*Chapter 14*

# Mental and Behavioral Disorders

This chapter discusses impairments due to mental disorders and considers behavioral impairments that may complicate any condition. Fundamental principles relating to impairments, their assessment, and the methods underlying the *Guides* are discussed in Chapters 1 and 2 and the Glossary (p. 315). The reader should peruse these parts before undertaking an impairment evaluation.

A medical impairment evaluation report performed according to the *Guides* should include information such as that shown below.

*A. Medical Evaluation*
- History of mental and behavioral disorder(s)
- Results of most recent clinical evaluation
- Assessment of current clinical status and statement of further medical plans
- Diagnosis

*B. Analysis of Findings*
- Impact of mental condition on normal life activities
- Explanation for concluding that the condition has been present for several months, is stable, and is unlikely to change
- Explanation for concluding that the individual is or is not likely to suffer impairment by engaging in usual activities
- Explanation for concluding that accommodations or restrictions related to the impairment are or are not warranted

*C. Comparison of Analysis with Impairment Criteria*
- Description of clinical findings and how these findings relate to the impairment and *Guides* criteria
- Description of the effect of impairment on the individual's ability to function
- Estimate of the severity of the impairment

**Basic Principles**

Three principles, described below, are central to assessing mental impairment.

*1. The diagnosis* is among the factors to be considered in assessing the severity and possible duration of the impairment, but it is not the sole criterion.

*2. Motivation* for improvement may be a key factor in the outcome of an individual's impairment.

*3. Assessing impairment* requires a thorough review of the history of the impairment, its treatment, and attempts at rehabilitation.

Some of the material in this chapter is taken from Social Security Administration (SSA) regulations that were developed with the advice of a knowledgeable working group.[1] In the SSA regulations there are three underlying concepts: (1) a medically determinable impairment must exist; (2) the impairment must result in an inability to work; and (3) the impairment must be expected to last for at least 12 months.

The SSA's "Listing"[1] for mental disorders conforms to the terminology of *Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition* (*DSM-III-R*)[2] terminology and is divided into eight broad categories. The Listing describes the criteria that must be met if the person may be said to "meet the Listing" and thus be unable to engage in work. For example, the first of the eight categories deals with schizophrenic, paranoid, and other psychotic disorders. To meet the Listing, the claimant must satisfy criteria that are arranged in a menu format somewhat like that of *DSM-III-R*.[2]

The group A criteria are symptoms, and in addition to satisfying them, the claimant must satisfy group B criteria, which are expressed in terms of ability to function in various settings (see Section 14.3, p. 293). Alternatively, the claimant may meet group C criteria by exhibiting a specified duration of the disorder with frequent deterioration or inability to function outside of highly supportive living situations. For detailed information, the reader should consult the SSA Listing,[1] which is available through state agencies responsible for disability determinations or the SSA.

The *Guides* is also useful in conjunction with other approaches. These may be different from the *Guides*' approach and definitions. The *Guides* user should become familiar with the guidelines and approaches of the system within which the evaluation is being performed. Meyerson and Fine[3] reviewed and discussed aspects of disability evaluation systems. The Glossary (p. 315) considers programs, regulations, and procedures of the SSA.

## 14.1 Diagnosis of Impairment

### Diagnostic Systems

The *Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition*,[2] commonly known as *DSM-III-R*, is a widely accepted classification system for mental disorders. It is similar to another system, the International Classification of Diseases (ICD), which also is in widespread use.[4] The criteria for mental disorders include a wide range of signs, symptoms, and impairments. Most mental disorders are characterized by one or more impairments. However, an individual may have a mental or behavioral impairment without meeting the criteria specified in *DSM-III-R* or the ICD.

The *DSM-III-R* calls for a multiaxial evaluation. Each of five axes refers to a different class of information. The first three axes constitute the official diagnostic evaluation. These include the clinical syndromes and the conditions that are the focus of treatment (axis I); the personality and developmental disorders (axis II); and the physical disorders and conditions that may be relevant to understanding and managing the care of the individual (axis III). Axis IV, referring to psychosocial stressors, and axis V, referring to adaptive functioning, may be particularly important for assessing impairment severity.

In some individuals it is not possible to make a determination on the basis of the available information. Under these circumstances the examiner should not feel obligated to provide an opinion about which he or she is uncertain but should seek and review relevant information from additional sources, such as medical and employment records, before rendering an opinion.

### Specific Impairments

In judging the degree of mental impairment it is important to recognize that there are various types of mental disorders, each of which, like a physical disorder, has its own natural course and unique characteristics. It is apparent that some serious mental disorders are chronic. The term "remission," rather than "cure," is used to indicate an individual's improvement. The remission may be intermittent, long-term, or short-term, and it may occur in stages rather than all at once. Degrees of impairment may vary considerably among patients, and the severity of an impairment is not necessarily related to the diagnosis. Indeed, the diagnosis per se is of limited relevance to an objective assessment of a psychiatric impairment, because the words do not provide sufficient insight into the nature of the impairment.

An episode of depression that follows a stressful life event, for instance, often is a short-term, self-limiting illness that clears up when the stressful situation is relieved. Other affective disorders have their own patterns of recurrence and chronicity and often respond well to therapeutic interventions. Somatic and psychological treatment and adequate supervision are important in all affective disorders, because of the risk of suicide.

