parts of the mental status examination are divided into numerous subcategories.

⁵ See § 40.03[2][c][ii].
⁶ See § 40.03[2][c][iii].
There are three levels of objectivity of the data recorded in the mental status examination. Some information is highly objective such as describing a patient’s dress, hygiene or directly observable behavior. For example, one well-written report noted, “Patient repeatedly looked away from examiner and engaged in angry whispers at a blank wall.” Other information is highly subjective, such as the same patient’s report of threatening auditory hallucinations,\(^7\) an inner experience or symptom.

In between these two extremes is data which requires some observation on the interviewer’s part, but also some low-level inference such as the linking of the above described patient’s behavior (“talking to the wall”) and his report of hostile auditory hallucinations. Other examples combining observation as well as inference include describing a patient’s affect\(^8\) or mood, or assessing suicidal or homicidal risk.

The findings of the mental status examination should be organized with an emphasis on actual descriptions of the claimant as well as direct quotations from the claimant and other informants.

**[ii] General Observations and Reports of Signs and Symptoms**

The psychiatric examination of your client begins from the time the consultant reviews the available records and first speaks to your client by phone to arrange the appointment. The consultant is a highly trained observer who will note how your client manages the task of participating in a psychiatric evaluation as one example of participating in a “work” or “task-oriented” experience. For example, is your client punctual or are there any major restrictions in your client’s attending and participating in the evaluation?

**Example:** One young mentally impaired person refused to come to the first evaluation appointment unless driven by his father. His stated reason for this special request was, “They all read my mind by radio waves on the bus.”

**Example:** A psychotic young woman would only accept an evening appointment due to her daily routine of waking in the late afternoon after staying up until dawn each day. This reversing of day and night is not an unusual clinical finding in the chronically psychotic. Family members and hospital records confirmed the pattern as longstanding.

Appearance including dress and personal habits should be fully described. Disheveled dress and dirty hair, skin or nails suggest chronic disorganized thinking and planning abilities often found in chronic psychosis.\(^9\) Alcoholism, of course, may be present in a similar manner. Neat dress in a psychotic individual suggests an acute onset of an illness or relapse. Seductive dress may indicate histrionic\(^10\) traits or may be culturally determined.

\(^7\) Hallucination—A false sensory perception which may occur in any of the five sensory channels without external stimulation of the relevant sensory organ.

\(^8\) See § 40.03[1] n.3, above.

\(^9\) 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.

\(^10\) Histrionics—A personality trait or disorder characterized by dramatic and intensely expressed behavior and emotions as characteristic disturbances in interpersonal relationships.
Behavior as noted in the mental status examination should include descriptions of the amount and quality of activity. For example, an individual may be described as being unable to sit in the waiting room, pacing in the hallway, and making wild hand movements during the interview as well as going on five trips to get drinks of water during a 90-minute initial interview. This behavior would be consistent with a mania\textsuperscript{11} or severe agitation.\textsuperscript{12}

Another individual described as moving slowly with few or no hand movements or shifts of posture during a 90-minute interview most likely has a moderate to severe depression.\textsuperscript{13} The presence of abnormal motor movements such as tics, tremors, or agitation (including hand-wringing or fidgeting) should be noted. Eye movements including scanning (eye movements from side to side characteristic of paranoid conditions) and level of eye contact should also be described.

Affect is expressed and observed emotion. The description of affect should include quality (i.e., calm, sad, worried, angry, flat) as well as the degree and timing in the changes of affect during the interview. A patient may rapidly change from laughing to crying in a short amount of time demonstrating the labile affect\textsuperscript{14} seen in either manic patients or persons with organic brain disorders. Bland and unvarying facial expressions are often seen in either mentally impaired persons or seriously depressed individuals.

Mood is the sustained emotional tone that colors a person’s experience of the world. There is often one predominant mood throughout the course of the evaluation. This may be described by the evaluator but is often viewed as a highly subjective finding.

Speech and the content of thought are closely linked. Normal speech and thought is organized and purposeful. This portion of the mental status examination is best handled with direct quotes as well as description. The descriptions should convey both what is said (content) and how it is said (process).

The mental status should note the amount and quality of speech. Individuals with slow or sparse speech are often depressed, have intellectual deficits or are chronically psychotic. A patient who speaks in a rapid and excited manner may be manic or highly anxious. There may be a prolonged waiting period between a question and the claimant’s answer. Such an increased latency of reply may indicate a depressed person with little energy to engage in the interview or may demonstrate blocking in a psychotic individual. Blocking occurs when the patient appears to be thinking in response to a question but upon inquiry states that his mind has gone blank and he is unable to answer the question.

\textsuperscript{11} 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.

\textsuperscript{12} 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.

\textsuperscript{13} Depression—A mood often described as sad, hopeless, discouraged, or an inability to experience pleasure.

\textsuperscript{14} Lability—A trait of emotional instability with rapid and wide shifts in mood or affect; e.g., sudden, unexpected crying.
Other findings may include the patient speaking of ideas which do not connect up together in any logical way (loose associations) or the patient jumping from topic to topic (tangential thinking or its extreme form, flight of ideas). Loose associations are most characteristic of the disorder of thinking in schizophrenia. Flight of ideas is seen in mania. Tangential thinking may be seen in mania, hypomania or some personality disorders.

The content of thought may include a wide range of symptoms experienced by the patient. These may include hallucinations, delusions, ideas of reference, phobias or obsessions. Each symptom should be described fully and, if possible, in the patient’s own words. For example, a report should not simply record, “Patient complains of auditory hallucinations.” A thorough report will describe:

Patient complains of men’s and women’s voices experienced outside his head the past five years. The voices discuss a running commentary on his thoughts and actions. He last heard a voice during the course of the current interview saying, “You snitch.” The voices are worse at night or during periods of inactivity. Chlorpromazine, an antipsychotic medication, has been particularly helpful in controlling the voices. The voices were most troublesome three months ago just prior to his most recent hospitalization.

Such a description would demonstrate to the reviewer that the type of auditory hallucinations described are consistent with schizophrenia and highly unlikely to be malingered. Other portions of the mental status examination such as “Behavior,” “Affect,” or portions of the Cognitive Exam including “Attention” and “Concentration” should record the direct effect of the symptoms of auditory hallucinations on the claimant’s functioning.

Direct inquiry should always be made concerning suicidal or homicidal ideas or intentions. Direct quotes are most valuable. The evaluator should make an assessment of the risk for such behaviors.

[iii] Cognitive Examination

The cognitive portion of the mental status examination begins with asking the patient the time, the date, the location and her/his name. These are sensitive indicators of organic disorders. Knowledge of the time and date is most sensitive to confusion. Hospital

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15 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.

16 See § 40.03[1] n.3, above.

17 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.

18 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, “delusion of reference,” Glossary, App. § 40A.

19 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).

20 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.

21 Malingering—The production or exaggeration of psychological or physical symptoms in pursuit of a goal.
inpatients or incarcerated claimants may have difficulty with the time and date even if not organically impaired.

Memory is divided into past memory and recent memory. If deficits are noted, specific examples should be given. For example, if a person cannot recall their birthday, place of birth or address, have the report say so. The examiner should note how many objects the claimant can recall after five minutes. Family members, landlords or hospital records will also give confirmatory examples of memory deficits. These may include getting lost in their apartment building, leaving stove burners on, or signs of mismanaging bill payments.

Attention is the ability to focus on a task or activity. The claimant's ability to attend to the evaluator's questions should be noted. Digit span is one formal way to test attention. The evaluator asks the patient to repeat digits which are pronounced at the rate of one per second. Most people of normal intelligence can repeat five or more forward, and four or more backward.

Concentration involves the ability to follow a task which involves memory of the rules of the task as well as attention to where one is in the task. Naturalistic observations of a claimant's concentration may be made as he or she fills out a release of information form or a screening questionnaire. Common formal methods of testing concentration include simple math calculations or serial subtractions. Results are often influenced by intelligence and education as well as level of anxiety, and disorganization of thinking caused by organic illness or psychosis.

A claimant's ability to use abstract thinking is correlated with intelligence as well as the presence or absence of a thought disorder. An astute examiner will note the claimant's degree of abstract versus concrete thinking during the course of the interview. The traditional method of recording this dimension of the mental status examination is to ask the claimant to interpret the meaning of proverbs. The patient is generally given several proverbs of varying difficulty. An example of an easy proverb is, "Don't cry over spilled milk"; one of medium difficulty is, "You can lead a horse to water but you can't make him drink"; and a difficult one is, "People in glass houses shouldn't throw stones." Proverbs are strongly determined by culture. Examiners should make certain that a claimant has heard the proverb prior to being asked for an interpretation.

Concrete thinking is characterized by an inability to go beyond actual things, events, words or immediate experience to a general principle. A concrete interpretation of the easy proverb, "Don't cry over spilled milk," might be, "If you spill the milk, it's okay, it's already spilled and you cannot do anything about it." This is merely a restatement of the proverb without reference to the general principle it addresses, namely, there is no use fretting over things that cannot be changed.

General knowledge is useful to test when it is uncertain how in touch a person is with relevant local or national events or necessary vocational or daily living information. The

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22 Thought Disorder—Any disturbance of thinking that affects language, communication, thought content or thought process; in DSM-IV, a disturbance in the form of thought as distinguished from the content of thought. This may include loosening of associations, neologism (newly invented words), per sevierung or blocking.
experienced evaluator will inquire about transportation, shopping, meal preparation and money management matters.

Insight refers to a person's ability to understand the point of a problem or situation. The mental status examination should note the claimant's understanding of his own psychological problems as this has important prognostic and treatment implications.

Finally, the examiner should describe the claimant's degree of social judgment. This can include observed examples of behavior. One claimant openly brushed his teeth in the waiting room water fountain. Inquiries can be made of the claimant's actions in hypothetical situations. The common examples are, "What would you do if you found an envelope stamped, sealed and addressed, on the ground?" or "What would you do if you were the first one in a movie theater to smell smoke?" Individuals with poor impulse control and planning abilities would open the letter or yell "fire" or dash out of the theater without telling anyone.

[iiv] Psychiatric Report

The final psychiatric report should follow a standard format that includes the following major subdivisions:

1. Identifying Data—This section should include basic data on the claimant including name, age, sex, race, and marital status. The method and purpose of the referral should be noted.

2. Source of Data—All sources used should be identified. Common types of sources such as interviews, documents and telephone contacts should be grouped together. The date and length of each interview and its participants should be recorded.

3. Current Situation—The claimant's current symptoms, treatment and medication should be fully described. The claimant's daily activities, interests and ability to relate to others should also be carefully recorded. Current level of alcohol or drug use should be indicated.

4. Past Psychiatric History—A full description of the patient's past hospitalizations, outpatient treatments and medications should be recorded. Past diagnoses and course of prominent signs and symptoms should be noted. Known responses to stresses or different levels of treatment should be described. A history of alcohol and drug use should be included here. A detailed description of the claimant's functioning over the course of the illness should be described.

5. Relevant Social History—This section should include important family history, medical and developmental history, work and military service history as well as educational history.

6. Mental Status Examination.

7. Diagnoses Under the Five Axes of the DSM-IV, Including GAF and SOFAS.

8. Opinion—This section should explain to the reader: (a) the basis for the psychiatric diagnosis; (b) the diagnosis's relationship to a recognized mental impairment; and an assessment of the level of functional impairment directly caused by the mental disorder. This section should be well reasoned and relate specifically to the direct observations or data available to the examiner. A clear statement should be made of the evaluator's
opinion concerning the claimant’s prognosis as well as the claimant’s ability to manage his own funds. The reasons for each statement must be provided.


There are a large number of common problems which limit the usefulness of psychiatric disability reports, all of which can be avoided. It is imperative that reports be free of jargon and conclusions not supported by specific findings. Ambiguity or confusion can be avoided in reports by clearly describing the course of exacerbations or remissions of a claimant’s illness over time. Specific data including the duration of the exacerbations or remissions and their effect on functioning should be outlined in order to fully inform the reviewer.

Remission is generally defined as a significant improvement or recovery from a mental disorder. It may be partial or complete. It may or may not be permanent. Several illnesses such as schizophrenia, major depression and bipolar (manic-depressive) disorder, as well as others, have natural histories which may include full or partial remissions alternating with relapses back into acute illness. The consultant should fully document the course of the mental illness, including the duration and degree of remissions and relapses and the accompanying degrees of functional impairment.

An additional important part of the clinical history is the role of stressors (or events) upon a patient’s clinical course. Mild stress such as an argument with a family member or the moderate stress of a pregnancy may cause major relapses with subsequent marked functional impairment in the mentally ill. Just as a diagnosis is not sufficient to establish disability, neither is it sufficient to establish the degree of the capability to engage in normal work activity or normal social interactions. For example, an individual with schizophrenia in partial remission at the time of the evaluation may have a well-documented history of clinical psychosis which has existed for many years. A patient’s current minimal symptoms may be maintained by anti-psychotic medication, weekly supportive group and individual psychotherapy, and a highly constricted level of functioning aimed at minimizing stress.

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.


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. 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.

[5] The Folstein Mini Mental State Examination

The Folstein Mini Mental State Exam helps to rigorously assess the extent areas of memory and cognitive deficits in an individual suffering from a dementia. A perfect score is 30. A score of 23 or less indicates the presence of a mild dementia. The lower the score, the more profound the dementia. This test can also be used sequentially over time to follow the progress of someone with a dementia.

§ 40.04 [Reserved]

§ 40.05 The Role of Psychology in Mental Disorders Evaluations

[1] Psychological Assessment of Social Security Disability

Historically, assessment of mental impairment was considered to be the role of the psychiatrist. Due to changing economics, the social landscape, and the training of mental health providers, this situation has been changing. Psychologists can and are becoming increasingly involved in the evaluation of mental impairments, both in clinical and forensic situations.

Until the Second World War, psychologists were engaged in almost exclusively academic pursuits, teaching and research. With psychiatry's inability to meet the personnel requirements of Veterans Administration institutions, the federal government funded the clinical training of doctoral level psychologists. Initially supervised by psychiatrists and more recently independent of them, psychologists focused initially on the use of psychological tests for diagnostic purposes. Indeed, the original role of the psychologist in clinical practice was relegated to the administration of psychological tests. Over time, psychologists not only continue to administer tests but also interview and provide interventions as well.

Whereas a chapter in a volume of this type is often considered to be practical in nature, this chapter will focus on both the practical and theoretical aspects of psychological assessment of Social Security Disability. As a consequence, some background will be

\[23\] See Chapter 39.

\[24\] See § 40.02[3][a][i], for discussion of dementia.
provided as a means of presenting important foundations of psychological issues. Without these foundations, advocates of disability claimants will not be able to fully use psychological information and findings. The foundation will include; difference between a psychologist and a psychiatrist as well as the differences between their reports, brief overview of psychological testing theory, and, finally, a review of the published literature involving the psychological assessment of disability with special focus on Social Security issues. After this section, the listings will be individually considered.


