CD Part 12

Mental Disorders

A. Definitions

The following definitions are for words used in this chapter and during the SSA disability process. If you need additional definitions, consult a good medical dictionary, available in most bookstores and libraries. You can also look at online medical dictionaries like the one at www.medlineplus.gov.

Affect. Emotion.

Agoraphobia. Irrational fear of leaving familiar surroundings, such as one's home.

Akinesia. Absent or decreased movement.

Anhedonia. Inability to experience pleasure.

Anorexia nervosa. A serious mental disorder, usually in women and characterized by the fear of excessive weight gain although the person is markedly underweight.

Anxiety. An uncomfortable emotional state with effects both on the mind and body, resulting from anticipation of real or imagined danger. In "free-floating" anxiety, the person is not aware of the object of danger. Physiological effects may include increased heart and respiration rates, sweating, weakness, and trembling.

Apathy. Lack of interest; indifference.

Autism. A pervasive developmental disorder starting in early childhood and characterized by marked social and communication deficits.

Bipolar disorder. A psychotic mental disorder involving episodes of both *mania* and *depression*.

Blunt affect. Decreased emotion for what would be considered appropriate to a particular situation.

Bulimia. Eating disorder, usually in younger females, characterized by episodes of binge eating. Bulimics may engage in self-induced vomiting after eating or other extreme activities in an attempt to control their eating disorder.

Catatonia. A disorganized mental state ranging from stupor to agitation.

Circumstantial speech. The injection of an excessive number of irrelevant details into speech.

Cognitive functions. The rational thinking functions of the mind that are in conscious awareness, as opposed to affective (emotional) functions. A more complex definition of cognitive functions used by the SSA is: "Cognition involves the ability to learn, understand, and solve problems through intuition, perception, auditory and visual sequencing, verbal and nonverbal reasoning, and the application of acquired knowledge. It also involves the ability to retain and recall information, images, events, and procedures during the process of thinking."

Compulsion. An irrationally repeated act or ritual that helps a person decrease anxiety.

Confabulation. Filling in memory gaps with false or irrelevant facts.

Cyclothymic syndrome. Alternating moods of *hypomania* and *depression*, more extreme than normal but less extreme than bipolar disorder.

Decompensation. Worsening of a mental disorder.

Delirium. A temporary condition in which there is gross loss of awareness of surroundings (severe clouding of consciousness), often involving incoherent speech, hallucinations, delusions, psychomotor agitation, memory loss, emotional disturbance, and disturbed sleep.

Delusion. Beliefs held despite evidence or experience to the contrary.

Dementia. Loss of intellectual ability, judgment, abstract thinking, and memory caused by organic brain damage. Personality changes may also be present but, unlike delirium, there is no clouding of consciousness regarding general awareness of surroundings.

Depression. Depressed mood, as in sadness or despair.

Development. The attainment of mental and physical skills.

Developmental milestones. The attainment of particular mental or motor skills at age-appropriate levels.

Disorientation. Loss of knowledge of time, person, or place.

Down syndrome. Hereditary disorder involving the presence of an extra #21 chromosome in cells, associated with mental retardation and possible abnormalities in various organs such as the heart. Also known as *trisomy 21*.

Dyskinesia. Abnormal movements.

Elation. The abnormally elevated mood component of mania; also used synonymously with *mania*.

Emotional lability. Emotional instability.

Extrapyramidal side effects (EPS). Abnormalities sometimes caused by antipsychotic drugs, especially

older ones. Features of EPS that may be present include restlessness with a constant urge to move (akathisia), tremors, muscle rigidity, abnormal gait, and muscle spasms in the head and neck. The risk of developing EPS is minimized with the newer drugs used to treat psychotic disorders.

Factitious disorders. Disorders in which a person intentionally fakes symptoms, with no other aim than assuming the role of a patient. Factitious disorders should be distinguished from malingering, in which there is intentional faking of symptoms to obtain some other goal than being a patient, such as avoiding work or obtaining monetary benefits.

Fine motor function. Reference to ability to use small muscles in a coordinated way, especially the hands and individual fingers.

Flat affect. Absence of emotional responsiveness even when it would be appropriate.

Flight of ideas. Rapid succession of thoughts that are not logically connected.

Functional disorder. Disorder that has no organic basis. Also known as a *psychogenic disorder.*

Gross motor function. Reference to ability to use large muscles in a coordinated way, such as walking, pushing, and pulling.

Hallucination. A false sensory experience—that is, when no sensory stimulus is present. Any of the senses can be involved.

Hypomania. An expansive mood that is not severe enough to be mania and is not associated with psychotic features such as delusions and hallucinations. Hypomania is severe enough to be noticeable to other people.

Hysterical seizures. See *psychogenic seizures.*

Illogical thinking. Thoughts that do not follow a rational connection between cause and effect.

Illusion. A false interpretation of a real sensory experience. Should not be confused with *delusion.*

Impulse control. Ability to self-restrain inappropriate behavior.

Inappropriate affect. Emotion that is not appropriate to a particular situation, such as excessive sadness or laughter that would not be present in a normal person under the same circumstances.

Incoherence. Disorganized thought or language, to the point of making rational communication impossible. More extreme mental disorganization than illogical thinking.

Incoherent speech. Speech without meaning.

Judgment. Ability to make accurate decisions, determinations, or courses of action appropriate to a particular situation.

Lability. Emotional instability, rapidly changing emotions.

Loosening of associations. An abnormal mental process whereby the logical connection between thoughts is lost. If loosening of associations is severe enough, it becomes incoherent.

Malingering. A conscious effort to fake an illness to obtain some goal (such as avoidance of work or obtaining monetary benefits) other than playing the role of a patient. Also see *factitious disorder.*

Mania. Abnormal mental condition associated with *bipolar disorder* and characterized by elation, hyperactivity, poor judgment, and increased speed of thought and speech.

Mental retardation. A disorder characterized by a significantly subaverage general intellectual functioning with deficits in adaptive behavior, initially manifested during the developmental period (before age 22). Decreased intellectual functioning as measured by IQ is not mental retardation.

Mental status examination. Direct personal evaluation of a person's mental condition by a psychiatrist or psychologist for the purpose of determining mental health, particularly regarding possible abnormalities of behavior, affect, thought, memory orientation, or contact with reality.

Mood. A persistent emotion that broadly affects mental experience. As used by the SSA in listings, mood is a prolonged emotion that colors the whole psychic life, generally involving either *depression* or *elation.*

Motor development. Motor function acquired by a child compared to that normally expected.

Motor dysfunction. Abnormal motor function.

Motor function. Abilities related to movement, such as walking and use of the hands and arms.

Motor skills. See *motor function.*

Neuroleptics. Drugs used to treat mental disorders.

Obsession. Involuntary repetitious thoughts. Obsessions can be about anything but typically

involve things like aggression, fear of contamination, religion, sex, physical illness, and a need to be overly exact. Obsessions cause anxiety that results in compulsive behaviors for relief.

Organic brain syndrome (OBS). Mental abnormalities associated with physical brain damage.

Orientation. A person's knowledge of time, person, and place.

Overt. Outward, observable.

Paranoid thinking. Structured delusions of persecution and suspiciousness.

Passive-aggressive. Disorder in which a person is aggressive against others by means of passivity, such as being stubborn or otherwise obstructing a relationship.

Perception. Any kind of sensory experience.

Phobia. A persistent irrational fear of—and a compelling desire to avoid—a specific object, activity, or situation.

Poverty of speech. Abnormal decrease in speech activity.

Premorbid. Before the onset of an illness.

Pressure of speech. Abnormal increase in the speed and amount of speech.

Pseudoseizures. See *psychogenic seizures.*

Psychogenic seizures. Seizures of psychological origin rather than the brain dysfunction characteristic of true epilepsy. Also known as *pseudoseizures* and *hysterical seizures.*

Psychomotor agitation. State of abnormally increased thinking and increased physical activity.

Psychomotor retardation. State of abnormally slowed thinking and slowed physical activity.

Psychotic disorders. Disorders, such as schizophrenia and manic-depressive illness that result in gross loss of contact with reality. Hallucinations and delusions are usually prominent features.

Psychotropic medications. Drugs used to treat mental disorders.

Remission. Recovery from an illness to some degree (full or partial remission).

Serial sevens. A standard part of mental status examinations to test a person's concentration by asking them to subtract seven from 100 repetitively, such as 100, 93, 86, 79, 72 … etc., until zero is reached. Many otherwise normal people can't do this task very well. A more reasonable test of concentration in most people is subtraction of serial fives.

Somatoform disorders. Disorders that involve physical symptoms that are actually of psychological origin.

Standard deviation. A statistical calculation expressing the amount of deviation of a value from average.

Structured settings. Highly supervised and controlled environments where individual responsibility, decision making, and stress are minimized.

Tic. An involuntary, repetitive, rapid, purposeless movement. Tics are most often seen in the facial muscles, but may also involve muscles in other locations. Tics can be of physical cause, such as in Tourette's syndrome, or of psychological cause.

B. General Information—Adult Mental Disorders

The SSA Listings for mental disorders are arranged in eight diagnostic categories: organic mental disorders (12.02); schizophrenic, paranoid, and other psychotic disorders (12.03); affective disorders (12.04); mental retardation and autism (12.05); anxiety-related disorders (12.06); somatoform disorders (12.07); personality disorders (12.08); and substance addiction disorders (12.09). One listing may contain the criteria for several different mental disorders that fall in a diagnostic category. For example, Listing 12.08 is used to evaluate more than one type of personality disorder. Except for Listings 12.05 and 12.09, part Ⓐ of each listing gives the diagnostic clinical criteria that must be present to establish the presence of a mental disorder. If the part Ⓐ criteria are met, consideration is then given to the functional restrictions in part Ⓑ. There are additional considerations (part Ⓒ criteria) in Listings 12.03 and 12.06.

The structure of the listing for substance addiction disorders, Listing 12.09, is different from that for the other mental disorder listings. Listing 12.09 is a reference listing; that is, it only serves to refer evaluation of disorders resulting from substance addiction to other appropriate listings.