The schizophrenias are usually chronic disorders; the onset may be insidious and recognized only in retrospect. Certain organic disorders such as traumatic brain injury and life-long mental retardation are persistent and chronic, and treatment consists of minimizing the response to the pathophysiologic changes. For some patients, achieving a degree of capability and habilitation may be the goal.

The types of mental dysfunction in the various psychiatric disorders are curiously similar regardless of the specific diagnosis. Just as "fever" and "pain" are seen in different kinds of somatic illnesses, so "anxiety" and "hostility" may be observed in different kinds of mental disorders.

## 14.2 Evidence of Mental Impairment

The following recommendations for documentation draw heavily on the "Listing of Mental Impairments" in regulations from the SSA.[1] The SSA's evaluation system and most other systems require the existence of an impairment that is established and documented by medical evidence relating to signs, symptoms, and results of laboratory tests, including psychological tests. In general, the diagnosis of a mental disorder should be justified by the history, signs, and symptoms, and a diagnosis according to *DSM-III-R* should be given. If there is uncertainty about the exact diagnosis, the differential diagnosis should be discussed.

The methodology of the *Guides* requires that the presence of a mental disorder be documented primarily on the basis of reports from accepted professional sources, such as psychiatrists, psychologists, psychiatric nurses, psychiatric social workers, and health professionals in hospitals and clinics. Adequate descriptions of functional limitations should be obtained from these sources and, if possible, from programs in which the individual has been observed over a period of time. Data gathered during a period of years are particularly useful.

The individual's own description of his or her functioning and limitations is an important source of information. The presence of a mental disorder does not automatically rule out the individual as a reliable source of information. Information from nonmedical sources, such as family members and others who have knowledge of the patient, may be useful in indicating the level of functioning and the severity of the impairment.

Information from medical and nonmedical sources may be used to obtain detailed descriptions of the individual's activities of daily living, social functioning, concentration, persistence, pace, and ability to tolerate increased mental demands (stress). This information may be available from professionals in community mental health centers, day-care centers, and sheltered workshops, and it also can be provided by family members. If the descriptions from these sources are insufficiently detailed or in conflict with the observed clinical picture or the reports of others, it is necessary to resolve the inconsistencies. Also, any gaps in the history should be explained.

An individual's level of functioning may vary considerably over time. The level of functioning at a specific time may seem relatively adequate or, conversely, rather poor. Proper evaluation of an impairment must take into account variations in the level of functioning with time in arriving at a determination of severity. Thus, it is important to obtain evidence over a sufficiently long period before the date of examination. This evidence should include treatment notes, hospital discharge summaries, work evaluations, and rehabilitation progress notes if they are available.

An individual may have worked or have attempted to work when there was a question about impairment. The individual's efforts may have been independent, or the work may have been in conjunction with a community mental health or other sheltered program and of short or long duration. Information concerning the individual's behavior during the attempt, and the circumstances surrounding termination of the work effort, are particularly useful in determining the individual's ability to function in a work setting and with others. Results of work evaluations and rehabilitation programs can be significant sources of data concerning impairments affecting work capabilities.

The results of well-standardized psychological tests, such as the Wechsler Adult Intelligence Scale, the Minnesota Multiphasic Personality Inventory-2, the Rorschach Psychodiagnostic Inkblot Test, and the Thematic Apperception Test, may be useful in establishing the existence of a mental disorder. For example, the Wechsler Adult Intelligence Scale is useful in establishing mental retardation. Broad-based neuropsychological assessments using, for example, the Halstead-Reitan or the Luria-Nebraska batteries may be useful in determining deficiencies in brain functioning, particularly in individuals with subtle signs such as those that may be seen in traumatic brain injuries.

Taking a standardized test requires concentration, persistence, and pacing; thus, observing individuals during the testing process may provide useful information. The description of test results should include the objective findings, a description of what occurred during the testing, and the test results. A report of intellectual assessment should include a discussion of whether the obtained intelligence quotient (IQ) score is considered to be valid and consistent with the individual's impairment and degree of functional limitation.

## 14.3 Assessing Impairment Severity

The system of the SSA is recommended for assessing the severity of mental impairments. Although by definition under that system an impairment arising from a mental disorder must be severe enough to cause inability to work, it should be understood that the severity of a mental disorder does not necessarily equate with the inability to work. For instance, an individual with a serious illness, such as a delusional disorder, may be able to work in certain settings.

The SSA suggests four aspects or areas for assessing the severity of mental impairments[1]: (1) limitations in activities of daily living; (2) social functioning; (3) concentration, persistence, and pace; and (4) deterioration or decompensation in work or worklike settings. Also, independence, appropriateness, and effectiveness of activities should be considered. The four aspects of functional limitation are discussed below.

*1. Activities of daily living* include such activities as self-care, personal hygiene, communication, ambulation, travel, sexual function, sleep, and social and recreational activities. Any limitations in these activities should be related to the mental disorder rather than to such factors as lack of money or lack of transportation. In the context of the individual's overall situation, the quality of these activities is judged by their independence, appropriateness, effectiveness, and sustainability. It is necessary to define the extent to which the individual is capable of initiating and participating in these activities independent of supervision or direction.