Although the typical focus of a psychological evaluation and its understanding is pragmatic (i.e., does the claimant meet a listing based on the psychological testing), a basic understanding of the underpinnings of a psychological evaluation are important. Towards this end, four major issues will be discussed: (1) the difference between psychiatric and psychological evaluations; (2) the basics of psychological tests and testing; (3) understanding psychological perspectives of disability; and (4) the foundation, format, and errors of psychological reports.

[3] Psychiatric vs. Psychological Approaches

Individuals with emotional and cognitive disorders comprise the largest group of disabled individuals in the Social Security program. In order to receive disability benefits an evaluation is typically completed by either a psychiatrist or psychologist. However, there are substantial differences in the training and diagnostic approaches by psychiatrists and psychologists. Psychiatrists obtain their psychiatric training after receiving their medical degree. Considering their training is primarily focused in medical schools settings, their orientation has historically been more biological than psychologists. Thus, it is not atypical for psychiatrists to be more interested in medication issues than psychotherapeutic ones. However, psychiatrists are obviously interested in the diagnostics process albeit primarily in the realm of the mental status exam. Psychologists are also, by definition, doctoral level heal-care providers. Some states, such as North Carolina, allow for individuals with training at the Masters-level to be licensed to practice under doctoral-level supervision. The model is similar to that of medicine’s Physician Assistant. Psychologists, in contrast to psychiatrists, perform mental status exams but have a greater interest in the use of psychological tests. Hence, psychologists usually do not initiate therapy without the opportunity to complete a battery of psychological tests. Thus, for the last 100 years psychologists have focused on diagnosing through the use of both the mental status exam and psychological tests. As a consequence, the next section will focus on providing an overview of this area.

[4] Psychological Tests

Depending on what source one would explore, there are thousands of psychological tests available today. In general, they can be divided into two types—projective or

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objective. Projective tests are typically non-standardized tests whose theoretical underpinnings tend to be Freudian or psychoanalytic in nature. Non-standardized implies that the test, while often being administered in a specified fashion, is interpreted according to the clinical context and without reference to a comparison. Indeed, this is the major difference between both types of tests. Objective tests by design are scientifically derived with the purpose of reducing error and bias in the diagnostic process. This approach is comprised of careful and systematic development of the test, specific administration, scoring, and interpretation guidelines, and a comparison or norm-reference sample. Each objective test takes several years to develop as items and scales have to be empirically evaluated. That is one reason why tests are much more expensive than the final byproduct. In other words, one is actually paying for the scientific knowledge that went into the development of the test not just of printing the materials. Each test has very specific guidelines, often with specific wording, that needs to be adhered in the administration as well as the scoring. Interpretation is more flexible, allowing the data to be understood in a wider biopsychosocial context. And, finally, each test has one or more comparison groups. These groups, or norms as they are called, provide a reference from which to compare the actual score and are reflective of the intended target group. For example, a group of 100 patients with well-diagnosed schizophrenia residing in a state psychiatric institution could serve as the norms for a test of schizophrenic thinking. In addition, non-schizophrenic patients and normal controls are typically included in the norm references. Tests that are popular tend to have well developed and multiple group norms. Further, most tests have a life-span of no more than a decade and, in fact, recently we polled the publishers of the top ten psychological tests regarding this issue. The average longevity of a psychological test is closer to five years.

Another important aspect of objective tests is the ability of a subtest or test score to be compared to others. Although some tests report z scores, they are not that common. However, for purposes of clarification a z score is defined as follows: \( z = \frac{(X - \overline{X})}{s} \) with \( X \) being the raw score, \( \overline{X} \) the mean score, and \( s \) the standard deviation of the scores. More typical than z scores are T, percentile and deviation scores. In T scores, the average or mean score is 50 with each 10-point increment being reflective of one standard deviation (or about 34.13% difference relative to the entire sample). Thus, scores between 40 and 60 represent about 68.26% of the population; scores between 30 and 70 reflect 95.47% of the population, and scores between 20 and 80 represent over 99% of the population. As a rule, psychologists are interested in outliers, primarily those over 2 standard deviations away from the mean, or outside the 95% confidence level. However, it is important to note that different tests have different T score descriptions for clinical significance.

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

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

The usefulness of a test depends on reliability and validity. Reliability is defined as the ability of a test to measure the same thing each time the test is given. Of course, if external variables intervene (e.g., psychological treatment), the test scores would be expected to change. Validity is defined as the ability of a test to measure what it is intending to measure. There are three kinds of validity: content; criterion; and construct. Content is defined as the ability of the test to measure what it should measure. Criterion validity refers to a reference or related measure. Construct validity is related to understanding the more comprehensive issue in question (e.g., intelligence).

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

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

Recently, approximately 2,000 members of the American Psychological Association were surveyed. The results provide a further understanding of current patterns of testing. For example, clinical psychologists tended to be more likely to assess for personality and psychopathology (33%), whereas neuropsychologists tended to focus more on organic disorders (approximately 60% of their assessment time). Another interesting contrast is that clinical psychological evaluations tended to be less than four hours in length while neuropsychological evaluations had an even distribution ranging from a couple of hours to well over 20 hours. In addition, the tests appear similar but are actually quite different in content and scope. The top ten tests used by each sample are found in the table below.

<table>
<thead>
<tr>
<th>Clinical Psychology</th>
<th>Neuropsychology</th>
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<tbody>
<tr>
<td>WAIS</td>
<td>MMPI</td>
</tr>
<tr>
<td>MMPI</td>
<td>WAIS</td>
</tr>
<tr>
<td>WISC</td>
<td>WMS</td>
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Table 1: Top 10 Tests
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<table>
<thead>
<tr>
<th>Clinical Psychology</th>
<th>Neuropsychology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rorschach</td>
<td>F A S</td>
</tr>
<tr>
<td>Bender</td>
<td>F A S</td>
</tr>
<tr>
<td>TAT</td>
<td>Finger Tapping</td>
</tr>
<tr>
<td>WRAT</td>
<td>Halstead-Reitan</td>
</tr>
<tr>
<td>House-Tree-Person</td>
<td>Boston Naming</td>
</tr>
<tr>
<td>WMS</td>
<td>Category</td>
</tr>
<tr>
<td>Millon</td>
<td>WRAT</td>
</tr>
</tbody>
</table>

Of these tests, the most commonly used in the disability process is the WAIS. The Weschler Adult Intelligence Scale is currently in its third edition, although the fourth edition is in production. The third edition has excellent norms ranging from ages 16 to 89. The WAIS-R and the WAIS-III are similar, or closely similar, in about two-thirds of the items and, in general, the overall structure of the test. There are now 14 subtests and although not all are required to obtain an IQ, the extra subtests yield valuable information. The Table below provides a grouping of the subtests according to category (number in parentheses ( ) reflects the order of appearance of the subtest):

Verbal: Vocabulary (2), Similarities (4), Arithmetic (6), Digit Span (8), Information (9), Comprehension (11), Letter-Number Sequencing (13)

Performance: Picture Completion (1), Digit Symbol-Coding (3), Block Design (5), Matrix Reasoning (7), Picture Arrangement (10), Symbol Search (12), Object Assembly (14)

The WAIS-II Subtests are then grouped further into four functional categories. These categories are statistically derived but may be particularly useful in relating to the functional capacity of the claimant. The groupings are as follows:

Verbal Comprehension: Vocabulary (2), Similarities (4), Information (9)
Perceptual Organization: Picture Completion (1), Block Design (5), Matrix Reasoning (7)
Working Memory: Arithmetic (6), Digit Span (8), Letter-Number Sequencing (13)
Processing Speed: Digit Symbol-Coding (3), Symbol Search (12)

What is most important is not the test itself but matching the test to the disorder in question. Thus, it would be wise to establish a rapport with both the claimant and the psychologist in order to increase the likelihood that specific tests given match the functional limitations in question. This is particularly sensitive in cases where the evaluation is on record and has been requested by the disability services office. The two

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most frequent requests are a clinical interview and a WAIS intellectual test. Although each of these are important in many disability evaluations, they are by no means sufficient in most cases of mental impairment.

A final and sometimes overlooked aspect of psychological testing is the use of current tests. In a recent telephone interview of the publishers of the top 10 psychological tests, most tests had a life span of approximately five years before another edition or revision was to be published. Research and clinical information, together with shifting demographics, require that all psychological tests or their norms be revised at least once every 10 to 20 years at a minimum.

[5] Psychological Assessment of Disability

From 1983 to 1994, the percentage of the US population with work disability has ranged between 3–4%. And while the increase in work disability has increased slightly and steadily over the past two decades, a particularly important concern is that workers are becoming disabled younger. In addition, a larger percentage of those applying for disability do so with mental impairments.

Of the articles published in psychological literature since its inception in 1887, a total of 4,347 articles were published on psychological testing. The first known article was by F. N. Freeman, published in 1911 in Psychological Bulletin. The article focuses on the work of 12 psychologists between 1909–1910. Interestingly, their primary activity was in the administration of intelligence tests, primarily the Binet scales, eventually becoming the foundation for the Stanford-Binet Intelligence Scales. By 1937, psychology had become a rigorous and quantitative science. According to one of the pioneers of psychological testing, L.L. Thurstone, psychology was destined to become a science by having its foundation in mathematics. In many respects, this pattern not only lays the groundwork for psychological testing but provides a framework from which to understand psychological information.

A few articles exist that address the application of psychological testing to Social Security Disability. Indeed, of the over 4,000 articles in the literature approximately 100 refer to Social Security Disability. However, most are in passing reference and, hence, will not be reviewed in this chapter. Several articles/chapters by Puente outline specific procedures in greater psychological detail. However, other articles provide differing approaches to disability evaluation including one by Wiggins and the first known article on the topic by Nussbaum, Shaffer, and Schneidmuhl. As early as this 1969 article,

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psychologists were interest in developing "evidentiary needs". However, prior to addressing the necessary psychological information, a brief discussion on related matters will be initially presented.

Probably one of the major burdens facing the usefulness of disability evaluations is the "abuse of Social Security income." In one article, a psychiatrist presented three cases of mental patients that were "incorrectly" receiving SSI income. The premise was that these patients were unable or unwilling to get better in part because of the secondary gains associated with having this type of income. The question then becomes how to distinguish between mental disorders and malingering. It is important to note that according to Okpaku,\(^8\) psychiatric evaluations of 248 consecutive cases that were in the process of adjudication showed an over-representation of individuals with chronic moderate to severe psychiatric impairments. Hence, the base rate of individuals that are probably being evaluated have a much higher level of psychopathology than typical. However, since the publication of the August 28, 1985 guidelines, increasing concerns have been raised, most often implicitly about the validity of psychological test results in determining disability. According to Griffin, Normington, May, and Glassmire,\(^9\) 100 disability applications in Los Angeles seeking disability on psychological grounds were reviewed and was the foundation for the development of a composite malingering index. This index was then applied to 167 applicants, 63 psychologically impaired individuals without any need to dissimulate, and 45 disability examiners with instructions to malinger. Based on a empirically-based cutoff score, a total of less than 20% appeared to be malingering.

However, this estimate may be over-inflated. Careful review of the applicants might have revealed that they did not fit into one of the basic diagnostic categories. Secondly, and most importantly, these applicants may have been exaggerating their disorders as a call for help or an actual coping strategy. Thus, this 20% may actually reflect a composite group of both true malingerers as well as a larger percentage of patients that could have been dually diagnosed—with their original problems (e.g., organic brain syndrome) and a somatoform disorders (e.g., hypochondriasis).

Another point of note relative to psychological evaluations is the issue of providing meaningful reports with appropriate documentation.\(^10\) Often the issues in question are skirted and documentation is sparse. There are several typical problems found in these reports, including: (1) limited prior documentation due to no records being sent or provided at the time of the evaluation; (2) limited or no history of the patient including medical, psychological, vocational, social, and personal; (3) misunderstanding of the clinical issues in question; and (4) very limited documentation. If the patient is referred for an evaluation by the Social Security Administration, the chances are high that little or no documentation will be available. As a consequence, little historical evidence will

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be provided, resulting in a limited understanding of the patient’s history. This is particularly problematic when the applicant has a severe mental illness and is not accompanied to the evaluation by significant others. A second problem is that evaluations often begin with a history but with the presenting problems. As a consequence, valuable information is obtained in the interview process and, thus, not reported in the findings. Considering that the ultimate goal is to understand the applicant’s current status relative to a premorbid condition, history is critical. Further, some types of disorders (e.g., personality, affective, etc.) are often best understood from an historical perspective. When evaluations are requested, the presenting problem is not often clearly described. Further, most psychological evaluations for the Social Security Administration tend to be based on a brief mental status examination combined with intellectual assessment. In many cases (e.g., organic disorders) this type of evaluation may serve as a useful screening examination. However, for other situations (e.g., somatoform, affective, etc.), an evaluation of this type would not glean enough useful information. Considering that most disability applicants enter the system of disability support due to mood and anxiety disorders,\(^{11}\) such limited evaluations may be insufficient. Thus, the evaluation should be related to type of mental disorder suspected. In other words, standard evaluations across all mental disorders do not yield the necessary data to understand the applicant’s clinical situation. Finally, inappropriate or incomplete documentation is provided. Since psychological tests are the foundation of a psychological report, all scores should be reported. If possible both raw and scaled scores (and, if feasible, age-related) should be included. T, percentile or related scores should also be found. Subtests as well as summary scores should be included if possible. Most likely the most important issue regarding documentation is providing information regarding Part B of the listing. Care should be taken to provide extrapolations from the psychological test data as well as the interview to reflect the issues addressed in Part B—essentially the activities of daily living. For example, continuous and failed attempts to return to gainful employment should be carefully documented and referred to relative to Part B.

It is also important to note that the difference between real or imagined disorder is not that critical to a disability evaluation. Though such information is important from the standpoint of diagnosis and prognosis, the focus is on the functional ability of the claimant in their personal, social, and vocational spheres. Thus, the ultimate goal of a psychological evaluation of a disability claimant is to assess the functional limitations and assets of the client at the present time with reference to a premorbid level of functioning as well as to functioning 12 months from the time of the evaluation.