The criteria defining specific mental disorders considered by the SSA are essentially the same as those given in part Ⓐ of each listing. The criteria the SSA uses in disability determination are derived from the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association. However, the SSA criteria are interpretations of DSM criteria, rather than exact reproductions. The definitions of some specific mental disorder terms are given above.

1. Need for Medical Evidence

The existence of a mental disorder of the required duration must be established by medical evidence consisting of clinical signs, symptoms, and/or laboratory or psychological test findings. These findings may be intermittent or persistent depending on the nature of the disorder. Clinical signs can be medically demonstrated and reflect specific abnormalities of behavior, affect, thought, memory orientation, or contact with reality. These signs are typically assessed by a psychiatrist or psychologist and are documented by psychological tests. Symptoms are complaints presented by the individual. Signs and symptoms generally cluster in ways characteristic of particular mental disorders. Both symptoms and signs that are part of any diagnosed mental disorder must be considered in evaluating severity.

2. Assessment of Severity

The severity of mental disorders for disability purposes is determined by the functional limitations imposed by the impairment. As previously mentioned, part Ⓑ or Ⓒ of a listing gives the functional criteria needed to establish allowance-level severity. When a listing uses "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, so long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately, and effectively. These functional limitations are determined by descriptions of restrictions of activities of daily living; social functioning; concentration, persistence, or pace; and ability to tolerate increased mental demands associated with competitive work.

These four areas are considered in more detail as follows:

1. *Activities of daily living* include adaptive activities such as cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring appropriately for one's grooming and hygiene, using telephones and directories, using a post office, etc. The quality of these activities is judged by the person's independence, appropriateness, and effectiveness in carrying them out. It is necessary to determine the extent to which the individual is capable of initiating and participating in activities independent of supervision or direction.

   "Marked" does not define the number of activities that are restricted but the overall degree of restriction or combination of restrictions. For example, a person who is able to cook and clean might still have marked restrictions of daily activities if he or she is too fearful to leave the immediate environment of home and neighborhood, hampering the ability to obtain treatment.
2. *Social functioning* refers to a person's capacity to interact appropriately and communicate effectively with others. Social functioning includes the ability to get along with others, for example, family members, friends, neighbors, grocery clerks, landlords, and bus drivers. A history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, and social isolation may demonstrate impaired social functioning. Strength in social functioning may be documented by a person's ability to initiate social contacts with others, communicate clearly with others, interact, and actively participate in group activities. Cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity also need to be considered. Social functioning in work situations may involve interactions with the public, responding appropriately to persons in authority, such as supervisors, or cooperative behaviors involving coworkers.

   "Marked" does not define the number of areas in which social functioning is impaired, but the overall degree of interference in a particular

area or combination of areas of functioning. For example, a person who is highly antagonistic, uncooperative, or hostile but is tolerated by local storekeepers may nevertheless have marked restrictions in social functioning because that behavior is not acceptable in other social contexts.

3. *Concentration, persistence, and pace* refers to the ability to sustain focused attention sufficiently long 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 tasks in everyday household routines. Deficiencies in concentration, persistence, and pace are best observed in work and work-like settings. Major impairment in this area can often be assessed through direct psychiatric examination and/or psychological testing. However, mental status examination or psychological test data alone should not be used to describe concentration and sustained ability to adequately perform work-like tasks. On mental status examinations, concentration is assessed by tasks such as having the individual 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, and pace are assessed through such tasks as filing index cards, locating telephone numbers, or disassembling and reassembling objects. Strengths and weaknesses in areas of concentration can be discussed in terms of frequency of errors, time it takes to complete the task, and the extent to which assistance is required to complete the task.
4. *Episodes of decompensation* are periods of temporary worsening of symptoms or signs accompanied by a loss of adaptive functioning: difficulties performing activities of daily living, maintaining social relationships, or maintaining concentration, persistence, or pace in the completion of tasks. Episodes of decompensation can be shown by a worsening of symptoms or signs that would ordinarily require increased treatment or change to a less stressful situation (or a combination of the two). Episodes of decompensation can be documented by medical records showing significant alteration in medication; or documentation of the need for a more structured psychological support system (for example, hospitalizations, placement in a halfway house, or a highly structured and supervised household); or other relevant information in records 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 one year, or an average of once every four months, each lasting for at least two weeks. If the claimant has experienced more frequent episodes of shorter duration or less frequent episodes of longer duration, the SSA must use medical judgment to determine if the episodes produce enough functional limitation to be considered equal in severity.

3. Documentation

The presence of a mental disorder should be documented primarily on the basis of reports from individual treating sources such as psychiatrists and psychologists and facilities such as hospitals and clinics. Adequate descriptions of functional limitations must be obtained from these or other sources, which may include programs and facilities where the individual has been observed over a considerable period of time.

Information from both medical and nonmedical sources may be used to obtain detailed descriptions of the claimant's activities of daily living, social functioning, concentration, persistence, and pace, or ability to tolerate increased mental demands (stress). Programs such as community mental health centers, day care centers, and sheltered workshops can provide this information. Others, including family members, who have knowledge of the claimant's functioning, can also provide it. In some cases, descriptions of activities of daily living or social functioning given by claimants or their treating sources might not have enough detail or may be in conflict with information in examinations or reports. The SSA should resolve any inconsistencies or gaps in information that may exist, in order to obtain a proper understanding of the claimant's functional

restrictions. Usually, this is done by asking treating sources for clarification or sending the claimant for mental status examination by a psychologist or psychiatrist.

A person's level of functioning may vary greatly over time, so that information from one specific time can be misleading. It is vital to obtain evidence from relevant sources over a sufficiently long period before the date of disability determination, in order to establish the severity of a mental disorder. This evidence should include treatment notes, hospital discharge summaries, and work evaluation or rehabilitation progress notes if these are available.

Some claimants may have attempted to work or may actually have worked during a period of time relevant to their condition when applying for disability. This may have been an independent attempt at work or it may have been in conjunction with a community mental health or other sheltered program. Information concerning the individual's behavior during any attempt to work and the circumstances surrounding termination of the work effort are particularly useful in determining her ability or inability to function in a work setting.

The results of well-standardized psychological tests such as the Wechsler Adult Intelligence Scale (WAIS), the Minnesota Multiphasic Personality Inventory (MMPI), the Rorschach, and the Thematic Apperception Test (TAT), may be useful in establishing the existence of a mental disorder.

The WAIS is an IQ test useful in establishing subaverage intellectual functioning and mental retardation. The MMPI (Minnesota Multiphasic Personality Inventory) is a widely used test consisting of hundreds of questions to be answered "true" or "false." The MMPI supposedly measures a variety of personality traits and mental abnormalities. The Rorschach consists of a series of cards, each with an inkblot design; the subject tells the examiner what he or she sees in the card and explains what it was about the design that influenced their response. The Rorschach supposedly reveals unconscious personality traits. The Thematic Apperception Test (TAT) consists of a set of drawings of people engaged in various activities and the subject is asked to explain the activities. Supposedly, when the subject "explains" the pictures there is personal identification with the people in the images and the answers are therefore revealing about the subject's own personality.

Neuropsychological tests, such as the Halstead-Reitan or the Luria-Nebraska batteries, can be useful in determining brain function deficiencies. They are particularly helpful in cases involving subtle findings such as might be seen in traumatic brain injury. In addition, observations of a claimant taking a standardized test can provide information about their ability regarding concentration, persistence, and pace. Therefore, test results should include both the objective data and a narrative description of clinical findings. Narrative reports of intelligence testing should include a discussion of whether or not the IQ scores are considered valid and consistent with the claimant's developmental history and degree of functional restriction.

Identical IQ scores obtained from different tests do not always reflect a similar degree of intellectual functioning. In this connection, it must be noted that on the WAIS, for example, IQs of 70 and below are characteristic of approximately the lowest 2% of the general population. In instances where other IQ tests are used, it would be necessary to convert the IQ to the corresponding percentile rank in the general population in order to determine the actual degree of impairment reflected by those IQ scores. In other words, if the score on the non-WAIS IQ test was 75 and characteristic of the lowest 2% of the general population, it would be considered by the SSA to be an IQ of 70. Some claimants may have neurological or communication disorders that prevent the use of a standard IQ test like the WAIS, or they may have a culture and background that is not principally English-speaking. In these cases, other IQ tests can be used, such as the Test of Nonverbal Intelligence, Third Edition (TONI-3), Leiter International Performance Scale-Revised (Leiter-R), or Peabody Picture Vocabulary Test (PPVT-III).

In cases where more than one IQ is customarily derived from the test administered—where, for example, verbal, performance, and full-scale IQs are provided as on the WAIS—the lowest of these is used in conjunction with Listing 12.05.

In cases where the claimant is incapable of taking a standard intelligence test, the SSA should obtain medical reports specifically describing the level of

intellectual, social, and physical function. Actual observations by Social Security Administration or state agency personnel, reports from educational institutions, and information furnished by public welfare agencies or other reliable objective sources should be considered as additional evidence.

Anxiety disorders involving phobias, panic disorders, and post-traumatic stress disorder should be documented with at least one good description of a typical reaction. The description should include the nature, frequency, and duration of any panic attacks or other reactions, what brings on the attacks, what makes them worse, and what effect they have on the claimant's ability to function normally. If the claimant's treating doctor provides the description, the doctor should indicate what part of the description they personally observed.

4. Chronic Mental Impairments

Special problems are often involved in evaluating mental impairments in people who have long histories of repeated hospitalizations or prolonged outpatient care with supportive therapy and medication. Claimants with chronic psychotic disorders, such as chronic schizophrenia, commonly have their lives structured in such a way as to minimize stress and reduce their signs and symptoms. Such claimants may be much more impaired for work than their signs and symptoms would indicate. The results of a single examination might not adequately describe their sustained ability to function. Therefore, it is vital for the SSA to review all information relevant to the claimant's condition, especially at times of increased stress. It is mandatory for the SSA to attempt to obtain adequate descriptive information from all sources that have treated the claimant either currently or in the time period relevant to the decision.