What is assessed is not simply the number of activities that are restricted, but the overall degree of restriction or combination of restrictions. For example, a person who can cook and clean might be considered to have marked restriction of daily activities, if he or she were too fearful to leave the home to shop or go to the physician's office.

*2. Social functioning* refers to an individual's capacity to interact appropriately and communicate effectively 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. Impaired social functioning may be demonstrated by a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, social isolation, or similar events or characteristics. It is helpful to give specific examples illustrating the impaired functioning.

Strength in social functioning may be documented by an individual's ability to initiate social contact with others, communicate clearly with others, and interact and actively participate in group activities. Cooperative behavior, consideration for others, awareness of others' sensitivities, and social maturity also need to be considered. Social functioning in work situations may involve interactions with the public, responding to persons in authority such as supervisors, or being part of a team.

It is not only the number of aspects in which social functioning is impaired that is significant, but also the overall degree of interference with a particular aspect or combination of aspects. For example, a hostile, uncooperative person who is tolerated by local storekeepers and neighbors may have marked restriction in overall functioning, because antagonism and hostility are not acceptable in the workplace or in social contexts.

*3. Concentration, persistence, and pace* are called "task completion" in proposed SSA Rules.[5] These refer to the ability to sustain focused attention long enough to permit the timely completion of tasks commonly found in work settings. In activities of daily living, concentration may be reflected in terms of ability to complete everyday household tasks. Deficiencies in concentration, persistence, and pace are best noted from previous work attempts or from observations in worklike settings, such as day-treatment centers and incentive work programs. Describing specific examples of the patient's capabilities is useful. Major impairments of these abilities can often be assessed through direct psychiatric examinations or psychological testing. However, mental status examinations or psychological test data alone should not be considered adequate to describe fully the patient's concentration and sustained ability to perform work tasks.

Concentration and mental status may be assessed by such tasks as subtracting 7s serially from 100. In psychological tests of intelligence or memory, concentration is assessed through tasks requiring short-term memory or tasks that must be completed within established time limits.

In evaluating fitness for work, capability may be assessed by the completion of such tasks as filing index cards, locating telephone numbers, and disassembling and reassembling objects. Strengths and weaknesses in mental concentration may be described in terms of frequency of errors, the time it takes to complete the task, and the extent to which assistance is required to complete the task. A person who appears to concentrate adequately during a mental status examination or a psychological test might not do so in a setting more like that of the working world.

*4. Deterioration or decompensation in work or worklike settings* refers to repeated failure to adapt to stressful circumstances. In the face of such circumstances the individual may withdraw from the situation or experience exacerbation of signs and symptoms of a mental disorder; that is, decompensate and have difficulty maintaining activities of daily living, continuing social relationships, and completing tasks. Stresses common to the work environment include attendance, making decisions, scheduling, completing tasks, and interacting with supervisors and peers. It is useful to give examples of decompensation and the stresses that might have brought it about.

In assessing the *stress* tolerance of the individual, the examiner should be mindful of the following

issues. First, "stress" may be defined with reference to an objective ("reasonable man") standard in some systems and a more subjective standard in others. Second, the circumstances of a given case might suggest a prophylactic preclusion from certain types of tasks or work settings; for example, a patient with symptoms of posttraumatic stress disorder dating from a robbery and assault might require a prophylactic preclusion from jobs involving contact with the general public or handling large sums of money. In another case, a "personality clash" between the individual and his or her supervisor might require only that the individual be precluded from working with the particular supervisor.

Under the SSA system, the medical reviewer may need to determine the residual functional capacity, a multidimensional description of work-related abilities retained by the individual in spite of medical impairment. The residual functional capacity involves four capacities related to the main aspects or areas described previously. The four capacities are indicated below.

*1. Understanding and memory* relate to the ability to remember procedures related to work; to understand and remember short and simple instructions; and to understand and remember detailed instructions.

*2. Sustained concentration and persistence* relate to the ability to carry out short, simple instructions; carry out detailed instructions; maintain attention and concentration for extended periods; perform activities within a schedule; maintain regular attendance and be punctual within customary tolerances; sustain an ordinary routine without special supervision; work with or near others without being distracted; make simple work-related decisions; complete a normal workday and workweek without interruptions from psychologically based symptoms; and perform at a consistent pace without an unreasonable number of and unreasonably long rest periods.

*3. Social interaction* involves the ability to interact appropriately with the general public; ask simple questions or request assistance; accept instructions and respond appropriately to criticism from supervisors; get along with coworkers and peers without distracting them or exhibiting behavioral extremes; maintain socially appropriate behavior; and adhere to basic standards of neatness and cleanliness.

*4. Adaptation* is the ability to respond appropriately to changes in the work setting; to be aware of normal hazards and take appropriate precautions; to use public transportation and travel to and within unfamiliar places; to set realistic goals; and to make plans independently of others.