Complicating the claimant’s functional status is the individual’s perceived competence, employability, physical beauty and attractiveness, mental ability, and social acceptance. It is critical to appreciate the interface between the issues, of which many are perceived rather than real, and the actual functional capacity of the individual. Whereas the original problem may be physical in nature (e.g., cardiovascular, orthopedic, etc.), the functional disability may be more due to the psychological impact of the disease process or injury than to the origin of the problem itself. The most common secondary symptom and the

most common reason for a worker to be introduced into the disability process is depression. While it is not critical whether the perceived loss is real nor imagined, the important aspect is the extenuating circumstances that result as a function of the depression. Other secondary symptoms that should be considered include the following: anxiety; anger; denial; and somatization. Of course, the opposite is also true. An individual with a long history of mental illness may eventually come to develop bone fide physical symptoms that are associated with the original mental illness. The following table provides a sampling of these behaviors and their explanations:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Physical, cognitive, and emotional changes resulting in a significant decrease in functioning.</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Primarily characterized by apprehensive expectations combined with significant psychophysiological symptoms.</td>
</tr>
<tr>
<td>Anger</td>
<td>Acute, emotional reaction associated typically with stressors.</td>
</tr>
<tr>
<td>Denial</td>
<td>Cognitive avoiding of situations and/or individuals causing significant distress.</td>
</tr>
<tr>
<td>Somatization</td>
<td>The alteration of psychological distress into physiological symptomology.</td>
</tr>
</tbody>
</table>

[6] Psychological Reports

Some of the issues involved in psychological reports have already been addressed in the context of the evaluation. However, a few more comments are in order. First, the report should be comprehensive enough that if another evaluation were to be completed in the same manner at a later date, similar findings would be comparable. Hence, descriptions of what actually transpired and the tests administered are required. This would include at a minimum the results of an interview, historical analysis, and testing results. The names of the tests should be included along with their specific test scores. If possible, it would be useful to have both raw and derived scores included. A summary section should integrate the interview, history, and test results. Findings should be related to the mental impairment listings. The most typical flaw is the lack of reporting functional data and integration of such data to the test results. Thus, Part B, of the functional aspects of the evaluation, need special attention. Indeed, despite an overall improvement in the status of disabled people, partially due to the Americans with Disabilities Act, individuals with disabilities continue living in social isolation.\(^{12}\) The following activities have been found to be significantly decreased in disabled people as compared to non-disabled people: social contact; going to movies; live music or sports performances; eating out; church attendance; and food and regular shopping.

Findings of an evaluation could either be presented in the form of a letter or a formal report. In either case, as much information supporting a conclusion should be contained. As a rule, this would include, as a minimum, the following:

• Demographic Information
• General History
• Mental Status Exam and Clinical/Behavioral Observations
• Testing
• Summary

In addition, the report should contain enough data and procedural information that could serve as a baseline for future studies or evaluations. This is especially important in that disability applicants often require re-evaluations at later dates. The bulk of the report should be in simple English and jargon should be avoided. Similarly, all tests and important data (e.g., IQ scores) need to be included.

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

• Medical (Psychological) History
• Clinical Findings (e.g., Mental status exam)
• Laboratory Findings (e.g., Test scores)
• Diagnosis
• Treatment Prescribed with Response and Prognosis
• Estimate of Patient’s Abilities

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

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

• Reason for Service
• History
• Mental Status Exam
• Description of Speech, Thinking, Judgment

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

• Reason for Service
• History
• Attention
• Memory
• Visual-spatial abilities
• Language Functions
• Planning/Organization
Impression/Diagnosis

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

Name of Tests Used

Interpretation of Test Results

Impression/Diagnosis

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

[7] Addressing the Listings

Before addressing the listings, several issues regarding the information that is to be reviewed for disability should be considered. These include the following: length of disability for gainful activity; need for evidence; documentation of the problem; and effects of medication and treatment. The length of a disability is significant according to the guidelines if it has existed or will exist for at least 12 months. “Medical” evidence is required in the form of documentation that would allow for an understanding of symptoms, signs, and laboratory findings. Finally, documentation should include information from the claimant as well as other sources including significant others and prior medical and psychological findings. Of particular value is information that provides insight into longitudinal status. Work attempts, even if they are for a few hours or days, are also important. Medication and/or treatment can help either ameliorate or control signs and symptoms of a disorder. Attention to their use, their intended, perceived, and actual effect, as well as their compliance are critical to understanding the stability and chronicity of the disorder.

There are two essential things that need to be considered in addressing the mental impairment listings. One is to consider Part A and the other Part B. Part A should be based on careful documentation based on the results of psychological testing. As a consequence, this section will address the major issues involved with each of the different listings and suggestions for types of tests that could be used in assessing for those particular disorders. In each case, it is important to determine whether the condition that is being listed is expected to last “for a continuous period of not less than 12 months”. Furthermore, a “medically determinable impairment” is “an impairment that results from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques”.\textsuperscript{13} Medical evidence is also based on signs, symptoms and laboratory (test) findings.

§ 40.06 Organic Mental Disorders—Listing 12.02

[1] Text of Listing 12.02

\textit{Listing 12.02 Organic Mental Disorders}: Psychological or behavioral abnormalities associated with a dysfunction of the brain. History and physical examination or laboratory

\textsuperscript{13} 20 C.F.R. § 404.1508.
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, or when the requirements in C 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 liability (e.g., explosive temper outbursts, sudden crying, etc.) and impairment in impulse control; or
7. Loss of measured intellectual ability of at least 15 I.Q. points from premorbid levels or overall impairment index clearly within the severely impaired range on 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. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of a chronic organic mental disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:
1. Repeated episodes of decompensation, each of extended duration; or
2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.


Part B is often misunderstood or ignored in psychological evaluations. This section of the listings involves understanding the impact of a diagnostic problem (e.g., brain damage) on the claimant's functional capacity. Hence, the focus is on the assessment of the problem's severity. Restrictions of daily living, difficulties in maintaining social functioning, deficiencies in concentration, persistence, or pace, and repeated episodes of
deterioration or decompensation in work or work-like settings need to be individually addressed. These activities of daily living can best be understood by careful history-taking as well as collateral interviews of accompanying significant others. Activities of daily living include such things as cooking, cleaning, transportation, and independence. Social functioning involves the “capacity to interact independently, appropriately, effectively, and on a sustained basis”. Concentration, persistence and pace involve the ability to sustain attention and concentration for a relatively lengthy period of time.\footnote{20 C.F.R. Part 404, Appendix 1, Listing 12.00C1, Listing 12.00C2, Listing 12.00C3.}

Finally, episodes of decompensation relate to the claimant developing problems during periods of structured activity or employment. Technically, this involves three episodes of deterioration lasting at least two weeks each time or an average of once every four months. If possible, relating the results of the psychological tests to the information contained in the interview, especially as it relates to activities of daily living, would be valuable.\footnote{20 C.F.R. Part 404, Appendix 1, Listing 12.00C4.}

[3] Description

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


The two most common batteries to test brain dysfunction are the Luria-Nebraska and the Halstead-Reitan. These batteries represent the fixed approach to testing which indicates that the same tests are administered to each patient in the same fashion. Gaining in popularity are the flexible batteries that are batteries of singular tests customized to fit the problem in question. Segments of the Halstead-Reitan Battery are very popular, including the Finger Tapping, Trail Making, and Category tests. However, these tests do not directly reflect the issues addressed in Listing 12.02 Part A. As a consequence, the WAIS and WMS, which measure intellectual and memory functions, respectively, may be more appropriate. Disturbances of mood and emotion are best understood using history, interview, and the MMPI.

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

[1] Text of Listing 12.03

Listing 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. Marked difficulties in maintaining concentration, persistence, or pace; or
   4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of a chronic schizophrenic, paranoid, or other psychotic disorder of at least 2 years’ duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:
   1. Repeated episodes of decompensation, each of extended duration; or
   2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
   3. Current history of 1 or more years’ inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.


Part B is often misunderstood or ignored in psychological evaluations. This section of the listings involves understanding the impact of a diagnostic problem (e.g., brain damage) on its functional capacity. Hence, the focus is on the assessment of the problem’s severity. Restrictions of daily living, difficulties in maintain social functioning, deficiencies in concentration, persistence, or pace, and repeated episodes of deterioration or decompensation in work or work-like settings need to be individually addressed. These activities of daily living can best be understood by careful history-taking as well as collateral interviews of accompanying significant others. Activities of daily living include such things as cooking, cleaning, transportation, and independence. Social functioning involves the “capacity to interact independently, appropriately, effectively, and on a
sustained basis”. Concentration, persistence and pace involve the ability to sustain attention and concentration for a relatively lengthy period of time.\(^1\)

Finally, episodes of decompensation relate to the claimant developing problems during periods of structured activity or employment. Technically, this involves three episodes of deterioration lasting at least two weeks each time or an average of once every four months. If possible, relating the results of the psychological tests to the information contained in the interview, especially as it relates to activities of daily living, would be valuable.\(^2\)

[3] Description

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


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

§ 40.08 Affective Disorders—Listing 12.04


Listing 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, or when the requirements in C 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

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\(^{1}\) 20 C.F.R. Part 404, Appendix 1, Listing 12.00C1, Listing 12.00C2, Listing 12.00C3.

\(^{2}\) 20 C.F.R. Part 404, Appendix 1, Listing 12.00C4.
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. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of a chronic affective disorder of at least 2 years’ duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:
1. Repeated episodes of decompensation, each of extended duration; or
2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
3. Current history of 1 or more years’ inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.


Part B is often misunderstood or ignored in psychological evaluations. This section of the listings involves understanding the impact of a diagnostic problem (e.g., brain damage) on its functional capacity. Hence, the focus is on the assessment of the problem’s severity. Restrictions of daily living, difficulties in maintaining social functioning, deficiencies in concentration, persistence, or pace, and repeated episodes of deterioration or
decompensation in work or work-like settings need to be individually addressed. These activities of daily living can best be understood by careful history-taking as well as collateral interviews of accompanying significant others. Activities of daily living include such things as cooking, cleaning, transportation, and independence. Social functioning involves the “capacity to interact independently, appropriately, effectively, and on a sustained basis”. Concentration, persistence and pace involve the ability to sustain attention and concentration for a relatively lengthy period of time. Finally, episodes of decompensation relate to the claimant developing problems during periods of structured activity or employment. Technically, this involves three episodes of deterioration lasting at least two weeks each time. If possible, relating the results of the psychological tests to the information contained in the interview, especially as it relates to activities of daily living, would be valuable.

[3] Description

There are three main types of affective disorders. By far the most common affective disorder is depression, characterized by literally depressed mood, behavior, and thinking. The opposite end of the emotional spectrum is mania although this problem is most often part of the third type of affective disorder-manic-depression or bipolar disorder. In this scenario, the patient cycles very slowly (over a period of weeks or months) between depression to mania and back.


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

§ 40.09 Mental Retardation and Autism—Listing 12.05

[1] Text of Listing 12.05

Listing 12.05 Mental retardation: Mental retardation refers to significantly subaverage general intellectual functioning with deficits in adaptive functioning initially manifested during the developmental period; i.e., the evidence demonstrates or supports onset of the impairment before age 22.

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 through 70 and a physical or other mental impairment imposing an additional and significant work-related limitation of function;
OR
D. A valid verbal, performance, or full scale IQ of 60 through 70, 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. Marked difficulties in maintaining concentration, persistence, or pace; or
   4. Repeated episodes of decompensation, each of extended duration.


Part B is often misunderstood or ignored in psychological evaluations. This section of the listings involves understanding the impact of a diagnostic problem (e.g., brain damage) on its functional capacity. Hence, the focus is on the assessment of the problem’s severity. Restrictions of daily living, difficulties in maintain social functioning, deficiencies in concentration, persistence, or pace, and repeated episodes of deterioration or decompensation in work or work-like settings need to be individually addressed. These activities of daily living can best be understood by careful history-taking as well as collateral interviews of accompanying significant others. Activities of daily living include such things as cooking, cleaning, transportation, and independence. Social functioning involves the “capacity to interact independently, appropriately, effectively, and on a sustained basis”. Concentration, persistence and pace involve the ability to sustain attention and concentration for a relatively lengthy period of time.¹

Finally, episodes of decompensation relate to the claimant developing problems during periods of structured activity or employment. Technically, this involves three episodes of deterioration lasting at least two weeks each time or an average of once every four months. If possible, relating the results of the psychological tests to the information contained in the interview, especially as it relates to activities of daily living, would be valuable.²

[3] Description

These two disorders are actually quite different in their behavioral and cognitive expression. They do share, however, the idea that there is an organic or physiological component and that their origin is early in the development of the patient. In Autism, the patient has significant problems with communication and socialization. The hallmark of retardation has traditionally been an Intelligence Quotient of 69 or below. However, maladaptive patterns of behavior are now often added for such diagnoses. Indeed Social Security requires evidence of deficits in adaptive functioning prior to age 22 to fulfill the requirements for the mental retardation listing. In order to accomplish this one might use the DSM-IV guidelines, more structured information from checklists such as the Vineland, and/or carefully chronicled historical information from whatever sources (especially institutional) are available. The DSM-IV uses concurrent deficits or impairments in present adaptive functioning of at least two of the following areas: communication; self care; home living; social/interpersonal skills; use of community resources; self

¹ 20 C.F.R. Part 404, Appendix 1, Listing 12.00C1, Listing 12.00C2, Listing 12.00C3.
² 20 C.F.R. Part 404, Appendix 1, Listing 12.00C4.
direction; functional academic skills; work; leisure; health and safety. However, school records often show functional academic deficiencies in terms of such things as attendance, conduct, grades passed or held back, as well as standardized achievement and intellectual tests. This type of documentation could in turn be easily translated into present day difficulties such as limitation of communication.


[a] Introduction

Psychological testing and assessment is as old as the discipline of psychology. Indeed, psychological testing has been part of life in the clinic, hospital, classroom, industry, and the military. There has been a great deal of discussion regarding the usefulness of psychological testing. In other words, what is the predictive and ecological validity of these tests? For example, if a person obtains a low intelligence score on an I.Q. test, does that mean that he or she is “retarded” as well as unemployable? Indeed, these types of questions challenge the validity of psychological tests.

The other side of psychological assessment is the applicability of real world behaviors to predict a patient’s hypothetical performance later in life. Adaptive behavior is related to an individual’s social competence—that is, how well the individual performs within a particular context and situation.

The American Association on Mental Retardation (AAMR) in its *Mental Retardation Definitions, Classification, and System of Groups*, established a definition of adaptive behavior that includes consideration of the relationship between adaptive behavior and the diagnosis of mental retardation. The AAMR defines adaptive behavior as “the collection of conceptual, social, and practical skills that have been learned by people in order to function in their everyday lives.” According to the AAMR, this definition was established because of its consistency with the structure of the current measures of adaptive behavior, and because it is also consistent with the current empirical research in this area. Adaptive behavior refers to the effective interaction of an individual and his or her environment, and the ability to deal effectively with personal and social demands; therefore, adaptive behavior is defined by a situation and it is specific to an environment.

It has been argued that adaptive behavior and social skills represent two aspects of social competence. Within this broad construct of social competence, adaptive behavior is related to how the social and cultural values of personal independence and

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social responsibility are effectively and appropriately accomplished by a particular individual.⁵

**PRACTICE GUIDE** Within the interaction of social competence, adaptive behavior includes aspects such as independent functioning, physical development, self-direction, personal responsibility, economic-vocational activity, and functional skills; social skills include interpersonal behaviors, self-related behaviors, academic-related skills, assertion, peer acceptance, and communication skills.⁶

It has been stated that adaptive behavior is a construct related to age. It is determined by the principles of other people, and it is defined by an individual’s daily performance, that is, what a person does day by day.⁷ The concept of adaptive behavior implies multiple factors, and different definitions have been proposed to describe this construct. One of those definitions was established by the American Psychiatric Association, which describes adaptive functioning as “how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected for someone in their particular age group, sociocultural background, and community setting.”⁸

[b] **Relationship Between Adaptive Behavior and Intelligence**

Adaptive behavior and intelligence are related to one another. It has been argued that both of them have common meaning, because it has been established that general adaptation is mediated by the level of intelligence.⁹ Measures of adaptive behavior assess behaviors related to physical and mental skills, abilities, and intelligence, because it has been determined that adaptive behaviors involve behavioral skills.¹⁰

**PRACTICE GUIDE** It is assumed that a person with mental retardation will have significant limitations in adaptive behavior.¹¹

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⁸ *Diagnostic and Statistical Manual of Mental Disorders (DSM IV)*, American Psychiatric Association, p. 42.