5. Effects of Structured Settings

Particularly in cases involving chronic mental disorders, symptoms might be controlled or lessened by psychosocial factors such as placement in a hospital, board-and-care facility, or other environment that provides similar structure. Such highly structured and supportive settings may greatly reduce the mental demands placed on an individual. With lowered mental demands, outward signs and symptoms of the underlying mental disorder may be minimized. At the same time, however, the claimant's ability to function outside of such a structured and/or supportive setting may not have changed. An evaluation of claimants whose symptoms are controlled or lessened by psychosocial factors must consider their ability to function outside of such highly structured settings. (For these reasons the part © criteria were added to Listings 12.03 and 12.06.)

6. Effects of Medication

Attention must be given to the effect of medication on the claimant's signs, symptoms, and ability to function. For example, psychotropic medications might control certain manifestations of a mental disorder, such as hallucinations, but not necessarily improve functional limitations. In cases where overt symptoms are lessened by medications, particular attention must be focused on the functional restrictions that may persist. These functional restrictions are also to be used as the measure of impairment severity. (See the part © criteria in Listings 12.03 and 12.06.)

The medicines used in the treatment of some mental illnesses may cause drowsiness, blunted emotions, or extrapyramidal side effects. Side effects must be considered in evaluating overall impairment severity, including the assessment of residual functional capacity.

7. Effect of Treatment

It must be remembered that with adequate treatment some individuals suffering with chronic mental disorders are so much improved that they return to a nearly normal condition. Treatment of a mentally impaired person may or may not result in the ability to work. (See the part © criteria in Listings 12.03 and 12.06.)

C. General Information—Child Mental Disorders

The listings for mental disorders in children under age 18 are arranged in 11 diagnostic categories: Organic mental disorders (112.02); schizophrenic, delusional (paranoid), schizoaffective, and other psychotic disorders (112.03); mood disorders (112.04); mental retardation (112.05); anxiety disorders (112.06); somatoform, eating, and tic disorders (112.07); personality disorders (112.08); psychoactive substance dependence disorders (112.09); autistic disorder and other pervasive developmental disorders (112.10); attention deficit hyperactivity disorder (112.11); and developmental and emotional disorders of newborns and younger infants (112.12).

There are significant differences between the listings for adults and the listings for children. The presentation of mental disorders in children, particularly the very young, may be subtle and different from the signs and symptoms found in adults. The activities appropriate to children, such as learning, growing, playing, maturing, and adjusting to school, are also different from the activities appropriate to the adult and vary widely in the different childhood stages of development.

Each listing begins with an introductory statement that describes the disorder or disorders addressed by the listing. This is followed (except in Listings 112.05 and 112.12) by medical findings (part Ⓐ criteria). If part Ⓐ criteria are satisfied, evaluation is then done for impairment-related functional limitations (part Ⓑ criteria). A child will meet the listing when the criteria of both parts Ⓐ and Ⓑ are satisfied.

The purpose of the criteria in part Ⓐ is to substantiate medically the presence of a particular mental disorder. Specific symptoms and signs under any of the child listings must have a reasonable relationship to the description of the mental disorder contained at the beginning of each listing.

The purpose of the part Ⓑ criteria is to describe impairment-related functional limitations that are applicable to children. Standardized tests of social development, rational thinking, and adaptive behavior are frequently available and appropriate for the evaluation of children and included in the part Ⓑ functional parameters. The functional restrictions in part Ⓑ must be the result of the mental disorder which is manifested by the medical findings in part Ⓐ.

1. Need for Medical Evidence

The same comments as for adult mental disorders apply here.

2. Assessment of Severity

In childhood cases, as with adults, severity is measured according to the functional limitations imposed by the mental disorder. However, the range of functions normally expected of children varies for different ages. As previously mentioned, part Ⓑ of a listing gives the functional criteria needed to establish allowance-level severity. The functional areas that the SSA considers in child claims are: Motor function; cognitive/communicative function; social function; personal function; and concentration, persistence, or pace. In most functional areas, the listings have two alternative methods of documenting the required level of severity:

- use of standardized tests alone, where appropriate test instruments are available, or
- use of other medical findings.

The use of standardized tests is the preferred method of documentation if such tests are available. (See "Documentation," below, for further explanation of these requirements.)

When "marked" is mentioned as the 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 the ability to function (based upon age-appropriate expectations) independently, appropriately, effectively, and on a sustained basis. When standardized tests are used as the measure of a child's functional abilities, a valid score that is two standard deviations below the norm for the test will be considered a marked restriction.

The following information will give you some idea of how the SSA looks at functional limitations imposed by mental disorders in different age groups under the listings.

Older infants and toddlers (ages one and two). In this age group, impairment severity is assessed in three areas.

Motor development. Much of what can be learned about mental function in these children comes from observation of the degree of development of fine and gross motor function. Developmental delay is best measured by medical examination and a good developmental history. This information should be available in the child's medical records, supplemented by information from nonmedical sources, such as parents, who have observed the child and can provide historical information. Measurement of motor development can also be done by standardized testing. If the child has not achieved motor development generally acquired by children no more than one-half the child's age, the criteria of the listing are satisfied.

Cognitive/communicative function. Cognitive/communicative function is measured using one of several standardized infant test scales. Appropriate tests for the measure of such function are discussed in the documentation section below. For older infants and toddlers, disruption in communication, as measured by the capacity to use simple verbal and nonverbal means to communicate basic needs, may substitute for test scores.

Social function. Social function in older infants and toddlers is measured in terms of the development of relationships to people (e.g., bonding and stranger anxiety) and attachment to animate or inanimate objects. Standard tests of social maturity or alternative criteria can be used to describe marked impairment in socialization.

Preschool children (ages three, four, and five). Four functional areas are used to measure severity.

Cognitive/communicative function. In the preschool years and beyond, cognitive function can be measured by standardized tests of intelligence, although the appropriate instrument may vary with age. A primary criterion for limited cognitive function is a valid verbal, performance, or full-scale IQ of 70 or less. The listings also provide alternative criteria, consisting of tests of language development or bizarre speech patterns.

Social function. Social functioning refers to a child's capacity to form and maintain relationships with parents, other adults, and peers. Social functioning includes the ability to get along with others (family members, neighborhood friends, classmates, teachers). Impaired social functioning may be caused by inappropriate externalized actions, such as running away or physical aggression which is not self- injurious. Or there may be inappropriate internalized actions, such as social isolation, avoidance of interpersonal activities, or mutism. Decreased social function severity must be documented in terms of intensity, frequency, and duration and shown to be beyond what might be reasonably expected for the child's age. Strength in social functioning may be documented by such things as the child's ability to respond to and initiate social interaction with others, to sustain relationships, and to participate in group activities. Cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity appropriate to a child's age, also need to be considered. Social functioning in play and school may involve interactions with adults, including responding appropriately to persons in authority (for example, teachers and coaches), or cooperative behaviors involving other children. Social functioning is observed not only at home but also in preschool programs.

Personal function. Personal functioning in preschool children pertains to self-care; in other words personal needs, health, and safety. Examples include feeding, dressing, toileting, and bathing; maintaining personal hygiene, proper nutrition, sleep, and health habits; adhering to medication or therapy regimens; and following safety precautions. Development of self-care skills is measured in terms of the child's increasing ability to help himself or herself and to cooperate with others in taking care of these needs. Impaired ability in this area is manifested by failure to develop such skills, failure to use them, or self-injurious actions. Personal function may be documented by a standardized test of adaptive behavior or by a careful description of the child's full range of self-care activities. These activities are often observed not only at home but also in preschool programs.

Concentration, persistence, or pace. This function may be measured through observations of the child in the course of standardized testing and in the

course of play. For example, can the child maintain attention and motivation to finish play or other tasks in a reasonable amount of time?

Primary school children (ages six through eleven). The measures of function here are similar to those for preschool-age children except that the tests used may be different and the capacity to function in the school setting is used as supplemental information. Standardized measures of academic achievement, such as the Wide Range Achievement Test-Revised or Peabody Individual Achievement Test, may be helpful in assessing cognitive impairment. Problems in social functioning, especially in the area of peer relationships, are often observed firsthand by teachers and school nurses. As described in the documentation section below, school records are an excellent source of information concerning function and standardized testing and should always be sought for school-age children.

Adolescents (ages 12 through 17). Functional criteria are like those for primary school children. Tests appropriate to adolescents should be used where indicated. Comparable findings to test results for showing disruption of social function must consider the capacity to form appropriate, stable, and lasting relationships. If information is available about cooperative working relationships in school or at part-time or full-time work, or about the ability to work as a member of a group, this information should be considered when assessing the adolescent's social functioning. Markedly impoverished social contact, isolation, withdrawal, and inappropriate or bizarre behavior under the stress of socializing with others also constitute findings comparable to test results. (Note that self-injurious actions are evaluated in the personal area of functioning.)

Personal functioning in adolescents pertains to self-care. It is measured in the same terms as for younger children, but the focus is on the adolescent's ability to take care of his or her own personal needs, health, and safety without assistance. Impaired ability in this area is manifested by failure to take care of these needs or by self-injurious actions. This function may be documented by a standardized test of adaptive behavior or by careful descriptions of the full range of self-care activities.

3. Documentation

The presence of a mental disorder in a child must be documented on the basis of reports from acceptable sources of medical evidence. Descriptions of functional limitations may be available from these sources, either in the form of standardized test results or in other medical findings supplied by the sources or both. (Medical findings consist of symptoms, signs, and laboratory findings.) Whenever possible, a medical source's findings should reflect their consideration of information from parents or others who are aware of the child's activities of daily living, social functioning, and ability to adapt to different settings and expectations. The medical sources should also report to the SSA findings and observations on examination of the child, consistent with standard clinical practice. As necessary, information from nonmedical sources, such as parents, should be used to supplement the record of the child's functioning. This will allow the SSA to establish the consistency of the medical evidence and impairment severity over a period of time.