## 14.4 Additional Considerations

Particular problems often arise in evaluating mental impairments of individuals who have long histories of repeated hospitalizations or prolonged outpatient care with supportive therapy and medication. Individuals with chronic psychotic disorders commonly have their lives structured in such a way as to minimize stress and reduce their signs and symptoms. Such individuals may be more impaired in terms of work capability than their signs and symptoms indicate. The results of a single examination may not adequately describe the ability of a such person to function in a sustained way. Thus, it is necessary to review information pertaining to the individual's functioning at times of increased stress.

### Effects of Structured Settings

Particularly in cases involving long-standing mental disorders, overt symptoms may be controlled or attenuated by psychosocial factors, such as placement in a hospital, halfway house, board and care facility, or similar environment. These highly structured and supportive settings may greatly reduce the mental demands placed on an individual. With lowered mental demands, overt signs and symptoms of the underlying mental disorder may be minimized; however, the individual's ability to function outside of the structured setting may not have changed. The evaluator of an individual whose symptoms are controlled in the structured setting must consider the individual's ability to function independently of that setting.

### Effects of Medication

Attention must be given to the effects of medication on the individual's signs, symptoms, and ability to function. Although psychoactive medications may control certain signs or symptoms, such as hallucinations, impaired attention span, restlessness, or hyperactivity, the treatment may not affect all limitations imposed by the mental disorder. If an individual's symptoms are attenuated by psychoactive medications, the evaluator should focus particular attention on limitations that may persist. Those limitations should be used as measures of the impairment's severity.

Psychoactive medications used to treat some mental illnesses may cause drowsiness, blunted affect, or unwanted effects involving various body systems. Medications that are necessary to control such symptoms as hallucinations may cause a decrease in motivation and level of activity. These side effects should be considered in evaluating the overall severity

of the individual's impairment and ability to function. As explained in Chapter 2, the evaluator may need to provide an impairment estimate for the drug's side effect.

**Effects of Rehabilitation**

Of paramount importance to the evaluator is the degree of vocational limitation of the impaired individual, which may range from minimal to total. The severity of an impairment may change with the course of the illness, and when the individual needs less medical care, vocational skills may be intact, or the individual may have limitations that may or may not be reversible. The evaluator should judge the possible duration of the impairment that remains, whether remission is likely to be fast or slow, whether it will be partial or total, and whether the impairment is likely to remain stable or to change. These considerations should contribute to the examiner's judgment about the degree of impairment.

Rehabilitation is a sine qua non in the treatment of most patients who have recovered or are recovering from the acute phase of a mental disorder, especially a major mental disorder. Even if it is not possible to effect total remission, an outcome may be considered worthwhile if the individual has been able to move from one degree of impairment to a lesser degree.

For some persons, lack of motivation seems to be a major feature of a continuing impairment. However, many patients who undergo proper rehabilitative measures, including some who have organic illnesses, achieve improvements in functioning. But determining permanent impairment is often imprecise, and rarely is there certainty that it exists. The use of the "impairment" label tends to be pessimistic, providing an adverse prediction that may be self-fulfilling. However, the tendency for physicians and others to minimize psychiatric impairments must also be considered; this may lead to failure to refer patients for potentially helpful rehabilitative measures.

An important aspect of rehabilitation is the recognition that an individual who is taking certain types of medication may be able to sustain a satisfactory degree of functioning, whereas without medication he or she might fail to do so. For instance, there may be only a slight problem in the thinking process while the patient is taking a suitable medication, but a severe one if the patient is not taking medication.

Another consideration is that an employer needs the assurance that a worker who is taking the proper medication and is in an appropriate job can avoid injury to himself or herself and to coworkers. An analogy is seen in the care and treatment of a worker who has seizures: in such an instance, informing and educating the patient, family, employer, and coworkers are vital and should be a part of the rehabilitation process.

Just as there are degrees of impairment, total rehabilitation may not be possible. To use an example from physical medicine, it is essentially impossible for an amputated leg to be replaced, and the affected individual cannot hope to regain perfect, preinjury ambulation. However, a well-fitted prosthesis, accompanied by practice and training, can greatly improve the individual's ability to walk. If, in addition, the individual obtains suitable transportation, he or she may be restored to full gainful employment. If normal ambulation is a job requirement, an employer might be able to provide an alternative position or modify existing tasks so that they can be performed by an amputee making skillful use of a prosthesis.

Although the analogy between the loss of a limb and the loss of capability resulting from a mental disorder has limitations, it is important to recognize that impairment from a mental disorder may be just as real and severe as the impairment resulting from an injury or other illness. The link between motivation and recovery may need strengthening in individuals who are impaired by either physical or mental illnesses. This task falls especially on rehabilitationists and psychiatrists. But others can assist: an employer's providing alternative tasks or modifying existing work conditions may be an important part of restoring vocational ability to a patient with mental illness, to one recovering from an injury, or to a patient who has elements of both mental and physical illness.

## 14.5 Special Impairment Categories

Each of the systems of assessing impairments and disabilities recognizes some types of mental disorders and rejects others as causes of mental impairment. There is controversy about substance dependence disorders and personality disorders and especially about antisocial personality disorders. Adjustment disorders also present a dilemma to the evaluator. These are characterized by abnormal emotional responses to stressful life events, which resolve in a short time when the stressor is removed. Some authorities do not consider these responses to be medical impairments.