Different factors such as education, motivation, personality characteristics, social and vocational opportunities, and the mental disorders and general medical conditions that in many cases are presented with mental retardation may influence adaptive functioning.\textsuperscript{12}

The American Association on Mental Retardation has defined mental retardation as “a disability characterized by significant limitations both in intellectual functioning and adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before the age 18.”\textsuperscript{13} Even though the relationship between adaptive behavior and intelligence is clear, it has been argued that the measurements of these two constructs are significantly different. The difference between the two is that the measures of adaptive behavior are focused on the individual’s common and typical everyday performance, while intelligence measurement is used to determine the potential of maximal performance in areas related to language, academic skills, reasoning, and abstract abilities.\textsuperscript{14} In essence, then, adaptive behavior is “what is,” whereas intelligence is “what could be.”

[c] Measurement of Adaptive Behavior

The daily performance activities required for personal and social effectiveness are measured through adaptive behavior scales, particularly for individuals with and without handicaps in different settings and contexts.\textsuperscript{15} The assessment of adaptive behavior is used to determine how individuals function in their environment.\textsuperscript{16} The instruments employed to measure adaptive behavior are used to identify and classify individuals with variations in independent functioning and socialization expectations; additionally, they are employed with educational and instructional objectives.\textsuperscript{17}

Under the AAMR definition of adaptive behavior, it is established that deficits in adaptive skills include acquisition and performance deficits—that is, difficulties in knowing how to perform skills, difficulties knowing when to use learned skills, or other difficulties in the expression of skills. Those limitations of adaptive functioning are considered under dimensions of intellectual abilities, participation, interaction, social roles, health, and context.

According to DeStefano and Thompson, different kinds of information can be

\textsuperscript{12} Diagnostic and Statistical Manual of Mental Disorders (DSM IV), American Psychiatric Association.

\textsuperscript{13} American Association on Mental Retardation in its Mental Retardation Definitions, Classification, and System of Groups (AAMR).


obtained from adaptive behavior assessments; the characteristics of that information include identification and/or placement, program planning, monitoring or progress, and program evaluation.\footnote{DeStefano, L. and Thompson, D.S. (1990), Adaptive behavior: the construct and its measurement, (contained in Reynolds, C.R. and Kamphaus, R.W. (Eds.), Handbook of psychological and educational assessment of children: personality, behavior, and context (N.Y.: Guilford Press), pp. 445–469.)}

**PRACTICE GUIDE** DeStefano and Thompson explained that in order to understand an individual’s adaptive behavior it is necessary to obtain information from different contexts such as home, school, peer groups, and community. In addition, they indicated that interpersonal relations, social responsibility, cognitive competencies, and social skills are dimensions included in most adaptive behavior.\footnote{DeStefano, L. and Thompson, D.S. (1990), Adaptive behavior: the construct and its measurement, (contained in Reynolds, C.R. and Kamphaus, R.W. (Eds.), Handbook of psychological and educational assessment of children: personality, behavior, and context (N.Y.: Guilford Press), pp. 445–469.)}

As previously mentioned, the assessment of adaptive behavior has as its function the diagnosis, through which it is established the eligibility for services, benefits, and legal protection. However, according to the specific purposes of the assessment, different methods of measurement will have strengths and weaknesses in determining and/or evaluating adaptive behavior.\footnote{American Association on Mental Retardation, Mental Retardation Definitions, Classification, and System of Groups (AAMR). See also [d], [f], below.} For that reason it is important to select adequate instruments for each particular individual.

**[d] Adaptive Behavior Scales**

Among the adaptive behavior measures is the Vineland Adaptive Behavior Scales (VABS). Developed by Sara S. Sparrow, David A. Balla, and Dominic V. Cicchetti in 1984, the VABS is a structured interview that assesses personal and social adaptability from birth to adulthood. This measurement is composed of four general areas: (1) Communication, which includes receptive and expressive language; (2) Daily Living Skills, including the self-care activities of eating, dressing, washing, etc.; (3) Socialization, which measures interpersonal relations, such as play and leisure; and (4) Motor Skills, including gross and fine coordination.\footnote{Holden, R.H. (1994), Review of Vineland Adaptive Behavior Scales, (contained in Keyser, D.J. and Sweetland, R.C. (Eds.), Test Critiques (Vol. 1), pp. 715–719 (Kansas City, MO: Test Corporation of America).}

The interview edition of the VABS includes a Survey Form, used for screening, placement, and diagnostic purposes, and an Expanded Form, used for developing specific educational or treatment plans. The Survey Form, which includes 297 items, takes 20–60 minutes to administer; the Expanded Form includes 577 items, and its administration time is 60–90 minutes.\footnote{Campbell, I.A. (1985), Review of Vineland Adaptive Behavior Scales, (contained in Mitchell, J.V., Jr. (Ed.), Ninth Mental Measurements Yearbook (Lincoln, NE: Buros Institute of Mental Measurements), pp. 1660–1662.} A Classroom Edition of the Vineland is also
available, which is used to obtain adaptive behavior in the classroom setting. This 244-item form is completed by the teacher, and covers the ages 3 years to 12 years. 23

The VABS provides information about strengths and weaknesses in different areas that can be employed to develop educational, rehabilitative, and treatment programs. 24 The use of VABS in a variety of settings provides information for the diagnosis of disabilities, such as mental retardation, developmental delays, functional skills impairment, and speech/language impairment.

The VABS is a widely used instrument that has been employed in different settings with legal, clinical, and research purposes. 25 The popularity of the VABS as an adaptive behavior scales is due to its extensive norms obtained from populations with and without disabilities. 26 However, the effectiveness of these scales is limited when it is used with populations of adults with mental retardation, since it has a small normative sample size for the ages 18 and older, and these norms are usually employed to obtain scores for adults. 27

Recently a new version of the VABS has been developed, the Vineland-II, which addresses special issues regarding the assessment of adaptive behavior of individual with conditions such as mental retardation, Autism Spectrum Disorders (ASDs), Attention Deficit Hyperactivity Disorder (ADHD), post-traumatic brain injury, hearing impairment, and dementia/Alzheimer’s disease. According to its publisher, this new version includes updated and new norms, an expanded age range, and new items that will provide accurate information to diagnose or confirm the diagnosis of adaptive behavior deficits from birth to adulthood, to determine eligibility for special services, to plan intervention or rehabilitation programs, and to track and report the progress of the individual observed.

In addition to the VABS, there are other instruments such as the American Association on Mental Retardation Adaptive Behavior Scales—School and Community, 28 the Scales of Independent Behavior—Revised, 29 and the Comprehensive Test of

Adaptive Behavior–Revised,\textsuperscript{30} which, according to the AAMR, have appropriate psychometric properties and normative data on the general population. In addition, these tests provide scores in the conceptual, social, and practical skills domains included in the AAMR definition of adaptive behavior.

The AAMR Adaptive Behavior Scales (ABS)\textsuperscript{31} includes a school and community version, and a residential and community version. The first one is employed to diagnose adaptive functioning deficits and to determine the effectiveness of intervention programs in students. This version includes norms until age 21. The residential community version is for adults up to age 79; however, there are no norms available from adults with typical functioning. The Scales of Independent Behavior–Revised (SIB-R)\textsuperscript{32} is employed for diagnosis and planning supports for infants and adults. The Comprehensive Test of Adaptive Behavior–Revised (CTAB-R)\textsuperscript{33} is employed to assess independent functioning in different contexts. This test provides normative data for children, adolescents, and adults in school, community programs, and residential facilities settings.

Unfortunately, these scales are typically directed at the assessment of adaptive abilities in young, rather than mature, individuals. Further, the samples used in the normative studies are, as a rule, not well representative of non-majority groups, such as Hispanics.

[e] Research on Adaptive Behavior

Adaptive behavior has been the subject of much research in different areas, particularly those related to mental retardation and other mental and developmental disorders. It has been indicated that the assessment of adaptive behavior on mentally retarded children has received more attention than the assessment of adaptive behavior in other populations.\textsuperscript{34} Some authors have stated that little research has been conducted with the purpose to study the changes across time of the social skills of children and adults with intellectual disabilities.\textsuperscript{35}

Beadle-Brown, et al. conducted research to study the changes in social skills and social impairments in a population with intellectual disabilities and/or autism. They studied social and intellectual skills of children with intellectual disabilities and/or


autism under the age of 15. Later, they reassessed the same group of children when they were adolescents. These researchers found little change in social skills among the children—that is, the children who were socially impaired in the first assessment continued showing social impairment when they were assessed as adolescents. A few years later, Beadle-Brown, et al. conducted a follow-up study on the same group of individuals when they were adults, and specific measures of independent functioning, residential replacement, employment, and quality of life were included. The results indicated that there was little change in social skills. Overall, the authors of these longitudinal studies concluded that the group of individuals who showed social impairment when they were children tend to show the same impairment as adolescents and as adults. Furthermore, Beadle-Brown, et al. discussed how the level of impairment had the tendency to decline over time, probably because social demands became higher during adulthood.

[f] Limitations of Measurements of Adaptive Behavior

It is important to consider the different factors that play important roles in the measurement of adaptive behavior, especially in the context of the diagnosis of mental retardation. The Vineland, and most of the measures of adaptive behavior, are limited because of reduced validity, since these measures are completed with an informant who is usually related to the individual being assessed. The use of an “informant” is one of the many limitations regarding the assessment of adaptive functioning. Other problems include the limits of applicability to non-majority, adult, or forensic circumstances. In turn, such applications potentially reduce the accuracy of the assessment.

DeStefano and Thompson have pointed out the weaknesses of the adaptive behavior assessment in different areas, emphasizing the directions that need to be given in order to overcome them. These authors argued for third party interviews in contrast to clinical or naturalistic observations, indicating that new interview methods need to be developed. They cited the advantages of obtaining information from multiple informants familiar with the different aspects of the life of the individual under assessment. In addition, they pointed out that for the identification, placement, and planning purposes, it is important to take into account other educational and independent living variables.

The selection of the appropriate adaptive behavior measures include the purpose of the assessment, such as diagnosis, classification, planning for support, the psychomet-

36 American Association on Mental Retardation, Mental Retardation Definitions, Classification, and System of Groups (AAMR); Beail, N. (2003), Utility of the Vineland Adaptive Behavior Scales in diagnosis and research with adults who have mental retardation, Mental Retardation, 41(4), 286–289.
37 See [d], above.
38 See [a]–[c], above.
ric properties, appropriateness of the measure for the individual, and purpose of the diagnosis.\textsuperscript{40}

[g] Documenting Deficits in Adaptive Functioning

The definition of mental retardation requires deficits in adaptive functioning initially manifested during the developmental period; i.e., the evidence demonstrates or supports onset of the impairment before age 22. Generally, individuals with an I.Q. of 70 or below will have deficits in adaptive functioning manifested prior to age 22. The American Association of Mental Retardation sets out specific examples of the adaptive behavior skills that include the following:\textsuperscript{41}

CONCEPTUAL SKILLS

1. Language (receptive and expressive), which includes reading and writing, the ability to express oneself verbally and to understand what is being said
3. Time and number concepts
4. self-direction

INTERPERSONAL/SOCIAL SKILLS

1. Social responsibility.
2. Self-esteem.
3. Gullibility
4. wariness.
5. Follows rules/obeys
6. avoids being victimized.
7. Social problem solving.\textsuperscript{41.1}

PRACTICAL SKILLS

1. Activities of daily living (personal and self care).
2. Occupational skills (obtaining and retaining employment).
4. Safety.
5. Health care.
6. Travel/transportation.
7. Schedule/routine.

\textsuperscript{40} American Association on Mental Retardation, *Mental Retardation Definitions, Classification, and System of Groups* (AAMR).

\textsuperscript{41} American Association on Intellectual and Developmental Disabilities (AAIDD), www.aamr.org/Policies/faq_mental_retardation.shtml. See also: AAIDD Manual at p. 44

\textsuperscript{41.1} Id.
CONCEPTUAL SKILLS: PRACTICAL EXAMPLES
1. The ability to express oneself’s clearly to others.
2. The ability to express one’s needs.
3. The ability to understand what others say.
4. The ability to read, interpret, and comprehend what he/she reads (read and understand the newspaper).
5. The ability to write in a clear understandable manner.
6. The ability to understand the value of money and how to make change.

PRACTICAL SKILLS: PRACTICAL EXAMPLES
1. The ability to pay bills (the ability to balance a checkbook).
2. Ability to tell time.
   • Ability to use public transportation.
   • Ability to obtain a driver’s license.
   • Ability to obtain a driver’s license.
   • Ability to make reasonable medical decisions.

SOCIAL SKILLS: PRACTICAL EXAMPLES:
1. The ability to get along with others.
2. The ability to know how to handle verbal conflicts.
3. The ability to handle stress induced by others.
4. The ability to make appropriate relationships/boundaries.
5. The ability to avoid being victimized.
6. The ability to obtain and maintain steady employment (the ability to perform work on a regular, reliable and productive basis (often you will see a work record marked by sporadic work in unskilled occupations in which the claimant was dependent upon the support of relatives, friends or co-workers to produce at a productive pace and at the prescribed quality standards of the job)
7. Has the claimant demonstrated the ability to live on his own and to maintain a household (or perform household chores consistently and reliably)?

Deficits in any 2 areas of either conceptual skills, social skills, or practical skills, is an indication of significant deficits in adaptive function. The Social Security Administration has indicated that it will rely on the definition of adaptive function from professional organizations like AAIDD or the American Psychiatric Association.41.2

41.2 see 67 FR 20018 Technical Revisions to Medical Criteria for Determinations of Disability 20 CFR 404 (4/24/02).
DEVELOPING THE RECORD TO DOCUMENT A CLAIMANT'S CONCEPTUAL DEFICITS

1. Review of school records. Determine whether the claimant was in a regular classes or special education classes and whether the claimant graduated from High School or received a certificate, which happens for many in Special Education classes.

2. Review school records for grades in math and English to determine how well he performed—whether he passed.

3. Review school records to determine whether the claimant dropped out of school (at what age did the claimant drop out of school?)

4. Do the school records indicate that the claimant failed any grades, if so, how many grades did the claimant fail?

5. Have the Wide Range of Achievement Test or Woodcock-Johnson Test administered to the claimant, which provides grade equivalent scores for reading, math, and language.