For some newborn and young infants, it may be very difficult to document the presence or severity of a mental disorder. Therefore, with the exception of some genetic diseases and catastrophic congenital abnormalies, it may be necessary for the SSA to defer making a disability decision until the child attains three months of age, in order to obtain adequate observation of behavior or emotions. This period could be extended in cases of premature infants, depending on the degree of prematurity and the adequacy of documentation of their developmental and emotional status.

For infants and toddlers, programs of early intervention involving occupational, physical, and speech therapists, nurses, social workers, and special educators are a useful source of data. They can provide the developmental milestone evaluations and records on the fine and gross motor functioning of these children. This information is valuable and can complement the medical examination by a physician. A report of an interdisciplinary team that contains the evaluation and signature of an acceptable medical source is considered acceptable medical evidence rather than supplemental data. (See the discussion of acceptable medical sources in Chapter 5.)

In children with mental disorders, particularly those requiring special placement, school records are a useful source of data. Also, the required re-evaluations at specified time periods can provide the data needed to follow the severity of the condition over time.

In some cases where the treating sources lack expertise in dealing with mental disorders of children, it may be necessary to obtain evidence from a psychiatrist, psychologist, or pediatrician with experience and skill in the diagnosis and treatment of mental disorders as they appear in children. In these cases, however, every reasonable effort must be made to obtain the records of the treating sources, because these records will help establish a longitudinal picture that cannot be established through a single purchased examination.

Identical IQ scores obtained from different tests do not always reflect a similar degree of intellectual functioning. In this connection, it must be noted that on the WAIS, for example, IQs of 70 and below are characteristic of approximately the lowest 2% of the general population. In instances where other IQ tests are used, it would be necessary to convert the IQ to the corresponding percentile rank in the general population in order to determine the actual degree of impairment reflected by those IQ scores. In other words, if the score on the non-WAIS test was 75 and characteristic of the lowest 2% of the general population, it would be considered by the SSA to be an IQ of 70. Some claimants may have neurological or communication disorders that prevent the use of a standard IQ test like the WAIS, or they may have a culture and background that is not principally English-speaking. In these cases, other IQ tests can be used, such as the Test of Nonverbal Intelligence, Third Edition (TONI-3), Leiter International Performance Scale-Revised (Leiter-R), or Peabody Picture Vocabulary Test (PPVT-III).

In cases where more than one IQ is customarily derived from the test administered, such as where verbal, performance, and full-scale IQs are provided as on the WAIS, the lowest of these is used in conjunction with Listing 112.05.

IQ test results must also be sufficiently current for accurate assessment under 112.05. Generally, the results of IQ tests tend to stabilize by the age of 16. Therefore, IQ test results obtained at age 16 or older should be viewed as a valid indication of the child's current status, provided they are compatible with the child's current behavior. IQ test results obtained between ages seven and 16 should be considered current for four years when the tested IQ is less than 40, and for two years when the IQ is 40 or above. IQ test results obtained before age seven are current for two years if the tested IQ is less than 40 and one year if at 40 or above.

Where reference is made to developmental milestones, these are the skills achieved by an infant or toddler in the motor and manipulative areas, in general understanding and social behavior, in self-feeding, dressing, and toilet training, and in language. The result is sometimes expressed as a developmental quotient (DQ), the relation between developmental age and chronological age. Such tests include, but are not limited to, the Cattell Infant Intelligence Scale, the Bayley Scales of Infant Development, and the Revised Stanford-Binet.

Formal psychological tests of cognitive functioning are generally used for preschool children, for primary school children, and for adolescents. Exceptions may be considered in the case of ethnic or cultural minorities where the native language or culture is not principally English-speaking. In such instances, psychological tests that are culture-free, such as the Leiter International Performance Scale or the Scale of Multi-Culture Pluralistic Assessment (SOMPA) may be substituted for the standardized tests described above. Any required tests must be administered in the child's principal language. When this is not possible, appropriate medical, historical, social, and other information must be reviewed in arriving at a determination. Furthermore, in evaluating mental impairments in children from a different culture, the best indicator of severity is often the level of adaptive functioning and how the child performs activities of daily living and social functioning.

"Neuropsychological testing" refers to the administration of standardized tests that are reliable and valid with respect to assessing impairment in brain functioning. It is intended that the psychologist or psychiatrist using these tests will be able to evaluate the following functions: Attention/concentration, problem-solving, language, memory, motor, visual-

motor and visual-perceptual, contribution of right and left brain function, and general intelligence (if not previously obtained).

4. Effect of Hospitalization or Residential Placement

As with adults, children with mental disorders may be placed in a variety of structured settings outside the home as part of their treatment. Such settings include, but are not limited to, psychiatric hospitals, developmental disabilities facilities, residential treatment centers and schools, community-based group homes, and workshop facilities. The reduced mental demands of such structured settings may decrease overt symptoms and superficially make the child's level of adaptive functioning appear better than it is. Therefore, the capacity of the child to function outside highly structured settings must be considered in evaluating impairment severity. This is done by determining the degree to which the child can function (based upon age-appropriate expectations) independently, appropriately, effectively, and on a sustained basis outside the highly structured setting.

On the other hand, there may be a variety of causes for placement of a child in a structured setting that may or may not be directly related to impairment severity and functional ability. Placement in a structured setting does not, in and of itself, guarantee a finding of disability. The severity of the impairment must be compared with the requirements of the appropriate listing.

5. Effects of Medication

The same comments as for adult mental disorders apply here.

D. Specific Listings and Residual Functional Capacity

The listings that follow are in the federal regulations. They have been interpreted and commented on for greater ease of understanding while explaining their requirements. It is impossible to discuss here all of the medical possibilities related to every kind of disorder, and you may need to seek help from your treating doctor to more fully understand how your particular impairment relates to these listings. The discussion of residual functional capacity does not apply to children.

1. Listing 12.02: Organic Mental Disorders (Adults)

Organic mental disorders are those caused by physical brain damage. Examples of causes include toxins, heavy metals like lead or mercury, degenerative brain diseases like Alzheimer's disease and Huntington's chorea, strokes, trauma, tumors, cerebrovascular disease, genetic or congenital brain deformities, drugs, and many other diseases. Doctors frequently refer to organic mental disorders in general as organic brain syndrome (OBS). For adults, the SSA frequently uses tests of neurological and mental functioning (neuropsychological testing) like the Halstead-Reitan and Luria-Nebraska tests. These tests require psychologists or psychiatrists experienced in their use and interpretation.

It is important that family members and others in frequent contact with the claimant make accurate observations about how the claimant's daily activities are abnormal and that they give this information to the SSA. For example, it is an important observation that an adult claimant or older child gets lost traveling alone, since that can indicate disorientation and memory impairment. Family members may note a change in the claimant's mood, such as depression and withdrawal or unstable emotions like sudden crying. Such observations can help examining psychiatrists or psychologists and the SSA reach a more accurate evaluation of the severity of the organic mental disorder.

The manifestations of organic mental disorders depend on the cause, location, and severity of the brain abnormalities, including the age of the patient. It is important to understand that a fall in IQ associated with organic brain damage, such as that caused by brain trauma from an automobile wreck, produces much more serious limitations than in a person who is born with the same low IQ. In other words, a person who is born with an IQ of 70 will be

much more capable than a person with an IQ of 100 whose IQ falls to 70. The reason for this is that a fall in IQ in a previously normal person diminishes other capacities in addition to intellect.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have psychological or behavioral abnormalities associated with a dysfunction of the brain. History and physical examination or laboratory tests must demonstrate the presence of a specific organic factor causing the abnormal mental state and the loss of previously acquired functional abilities.

The required level of severity is met when both Ⓐ and Ⓑ are satisfied, or when the requirements in Ⓒ are satisfied. Part Ⓐ provides abnormalities that may be present in organic mental disorders. Parts Ⓑ and Ⓒ discuss the functional severity of the disorder—that is, how it limits the claimant.

Ⓐ Demonstration of a loss of specific thinking abilities or emotional changes and the medically documented persistence of at least one of the following:
1. Disorientation as to time and place.
2. Memory impairment, either short-term (involving an inability to learn new information), intermediate, or long-term (involving an inability to remember information that was known sometime in the past).
3. Perceptual or thinking disturbances (for example, hallucinations, delusions).
4. Change in personality.
5. Disturbance in mood.
6. Emotional lability—such as explosive temper outbursts or sudden crying and impairment of impulse control.
7. Loss of measured intellectual ability of at least 15 IQ points from premorbid levels or an overall impairment index that clearly falls within the severely impaired range on neuropsychological testing—such as the Luria-Nebraska or Halstead-Reitan.

Ⓑ Demonstration of a loss of specific thinking abilities or emotional changes resulting in at least two of the following:
1. Marked restriction of activities of daily living.
2. Marked difficulties in maintaining social functioning.
3. Marked difficulties in maintaining concentration, persistence, or pace.
4. Repeated episodes of decompensation, each of extended duration.

Ⓒ Medically documented history of a chronic organic mental disorder lasting at least two years that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently decreased 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. A current history of inability to function outside a highly supportive living arrangement for one or more years with signs that the individual will continue to need such an arrangement.

b. Residual Functional Capacity

Residual functional capacity must be determined on an individual basis, depending on the kinds of abnormalities and functional limitations present. If you have no coexisting physical disorder and are capable of at least unskilled work on a mental RFC, your claim will almost always be denied. In other words, your claim will be denied with mental RFCs for unskilled, semiskilled, or skilled work. Even if you can't return to your prior job (if any), unskilled work requires no special training and there are many unskilled jobs the SSA can say you are capable of doing. If your mental RFC is for less than unskilled work, then the SSA can't find any jobs for you and you would be a medical-vocational allowance. However, there is usually little point in giving claimants mental RFCs showing abilities for less than unskilled work, since that implies such a severe disorder that it would probably satisfy a listing. So, with a mental impairment alone, your chance of medical-vocational allowance based on your mental RFC is slim.