**Substance Abuse**

Controversy has been associated with the various systems for determining impairments and disabilities associated with substance abuse. Under past SSA

regulations, documenting a disability required that certain complications or conditions known to be associated with substance abuse be present, and that their levels of severity match those for organic mental disorders, peripheral neuropathies, liver damage, gastritis, pancreatitis, or seizures.

Current SSA policy for determining disability related to substance addiction disorders is a modification of the Listing[1] and permits a substance addiction disorder in and of itself to be a disabling "impairment." Once a substance addiction impairment is established, a finding of disability will depend on the severity and duration of the impairment and the individual's remaining functional capacity. An impaired or lost ability to control the use of addictive substances does not in and of itself establish disability, and, as with any impairment, a diagnosis alone cannot be the basis for determining the presence of a disability. Rather, the basis is the severity of the individual's functional limitations.

Proposed SSA rules would evaluate substance abuse disorders in the same way as with other mental disorders.[4] The disorders would meet the listings if they result in at least *two* of the following: (1) marked restrictions in activities of daily living; (2) marked difficulties in maintaining social functioning; (3) marked difficulties in completing tasks in a timely manner because of deficiencies in concentration, persistence, and pace; and (4) repeated episodes of decompensation and loss of adaptive functioning, averaging three times per year, with each episode lasting 2 or more weeks.

**Personality Disorders**

Proposed SSA rules would handle personality disorders in much the same way as was described above for psychoactive substance dependence disorders. The disorder would meet the Listing[1] if a pathologic behavior pattern of severity prescribed in the rules resulted in marked difficulties in at least two of the four aspects described above, that is, activities of daily living, social functioning, task completion, and episodes of decompensation.

**Mental Retardation**

Under Social Security Disability Insurance, childhood benefits apply to dependent, disabled, adult children of an insured parent who dies, retires, or is disabled. Disability benefits are not payable to the children until age 18 years, and to qualify, the children's disabilities must begin before age 22 years. Under the Supplemental Security Income Program, disabled children under 18 years old are eligible, and there is no minimum age. The definition of disability for children is that there must be "an impairment or impairments of comparable severity to that which is considered disabling for an adult." Since a child is not expected to work, vocational factors are not considered.

The child's impairment must meet the criteria specified in the Listing,[1] with normal growth and development being a prime consideration. Under the Listing, mental retardation and autism require the presence of mental incapacity evidenced by dependence on others for personal needs, such as toileting, eating, dressing, or bathing, and an inability to follow directions, which precludes tests of intellectual functioning, or a valid verbal performance or full-scale IQ of 59 or less, or a score of 60 through 69 along with physical or mental impairment affecting daily activities, social functioning, or concentration, persistence, and pace.

**Pain**

The assessment of impairment due to pain, especially in circumstances in which the complaint exceeds what is expected on the basis of medical findings, is complex and controversial. While pain is discussed in the chapter on pain (p. 303) and elsewhere in this book, it is germane also to the consideration of mental and behavioral disorders. Mental illness may distort the perception of pain. Pain may be part of a somatic delusion in a patient with a major depression or a psychotic disorder. Pain may become the object of an obsessive preoccupation, or it may be the chief complaint in a conversion disorder.

The essential feature of somatoform pain disorder in *DSM-III-R* is preoccupation with pain in the absence of physical findings that adequately account for the pain and its intensity. In the past, this syndrome has been called "psychogenic pain disorder" or "idiopathic pain disorder," but these terms are often used more loosely to describe any complaint of pain that is greater than the physician expects for the average patient who has the same physical findings. The physician should recognize that anxiety and depression almost always magnify pain, and vice versa. The disorders with *impaired pain perception* are easier to evaluate than cases in which the pain is said to have a psychogenic component.

Establishing that pain is or is not a symptom of a mental impairment may be a difficult and complex task. Pain that presents only as a symptom of a mental disorder is rare. The following guidelines may be useful in determining whether pain is a symptom of a mental impairment. (1) All possible somatic causes of the pain have been eliminated by careful, comprehensive medical examinations. (2) Some significant emotional stressor has occurred in the patient's life that may have acted as a triggering agent, and the

stressor and the pain have occurred in a reasonable sequence. (3) Evidence exists of a mental disorder other than a conversion-related one, and the pain may be a symptom of the former; for example, delusional pain may occur in a patient who has a subtle paranoid disorder.

Assessing impairment related to pain is difficult, and the process is not as clearly and precisely defined as with some kinds of impairments. Therefore, determinations about difficult and borderline cases in this category should be made through a multidisciplinary, multispecialty approach, in which physicians who are knowledgeable about the different body systems are involved as needed.

**Malingering**

Although malingering is thought to be rare, the physician should be aware of this possibility when evaluating impairments. The possibility of obtaining monetary awards and still avoiding work increases the likelihood of malingering. Malingering may arise with mental disorders or with nonpsychiatric conditions.