6. Ask the claimant whether he was able to read the test to obtain a driver's license, or did he have the test administered orally?

7. Ask the claimant whether he ever attempted to enter the military, and if he was not admitted, was it because he their written test?

8. Administer one of the adaptive function tests

Remember that deficits in adaptive function must be manifested prior to age 22. This is the primary reason school records play such an important role in establishing deficits with regard to academic performance and reading and writing ability. In the case of Turner vs. Bowen, the court held that illiteracy was a clear manifestation of deficits in adaptive function.\textsuperscript{41,3}

CASE STUDY

Mr. Ferguson was 34 years of age at the time he was last able to work in January 1, 2007. He had completed the 7th grade in special education, when he dropped out of school. His school records indicated that he had “problems with reading”, and he testified at hearing that he acquired a driver's license by having the test read to him. He suffered a traumatic injury to his left leg in a dirt bike accident that required surgical repair, but it remained painful such that he required the use of a cane. The Wechsler Adult Intelligence Test demonstrated that he possessed an I.Q. Of 70, and The Woodcock-Johnson Test showed that his math, formal reading, and written language abilities fell 2 standard deviations below the norm.

Mr. Ferguson worked as a welder for 15 years, which he learned through the guidance of his uncle with whom he worked for much of the 15 years, but because of

\textsuperscript{41,3} see Turner v. Bowen, page 55, 2nd, F .2d 695, 699. (4th Cir. 1998).

See also Lackey v. U.S. Department of Health and Human Services, 890 F.2d 666, 668 (4th Cir. 1989).

injury to his leg and back pain, he could no longer stand as required to perform his work. There was clinical evidence that he walked with an antalgic gait, ambulated with a cane, had limited range-of-motion of the lumbar spine with impaired ability to bend at the waist, indicating he could not bend more than occasionally. Lumbar pain, he stated, limited his ability to sit to 10-15 minutes at a time. Finally, Mr. Ferguson had been sent to anger management classes by the courts for his public altercations and fights.

At hearing, we argued the Diagnostic and Statistical Manual-IV-TR (DSM-IV-TR) of the American Psychiatric Association states that an individual who has deficits in any two of the following domains has demonstrated deficits in adaptive functioning and taken with the I.Q scores, his documented impairment related inability to perform his past work, he should be found disabled under Listing 12.05C.

The 10 domains including the following:

1. Communication.
2. Self-care.
3. Home living.
4. Social/interpersonal skills.
5. Using community resources.
7. Functional academic skills.
8. Work.

We argued that Mr. Ferguson had well-documented deficits in functional academic skills and social skills, as indicated by his school record, his need for special education classes and his dropping out of school. He also had demonstrated deficits of social skills, as indicated by his court directed anger management. There was also clear indication of deficits in his ability to perform simple math and reading, as indicated in his school records and the results of the Woodcock-Johnson Test. It is clear that this physical problems markedly impaired his ability to function at more than a sedentary level. Therefore, it was established that his I.Q. fulfilled the requirements of listing 12.05C.\textsuperscript{41,4}

The American Psychiatric Association has set out criteria for adaptive functioning which include the following:\textsuperscript{42}

Evidence of deficits or impairments in present adaptive functioning of a person's effectiveness in meeting the standards expected of his or her age by his or her cultural group in at least two of the following areas:

\textsuperscript{41,4} See Social Security ruling 96-8p.
\textsuperscript{42} Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, p. 46.
1. Communication;
2. Self care;
3. Home living;
4. Social/interpersonal skills;
5. Use of community resources;
6. Self direction;
7. Functional academic skills;
8. Work;
9. Leisure;

Deficits in functional academic skills can be readily documented by school records, such as when an individual was in special education classes, was held back in school, failed a grade, or dropped out of school. It can further be argued that by dropping out of school or failing in school, the claimant has also demonstrated deficits in self direction. Individuals who have been arrested have demonstrated deficits in social/interpersonal skills and safety. Deficits in communication can be documented through standardized testing used in school, through the grades for writing or language arts, or through scores from the Wide Range Achievement Test.

Deficits in other areas such as home living and self care would have to be documented either through one of the adaptive function tests, such as the Vineland test,\footnote{See [d], above.} or through testimony from a relative.

Administrative Law Judges like to point to the fact that the claimant worked after age 22 as indication that there is no evidence of deficits in adaptive functioning. In such a case, one should point to the research done by Beadle-Brown, et al., that an impairment in adaptive functioning has a tendency to decline over time, probably because of social demands,\footnote{See [e], above.} and that Listing 12.05C requires that deficits in adaptive functioning be manifested prior to age 22.

The Commissioner of Social Security has argued that an I.Q. in the 60’s is not consistent with the claimant’s demonstrated life functioning, when a claimant testified

\textit{(Text continued on page 40-75)
that he obtained a driver’s license, was able to work in the past, and was able to perform simple household functions.\textsuperscript{45}

In \textit{Markle v. Barnhart},\textsuperscript{46} the Third Circuit held that the claimant had the burden of establishing that mental retardation commenced during the developmental period and that there was competent evidence during that time of deficits in adaptive functioning. The court held that it was error to discount the I.Q. tests performed after age 22 to meet this standard; the test was whether the sub average intelligence with deficits in adaptive functioning were initially “manifested” during the developmental period. Mr. Markle was in special education through ninth grade and dropped out after two months into the tenth grade. Then he “struggled” to obtain a GED in the 1970’s. He had very limited work history. The court remanded the case with instructions for the ALJ to develop the record regarding the claimant’s special education and the nature of his special education, and to obtain an expert’s opinion as to the likely onset of claimant’s retardation.

In \textit{Luckey v. U.S. Department of Health and Human Services},\textsuperscript{47} the Fourth Circuit held that there must be evidence of significantly sub average general intellectual functioning with deficits in adaptive behavior initially manifested prior to age 22. The court noted that the Secretary’s regulation expressly defined mental retardation as a “lifelong condition,” citing \textit{Branham v. Heckler}.\textsuperscript{48} Therefore, I.Q. testing conducted after age 22 can be presumed to apply to the developmental period, because I.Q. scores are—unless there is an intervening event, such as head trauma—presumed to be a lifelong condition. Luckey’s inability to read was a clear indication of deficits in adaptive functioning (lack of communication skills and lack of academic skills). The court again noted that the Social Security Administration could not rely on his previous work history to prove non-disability due to mental retardation, citing \textit{Murphy v. Bowen}, in which the court held that where a claimant satisfies the criteria of a disability Listing, disability is warranted “notwithstanding any prior efforts of the claimant to work despite the handicap.”\textsuperscript{49}

If the claimant’s history is consistent with the current level of functioning as found on these tests, it is not necessary to establish that the claimant’s deficits in adaptive functioning were present prior to age 22. In \textit{Hodges v. Barnhart}, the 11th Circuit found that a claimant was not required to present evidence of deficits in adaptive functioning prior to age 22 when she presented evidence of a low I.Q. after the age 22. Here the court reasoned that retardation is not normally a condition that improves as the affected person ages. The court also cited Social Security’s remarks in the preamble to Listing 12.00 in which the administration comments as follows:\textsuperscript{50}

The proposed listing . . . stated that the significantly subaverage general intellectual functioning with deficits in adaptive behavior must have been initially “manifested”

\begin{footnotesize}
\textsuperscript{45} Brown v. Secretary of HHS, 948 F.2d 268, 270 (6th Cir. 1991).
\textsuperscript{46} Markle v. Barnhart, 324 F.3d 182 (3rd Cir. 2003).
\textsuperscript{47} Luckey v. U.S. Department of Health and Human Services, 890 F.2d 666 (4th Cir. 1989).
\textsuperscript{48} Branham v. Heckler, 775 F.2d 1271, 1274 (4th Cir. 1985).
\textsuperscript{50} Hodges v. Barnhart, 276 F.3d 1265 (11th Cir. 2001). \textit{See also} 65 Fed. Reg. 50746, 50772 (Aug. 20, 2000).
\end{footnotesize}
during the developmental period. We have always interpreted this word to include the common clinical practice of inferring a diagnosis of mental retardation when the longitudinal history and evidence of current functioning demonstrate that the impairment existed before the end of the developmental period.

Wide Range Achievement testing is also recommended for determining deficits in adaptive functioning, as this test can determine whether the claimant is functionally illiterate. Illiteracy would demonstrate deficits in functional academic skills and written communications. We should fulfill the requirements for demonstrating deficits in adaptive functioning.

The claimant must have a physical or mental condition that imposes additional and significant work related limitation of function to qualify for disability under this Listing. Social Security has clarified this to mean that the claimant has a severe impairment as defined in 20 C.F.R. §§ 404.1520(c), 416.920(c).\footnote{52}


Autism is best understood through history and interview. Indeed, the behavior patterns include easy to identify markers such as stereotypical behaviors. Retardation is almost always diagnosed using psychological tests. The Wechsler scales of intelligence are by far the most commonly used. Although the most common tests are the WISC (children) and the WAIS (for adults), other tests are sometimes used (e.g., Stanford-Binet, Kaufman, etc.). Sometimes tests such as the Raven, BETA, or GAMMA might serve as a good alternative for patients with communication difficulties and/or illiteracy. It might also be valuable to document academic abilities with achievement tests such as the WRAT.

§ 40.10 Anxiety Related Disorders—Listing 12.06

[1] Text of Listing 12.06

Listing 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

\footnote{51 [Reserved]}
\footnote{52 McDaniel v. Bowen, 800 F.2d. 1026, 1031 (11th Cir. 1986).}
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. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration.

OR

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


Part B is often misunderstood or ignored in psychological evaluations. This section of the listings involves understanding the impact of a diagnostic problem (e.g., brain damage) on its functional capacity. Hence, the focus is on the assessment of the problem’s severity. Restrictions of daily living, difficulties in maintain social functioning, deficiencies in concentration, persistence, or pace, and repeated episodes of deterioration or decompensation in work or work-like settings need to be individually addressed. These activities of daily living can best be understood by careful history-taking as well as collateral interviews of accompanying significant others. Activities of daily living include such things as cooking, cleaning, transportation, and independence. Social functioning involves the “capacity to interact independently, appropriately, effectively, and on a sustained basis”. Concentration, persistence and pace involve the ability to sustain attention and concentration for a relatively lengthy period of time.\(^1\)

Finally, episodes of decompensation relate to the claimant developing problems during periods of structured activity or employment. Technically, this involves three episodes of deterioration lasting at least two weeks each time or an average of once every four months. If possible, relating the results of the psychological tests to the information contained in the interview, especially as it relates to activities of daily living, would be valuable.\(^2\)

[3] Description

Anxiety disorders are comprised of generalized anxiety, phobias, and obsession-compulsion. Each of these three are quite different from each other. For example,

\(^1\) 20 C.F.R. Part 404, Appendix 1, Listing 12.00C1, Listing 12.00C2, Listing 12.00C3.

\(^2\) 20 C.F.R. Part 404, Appendix 1, Listing 12.00C4.
generalized anxiety is marked by increased psycho-physiological function (e.g., heart rate) as well as hypervigilance and a sense that the future holds only problems. Phobia is fear-mediated avoidance. Obsession is the mental aspect while compulsion is the behavioral expression of an illogical but "required" stereotypical behavior (e.g., cleanliness to an extreme such as constant hand washing).


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

§ 40.11 Somatoform Disorders—Listing 12.07

[1] Text of Listing 12.07

Listing 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 at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration.


Part B is often misunderstood or ignored in psychological evaluations. This section of the listings involves understanding the impact of a diagnostic problem (e.g., brain damage) on its functional capacity. Hence, the focus is on the assessment of the problem's
severity. Restrictions of daily living, difficulties in maintain social functioning, deficiencies in concentration, persistence, or pace, and repeated episodes of deterioration or decompensation in work or work-like settings need to be individually addressed. These activities of daily living can best be understood by careful history-taking as well as collateral interviews of accompanying significant others. Activities of daily living include such things as cooking, cleaning, transportation, and independence. Social functioning involves the “capacity to interact independently, appropriately, effectively, and on a sustained basis”. Concentration, persistence and pace involve the ability to sustain attention and concentration for a relatively lengthy period of time. Finally, episodes of decompensation relate to the claimant developing problems during periods of structured activity or employment. Technically, this involves three episodes of deterioration lasting at least two weeks each time. If possible, relating the results of the psychological tests to the information contained in the interview, especially as it relates to activities of daily living, would be valuable.

[3] Description

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


Several tests can be used in conjunction with the interview and a well-documented history (with medical records). The tests include the MMPI, especially of the ancillary scales, and the Millon. Several other lesser known tests have also proven to be valuable for specific types of this disorder.

§ 40.12 Personality Disorders—Listing 12.08

[1] Text of Listing 12.08

Listing 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 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 at least two of the following:
1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration.


Part B is often misunderstood or ignored in psychological evaluations. This section of the listings involves understanding the impact of a diagnostic problem (e.g., brain damage) on its functional capacity. Hence, the focus is on the assessment of the problem’s severity. Restrictions of daily living, difficulties in maintaining social functioning, deficiencies in concentration, persistence, or pace, and repeated episodes of deterioration or decompensation in work or work-like settings need to be individually addressed. These activities of daily living can best be understood by careful history-taking as well as collateral interviews of accompanying significant others. Activities of daily living include such things as cooking, cleaning, transportation, and independence. Social functioning involves the “capacity to interact independently, appropriately, effectively, and on a sustained basis”. Concentration, persistence and pace involve the ability to sustain attention and concentration for a relatively lengthy period of time.¹

Finally, episodes of decompensation relate to the claimant developing problems during periods of structured activity or employment. Technically, this involves three episodes of deterioration lasting at least two weeks each time or an average of once every four months. If possible, relating the results of the psychological tests to the information contained in the interview, especially as it relates to activities of daily living, would be valuable.²

[3] Description

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


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

¹ 20 C.F.R. Part 404, Appendix 1, Listing 12.00C1, Listing 12.00C2, Listing 12.00C3.
² 20 C.F.R. Part 404, Appendix 1, Listing 12.00C4.
§ 40.13 Substance Addiction Disorders—Listing 12.09

[1] Text of

Listing 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.
F. Liver damage. Evaluate under 5.05.
G. Gastritis. Evaluate under 5.00.
H. Pancreatitis. Evaluate under 5.08.
I. Seizures. Evaluate under 11.02 or 11.03.

[2] Elimination of Drugs and Alcohol as a Basis for Qualifying for Disability Benefits

The Social Security Independence and Program Improvements Act of 1994, Public Law Number 103-296, enacted on August 15, 1994, changed the rules regarding the treatment of cases in which alcoholism or drug addiction was a contributing material factor to the determination of disability. The legislation defined an individual whose alcohol or drug abuse was a contributing factor material to the determination of disability as one in which the claimant would “not otherwise be disabled but for alcoholism or drug addiction.”

