In other words, I am asking you to assume that an individual meets all of the requirements of Impairment Listing § 4.04(B)(1) and Impairment Listing § 4.04(C), but that his chest pain of cardiac origin only occurs three to four times a year. Is there an anginal frequency requirement built in to Impairment Listing § 4.04?

I shall look forward to your response to this inquiry.

Sincerely yours,
Carl Weisbrod

Mr. Carl M. Weisbrod, Esq.
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Dear Mr. Weisbrod:

This is in reference to your letter of January 19, 1984 to Mr. Peter H. Gilmore. Mr. Gilmore referred your letter to me because it raised questions concerning the criteria for evaluating disability under the Social Security programs. I regret the delay in responding.

In response to your first question, your understanding of the application of the listing of Impairmetns in Appendix I to Subpart P of the Social Security regulations is correct. Concerning your question on whether there is a requirement of frequency of occurrence of angina built into listing section 4.04, there is no specific requirement in this listing section that chest pain of cardiac origin (angina pectoris) must occur with a particular frequency.

With respect to the factual situation you describe, the occurrence of angina attacks only three to four times a year would not, in itself, be sufficient reason for ceasing disability benefits. Presumably, it has already been established at the time of the original decision of disability that the impairment was severe; that is, that it met Listing 4.04B1 and 4.04C, and there has been no indication or surgical or medical treatment which might be expected to significantly change the severity of the cardiac impairment.

At the time of the continuing disability review (CDR), records from the individual's treating physicians would generally provide the necessary information to update the clinical history, since the initial favorable decision was made, to determine whether or not the individual, at the time of the CDR, continues to meet or equal the listing or to have a severe impairment. The listing would continue to be met if it can be ascertained that the individual continues, at the time of the CDR, to have chest pain of cardiac origin. If the individual limits his/her activities to avoid angina at the time of the CDR and, as a consequence, does not have chest pain established at the CDR evaluation, we would need medical evidence, which is ordinarily obtained from the treatment source, containing a detailed description of daily activities and the characteristics of the chest pain that continues to occur, albeit infrequently, with respect to inciting factors, location, radiation and mode of relief. It would, in our experience, be rare for an individual with severe ischemic heart disease to have chest pain of cardiac origin as infrequently as has been described in the case example. In such a rare instance, we would require documentation by medical records that the individual has indeed limited himself/herself to light or sedentary activity and, despite this limitation, continues to have, albeit infrequently, the chest pain of requisite characteristics.

I hope this satisfactorialy answers your questions. Should you have additional questions, please feel free to contact me.

Sincerely yours,
Patricia M. Owens
Acting Associate Commissioner
for Disability

WAIS/WAIS-R COMPARISONS: IMPLICATIONS FOR DISABILITY DETERMINATION

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The Disability Determination Services of the Social Security Administration uses the intelligence test as the basis for psychological evaluations. Of the intelligence tests available today, the most popular have been developed by the late David Wechsler (e.g., the Wechsler Adult Intelligence Scale-Revised). Indeed, according to the Mental Measurements Yearbook (Buros, 1978), over 3,000 publications on this scale have been published to date. This body of literature has been well surveyed elsewhere (cff Matarazzo, 1972) and will not be the focus of this article. The purpose of this article is to discuss a timely and important issue of disability evaluations when using the adult version of the Wechsler scales; the difference between Wechsler Adult Intelligence Scale or WAIS (Wechsler, 1955) and the Wechsler Adult Intelligence Scale-Revised or WAIS-R (Wechsler, 1981).

HISTORY OF THE ADULT WECHSLER SCALES

The first adult intelligence scale developed by Wechsler was published in 1939 at the Wechsler-Bellevue Intelligence Scale (reflecting the hospital in New York where the original standardization studies were conducted). Due to the numerous objections raised of Wechsler-Bellevue (Anastasi, 1982), the Wechsler Adult Intelligence Scale was published by the Psychological Corporation in 1955 (Wechsler, 1955). In keeping with testing standards published by the American Psychological Association (American Psychological Association, 1978), which call for periodic revisions of test instruments, the revised version of the WAIS, the WAIS-R, was released in 1981.