The situation is different if you have a significant physical impairment in addition to a mental disorder. And, in fact, many claimants have both types. Then, in order to determine if you are a medical-vocational allowance, the SSA has to consider the combined effect of both your physical and mental RFCs to determine if you can return to your prior work, if any. If you can't do your prior work because of some physical or mental limitation, the question is then whether you can do other work. If you get a mental RFC, you have significant *nonexertional* limitations in the kind of work you can do—that is, limitations other than lifting, standing, walking, pushing, or pulling. The presence of such nonexertional limitations means that the SSA can't apply the Medical-Vocational Rules in Appendix C as they are written. For one thing, your "work experience" skills in the tables of rules might be higher than your current skills, because of your mental disorder and it wouldn't be fair to apply the rules to you as they are written. On the other hand, the SSA still uses the Medical-Vocational Rules as a "framework," which just means they can be applied more flexibly on an individual basis.

EXAMPLE: Considering physical RFC only. You are 55 years of age, did skilled work in the past, and have at least a high school education. Because of arthritis in your back, the SSA gives you a physical RFC for light work with only occasional bending. You can't do your prior job because of the frequent bending required and your education is not enough to permit your direct entry into another kind of work without additional training. However, your work skills could be transferred to another kind of job. By referring to Table 2 of the Medical-Vocational Rules (in Appendix C), you can see that your claim would be denied under Rule 202.07.

Adding effects of mental RFC. Because of your mental disorder, your mental RFC states you have the various abilities needed for unskilled work, but no higher. Taking your mental RFC into account, it would be wrong for the SSA to deny your claim under Rule 202.07, because you can no longer do the skilled work specified by the rule. The rule that most closely resembles your situation is 202.04 and you would be considered disabled under this rule. So the mental RFC completely changes the outcome of the disability decision.

The most important things to remember about mental RFCs are the abilities necessary to perform unskilled work. If you have a "marked" limitation in any of these abilities on your RFC, you should be granted an allowance, regardless of your age, education, or work experience. Carefully review the mental abilities needed for unskilled work in Chapter 8, as well as other skill levels.

2. Listing 112.02: Organic Mental Disorders (Children)

See the comments under adult Listing 12.02. Children do not develop Alzheimer's disease or brain damage caused by fatty blockage of a cerebral artery, but, aside from these, children can have the same kinds of physical brain damage as adults. However, young children have more adaptable brains than adults and can sometimes compensate better for traumatic brain injuries. Mental abnormalities in children must be interpreted in the context of their age. Between the ages of one and three years, developmental tests are particularly useful in children. For example, the SSA frequently uses the Bayley Scales of Infant Development to obtain a developmental quotient (DQ), which is the developmental age rather than the actual (chronological) age of the child. After about age three years, formal IQ testing can be done for cognitive (conscious thinking) skills.

As it applies to primary school children, the intent of the functional criterion described in part ®2.d is to identify the child who cannot adequately function in primary school because of a mental impairment. Although grades and the need for special education placement are relevant factors that must be considered in reaching a decision under part ®2.d, they are not conclusive. This is because school districts are not uniform in their standards for calculating grades or determining special education placement, and it would not be reasonable for the SSA to rely solely on these factors.

In adolescents, the intent of the functional criterion described in part Ⓑ2.d is the same as in primary school children. However, other evidence of this functional impairment may also be available, such as from evidence of the child's performance in work or work-like settings.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listing, the child must have abnormalities in perception, cognition, affect, or behavior associated with dysfunction of the brain. The history and physical examination or laboratory tests, including psychological or neuropsychological tests, must show an organic cause for the abnormal mental state, as well as for any associated deficit or loss of specific cognitive abilities or affective changes or loss of previously acquired functional abilities.

The required level of severity is met when both Ⓐ and Ⓑ are satisfied.

Ⓐ Medically documented persistence of at least one of the following:

1. Developmental arrest, delay, or regression.
2. Disorientation to time and place.
3. 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).
4. Perceptual or thinking disturbance, such as hallucinations, delusions, illusions, or paranoid thinking.
5. Disturbance in personality, such as apathy or hostility.
6. Disturbance in mood, like mania and depression.
7. Emotional lability, such as sudden crying.
8. Impairment of impulse control, which is seen as disinhibited social behavior or explosive temper outbursts.
9. Impairment of cognitive function, as measured by clinically timely standardized psychological testing.
10. Disturbance of concentration, attention, or judgment.

Ⓑ Select the appropriate age group under which to evaluate the severity of the impairment:

1. For older infants and toddlers (ages one or two) at least one of the following:
   a. Gross or fine motor development at a level generally acquired by children no more than one-half the child's chronological age, documented by:
      i. An appropriate standardized test.
      ii. Other medical findings (see Section B2, above).
   b. Cognitive/communicative function at a level generally acquired by children no more than one-half the child's chronological age, documented by at least one of the following:
      i. An appropriate standardized test.
      ii. Other medical findings of equivalent cognitive/communicative abnormality, such as the inability to use simple verbal or nonverbal behavior to communicate basic needs or concepts.
   c. Social function at a level generally acquired by children no more than one-half the child's chronological age, documented by at least one of the following:
      i. An appropriate standardized test.
      ii. Other medical findings of an equivalent abnormality of social functioning, shown by a serious inability to achieve age-appropriate autonomy, as manifested by excessive clinging or extreme separation anxiety.
   d. Attainment of development or function generally acquired by children no more than two-thirds of the child's chronological age in two or more areas covered by a, b, or c, as measured by an appropriate standardized test or other appropriate medical findings.
2. For children (ages three through 17) at least two of the following:
   a. Marked impairment in age-appropriate cognitive/communicative function, documented by medical findings (including consideration of historical and other information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, the results of appropriate standardized psychological tests

or, for children under age six, by appropriate tests of language and communication.

b. Marked impairment in age-appropriate social functioning, documented by history and medical findings (including consideration of information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, the results of appropriate standardized tests.

c. Marked impairment in age-appropriate personal functioning, documented by history and medical findings (including information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, appropriate standardized tests.

d. Marked difficulties in maintaining concentration, persistence, or pace.

3. Listing 12.03: Schizophrenic, Paranoid, and Other Psychotic Disorders (Adults)

Psychotic disorders involve a widespread disturbance in mental function with severe distortion of the ability to distinguish external reality from an abnormal mental reality.

The most serious and common psychotic disorder the SSA evaluates for disability is schizophrenia, an affliction affecting about 1% of the U.S. population, with a typical onset in the teenage years or early adulthood. However, some cases have an onset in childhood and rare cases can start in middle age or later. After many years of research, the cause of schizophrenia remains unknown, although there is no question it involves abnormalities in the structure and function of the brain. The newer drugs used to treat schizophrenia such as olanzapine (Zyprexa), resperidone (Risperdal), and clozapine (Clozaril) decrease the activity of dopamine and serotonin neurotransmitter chemicals in the brain. They have fewer side effects than the older drugs and have greatly improved the treatment of people with schizophrenia.

Hallucinations, especially auditory hallucinations in the form of persecutory voices, are often present. Delusions are common, especially paranoid delusions that others are out to harm the person in some way. Thinking may be confused and extremely irrational. The types of abnormalities in schizophrenia and other psychotic disorders that are of interest to the SSA are given in part Ⓐ of the listing. Parts Ⓑ and Ⓒ are used to determine the overall functional severity of the psychotic disorder.

The psychotic symptoms, such as hallucinations and delusions, of an acute schizophrenic episode can be controlled in the majority of cases. However, it should be remembered that a treating psychiatrist's medical note that a schizophrenic patient is "doing well," "stable," or something similar, does not imply normality and is not sufficient for the SSA to determine that a claimant does not qualify under the listing.

People with chronic schizophrenia should be evaluated with great care; they may not be capable of meaningful work. Symptoms that appear absent or mild while the claimant is in a protected environment, such as a family member's household, may become much more severe when the claimant is put under psychological stress. This possibility is addressed by part Ⓒ. It is in these cases of chronic schizophrenics living in highly structured environments that psychiatrists and psychologists working for the SSA are particularly apt to make mistakes in thinking that a claimant is more capable than is actually the case. That is why it is so important that the medical records of these claimants be clearly documented with any episodes of decompensation when subjected to stresses outside of a protected environment. In this way, the SSA has actual examples of the claimant's inability to function in real work situations, rather than having to make a judgment without that information.

The various subtypes of schizophrenia are paranoid, disorganized, catatonic, residual, and undifferentiated. There is also a schizophreniform disorder that is not as severe as schizophrenia and has a better prognosis for recovery of ability to function in a work-related and social environment.

It is important to understand that the suspiciousness and delusions of persecution that characterize paranoid thinking may be a part of schizophrenia or other psychotic disorders. However, paranoia can also

be a part of nonpsychotic mental disorders, such as occurs in a paranoid personality disorder.

Psychotic mental illness known as schizoaffective disorder is also seen by the SSA. In schizoaffective disorder, there are mental abnormalities characteristic of schizophrenia and also of mood (affective) disorders. There are other, atypical or more unusual types of psychotic disorders that could potentially qualify under this listing.

It cannot be too strongly emphasized that good medical records over the time of the claimant's psychotic disorder can be critical to the SSA's making an accurate determination. An appropriate determination is much more difficult if the only evidence the SSA can obtain is one mental status examination report, since this represents only one small slice of time.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, it must be characterized by the onset of psychotic features with deterioration from your previous level of functioning. The required level of severity is met when both Ⓐ and Ⓑ are satisfied or when Ⓒ is satisfied.

Ⓐ Medically documented persistence, either continuous or intermittent, of one or more of the following:
1. Delusions or hallucinations.
2. Catatonic or other grossly disorganized behavior.
3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:
   a. Blunt affect.
   b. Flat affect.
   c. Inappropriate affect.
4. Emotional withdrawal and/or isolation.

Ⓑ Medically documented persistence, either continuous or intermittent of the abnormalities described in part Ⓐ, resulting in at least two of the following:
1. Marked restriction of activities of daily living.
2. Marked difficulties in maintaining social functioning.
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration.

Ⓒ Medically documented history of a chronic schizophrenic, paranoid, or other psychotic mental disorder of two years or more that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently decreased 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 you to decompensate; or
3. A current history of one year or more of an inability to function outside a highly supportive living arrangement, with signs that you'll continue to need such an arrangement.

b. Residual Functional Capacity

The comments about RFC under Listing 12.02 also apply here. Some additional observations specifically about schizophrenia are also appropriate.