Under this legislation, restrictions were placed on individuals as to how much they could receive disability benefits (36 months), and how much they could receive in retroactive benefits (benefits were paid in the amount of two times the monthly benefit

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rate); benefits were paid to a representative payee and they had to seek treatment.\(^2\)

With this reform as a backdrop, in 1996 the Congress passed sweeping legislation regarding disability beneficiaries who were found disabled on the basis of drug or alcohol addiction. Effective March 29, 1996, no benefits are payable on a Title II or SSI disability claim in which either drugs or alcohol is material to a finding of disability.\(^3\)

This new legislation applies to any case that is “finally adjudicated” on or after March 29, 1996.

[a] Payment of Benefits to DA&A Claims Adjudicated Before March 29, 1996

Individuals who were found disabled on the basis of drugs or alcohol (DA&A) on or after March 29, 1996, will no longer be entitled to benefits as of January 1, 1997. Those individuals who were found disabled on this basis before March 29, 1996, and who are currently receiving disability benefits will have their benefits cease January 1, 1997. This new legislation effectively repeals the 36 month durational requirement for receipt of benefits on the basis of DA&A enacted under the 1994 legislation.

Any DA&A case finally adjudicated before March 29, 1996, will be processed but benefits will be terminated effective January 1, 1997.

SPECIAL NOTE Under the terms of the new legislation, an individual found disabled as a DA&A recipient on or after March 29, 1996, would not be paid retrospective benefits or retroactive benefits. In other words, if an Administrative Law Judge issued a decision on or after March 29, 1996, in which he or she found a DA&A claimant disabled from 1992, the claimant would not receive any of the retroactive benefits or prospective benefits.

[b] Notification of DA&A Recipients as to the Right to Redesignation and Readjudication of Their Claims

The Social Security Administration is required under this new legislation to notify DA&A beneficiaries within 90 days of March 29, 1996—June 27, 1996—that their benefits will be terminated effective January 1, 1997. Such beneficiaries will be notified that they have 120 days from the date of enactment—until July 27, 1996—to reapply and have their cases reviewed to determine whether they could qualify for disability on the basis of other impairments. The Social Security Administration is then required to reevaluate these claims and render a new determination on or before January 1, 1997.

[c] Representative Payee and Treatment Requirements

For those who are not DA&A but whose claims involve drugs or alcohol, Public


\(^3\) Public Law 104-121, 110 Stat. 847 (1996). See App. § 40M.
Law 104-121 requires that an individual who is eligible for disability on the basis of an impairment other than drugs or alcohol but who suffers from some alcohol or drug addiction and who is incapable of managing his or her benefits will have a representative payee appointed. Such individuals are also required to report to the State agency administering the Substance Abuse Treatment Block Grant for treatment. Congress appropriated $50,000,000 in additional substance abuse treatment monies for fiscal years 1997 and 1998.

[3] When DA&A is a Contributing Factor Material to the Determination of Disability

For an individual to be disqualified for receipt of disability benefits on the basis of drugs and alcohol, drugs and alcohol must be “a contributing factor material to the

(Text continued on page 40-83)
determination of disability." 4 Drugs and alcohol are a contributing factor material to the determination of disability when they form the exclusive basis for the finding of disability. In other words, the claimant would not be found disabled were it not for his or her alcohol or drug abuse. If there are other grounds for finding the claimant disabled such as found in the following case study of Natalie, below, then drugs and alcohol (DA&A) is not a contributing factor material to the determination of disability. 5

A claimant’s use of drugs or alcohol does not necessarily disqualify him or her from receiving disability, if that claimant has other disabling conditions. The State Disability Determination Sections and many judges seem to have trouble interpreting this regulation. They seem to want to interpret it to mean that, when the individual uses drugs or alcohol, DA&A is a contributing factor material to the determination of disability. That is simply not the case.

CASE STUDY

Natalie is a young woman who has not worked regularly since 1989 due to undifferentiated schizophrenia. She also has some history of drug and alcohol use. The psychiatrist to whom she was referred by Social Security diagnosed her with polysubstance abuse and factitious disorder, ignoring altogether the primary diagnosis from her treating psychiatrist of undifferentiated schizophrenia. Thus, the Administrative Law Judge who conducted her hearing entered the case with a bias that this was a drug abuser who could be disqualified from disability by virtue of the DA&A regulations.

In fact, Natalie had not used alcohol or drugs for seven months and then only on one occasion. She was on probation because of activity related to her “command hallucinations.” Each month her probation officer had her undergo a drug test, which was negative all but one month. Her treating physician made it clear that her primary diagnosis was undifferentiated schizophrenia characterized by command hallucinations and paranoid delusions. Natalie spends most of her day in a closet in her bedroom; she has lost custody of her children because she is afraid she might hurt them. She has lost many jobs in the past because of her paranoia and fear that others would hurt her or she would hurt them. It was clear from her treating psychiatrist’s report that her condition was characterized by all the clinical features discussed in Listing 12.03 and that she was disabled as a result. In this case, DA&A did not apply as it was not a contributing factor material to the determination of disability. It would not have been even had Natalie been consuming drugs or alcohol. 6

§ 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

4 See 20 C.F.R. § 404.1535.
5 See 20 C.F.R. § 404.1535(b)(2)(ii).
6 See Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition), The American Psychiatric Association, 1994, pp. 32, 761 (Global Assessment of Functioning Scale (GAF) and Social and Occupational Functioning Assessment Scale (SOFAS)).
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.

There is an interplay between a pain syndrome and depression, which is understood by looking at the two neuropathic pathways for discerning pain in the spinal cord. One is the A delta pain sensory tract, which transmits acute pain. If you place your hand on a hot stove, the signal is immediately transmitted to the brain through this neuro-pathway and the brain commands the hand to move.

The other pathway is the C fiber pathway for chronic pain in which serotonin is transmitted from the brain to help alleviate pain. An individual has only a certain amount of serotonin in the brain to help with this process. It also serves to regulate sleep, concentration and appetite. When a chronic pain syndrome more or less constantly stimulates C fibers requesting serotonin, there is a diminished amount of serotonin in the brain to regulate and modulate sleep, concentration, and appetite. This diminished serotonin capacity can be viewed as a medical or organic explanation for the development of depression. The serotonin delivery system is one way in which the central nervous system both inhibits and modifies pain messages.\footnote{1,01}

Both organic and psychogenic\footnote{1} 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 is a complicated psychophysiological phenomena, often diagnosed and treated by the neurologist, neurosurgeon, psychiatrist, oncologist\footnote{2} 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).\footnote{3}

**PRACTICE GUIDE**

The assessment of pain requires a detailed physical examination and assessment of the patient’s pain, a sample of which is provided in the sample report found in the Appendix to this section.\footnote{4}

\footnote{01 See also App. § 40R.}

\footnote{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.

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

\footnote{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.

\footnote{4} See App. § 40O, Sample Report on a Chronic Pain Patient.

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.

<table>
<thead>
<tr>
<th>Test</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>McGill Pain Questionnaire</td>
<td>Both a structured interview and questionnaire available; widely respected.</td>
</tr>
<tr>
<td>Pain Apperception</td>
<td>Semi-projective test with long history of use in the field.</td>
</tr>
<tr>
<td>Zung Pain Scale</td>
<td>Brief, easy to administer and score pain screening instrument.</td>
</tr>
<tr>
<td>Hendler’s Questionnaire</td>
<td>Used for low back pain patients.</td>
</tr>
<tr>
<td>Related tests</td>
<td>MMPI;⁵ Zung Depression Scale; Millon; State-Trait Anxiety.</td>
</tr>
</tbody>
</table>

§ 40.15 Summary

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

Case Examples

The following cases represent recent examples of individuals who were referred for the psychological assessment of disability. The sample of presented cases reflects referrals from three separate sources: Legal Services; private legal representatives; and Social Security. These cases represent typical, rather than unusual or clear cases of mental impairment. In order to reflect this approach, these three cases were drawn from the last six cases seen by the author for psychological assessment of disability. A fourth case is included to illustrate in greater detail the format of a psychological report as well as the presentation of psychological test data.

Organic Brain Syndrome—Epilepsy. General History and Status: Born with epilepsy. Was able to complete the 8th grade with significant difficulties. Terminated school with an

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⁵ 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.
average grade of F. He has been in prison approximately ten times. Seizures are treated aggressively by neurologist but poor medication compliance has occurred. He has been employed only once, by his uncle for 1.5 days. Was terminated due to a seizure on the job. He does not have a driver’s license, nor a checking account, and relies on family for assistance in these and related matters. He presents as poorly groomed and hygiene with over one dozen tattoos and related clothing. Testing: Unable to complete the WAIS due to its level of difficulty and instead the Peabody Picture Vocabulary was administered. The score places him in the mildly retarded range. The Wide Range Achievement Test verified that he is functionally illiterate. Summary: Meets Part A of the 12.02 as well as Part B.

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

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

*Abbreviated Neuropsychological Evaluation With a Follow-Up.* The following report provides an illustration of a “typical” psychological/neuropsychological evaluation. Note that the WAIS was not (re)administered in this case as other tests provided more critical information. Also, this is a particularly interesting case in that a medical problem, epilepsy, had numerous health, psychological, and social ramifications. In addition, the opportunity for a follow-up evaluation (for the purposes of the application) was provided.

**Consultation**

Identifying Information:

Name: D.M.
DOB: 8/05/71
Age: 27
Race: Caucasian
Sex: Male
Handedness: Right
Date: 4/24/99

**Reason for Referral and Evaluation Procedure:** D.M. was referred by his attorney. He was subsequently interviewed.

**Review of Records:** The only thing that was available was a letter from the Social Security Administration of April 10, 1999, indicating that he was able to return to gainful employment as of 5/99. It was said in the letter that there was evidence of epilepsy but that the headaches were not severe enough to not return him to work and the growth that was in his head “does not affect your ability to work.” Furthermore, that the “mental problems had greatly improved.”

This was based on what appear to be notes from the neurologist. Apparently this individual has also been in several hospitals.

Apparently he has been disabled due to organic mental disorder and mental retardation since 10/02/89.

**General History:** D.M. indicates that he was born in North Carolina. His father is a painter who is retired and is an alcoholic. He is 27 years of age. His mother died in 1987 due to leukemia. One brother is in prison for having stolen an automobile.

D.M. indicates that he attended school through approximately 8th grade but he was kicked out at that point. He had a bad temper and was involved in many fights. The average grade was an F.

He says that he has been in jail seven, eight, or possibly nine times due to bad checks, drinking under age, and assault in the early days. He has not gotten into a fight for a long time. He said he started going to jail as a juvenile and the last time he was there was four years ago.

As to work, D.M. indicates that he never had gainful employment. He has done odd jobs here and there for a few hours. The only job that he did have was about 6 years ago with his uncle. He had not told his uncle about his epilepsy and the second day at work he had a seizure and his uncle discharged him from his position.

From what I can gather he is seen by his neurologist on a regular basis for his seizures.

**PRESENTING COMPLAINTS:** According to D.M. he says he says he has several problems.

One of them is a knot on the top of his head that was diagnosed by Dr. D. The knot was removed by Dr. J who sent him to Dr. H. Dr. H. said it was not cancerous but, since that point, he has had bad headaches every day, ten times worse than a migraine, and nothing seems to resolve them. He says he also has a knot on his back at the present time.
The other major issue is that he has epilepsy, was born with this. He was on phenobarbital, then Dilantin, currently at 500 mg t.i.d. on Depakote. He has been pretty stable for the last 3–4 years and, as indicated earlier, is being followed by his neurologist.

This situation is causing him to have no energy and he is very drowsy. This could be secondary to the medications. He says he also has problems with memory and he always forgets things and if it were not for his cousin and his wife, he would be in trouble in regards to memory.

**ACTIVITIES OF DAILY LIVING:** D.M. says his life is relatively simple. He wakes up, does some laundry, some chores, tries to keep busy. He tried to do some yard work recently but that caused him a headache. Even after 30 minutes he was not even quite back to where he was before the activity. The headaches are secondary to, in his view, the removal of the “knot” in his head.

D.M. says he has never been gainfully employed and his one stint as a pony assistant for a couple of days was unsuccessful. He does not have a driver’s license at present and has never had one. He has also never driven and he gets driven to everywhere he goes. He lives with his cousin and his cousin’s wife. They are both employed. The cousin’s wife does the shopping and she pays the bills. He pays her cash from time to time. He obtains direct deposit from Social Security and that is what he uses to live on. He has no girlfriends and he likes to be more socially active with his cousins.

**BEHAVIOR:** D.M. is a relatively large, Caucasian, right-handed, male of his stated age. He wears a Chevrolet cap and Hank Williams, Jr. T-shirt. He sports 12 different tattoos ranging from a rose to animals. It appears that his friend is a tattoo artist and as a consequence gives him tattoos for free. He is pleasant and easy to relate to, cooperative. He is quiet, was not terribly spontaneous. However, he understood the purpose of the evaluation and participated accordingly.

Antonio E. Puente, Ph.D.

cc: Attorney

**EVALUATION PROCEDURES:** D.M. was tested on several occasions, including 06/02/99 and 06/04/99. Follow-up dictation is occurring on 06/12/99.

**NEUROPSYCHOLOGICAL TEST RESULTS:**

*Visual Motor:* The Manual Finger Tapping Test yielded scores of 37.4 and 49.2, which are well within normal range. The same is found on Part A of the Trail Making test where he obtained a score of 22. However when there was a significant cognitive component, as in the case of Part B of the Trail Making Test, his scores of 86 place him in the mild to moderate impairment. On the Symbol Digit Modalities Test he scored approximately one standard deviation below the mean for his age and education. The Raw score of 49 is lower than the average of 53.36.

*Problem Solving:* The Hooper Visual Organization Test yielded a score 25 which is the cutoff for impairment. He obtained a score of 120 correct and only 8 incorrect with 9 categories in the Wisconsin Card Sorting Test, his scores were within normal limits. However on the Halstead Category Test, Adult Form, he obtained 60 errors, which is below average with a T of 41.
Intellectual: The Peabody Picture Vocabulary Test, Third Edition, was administered. Due to the fact that on the day that this was done (06/2/1999), D.M. had a very bad headache, secondary to a recent seizure. His raw score of 138 yielded the same score as 76. The percentile rank is five. The age equivalent is 11.02.

Academic: The Wide Range Achievement Test-Revision Three yielded scores that were approximately in the lower one percentile of the population. The table below indicates the overall findings.

<table>
<thead>
<tr>
<th>SUBTEST</th>
<th>RAW SCORE</th>
<th>PERCENTILE</th>
<th>GRADE SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading</td>
<td>28</td>
<td>.6</td>
<td>2</td>
</tr>
<tr>
<td>Spelling</td>
<td>20</td>
<td>.09</td>
<td>1</td>
</tr>
<tr>
<td>Arithmetic</td>
<td>27</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

Personality: The MMPI-2 was administered but it could be considered to be invalid, in part because of the T-score of 85 and the F. There is also an F minus K dissimilation index of plus 8, suggesting this individual either does not understand the test or potentially is presenting himself in an overly negative light.