WAIS, WAIS-R COMPARISONS

Although the WAIS-R has been available for the past three years, questions still arise as to how these two versions compare. In the manual for the WAIS-R, Wechsler (1981) describes both the general similarities and differences between the two instruments. Structually, approximately 80% of the items from the original WAIS remain the same: No changes are found in the following tests: Digit Span, Block Assembly, and Digit Symbol. However,

the following tests do have modified items (number of revised items are found in parentheses); Information (9), Vocabulary (2), Arithmetic (1), Comprehension (4), Similarities (3), Picture Completion (5), Picture Arrangement (8), and Digit Symbol (3). While numerous items have been revised, the total number of tests (11) and the dichotomy be' n verbal and performance abilities remain unchanged.

Or greater significance for disability issues is that the tests appear to yield different IQ's (Wechsler, 1981).

Indeed, on the original sample of 72 individuals (between the ages of 35-44) which were tested by Wechsler using both tests, the mean Full Scale IQ for the WAIS-R was 7.5 point lower than for the WAIS. The mean Performance IQ was also lower for the WAIS-R although the verbal IQ scores were similar for both tests. Where do the differences between these two test lie? The correlation (or amount of relationship between tests) range from .5 out of a possible 1.0 for Picture Arrangement to .91 out of a possible 1.0 for Vocabulary with the mean correlation being .76 out of a possible 1.0. The Verbal IQ correlated well at .91 with the Performance IQ correlated at .79 and the Full Scale IQ at .88. Considering that a 1.0 correlation would indicate a perfect match (e.g., WAIS IQ = 10, WAIS-R = 100), these correlations suggest that a significant percentage of the variance was well accounted for and that these tests and IQ appear highly similar. Thus, the apparent IQ difference cannot be attributed to test construction alone; instead the difference probably lies in the new standardization norms used for the WAIS-R.

Regardless of the etiology for these IQ differences, Wechsler's findings clearly suggest that they exist. However, prior to accepting these findings a brief review of related studies is necessary.

Lippold and Clairborn (1983) essentially replicated Wechcler' itial findings on the WAIS, WAIS-R comparison by adm.. tering both versions of this test to 30 veterans. Although test scores correlated, differences between the two tests were again observed. Specifically, mean Verbal and Performance IQ's were both lower on the WAIS-R (7.6 and 8.6 points, respectively). The mean Full Scale IQ was 94.8 for the WAIS and 86.4 on the WAIS-R. Similar findings were also reported by Mishra and Brown (1983) using college students. For 10 of the 11 tests (except Picture Arrangement where the mean WAIS-R score was .15 higher than the WAIS), the WAIS-R scores were lower than the WAIS (mean = 1.28 points). The Verbal, Performance, and Full Scale IQ's were also lower for the WAIS-R than for the WAIS (mean = 5.07 IQ points). Using a clinical population, Prifitera and Ryan (1983) reported similar findings. Specifically, the WAIS--R scores were lower for the Verbal (7.59), Performance (7.06), and Full Scale IQ (7.75).

Regardless of the fact that differences appear to exist, it is still important to note the limitations of IQ testing. According to Carroli and Horn (1981) there are several problems with IQ tests including (a) no IQ test adequately measures intelligence, (b) patterns of cognitive processes are often ignored in favor of global ratings, and (c) norms for these tests are derived from relatively culturally and educationally homogenous populations. The implication for disability evaluation arising from these concerns include (a) IQ tests alone are often insufficient gauges of cognitive ability, (b) scores on all tests of the WAIS-R -not just IQ's- are necessary to evaluate the individual's abilities, and (c) in cases where a unique type of subject is being evalauted (e.g., brain-damaged), these tests may be entirely inadequate (cf. R , Rosenberg, & Prifitera, (1983)).

Clearly, the overuse and inappropriate understanding of IQ testing for disability determination warrants concern. It is up to the phychologist and the psychological community to be keenly aware of these issues and to suggest alternatives. However, when these issues are ignored or misinterpreted it is entirely appropriate for the legal community to play a more significant role in the psychological aspects of the disability determination process.

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DDS GUIDELINES FOR CONSULTATIVE EXAMINERS

EDITOR'S NOTE: **Claimants' representatives are learning the value, in appropriate cases, of requesting additional information from physicians who have performed consultative examinations of their clients at the request of the state agency. The following form letter was sent by the Disability Determiantion Bureau in Ohio to the consultative examiners there, and is useful to representatives in their efforts to obtain all the medical evidence.**

Dear Consultant:

The increased review of disability claims and a heightened public awareness of the Freedom of Information Act and the Privacy Act have caused an increase of requests by indi-