Although some people with schizophrenia can be improved greatly with drugs, it is difficult to find someone with schizophrenia who does not have some significant residual abnormality in mental function. Although the positive psychotic symptoms like hallucinations and delusions may respond to drug therapy, some degree of negative psychotic symptoms like blunted emotions, poor motivation, and poor social skills are more difficult to improve and usually remain present to some degree.

If you have no significant abnormalities after treatment for schizophrenia, the accuracy of your diagnosis should be questioned. It is very difficult, if not impossible, to restore schizophrenics to complete normality. If schizophrenia is the correct diagnosis, then the SSA would almost never be justified in determining that a claimant had a mild (not severe) impairment. To the contrary, significant limitations are most likely present and require a mental RFC if the listing is not satisfied.

4. Listing 112.03: Schizophrenic, Delusional (Paranoid), Schizoaffective, and Other Psychotic Disorders (Children)

See the comments under adult Listing 12.03.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listing, it must involve the onset of psychotic features, characterized by a marked disturbance of thinking, feeling, and behavior, with deterioration from the child's previous level of functioning or failure to achieve the expected level of social functioning.

The required level of severity is met when both Ⓐ and Ⓑ, below, are satisfied.

Ⓐ Medically documented persistence, for at least six months, either continuous or intermittent, of one or more of the following:

1. Delusions or hallucinations.
2. Catatonic, bizarre, or other grossly disorganized behavior.
3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech.
4. Flat, blunt, or inappropriate emotions.
5. Emotional withdrawal, apathy, or isolation.

Ⓑ For older infants and toddlers (ages one or two), impairment resulting in at least one of the appropriate age-group criteria in part Ⓑ1 of Listing 112.02; or, for children (ages three to 17), resulting in at least two of the appropriate age-group criteria in part Ⓑ2 of Listing 112.02.

5. Listing 12.04: Affective (Mood) Disorders (Adults)

Affective disorders involve abnormalities of mood, which is a persistent emotion that broadly affects mental experience. The two possible extremes of mood are depression or elation. In depression, a person may have the types of abnormalities listed in part Ⓐ1 below. Abnormalities characteristic of manic syndrome associated with elation are given in part Ⓐ2. The abnormalities of depression or mania can exist in various combinations. Part Ⓐ of the listing concerns establishing the type of affective disorder that is present. Part Ⓑ of the listing is used to establish functional severity.

In major depressive disorder, the main abnormality is depression that may involve a single episode or be recurrent. Treatment of major depression almost always requires the use of antidepressant drugs. If drug therapy fails, electroconvulsive therapy (ECT), involving an electrical shock to the brain, may be given to patients with strong psychotic features such as hallucinations and delusions.

In dysthymic disorder, a depressed mood is present most of the time but the abnormalities are much less severe than with major depression. While dysthymic disorder can affect social and occupational functioning, these claimants are rarely so mentally limited that they cannot perform some type of work. Antidepressant drugs may also be used to treat dysthymic disorder.

In bipolar disorder, there may have been a single episode of mania or a history of a mixture of major depression episodes and manic episodes. There are specific diagnostic categories for various combinations of depression and mania and their relative severity. Bipolar disorder is a serious mental illness and requires mood-stabilizing medications. The most frequently used drug used for long-term treatment of bipolar disorder is lithium carbonate. Valproic acid (Depakene) and carbamazepine (Tegretol) are also mood-stabilizing. Other potent antipsychotic and tranquilizing drugs may be necessary to treat an acute episode of mania. The SSA may look at blood levels of these drugs, if there is a question about compliance with prescribed therapy.

Cyclothymic syndrome refers to alternating moods of hypomania and depression, more extreme than normal but less extreme than bipolar disorder. The depression in cyclothymic disorder is not severe enough to be diagnosed major depression. While cyclothymic disorder can affect social and occupational functioning, these claimants are rarely so mentally limited that they cannot perform some type of work.

Major depression and bipolar disorder are the most frequent illnesses the SSA sees that qualify under this listing. Disability evaluation can be complicated by the fact that some claimants with genuine mood disorders also abuse alcohol or illegal drugs. Such

alcohol or drug abuse can ruin what otherwise might be effective treatment.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, it must be 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 is met when both Ⓐ and Ⓑ are satisfied, or when the requirements in part Ⓒ are satisfied.

Ⓐ Medically documented persistence, either continuous or intermittent, of 1, 2, or 3:

1. Depressive syndrome characterized by at least four of the following:
   a. Anhedonia or pervasive loss of interest in almost all activities.
   b. Appetite disturbance with change in weight.
   c. Sleep disturbance.
   d. Psychomotor agitation or retardation.
   e. Decreased energy.
   f. Feelings of guilt or worthlessness.
   g. Difficulty concentrating or thinking.
   h. Thoughts of suicide.
   i. Hallucinations, delusions, or paranoid thinking.
2. Manic syndrome characterized by at least three of the following:
   a. Hyperactivity.
   b. Pressure of speech.
   c. Flight of ideas.
   d. Inflated self-esteem.
   e. Decreased need for sleep.
   f. Easy distractibility.
   g. Involvement in activities that have a high probability of painful consequences that are not recognized.
   h. Hallucinations, delusions, or paranoid thinking.
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).

Ⓑ Medically documented persistence, either continuous or intermittent, of the abnormalities described in part Ⓐ, resulting in at least two of the following:

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

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

1. Repeated episodes of decompensation, each of extended duration;
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 you to decompensate; or
3. A current history of one year or more of your inability to function outside a highly supportive living arrangement, with signs that you'll continue to need such an arrangement.

b. Residual Functional Capacity

The comments about RFC under Listing 12.02 also apply here.

6. Listing 112.04: Affective (Mood) Disorders (Children)

See the comments under adult Listing 12.04.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listing, it must be characterized by a disturbance of mood (referring to a prolonged emotion that colors the whole psychic life, generally involving either depression or elation), accompanied by a full or partial manic or depressive syndrome. The required level of severity is met when Ⓐ and Ⓑ are satisfied.

Ⓐ Medically documented persistence, either continuous or intermittent, of 1, 2 or 3:

1. Major depressive syndrome, characterized by at least five of the following, which must include either depressed or irritable mood (a) or markedly diminished interest or pleasure (b):
   a. Depressed or irritable mood.
   b. Markedly diminished interest or pleasure in almost all activities.
   c. Appetite or weight increase or decrease or failure to make expected weight gains.
   d. Sleep disturbance.
   e. Psychomotor agitation or retardation.
   f. Fatigue or loss of energy.
   g. Feelings of worthlessness or guilt.
   h. Difficulty thinking or concentrating.
   i. Suicidal thoughts or acts.
   j. Hallucinations, delusions, or paranoid thinking.
2. Manic syndrome, characterized by elevated, expansive, or irritable mood and at least three of the following:
   a. Increased activity or psychomotor agitation.
   b. Increased talkativeness or pressure of speech.
   c. Flight of ideas or subjectively experienced racing thoughts.
   d. Inflated self-esteem or grandiosity.
   e. Decreased need for sleep.
   f. Easy distractibility.
   g. Involvement in activities that have a high potential of painful consequences, which are not recognized.
   h. Hallucinations, delusions, or paranoid thinking.
3. Bipolar or cyclothymic syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently or most recently characterized by the full or partial symptomatic picture of either or both syndromes).

Ⓑ For older infants and toddlers (ages one or two), impairment resulting in at least one of the appropriate age-group criteria in part Ⓑ1 of Listing 112.02. For children (ages three to 17), resulting in at least two of the appropriate age-group criteria in part Ⓑ2 of 112.02.

7. Listing 12.05: Mental Retardation (Adults)

If you care for or represent someone who is mentally retarded, or who has below-average intelligence, it is extremely important that you understand the disability determination issues involved in the use of this listing. Although large numbers of claimants are evaluated for disability under this listing, the SSA is prone to errors when evaluating such claims. A common mistake is diagnosing mental retardation on the basis of intelligence quotient (IQ) scores alone. A subaverage IQ—say an IQ of 70—is not considered to be mental retardation unless the individual has a loss of adaptive functions. The reason that adaptive functioning is important in addition to intellectual functioning is that claimants may differ greatly in their adaptive abilities despite having the same IQ. Ability to independently carry out daily activities and function socially are adaptations very much dependent on the type of environment in which a person lives. If he or she she lacks proper types of training, emotional support, and stimulation, a child can grow into an adult with an IQ of 70 who is highly limited in ability to adapt and live independently. Others with the same IQ can work and are able to achieve independence. Consequently, it is a serious mistake to diagnose mental retardation on the basis of IQ alone, unless it is less than 60 (see below).

Part Ⓐ is for claimants who are so severely retarded that they cannot even be given an IQ test. In these cases, low IQ and significantly decreased adaptive functioning are both obvious without formal testing.

Part Ⓑ applies to IQs below 60. Such an IQ is low enough that it is also reasonable to assume that there are severe deficits in adaptive functioning without requiring further documentation. In other words, it is assumed that the claimant is mentally retarded.

Part Ⓒ requires subaverage intellectual function of IQ 60 through 70, and some other additional *distinctly different* significant impairment like arthritis or a separate mental disorder. The additional impairment can't be some limitation that results from the low IQ, because that would be "double-weighting" the impairment for disability determination and is prohibited by the SSA. Note that the additional impairment has to be work-related to have any

meaning in disability determination. For example, baldness is not a significant impairment to the SSA, because it has no relationship to the ability to work. Remember, any disorder severe enough that it would require an RFC if rated alone is a significant work-related impairment. For instance, if a claimant had arthritis that would limit him or her to medium work on a physical RFC, that would be significant, as would be an anxiety disorder severe enough to require a mental RFC. That doesn't mean the SSA necessarily has to actually complete an RFC form to determine if the additional impairment is significant.