SUMMARY: D.M. is a 27 year old, Caucasian, right handed male, with a history of epilepsy. He comes from a complicated family history. He quit school in the 8th Grade, in part because the average grade at that point was an F. He has been in jail eight or nine times, ranging from bad checks to assault. He has had seizures and been treated by his neurologist. The seizures have been present all of his life. He has been relatively stable for the last 3–4 years and is on 500 mg t.i.d. of Depakote. He does relatively little. He keeps himself busy around the house and tries to keep the house intact. He has never been gainfully employed and does not have a driver’s license. He lives with his cousin and his wife and they are the ones that provide most of every basic necessity for him.

On the second day of testing he had experienced a seizure approximately one and a half days before. He fell in the back yard, passing out, bumping his head, and injuring his wrist. He has had a constant headache since then and today, on the day of the final consultation, he reports being nauseous and not focused and having a splitting headache. Indeed, as a consequence, the testing was limited and the Peabody Picture Vocabulary Test, instead of the Wechsler Adult Intelligence Scale, was administered. After that, relaxation response was taught, with significant success.

D.M. appears to have a combination of problems including, but not limited to, epilepsy. The epilepsy is causing what appears to be mild to moderate organicity. This is combined with what appears to be cultural-related retardation with IQ’s hovering only in the 5th percentile. The possibility of personality disorder certainly plays a role, in light of the long standing difficulties with the law.

Despite the fact that his epilepsy has been well-controlled, recent episodes would suggest otherwise. I do not believe that D.M. is capable of living on his own, handling his own funds, and history has shown he has never been, and most likely will never be, gainfully employed. If I can be of any further assistance, do not hesitate to contact me.
ANTONIO E. PUENTE, PH.D.

cc: Attorney

**EVALUATION PROCEDURE:** This individual was tested on 06/4/01 and interpretation and dictation are occurring on the same day.

**PSYCHOMETRIC TEST RESULTS:**

The results of the Wechsler Memory Scale-Third Edition provide continuing evidence of significant deficits with regards to memory. The table below provides specific information of these test results indicating that memory problems are present.

<table>
<thead>
<tr>
<th>SCALE</th>
<th>INDEX SCORE</th>
<th>PERCENTILE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditory Immediate</td>
<td>68</td>
<td>2</td>
</tr>
<tr>
<td>Visual Immediate</td>
<td>81</td>
<td>10</td>
</tr>
<tr>
<td>Immediate Memory</td>
<td>69</td>
<td>2</td>
</tr>
<tr>
<td>Auditory Delayed</td>
<td>77</td>
<td>6</td>
</tr>
<tr>
<td>Visual Delayed</td>
<td>72</td>
<td></td>
</tr>
<tr>
<td>Auditory Recognition Delayed</td>
<td>90</td>
<td>25</td>
</tr>
<tr>
<td>General Memory</td>
<td>74</td>
<td>4</td>
</tr>
<tr>
<td>Working Memory</td>
<td>81</td>
<td>10</td>
</tr>
</tbody>
</table>

He did substantially better this time relative to before on the Category Test where he only had 25 errors, a substantial improvement over the original score of 60 errors. This may be due to a practice effect. Considering that the Wechsler Memory Scale was not administered in my evaluation there are limited practice effects noted.

Similar results, nevertheless, are noted on the Wide Range Achievement Test-Revised Version, Level III. These scores are noted on the table below.

<table>
<thead>
<tr>
<th>TEST</th>
<th>RAW SCORE</th>
<th>PERCENTILE</th>
<th>GRADE SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading</td>
<td>28</td>
<td>.4</td>
<td>3</td>
</tr>
<tr>
<td>Spelling</td>
<td>21</td>
<td>.07</td>
<td>1</td>
</tr>
<tr>
<td>Arithmetic</td>
<td>26</td>
<td>.8</td>
<td>3</td>
</tr>
</tbody>
</table>

**SUMMARY:** Results of the current evaluation support and extend the original findings from my neuropsychological evaluation of 1999. There are significant memory problems noted on the Wechsler Memory Scale. He seems to be doing approximately the same on the Achievement Test. Hence, he is functionally illiterate. There is a surprising performance on the Category Test. Upon questioning, he did indicate that he recalled the test and it could be that there may be overall practice effects.

He is continuing to have seizures and still not continuing to work. What is particularly perplexing is that anyone would think that this individual is able to return to gainful employment when his entire life he has only worked for 1–2 days and halfway through the second day he experienced a seizure, resulting in his uncle laying him off.

I continue believing that this individual also has a personality problem that is
complicating the entire picture. Regardless, I continue to believe that this individual meets both Part A and B of 12.02. The GAF score at present is 50.

Antonio E. Puente, Ph.D.

cc: Attorney

§ 40.16  Special Considerations in Cases Involving Mental Impairments

[1]  Stress

Social Security recognizes that stress, the reaction to the demands of work, can be a critical factor in causing an individual to fail to meet the requirements of even “low stress or minimal stress jobs.” The Administration recognizes that, in Social Security Ruling 85-15, when it states that: “an individual’s reaction to the demands of work (stress) is highly individualized [as is] the mental illness characterized by adverse responses to seemingly trivial circumstances.” A mentally impaired individual, as social security recognizes in the ruling, may cease to function when required to report to work regularly, undergo supervision, and maintain performance over a full day of work.¹

An inability to carry out and remember or understand instructions, respond appropriately to supervision or co-workers in a usual work situation, and deal with changes in a routine work setting all could provide the basis for a finding of disability.²

Psychological evaluations, including the MMPI, with appropriate interpretation by a qualified psychologist can provide insight as to whether or not a claimant could reasonably be expected to tolerate the stress of even unskilled work. Some psychologists will look at the results of a Wechsler Adult Intelligence Scale for information about adaptive functioning and communication skills and state that they are related to intellectual ability; an individual with a very low IQ, in the eyes of many psychologists, would not be able to cope adequately with the demands of stress and pressures of day to day work activity or be able to communicate effectively with others. Look for the following features in the psychologist’s report and the results of the MMPI test:

1. Whether the individual represses or uses repression as a defense mechanism; these individuals often rely on sleep to avoid stress;
2. Whether the individual tends to keep feelings inside or withdraw from intersocial activity;
3. Whether the individual tends to respond in a hysterical way or with high anxiety;
4. A high scaled score (T score over 70) on the psychasthenia scale, scale 7 on the MMPI, for it could indicate a low threshold for coping with pressure as such individuals tend to obsess over concerns, have difficulty concentrating, are indecisive or hysterical, and tend to be aloof in interpersonal concerns.

¹ Social Security Ruling 85-15.
If you have an indication that the individual cannot tolerate stress, argue that this reduces the claimant’s residual functional capacity to less than the full range of sedentary work and calls for a finding of disability under 20 C.F.R. Part 404, Subpart P, Appendix 2, Grid 201.00(h) and Social Security Ruling 85-15.

CASE STUDY

In *Dennis v. Heckler*, the Court upheld the Appeals Council rejection of the Administrative Law Judge’s reliance on the vocational expert’s opinion that the claimant could perform a low stress job.\(^3\)

[2] The Lack of Treatment and the Question of Disability

Many Judges are fond of denying claims involving claimants who state that a mental impairment plays a role in disabling them where the claimant has not sought psychiatric treatment. The Judge will often cite the lack of indication in the treating physician’s notes to any mental impairment as support for this opinion. In a extremely cogent opinion, the District Court in *Caldwell v. Sullivan*, noted that often individuals suffering from mental impairments are unable to recognize the need to seek treatment and the failure of the claimant to seek treatment earlier is often because the claimant was unaware of the underlying emotional cause contributing to physical impairment.

In *Caldwell*, the claimant had been tested by a psychologist, who found through the MMPI and Luria-Nebraska, that Ms. Caldwell suffered from brain damage that had features of depression and anxiety. The Court criticized the Judge’s failure to rely on the psychologist’s findings and conclusions, saying that earlier test results are rarely available as the claimant has no reason to submit to such testing.\(^4\) The Judge in *Caldwell* also condemned, as the psychological equivalent of a sit and squirm test, the Administrative Law Judge’s conclusion that the claimant had no real mental problems because she demonstrated no memory or concentration problems at hearing.\(^5\)


The Social Security Administration has provided some important guidance on the evaluation of limitations stemming from mental impairments in, of all places, the DI Section of the Program Operations Manual System (POMS). In that section, Social Security concedes that to perform gainful employment on a competitive, productive, and reliable basis, an individual must be able to carry out and remember simple instructions, make simple work-related decisions, and respond appropriately to supervision, co-workers, and work situations as well as deal with routine changes in work settings.\(^6\)

The individual who has suffered “substantial loss” in the ability to meet any of these

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\(^3\) Dennis v. Heckler, 756 F.2d 971 (3d Cir. 1985); Gavin v. Heckler, 811 F.2d 1195 (8th Cir. 1987); see also Kuwahara v. Bowen, 677 F. Supp. 553 (N.D. Ill. 1988).


\(^6\) Social Security POMS DI25020.010 and 20 C.F.R. § 404.1545(c).
work-related demands is considered disabled.\textsuperscript{7} Substantial loss is not clearly defined, but the material in the POMS suggests that it means that the individual has suffered a mental impairment that significantly prevents the performance of certain work-related functions on a regular, reliable, and productive basis. The substantial loss of the ability to meet any of the basic mental demands means that the individual’s occupational basis has been severely limited and a finding of disability is justified.\textsuperscript{8}

Some of the mental abilities outlined in the POMS are listed as follows:\textsuperscript{9}

1. Ability to remember location and work-like procedures;
2. Ability to understand and remember short and simple instructions;
3. Ability to maintain concentration and attention for extended periods (approximately two-hour segments);
4. Ability to perform activities within a schedule, maintain regular attendance and be punctual within customary tolerances;
5. Ability to sustain ordinary routine without special supervision;
6. Ability to work in coordination with, or proximity to, others without being unduly distracted by them;
7. Ability to complete a normal work day and work week without interruption from psychologically based symptoms and to perform at a consistent pace without unreasonable numbers and length of rest periods;
8. Ability to make simple work-related decisions;
9. Ability to be aware of normal hazards and take appropriate precautions;
10. Ability to ask simple questions or request assistance;
11. Ability to accept instructions and respond appropriately to criticism from supervisors;
12. Ability to get along with co-workers or peers without unduly distracting them or exhibiting behavior extremes; and
13. Ability to respond appropriately to changes in a routine work setting.

§ 40.17 Evaluation Techniques for Mental Disorders

[1] Introduction

While psychiatric and psychological evaluations are invaluable aids in establishing the presence of the signs, symptoms, and residual capacity of a person with a mental disorder, some experts have suggested that a rehabilitation assessment is needed to fully evaluate a person’s work capacity.\textsuperscript{1} Rehabilitation assessment of a psychiatric

\textsuperscript{7} Social Security POMS DI25020.010 and 20 C.F.R. § 404.1545(c).
\textsuperscript{8} Social Security POMS DI25020.010 and 20 C.F.R. § 404.1545(c).
\textsuperscript{9} See App. § 40K.

disorder goes beyond a traditional psychiatric evaluation which focuses on a formal diagnosis and related symptomatology, and a psychological evaluation which may heavily emphasize the use of standardized instruments and cognitive functioning. A rehabilitation assessment can compliment these approaches to assessment because it is designed to evaluate a person’s ability to function in their living, working, learning, and social environments. Such an assessment is needed because of the experience of mental health practitioners which suggests that persons with the same psychiatric disorder can function in vastly different ways when it comes to work.

[2] Relationship Between Psychiatric Diagnosis, Symptoms and Vocational Outcomes

One of the controversies that persists in the field of psychiatric rehabilitation is the question of whether and how well psychiatric diagnosis and symptoms can predict later vocational functioning and outcome. While this controversy has raged for decades, recent studies are beginning to shed more light on this important question. We know, for example, that among individuals with serious mental disorders, it is not uncommon to be given a variety of diagnoses over the lifetime. Questions arise about whether this is due to the changing course of serious mental disorders, to the unreliability of establishing a psychiatric diagnosis, or to other factors (e.g., the ability of the person to articulate the symptoms and history of his or her psychiatric illness). Improvements in the Diagnostic and Statistical Manual (DSM-IV) are helping to make diagnoses more reliable; however, there still remains a certain amount of error in terms of inter-rater reliability with psychiatric diagnosis (i.e., two psychiatrists evaluating the same patient, using the same sources of information and yet arriving at a different diagnosis).

Despite these vast improvements in the ability of practitioners to establish psychiatric diagnoses in a valid and replicable way, diagnosis alone does not appear to be a potent predictor of later vocational functioning. The extent to which a person’s psychiatric diagnosis can predict their vocational performance or outcome varies considerably from study to study (see Anthony, Rogers, Cohen and Davies, 1995 and Rogers, Anthony, Cohen and Davies, 1996 for a review of this literature). Some studies have found that psychiatric diagnosis cannot predict who will or will not be employed at some future date, while others have found that a non-psychotic diagnosis is related to better vocational outcomes. However, even in those studies in which a difference

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is found among diagnostic categories, the amount of variation in vocational outcomes due to diagnosis alone is not very large.

Furthermore, the extent to which an assessment of psychiatric symptoms (as distinct from diagnosis) can be used to predict later vocational functioning among individuals with severe mental disorders is debatable. The research has been very contradictory in this area. At best, symptoms appear to have a only a modest ability to predict later vocational outcomes. Some research has suggested that psychotic-like symptoms, and the so-called “negative” symptoms of mental disorders (e.g., withdrawal, lack of affect, and so forth) are somewhat more related to vocational performance than are the so-called “positive” symptoms (e.g., hallucinations). This relationship between negative symptoms and vocational outcomes may occur because the positive symptoms are more easily treated pharmacologically, while the negative symptoms linger after treatment. While earlier studies had found that prior work history was a good predictor of later work success, more recent studies have not confirmed such a relationship. In fact, no one variable, psychological test, or instrument has been found to be a strong predictor of work capacity among individuals with psychiatric disorders.

Because it has been so difficult to establish the work capacity of persons with serious mental disorders, researchers have expended considerable resources trying to develop predictive models with very limited success. Scales which measure the global work or occupational functioning of individuals with psychiatric disability have been developed (see, for example, the “GAS or SOFAS”), however, they are too general to be of use in a comprehensive evaluation of work capacity. However, some promising work has been done which suggests that “situational assessments,” i.e., those assessments which use a work-like setting and a structured evaluation process to assess work capacity, are more useful than traditional vocational and psychological assessments to evaluate work capacity. Some progress has been made in developing such situational assessment procedures for persons with mental disorders and the

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Rehabilitation Services Administration is recommending broader use of such techniques.\footnote{Rehabilitation Services Administration. (October, 1995). The provision of vocational rehabilitation services to individuals who have severe mental illness: Program Administrative Review, Final Report. Washington, DC: US DOE, OSERS, Rehabilitation Service Administration.}

The premise behind situational assessment is that the evaluation of an individual’s work capacity can not be accomplished sitting in a practitioner’s office. The hallmarks of a good situational assessment include: 1) evaluating the individual in vivo in a work, or work-like setting, and, 2) a structured and reliable tool for rating an individual’s work performance using scales with established definitions. Work-related skills such as dependability (e.g., showing up on time), and reliability (e.g., getting the job done) are important components of the situational assessment, as are interpersonal skills on the job (i.e., sociability factors such as getting along with co-workers and supervisors).