Certain symptoms, such as headache, low-back pain, peripheral neuralgia, and vertigo, are notoriously difficult to assess. Conditions that have more of an organic basis, such as appendicitis, a fracture, or pregnancy, tend to be more amenable to objective diagnostic studies than are psychiatric and neurologic complaints. Psychiatric disorders have not been rewarded financially as well as other conditions. Malingerers with supposed psychiatric conditions may be seen in circumstances involving the avoidance of an unpleasant duty or requirement, such as going to jail or entering military service.

Rather than giving outright fabrications, individuals may consciously or unconsciously exaggerate the symptoms of a disorder in the clinical or the impairment evaluation setting. Malingering or exaggeration of symptoms may be suspected when the individual's symptoms are vague, ill-defined, overdramatized, inconsistent, or not in conformity with signs and symptoms known to occur. In this situation, results of the physical and mental status examinations and other data and information of the evaluation may be inconsistent with the nature and intensity of the patient's complaints.

Circumstances in which an unusual number of ill-defined complaints occur in a circumscribed group, perhaps in a setting of poor morale or conflict, also may be viewed with suspicion. But the most appropriate approach for the examining physician is one of clinical neutrality, the application of standard interview and diagnostic procedures, and, if warning signs appear, a careful investigation that includes multidisciplinary evaluation and psychological testing as appropriate. A recent text considered malingering more fully.[6]

**Motivation**

Assessing motivation is difficult, because lack of motivation may be difficult to distinguish from mental impairment. When is an individual lacking energy, concentration, and initiative "depressed," and when is the individual "unmotivated?" Ultimately, making this distinction requires a clinical judgment, which should be aided by a careful investigation of the individual's efforts and accomplishments before the onset of the alleged impairment and a search for associated signs and symptoms of common mental disorders.

Motivation is a link between impairment and disability. For some people, poor motivation is a major cause of poor functioning. An individual's underlying character may be important in determining whether he or she is motivated to benefit from rehabilitation. Personality characteristics usually remain unchanged throughout life. However, internal events and psychological reactions can influence the course of illness. An individual who tends to be dependent may become more dependent as the illness proceeds, and one who is inclined to act impulsively may develop a pattern of antisocial behavior. Indeed, the development of a pathologic character trait may become more pronounced and significant than the illness in negating motivation for improved functioning.

Thus, as explained in Chapter 1 and the Glossary, the degree of disability in the social and vocational contexts is not necessarily the same as the degree of impairment. The loss of function may be greater or less than the impairment might imply, and the individual's performance may fall short of, or exceed, that usually associated with the impairment. Here the complex issue of "secondary gain" arises, which involves not only the amount of a financial award, but also the individual's life-style. The individual's motivation to recover and be self-sufficient will either diminish or enhance the quality of life in terms of social, vocational, and other activities. Impairment may lead to an almost total or to a minimal disability, depending on motivational factors. Although some clues may appear in the individual's clinical or family history, these are likely to be only suggestive.

When considering the total background and underlying character and value system of the individual, the evaluator must not ignore the educational levels and financial resources of family members. The evaluator should assess the usefulness of family influences, and if rehabilitation efforts are to be made, the evaluator and the patient may find benefit in the participation of one or more family members.

## 14.6 Format of the Report

The following general format for impairment reports has been adapted from that recommended by the SSA.[7] The content of the report may vary, depending on the system for which the report is being prepared. An impairment report based on the *Guides* also should include the main features of the Report of Medical Evaluation form shown in Chapter 2 (p. 11).

### General Observations

1. How did the patient come to the examination, alone or accompanied? From what distance and by what transportation mode? If the patient came by automobile, who drove?

2. Note the patient's appearance: dress, grooming, appearance of invalidism.

3. Describe the patient's attitude and degree of cooperation.

4. Identify the informant and estimate his or her reliability. Ask if the patient has taken drugs or psychoactive substances within the past 24 to 48 hours, which might affect examination results.

**Medical History**
Describe the patient's general physical health. Describe significant past illnesses and injuries; ask about head injuries and residua. Describe hospitalizations for nonpsychiatric causes, diagnoses, durations, operations. Obtain information on human immunodeficiency virus (HIV) and sexually transmitted disease (STD) risk factors and exposures.

Describe current use of medication for nonpsychiatric causes and regimens; describe use of tobacco, alcohol, caffeine, and other drugs. Inquire about allergies.

**Present Illness**
Provide a detailed description of the pertinent history of the mental disorder and a detailed description of the individual's statement of the current complaint. Include (1) the date of onset, date when the patient became unable to work, description of how the disorder interferes with work, and information about outcome of attempts to resume work; (2) a description of the patient's daily activities, interests, and habits.

**Hospitalization for Mental Illness**
Obtain information on location, inclusive dates, duration, and status on admission. Describe therapy given and condition on discharge. Describe the results of psychological tests and other studies, such as electroencephalogram and radiographic studies.

**Outpatient or Other Treatment**
If treatment was given for a mental disorder, state the source of treatment, date, duration, and condition of the patient when first seen. Describe the type of therapy and response; if medications were used, list the drugs, dosages, and results. Describe the patient's condition when last seen.

**Personal and Family History**
Include a biographic description of the patient's relevant educational, social, military, marital, and occupational adjustment in terms of ability to conform to social standards, hold employment, advance in career, and adjust to supervisors and coworkers. Ask about mental illness in the family and conditions that may have familial or hereditary basis.