> **EXAMPLE:** The SSA evaluator could determine that an IQ of 65 is valid and arthritis in the claimant is severe enough to require a physical RFC if considered alone. Therefore, the arthritis is a significant work-related impairment and, combined with the IQ of 65, meets Listing 12.05©.

One of the most serious and frequent mistakes made by the SSA in part © is failing to properly take into account epilepsy as a significant impairment in addition to an IQ in the 60 through 70 range. People with subaverage IQs often have problems with epilepsy. Only one major seizure in the year prior to application for disability for epilepsy qualifies as a significant impairment.

Part Ⓓ requires a *documented* subaverage IQ of 60 through 70 and marked deficits in adaptive functions (parts Ⓓ1-4) for the diagnosis of mental retardation to be valid.

Falls in IQ in adults are not mental retardation, but indicate some type of organic brain disorder. Such cases would be evaluated under Listing 12.02, and are much more limiting than the same IQ associated with mental retardation.

The Stanford-Binet test yields only one IQ score. The Wechsler Adult Intelligence Scale (WAIS) yields a performance IQ, verbal IQ, and full-scale IQ. The IQ scores must be *valid*. IQ scores that are affected by lack of cooperation during testing, or are measured during acute psychosis or while the claimant is intoxicated with alcohol or other potent mind-altering drugs (legal or illegal) are not valid. The SSA may also suspect invalid IQ scores that are too low for a claimant's prior education or work experience. If there is more than one IQ score obtained as part of an IQ test, the SSA must use the *lowest* score. This works to the advantage of the claimant. When considering the validity of an IQ score, it is important to remember that IQ scores stabilize by about age 16.

Learning Disorders and Communication Disorders

Learning and communication disorders, which are rarely disabling, should not be confused with mental retardation. Reading disorder is a common type of learning disorder, and there are several types of communication disorder. These disorders sometimes result in a low IQ score for a particular part of an IQ test, especially a low verbal IQ, while the performance IQ is normal. However, these children or adults function fine in most aspects of their lives. Such low IQs associated with learning or communication disorders, rather than true subaverage intellectual functioning, *cannot* be used to satisfy this listing.

a. Listing Level Severity

For the claimant's condition to be severe enough to meet this listing, he or she must have mental retardation, that is, a significantly subaverage general intellectual functioning with deficits in adaptive functioning that initially manifested during the developmental period—in other words, the evidence demonstrates or supports the onset of the impairment before age 22. (**Note:** The scores specified below refer to those obtained on the WAIS, and are used only for reference purposes. Scores obtained on other standardized and individually administered tests are acceptable, but the numerical values obtained must indicate a similar level of intellectual functioning.)

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

Ⓐ Mental incapacity evidenced by dependence upon others for personal needs (for example, toileting, eating, dressing, or bathing) and inability to follow

directions, such that the use of standardized measures of intellectual functioning is precluded.

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

Ⓒ 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.

Ⓓ A valid verbal, performance, or full-scale IQ of 60 through 70, resulting in two of the following:

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

b. Residual Functional Capacity

The comments about RFC under Listing 12.02 also apply here. Although individual claimants may differ, those with subaverage IQs in the 60–84 range usually receive mental RFCs that are compatible with the ability to perform unskilled work. It is quite possible for the SSA to not consider an IQ over 84 as even requiring an RFC, but rather to decide that the person has mild subaverage intellectual functioning (not severe).

If the claimant has other mental problems of significant severity in addition to a subaverage IQ, these would also have to be addressed on the mental RFC. For example, a particular claimant with an IQ of 65 might have a moderate difficulty in maintaining social functioning, as well as moderate restrictions in activities of daily living. Since these fall short of the "marked" severity required by parts Ⓓ1 and Ⓓ2 of the listing, they would have to be considered on the mental RFC. But the SSA can suggest lots of unskilled jobs that don't require good social skills.

8. Listing 112.05: Mental Retardation (Children)

See the comments under adult Listing 12.05 regarding mental retardation and regarding learning disorders and communication disorders.

Between ages one and three, developmental tests are useful in children. For example, the SSA frequently uses the Bayley Scales of Infant Development to obtain a developmental quotient (DQ), which is the developmental age rather than the actual age of the child. Such developmental testing is particular useful in parts Ⓔ and Ⓕ of this listing. Other standardized developmental tests are also acceptable.

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, it must be characterized by significantly subaverage general intellectual functioning with deficits in adaptive functioning. The required level of severity for this disorder is met when parts Ⓐ, Ⓑ, Ⓒ, Ⓓ, Ⓔ, or Ⓕ are satisfied.

Ⓐ For older infants and toddlers (ages one and two), resulting in at least one of the appropriate age-group criteria in part Ⓑ1 of Listing 112.02, for children (ages three through 17), resulting in at least two of the appropriate age-group criteria in part Ⓑ2 of 112.02.

Ⓑ Mental incapacity evidenced by dependence upon others for personal needs (grossly in excess of age-appropriate dependence) and inability to follow directions such that the use of standardized measures of intellectual functioning is precluded.

Ⓒ A valid verbal, performance, or full-scale IQ of 59 or less.

ⒹA valid verbal, performance, or full-scale IQ of 60 through 70 and a physical or other mental impairment imposing an additional and significant limitation of function.

Ⓔ A valid verbal, performance, or full-scale IQ of 60 through 70 and either 1 or 2, below.

1. For older infants and toddlers (ages one and two), resulting in attainment of development or function generally acquired by children no more than two-thirds of the child's chronological age in either parts Ⓑ1.a or Ⓑ1.c of Listing 112.02.
2. For children (ages three through 17), resulting in at least one of parts Ⓑ2.b or Ⓑ2.c or Ⓑ2.d of listing 112.02.

Ⓕ Select the appropriate age group:

1. For older infants and toddlers (ages one and two), their condition must result in attainment of development or function generally acquired by

children no more than two-thirds of the child's chronological age in part Ⓑ1.b of Listing 112.02 and a physical or other mental impairment imposing an additional and significant limitation of function. The additional physical or other mental impairment need only be more than mild or slight (more than not severe).

2. For children (ages three through 17), their condition must result in the satisfaction of Listing 112.02 Ⓑ2.a and a physical or other mental impairment imposing additional and significant limitation of function.

9. Listing 12.06: Anxiety-Related Disorders (Adults)

Anxiety is an uncomfortable emotional state with effects both on the mind and body resulting from anticipation of real or imagined danger. In free-floating anxiety, the person is not aware of the object of danger. Many claimants allege anxiety by stating they are disabled because of nerves. It is important to understand that anxiety is a part of many mental disorders, but this listing concerns specific disorders in which anxiety is the major abnormality. Most claimants alleging nerves have a mild generalized anxiety disorder (see below) or even the normal anxieties of someone without work or sufficient income, and therefore do not qualify under this listing.

a. Listing Level Severity

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 is met when both Ⓐ and Ⓑ are satisfied or both Ⓐ and Ⓒ are satisfied. Part Ⓐ concerns establishing the type of anxiety-related disorder. Parts Ⓑ and Ⓒ establish functional severity.

Ⓐ 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 (such as restlessness, trembling, or inability to sit still).
   b. Autonomic hyperactivity (such as increased heart and respiration rates, sweating, weakness, and a dry mouth).
   c. Apprehensive expectation (thinking with emphasis on negative consequences and excessive worry).
   d. Vigilance and scanning (excessive alertness to the environment—that is, fear-based attention is far out of proportion to any danger actually present).
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. These are irrational fears called phobias. Phobias can exist to any object or situation. For example, a frequent phobia the SSA sees is agoraphobia, in which there is fear of being away from home or in some public place. If there is simple phobia in which the claimant can avoid the dreaded object, such as fear of high places, the resulting restrictions on their ability to function would be minimal. A social phobia, on the other hand, could be highly restrictive in a person with a job in public relations.
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. This describes panic disorder, which is characterized by unpredictable panic attacks with intense anxiety. About 3–4% of people have a panic attack at some time in their lives that then resolves. The prevalence of anxiety attacks is also significant: At any one point in time as many as 11% of the general population may be affected with panic attacks, according to some studies. One such attack would not qualify as a panic disorder. Panic attacks are believed to be caused by biochemical changes in the brain and are treated with certain types of antidepressant medications.
4. Recurrent obsessions or compulsions, which are a source of marked distress. This refers to obsessive-compulsive disorder (OCD).

Obsessions are involuntary repetitious thoughts; they can be about anything, but typically involve subjects like aggression, fear of contamination, religion, sex, physical illness, or a need to be overly exact. Obsessions cause anxiety that results in compulsive behaviors for relief. A compulsion is an irrationally repeated act or ritual that helps a person decrease anxiety. The exact cause of OCD is not known, but definitely involves the frontal lobes and their interaction with some other brain areas. Treatment with drugs and behavioral conditioning is tried first. Brain surgery has been done in extreme cases, in an attempt to interrupt activity in the abnormal brain circuit. Individual responsiveness to treatment with drugs or behavioral therapy varies. Patients with OCD generally have a 30–60% reduction in symptoms with medication. Onset of the disorder is usually in the late 20s to early 30s and there is a familial predisposition. Stopping medication causes a high relapse rate of nearly 90%. No cure is available.

5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress. This describes post-traumatic stress disorder (PTSD). The original traumatic event can be experienced or witnessed, but must involve the threat of death or serious injury to the person or to others who were present at the time. Additionally, the person's response to this event must have been at the time a sense of overwhelming fear, horror, or helplessness. In PTSD, the very painful catastrophic experience forces itself repeatedly back into consciousness, including dreams or reliving the experience, and produces marked emotional distress. These episodes often relate to wartime experiences, but could be any severely disturbing event such as rape or a natural catastrophe or an earthquake or flood that destroys one's family.

Ⓑ The condition results in at least two of the following:

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

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

b. Residual Functional Capacity

The comments about RFC under Listing 12.02 also apply here. Additionally, it should be pointed out that significant anxiety would limit the claimant's ability to work in highly stressful situations. Restrictions need to be individualized, depending on the type of anxiety disorder present. For example, a particular claimant may only have a phobia of a specific situation, such as high places or working under water. Other claimants have more severe fears and anxieties that have broader effects on their ability to function and require more restrictions on RFC. Obsessive-compulsive disorder, for example, is one in which the effects would be felt in both personal and work environments.