[3] Rehabilitation Assessment

Looking at the process by which mental health professionals assess a patient’s potential for rehabilitation and work can provide insights for us as we work with client’s mental health providers in assessing clients’ functioning.

Here is how professionals go about assessing a patient’s potential for rehabilitation:

1) \textbf{The process begins with a practical assessment of a person’s ability to function in the living, working, learning, or social environments of his or her choice.}\footnote{G., Hoffschmidt, S., Jonas, E., Razzano, L., and Weakland, R. (1994). Assessing vocational performance among persons with severe mental illness: A handbook of clinical and research assessments. Chicago, IL: Thresholds National RTC.}

   Typically, a rehabilitation assessment begins by establishing an environmental context. The idea is that it is not possible to perform an evaluation of a person’s capacity to function unless the environment and its demands are taken into account. The environmental context is generally established by assisting the person with a psychiatric disability to establish a rehabilitation goal (“I want go to work as a data entry clerk for ABC Corporation in the next 12 months”). For example, one work environment might demand that an employee be able to tolerate a great deal of noise, confusion, and rapid changes of pace and tasks, while another may not. Evaluating the person with the \textit{contextual demands} of the job and the setting in mind is essential to get an accurate picture of the residual capacity of an individual’s ability to function.

2) \textbf{Assess the person’s strengths and deficits in relation to the demands of the chosen environment}. The question to be answered is, \textbf{what skills and resources does this person need to function in the chosen environment}. A skill-based assessment should be based upon a thorough understanding of the

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demands of the work environment, including the specific technical and work-related skills needed, as well as the interpersonal and social demands of the work environment.

3) Determine the extent to which the individual can perform these skills or behaviors, or has the skill but for some other reason, lacks the capacity to use the skill. Apart from the skills needed to function in the environment of choice, what resources might the person need to perform in the chosen environment? The analogy in physical medicine might be made to a person who is visually impaired and who is unable to navigate his or her way to a job. That individual may need a combination of skills and resources to regain mobility and increase work capacity. He may need to be taught the skills of navigating the trip to work, but may also need resources (e.g., a seeing eye dog) for environmental demands which cannot easily be satisfied by developing skills.

In summary, a rehabilitation assessment can be used to supplement the information from traditional psychiatric and psychological evaluations. The focus of a rehabilitation assessment is on the skills and resources a person needs to function in a specific living, working, learning, or social environment. To be valid, a rehabilitation assessment must take into account the specific demands of that environment and does not attempt to predict an individual’s work capacity based upon either psychiatric diagnosis or symptom level. Situational assessments, alone or in combination with other vocational evaluation tools, have shown promise for evaluating the work capacity of persons with mental disorders.


This case example describes a rehabilitation assessment process that might be used in determining initial or continuing eligibility for Social Security disability benefits. Consider Jerome, a 36 year old man experiencing major depression of a persistent nature. He has been out of work for the last three years due to the disabling nature of his condition. Previously, Jerome worked at unskilled jobs as a general office worker and as a security guard.

The first step in a rehabilitation assessment should be an initial interview to analyze Jerome’s current status and satisfaction with his living, learning, working and social environments. This involves identifying the characteristics of each of those environments and his level of satisfaction with each of them. A description of his activities in each of those environments and his level of performance relative to the demands would be useful. Other interviews could then be conducted to gather information about past work and school experiences—dates of employment and education, hours worked, wages earned, credits earned and attempted, and reasons for leaving each experience. This information will give the interviewer a picture of the person’s strengths and deficits, and past successes and failures, especially in relevant work environments. For example, Jerome is currently not working or in school, but would like to return to work sometime in the future, even though he currently does not feel able to work. He has completed 2½ years of college with credits primarily in liberal
arts courses. He has 3 years of full-time work experience as a security guard, which is the work he performed most recently. He also has 6 years of part time and full time work experience as a clerical assistant in an office setting. Jerome’s strengths are in his organizational skills, filing and record keeping, his attention to detail as well as a strong work ethic when his efforts at work are noticed and appreciated by his supervisor. His deficits are in his interpersonal skills (interacting with coworkers, customers and telephone contact), his work attendance (frequent absences due to depression), and his intra personal skills (recognizing his strengths, evaluating his own performance accurately). When jobs have not worked out for him, it has been because of a high demand for interpersonal interaction (resulting in his being fired from an office job in which he was part of office team) and problems with a close, authoritarian style of supervision. Jerome responds to these stressors by becoming increasingly depressed, lethargic and unable to get out of bed, resulting in frequent absences from work to avoid these situations, and eventual termination.

Exploration of a person’s satisfaction with and competencies in prior work experiences assists the evaluator in assessing the person’s values and interests vis-a-vis certain work environments. This clarification of work values and interests is useful in beginning to determine the type of work environment most suitable in which to conduct a situational assessment. Regarding work values, Jerome enjoys working in an office setting doing intellectual tasks. He wants limited interpersonal contact with customers and coworkers but does not want to work totally alone, devoid of any contact with others, as occurred in his security jobs. He works best with a supportive supervisor who encourages independent work but who also recognizes a job well done and gives specific directions for improvement.

Finally, a review of psychiatric symptoms and related health status issues should focus on the impact of any related impairments on the person’s functioning in relevant environments. For example, since the age of 20, Jerome has experienced chronic feelings of sadness, lethargy and hopelessness, and has generally withdrawn from social interactions. In spite of the persistent nature of these symptoms Jerome has worked in the past. When these symptoms worsen periodically or in certain environments, they interfere with Jerome’s work attendance, his ability to initiate new tasks without direction, and his interactions with coworkers and supervisors in the areas of asking for help, clarifying feedback and instructions, responding to negative feedback and completing assigned tasks. A simple description of symptom patterns and intensity alone does not provide the functional information necessary for an assessment of capacity to work.

Once a review of past experiences and interests has been completed, the next step is to select a work environment for a situational assessment. The ideal environment for a situational assessment is a real work environment in a business in the community with well-defined tasks which can be observed during the assessment. This environment should be one that is close to either a future job that the person would like to pursue without additional education or training required (such as an entry level job in the field or occupation of choice) or a previous job in which the person was successful and satisfied. Careful selection of an environment in which the person is likely to do
well, or is of interest to the person, increases the likelihood that the assessment will be a valid one. For Jerome, this might mean selecting one of his previous jobs, such as clerical assistant, and arranging with a company to set up a worksite in an office for the situational assessment to be conducted. Although at first glance, security guard work may seem less stressful for someone wanting limited interaction with others, for Jerome, the routine, unchallenging nature of the work and the interpersonal isolation may be more stressful than an office setting with some interpersonal demands.

In arranging a situational assessment with an employer, he or she should be involved in not only defining the tasks and responsibilities but also the standards of performance that typical employees must meet. The situational assessment should provide an opportunity to assess not only the technical skills (i.e., job duties and specialized skills) of the job, but more importantly, those “dependability”, “sociability” and “adaptability” factors that comprise “work adjustment.” Some of these skills include arriving on time, completing assigned tasks, responding to criticism, organizing work tasks, prioritizing tasks, and following multi-step instructions, among others. For someone like Jerome with severe depression, areas of focus for the assessment might include those skills related to concentrating on tasks, stamina, decision-making, initiating tasks and interacting with coworkers and supervisors. There are several instruments available to use in the situational assessment process.14

These “work adjustment” or general work skills are the skills that often prevent people with psychiatric disabilities from succeeding in jobs, even “low stress” or unskilled work. In conducting the situational assessment one should not automatically assume that unskilled jobs are less stressful, or that unskilled jobs are ideal jobs for the person participating in the assessment process. Some highly skilled jobs may provide better situations in which to conduct the assessment if the person has the required technical skills to do the job in question.

Once the assessment tasks have been defined and the skills to be assessed are identified, the length of the assessment period, the number of hours per day, the physical location of the workstation, personnel involved, and supervisory responsibilities should be clarified. The length of the assessment period should be sufficient to allow the person to demonstrate skills in adapting to a new situation, learning the job tasks and expectations, and sustaining effort over time. Ideally, a situational assessment would range from 2 weeks to 2 months, depending on the person, the job and related circumstances.

Once all of the elements of the situation are clarified, the person participating in the assessment should be oriented to the assessment process, to the job and to people in

the work environment with whom he or she will have contact. The assessment should proceed, giving the participant opportunity to respond to feedback, follow instructions and interact with coworkers and supervisors. Periodic review and a review of the final results of the assessment should also be done with the participant to debrief him or her about the experience.

In reviewing the assessment results with Jerome, he initially could not identify anything that he did well. With assistance, he was able to say that he did a good job of organizing the work, copying and filing correspondence, but did not believe he did well in doing what he was told or getting along with his coworkers and supervisor, especially when he was told that he did something wrong. Jerome had many of the intellectual and physical skills necessary for the job, with the exception of limited stamina initially (he could only work for about 1 hour before feeling a need to take a break). However, his interpersonal and intrapersonal skill deficits severely limited his performance. Jerome had difficulty prioritizing tasks, clarifying instructions, initiating tasks and socializing with his coworkers, especially when cooperative interaction was required to complete his tasks. Jerome would become more depressed and anxious even when balanced feedback was given about his performance. He had difficulty maintaining eye contact, asking questions or recalling instructions for improvement. After the first time he was given negative feedback (the third day of the evaluation), Jerome did not show up for work as scheduled. He did return the following day after being contacted, but he worked at a much slower pace and was more hesitant to ask questions or clarify instructions.

These results suggest that Jerome would have difficulty working without significant support to sustain his work effort, in spite of having the intellectual and physical capacity to do clerical work. This is not atypical of other persons with psychiatric disorders, which is, in part, what makes assessing vocational capacity so difficult. Jerome would require some gradual return to work to help him build stamina, and possibly supported employment or rehabilitation services to assist him in the interpersonal and intrapersonal areas. This situational assessment would have greater validity than a traditional evaluation because the assessment took place in a real work environment, because Jerome was involved in the process, and because the process allowed an assessment of those skills necessary for success in employment.

Negative Symptoms May Be a Good Indicator Of a Claimant’s Capacity For Work

Negative symptoms represent a reduction of emotional responsiveness, motivation, socialization, speech, and movement. Primary negative symptoms are etiologically related to the core pathophysiology of schizophrenia whereas secondary negative symptoms are derivative of other symptoms of schizophrenia, other disease processes, medications, or environment.\textsuperscript{15}

As we have seen in the above discussion, a claimant’s ability to interact appropriately

\textsuperscript{15} Dawn I. Velligan, PhD and Larry D. Alphs, PhD, Negative Symptoms in Schizophrenia: The Importance Of Identification and Treatment, Psychiatric Times, March 1, 2008.
with others, her sociability, is a good indicator of potential for rehabilitation. Social Security has recognized the importance of this factor by stating that the capacity to interact appropriately is a key indicator of employability.\textsuperscript{16}

**Negative symptoms include the following:**

1) Affective flattening;
2) Anhedonia;
3) Avolition (apathy);
4) Alogia (severe reluctance to speak);
5) Attentional impairment.

**Affective flattening can include:**

a) flat facial expressions that show little or no emotion (no smiles or no facial movement);
b) decreased spontaneous movements, meaning little or no movement of any part of the body in the course of the interview such as no hand gestures or sitting forward;
c) poor eye contact;
d) no change in vocal inflection;
e) inappropriate affect—smiling or laughing when discussing a serious issue such as the death of a loved one.

**Alogia can manifest in the following ways:**

a) poverty of speech—brief, concrete replies to questions;
b) poverty of content of speech—speech that conveys little information, that is vague or overly abstract or even repetitive;
c) blocking—inaibility to complete a train of speech before the thought has been completely expressed;
d) increased latency of response—the person takes an abnormally long time to express himself.

**Indicators of Apathy:**

a) poor grooming and personal hygiene—a generally unkempt appearance, an overall disheveled appearance. On questioning the patient reveals he has not changed clothes in days or has not bathed for days.
b) inability to persist at tasks at work or school as demonstrated in the failure to complete tasks or failure to complete them in a time manner.

**Signs of Anhedonia:**

a) lack of interest in sexual activity;

\textsuperscript{16} SSR 96–9p.
b) inability to feel intimacy or closeness with spouse or family members.

**Signs of Impaired Attention/Concentration:**

a) abrupt termination of a conversation;

b) appears distant and uninvolved in conversation; appears uninvolved in the discussion;

c) inability to perform tests for concentration on mental status examination such as spelling WORLD backward or perform serial 7’s, or serial 3’s, or perform a series of 5 subtractions.\(^{17}\)

**§ 40.18 Internet Resources on Mental Impairments**

The Internet provides a rich bounty of resource material on all aspects of medicine. With regard to mental impairments, the National Institute of Mental Health has a helpful page detailing common symptoms of depression and bipolar disorders with the diagnostic criteria for these conditions. This home page is found at:


Here you will learn that 25 percent of all social security disability payments are for individuals with a severe mental illness and that 1 in 10 individuals—17 million people—experience depression each year, and that over a lifetime depression will affect 15 to 20 percent of all women and 5 to 8 percent of all men. A variety of news groups that provide information on the disabled are also listed. See alt.support.depression, alt.support.phobias and sci.psychology, sci.medicine, sci.medicine.psychology.

The University Of Iowa’s *Family Practice Handbook* has a home page that provides information on all aspects of illness; it can be found at http://indy.radiolo. . . Each listing there provides the diagnostic criteria for the condition. Other websites on mental conditions, particularly depression, are as follows:

**Depression FAQ (from alt.support.depression)**

http://avocado.pc.helsinki.fi/~janne/asdfaq/#concepts

How can I help myself get through depression on a day-to-day basis?

http://avocado.pc.helsinki.fi/~janne/asdfaq/47.html

**Book list**


**Mental depression**


Questions and Answers About Major Depression

http://www.save.org/tally.html

**NAMI-Facts About Severe Mental Illness**

http://www.cais.com/vikings/nami/disorder/disord3.htm

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\(^{17}\) Andreasen, Nancy, M.D., Ph.D, “Scale For the Assessment of Negative Symptoms” (1984).
Understanding Depression
   gopher://gopher.uiuc.edu/00/UI/CSF/Coun/SHB/depress
FTP site
   ftp://129.32.32.98/pub/psych
help! A Consumer’s Guide to Mental Health Information
   http://www.io.org/~madmagic/help/help.html
Poetry From A Depressed Person
   http://work1.utsi.edu:8000/~tdouglas/poems/
“Wings Of Madness: A Depression Guide”
   http://members.aol.com/depress/frames.htm
Medical Internet Gateways
   http://www.webcom.com/pgi/gateways.html
Hardin Meta Directory Internet Health Sources
   http://www.arcade.uiowa.edu/hardin-www/md.html