**Assessment of Severity**
Describe in detail the severity of limitations imposed by the disorder in the following four respects, giving examples.

1. Activities of daily living, including adaptive activities, such as cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring for self, grooming, using the telephone and directory, using the post office, and working.

2. Social functioning and ability to get along with others, including family members, friends, neighbors, grocery clerks, landlords, and others of the public. Social functioning in work situations may involve responding appropriately to persons in authority and cooperative behavior toward coworkers.

3. Concentration, persistence, and pace (task completion); this refers to the patient's ability to sustain focused attention long enough to permit the completion of everyday tasks in the workplace or home. Describe deficiencies in concentration, persistence, and pace that have been observed at work or in worklike settings. Include relevant information from the mental status examination and from psychological testing.

4. Deterioration or decompensation in worklike settings; describe failures to adapt to stressful circumstances that cause the individual either to withdraw from the situation or to experience signs and

symptoms and difficulties with activities of daily living, social relationships, and concentration, persistence, and pace. Describe any decompensation at work, which might involve decisions, attendance, schedules, completing tasks, interactions with supervisors, and interactions with peers.

**Mental Status**
Provide a description of the following: (1) patient's attitude and behavior; (2) stream of conversation and psychomotor activity (provide examples); (3) mood, affect, and emotional reactions; (4) content of special preoccupations (give verbatim examples); (5) sensorium, orientation, memory, and intellectual resources (provide examples); and (6) psychological testing (summarize tests used and results).

**Diagnosis**
Use current American Psychiatric Association nomenclature and the five axes of the multiaxial evaluation.[2]

## 14.7 A Method of Evaluating Psychiatric Impairment

There is no available empiric evidence to support any method for assigning a percentage of impairment of the whole person, but the following approach to estimating the extent of mental impairments is offered as a guide. Not everyone who has a mental or behavioral disorder is totally limited or totally impaired. Many individuals have specific limitations that do not preclude all of life's activities; on the other hand, there are individuals with less than chronic, but still unremitting, impairments who are severely limited in some areas of function. These impairments, too, are of concern.

Medically determinable impairments in thinking, affect, intelligence, perception, judgment, and behavior are assessed by direct observation, formal mental status examination, and neuropsychological testing. Translating specific impairments directly and precisely into functional limitations, however, is complex and poorly understood; for example, current research finds little relationship between psychiatric signs and symptoms such as those identified during a mental status examination, and the ability to perform competitive work.

To bridge the gap between impairment and disability, the group that advised the SSA on disability due to mental impairment identified the four categories of functional limitations discussed earlier (Section 14.3, p. 293). These categories tend to be complex social impairments that may be directly related to work or to other pursuits, such as recreation or caring for a family. Yet there is no specific medical test for any one of the categories. The physician's observations made during the medical examination should be incorporated into the evaluation together with other relevant observations, including those pertaining to carrying out activities of daily living, social functioning, concentration, persistence and pace, and adaptation.

The Table (p. 301) provides a guide for rating mental impairment in each of the four areas of functional limitation on a five-category scale that ranges from no impairment to extreme impairment. The following are recommended as anchors for the categories of the scale. "None" means no impairment is noted in the function; "mild" implies that any discerned impairment is compatible with most useful functioning; "moderate" means that the identified impairments are compatible with some but not all useful functioning; "marked" is a level of impairment that significantly impedes useful functioning. Taken alone, a "marked" impairment would not completely preclude functioning, but together with marked limitation in another class, it might limit useful functioning. "Extreme" means that the impairment or limitation is not compatible with useful function.

Extreme impairment in carrying out activities of daily living implies complete dependency on another person for care. In the sphere of social functioning, extreme impairment implies that the individual engages in no meaningful social contact, as with a patient in a withdrawn, catatonic state. An extreme limitation in concentration, persistence, and pace means that the individual cannot attend to conversation or any productive task at all; this might be seen in a person in an acute confusional state or in a person with a complete loss of short-term memory.

A person who cannot tolerate any change at all in routines or in the environment, or one who cannot function and who decompensates when schedules change in an otherwise structured environment, has an extreme limitation of adaptive functioning and an extreme psychiatric impairment. Such an individual might have a psychotic episode if a meal is not served on time or might have a panic attack when left without a companion in any situation.

In the ordinary individual, extreme impairment in only one class would be likely to preclude the performance of any complex task, such as one involving recreation or work. Marked limitation in two or more spheres would be likely to preclude

**Table.** Classification of Impairments Due to Mental and Behavioral Disorders.

| Area or aspect of functioning | Class 1: No impairment | Class 2: Mild impairment | Class 3: Moderate impairment | Class 4: Marked impairment | Class 5: Extreme impairment |
|---|---|---|---|---|---|
| Activities of daily living<br>Social functioning<br>Concentration<br>Adaptation | *No* impairment is noted | Impairment levels are compatible with *most* useful functioning | Impairment levels are compatible with *some*, but not all, useful functioning | Impairment levels *significantly impede* useful functioning | *Impairment levels preclude* useful functioning |

performing complex tasks without special support or assistance, such as that provided in a sheltered environment. An individual who was impaired to a moderate degree in all four categories of functioning would be limited in ability to carry out many, but not all, complex tasks. Mild and moderate limitations reduce overall performance but do not preclude performance.

Translating these guidelines for rating individual impairment on ordinal scales into a method for assigning percentage of impairments, as if valid estimates could be made on precisely measured interval scales, cannot be done reliably. One cannot be certain that the difference in impairment between a rating of mild and moderate is of the same magnitude as the difference between moderate and marked. Furthermore, a moderate impairment does not imply a 50% limitation in useful functioning, and an estimate of moderate impairment in all four categories does not imply a 50% impairment of the whole person.

Physicians, of course, must often make judgments based more on clinical impressions than on accurate, objective, analytic empiric evidence. In those circumstances in which it is essential to make an estimate, the ordinal or numeric scale might be of some general use. For instance, one might assume that the extreme estimate of 95% to 100% mental impairment implies a state like that of coma, which is the most extreme impairment of central nervous system functioning and consciousness. Approaching 100% impairment of the whole person, according to the *Guides*, is considered to be approaching death.

Eventually, research may disclose direct relationships between medical findings and percentages of mental impairment. Until that time, the medical profession must refine its concepts of mental impairment, improve its ability to measure limitations, and continue to make clinical judgments.

**Comment on Lack of Percents in This Edition**

The decision not to use percentages for estimates of mental impairment in this fourth edition of the *Guides* was made only after considerable thought and discussion. The second edition (1984) provided ranges of percentages for estimating such impairment. Mental functions, such as intelligence, thinking, perception, judgment, affect, and behavior, were considered to fall into five classes, and the ranges were given as follows: normal, 0% to 5%; mild impairment, 10% to 20%; moderate impairment, 25% to 50%; moderately severe impairment, 55% to 75%; and severe impairment, more than 75%. Ability to carry out daily activities was estimated as follows: class 1, self-sufficient; class 2, needs minor help; class 3, needs regular help; class 4, needs major help; and class 5, quite helpless. From estimates of the individual's functioning, a whole-person impairment estimate could be made.

The procedure for the second edition was highly subjective. The third edition (1988) did not list percentages but instead provided the same classes of impairment as the fourth edition. There are some valid reasons to use ranges of percents for mental impairments. If this were done, the chapter on mental disorders would be consistent with *Guides* chapters for the other organ systems. Another point is that various systems for estimating disability have developed ranges of percentages; if such estimates were not provided in the *Guides*, the material in the *Guides* on mental disorders might be ignored. This would increase the likelihood that estimates would be made inconsistently in the various jurisdictions.

A more persuasive argument is that, unlike the situations with some organ systems, there are no precise measures of impairment in mental disorders. The use of precentages implies a certainty that does not exist, and the percentages are likely to be used inflexibly by adjudicators, who then are less likely to take into account the many factors that influence mental and behavioral impairment. Also, because no data exist that show the reliability of the impairment percentages, it would be difficult for *Guides* users to defend their use in administrative hearings. After

considering this difficult matter, the Committee on Disability and Rehabilitation of the American Psychiatric Association advised *Guides*' contributors against the use of percentages in the chapter on mental and behavioral disorders of the fourth edition.

*Example:* A 27-year-old single woman was referred for evaluation of mental impairment. She had a 9-year history of chronic paranoid schizophrenia. She had not worked for longer than 2 months at a time since dropping out of business college at the age of 19 years. The young woman had lived at home and had been cared for and supported financially by her aging parents, who recently moved to a retirement community. For the past 3 months she had been living in a cooperative apartment and she had shown some ability to care for herself. However, she constantly needed to be reminded to bathe, take her medications, and complete the household chores.

The young woman had little self-confidence and did not engage independently in any activities, including cooking; however, when someone insisted that she cook, she was able to do so. Once she initiated a task, she was able to complete it in a timely manner. She had no friends and never initiated a conversation, and when she was approached or prodded she became terrified and occasionally abusive. The woman remained paranoid and said that "everyone is in my mind." Her attention span was limited to 25 to 30 minutes, and she frequently "blocked" in her speech and was unable to complete a thought.

Although the woman had been in a hospital only twice, she frequently stopped taking her neuroleptic medications, which were generally effective in controlling her delusions and hallucinations. During two periods when she was employed, she became overwhelmed by the pressures of work deadlines, blamed coworkers for slowing her down, stopped taking her medications, and needed intensive treatment. She handled some changes in her environment well but had considerable difficulty with deadlines and time constraints and with separation from her family.

A complete medical evaluation was performed, and there were no positive physical or laboratory findings. A mental status examination confirmed the history and findings described above.

*Impairment:* The evaluator believed the young woman's activities of daily living and social functioning were markedly impaired, and her ability to concentrate, maintain a reasonable pace, and adapt to change were moderately impaired. The evaluator believed that in more demanding social or vocational situations the woman would be markedly impaired in concentration and adaptation.

The evaluator concluded that, overall, the young woman had marked mental or psychiatric impairment (class 4).

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3. Meyerson A, Fine T. *Psychiatric Disability: Clinical, Legal, and Administrative Dimensions.* Washington, DC: American Psychiatric Press; 1987.

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