10. Listing 112.06: Anxiety Disorders (Children)

See the comments under adult Listing 12.06. Part Ⓐ1 deals with separation anxiety and part Ⓐ2 with abnormal fear of strangers. Parts Ⓐ3–Ⓐ7 match parts Ⓐ1–Ⓐ5 of the adult listing.

a. Listing Level Severity

In these disorders, anxiety is either the predominant disturbance or is experienced if the child attempts to master symptoms—that is, confronts the dreaded object or situation (in a phobic disorder), attempts to go to school (in a separation anxiety disorder), resists the obsessions or compulsions (in an obsessive-compulsive disorder), or confronts strangers or peers (in an avoidant disorder).

The required level of severity is met when both Ⓐ and Ⓑ are satisfied.

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

1. Excessive anxiety when the child is separated, or threatened with separation from a parent or parent surrogate.
2. Excessive and persistent avoidance of strangers.

3. Persistent unrealistic or excessive anxiety and worry (apprehensive expectation), accompanied by motor tension, autonomic hyperactivity, or vigilance and scanning.
4. 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.
5. Recurrent severe panic attacks, manifested by a sudden unpredictable onset of intense apprehension, fear, or terror, often with a sense of impending doom, occurring on the average of at least once a week.
6. Recurrent obsessions or compulsions, which are a source of marked distress.
7. Recurrent and intrusive recollections of a traumatic experience, including dreams, which are a source of marked distress.

Ⓑ For older infants and toddlers (ages one and two), the condition results in at least one of the appropriate age-group criteria in part Ⓑ1 of Listing 112.02. For children (ages three through 17), the condition results in at least two of the appropriate age-group criteria in part Ⓑ2 of 112.02.

11. Listing 12.07: Somatoform Disorders (Adults)

Somatoform disorders are mental disorders in which physical symptoms are of psychological origin. Somatoform disorders should not be confused with factitious disorders. Factitious disorders are those in which a person intentionally fakes symptoms, with no other aim than assuming the role of a patient. Factitious disorders should also be distinguished from malingering, in which there is intentional faking of symptoms to obtain some other goal than being a patient, such as avoiding work or obtaining disability benefits.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms. The required level of severity is met when both Ⓐ and Ⓑ are satisfied.

Ⓐ Medically documented by evidence of one of the following:

1. A history of multiple physical symptoms over several years, beginning before age 30, that have caused the individual to take medicine frequently, see a physician often, and alter life patterns significantly. This describes somatization disorder, characterized by frequent complaints and seeking frequent medical attention for minor physical symptoms.
2. Persistent nonorganic disturbance of one of the following:
   a. Vision.
   b. Speech.
   c. Hearing.
   d. Use of a limb.
   e. Movement and its control (such as coordination disturbance, psychogenic seizures, akinesia, dyskinesia).
   f. Sensation (such as diminished or heightened sensation).

   This listing describes conversion disorder, in which psychological factors are responsible for apparent physical abnormalities. People with conversion disorder are emotionally indifferent to their supposed physical abnormalities.
3. Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury. This describes hypochondriasis, in which preoccupation with symptoms erroneously thought to represent severe physical disease persist despite medical evaluation and assurance that none is present.

Ⓑ Resulting in three of the following:

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

b. Residual Functional Capacity

The comments about RFC under Listing 12.02 also apply here.

12. Listing 112.07: Somatoform, Eating, and Tic Disorders (Children)

See the comments under adult Listing 12.07. Here, parts Ⓐ3 and Ⓐ4 match parts Ⓐ2 and Ⓐ3 in the adult Listing, with an additional section for digestive symptoms or symptoms of waste elimination such as chronic constipation.

Eating disorders such as anorexia nervosa and bulimia require the use of weight tables found in a specific medical book—which must be the most recent edition. Doctors caring for children would probably have this book, as would medical school libraries and some large bookstores.

Anorexia nervosa is a serious mental disorder, usually found in females, and characterized by the fear of excessive weight gain although the person is markedly underweight. By definition, anorexia nervosa requires a weight less than 85% of the person's expected normal weight. People with anorexia do not recognize the seriousness of their disorder or the very disturbed way they perceive their bodies, and the mortality rate is high. Subtypes of anorexia nervosa involve people whose eating patterns don't include binge eating (restricting type) as well as those who engage in binge eating or purging with laxatives, vomiting, or enemas (binge-eating/purging type). The binge-eating/purging type actually has episodes of bulimia as a part of their anorexia nervosa.

Bulimia is a mental eating disorder, usually in younger females, characterized by episodes of binge eating. Bulimics may engage in self-induced vomiting after eating, laxatives, or enemas in an attempt to keep from gaining weight (purging type) or try to lose weight by excessive exercise or fasting (nonpurging type). Bulimia nervosa is the medical name for bulimia. The diagnosis of bulimia does not apply to individuals who have bulimic episodes as a part of anorexia nervosa. Anorexia nervosa is a much more serious disorder, but people with bulimia could die from a ruptured esophagus, ruptured stomach, aspiration pneumonia from regurgitating food into their lungs, or taking inappropriate drugs to treat their overeating.

A tic is an involuntary, repetitive, rapid, purposeless movement. Tics are most often seen in the facial muscles, but may also involve muscles in other locations. Tics can be of physical cause, such as in Tourette's syndrome, or of psychological cause. This listing uses language suggesting Tourette's syndrome, a rare physical disorder of unknown cause. The vocal tics produced involuntarily may be obscene sounds or words, snorting, or barking noises. Tourette's often responds to medication. In other cases, there may be secondary emotional disorders related to social difficulties caused by obscene and involuntary vocal tics. The disorder may improve after some years, but is incurable.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listing, the child must have a somatoform disorder manifested by physical symptoms for which there are no demonstrable organic findings or known physiologic mechanisms or an eating or tic disorder with physical manifestations. The required level of severity is met when both Ⓐ and Ⓑ are satisfied.

Ⓐ Medically documented findings of one of the following:

1. An unrealistic fear and perception of fatness despite being underweight, and persistent refusal to maintain a body weight which is greater than 85% of the average weight for height and age, as shown in the most recent edition of the *Nelson Textbook of Pediatrics*, Behrman and Vaughan, editors (W.B. Saunders Company).
2. Persistent and recurrent involuntary, repetitive, rapid, purposeless motor movements affecting multiple muscle groups with multiple vocal tics.
3. Persistent nonorganic disturbance of one of the following:
   a. Vision.
   b. Speech.
   c. Hearing.
   d. Use of a limb.
   e. Movement and its control—coordination disturbance, psychogenic seizures.
   f. Sensation—diminished or heightened.
   g. Digestion or elimination.
4. Preoccupation with a belief that one has a serious disease or injury.

Ⓑ For older infants and toddlers (ages one and two), the condition results in at least one of the

appropriate age-group criteria in part Ⓑ1 of Listing 112.02. For children (age three through 17), the condition results in at least two of the appropriate age-group criteria in part Ⓑ2 of 112.02.

13. Listing 12.08: Personality Disorders (Adults)

Various personality disorders include paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, obsessive-compulsive, and personality disorder not otherwise specified. Different personality disorders may share some of the same features, so that it is not possible to assign the numbers in part Ⓐ to a specific disorder. For example, a paranoid personality disorder would be expected to have the features of pathologically inappropriate suspiciousness or hostility, but this could also be present in schizotypal personality disorder.

Delusions and odd beliefs are most likely with schizoid, schizotypal, and avoidant personality disorders, as is avoidance of normal social interactions and odd or magical thinking. These individuals are particularly likely to be socially withdrawn and socially incapacitated.

Persistent disturbances of mood or affect are applicable to narcissistic and histrionic personality disorders, but may be relevant to many other personality disorders. Individuals with narcissistic personality disorder are preoccupied with self-importance and self-admiration, while histrionic personalities are emotionally over-reactive, emotionally shallow, and overly suggestible.

Pathological dependence, passivity, or aggressivity is especially relevant to those with dependent personality disorder. Intense and unstable interpersonal relationships and impulsive and damaging behavior can be found in those with borderline personality disorder, a mental illness that is sometimes disabling. This would also apply to claimants with antisocial personality disorders, but they would almost never qualify under the listing. People with antisocial personality disorders used to be called sociopaths and before that they were referred to as psychopaths.

Generally, claimants with personality disorders are far less likely to qualify for disability than those with the much more serious psychotic or affective (mood) disorders seen by the SSA. Most are capable of some type of work consistent with their particular mental limitations. Note that obsessive-compulsive personality disorder evaluated under this listing is not the same as obsessive-compulsive disorder (OCD) evaluated under Listing 12.04. OCD is much more severe and much more likely to be disabling.

a. Listing Level Severity

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 is met when both Ⓐ and Ⓑ are satisfied. Part Ⓐ concerns establishing the type of disorder. Part Ⓑ establishes functional severity.

Ⓐ Deeply ingrained, maladaptive patterns of behavior associated with one of the following:
1. Seclusiveness or autistic thinking.
2. Pathologically inappropriate suspiciousness or hostility.
3. Oddities of thought, perception, speech, and behavior.
4. Persistent disturbances of mood or affect.
5. Pathological dependence, passivity, or aggressivity.
6. Intense and unstable interpersonal relationships and impulsive and damaging behavior.

Ⓑ The condition results in three of the following:
1. Marked restriction of activities of daily living.
2. Marked difficulties in maintaining social functioning.
3. Marked difficulties in maintaining concentration, persistence, or pace.
4. Repeated episodes of decompensation, each of extended duration.

b. Residual Functional Capacity

The comments about RFC under Listing 12.02 also apply here. Because of the numbers of types of personality disorders, the RFC must be highly individualized. For example, paranoid thinking will limit working closely with others, while a person with dependent personality might require close

supervision. Despite the variety of restrictions that might be involved in individual cases, almost all cases of personality disorder are capable of at least unskilled work, and the SSA will usually deny their claims on a medical-vocational basis.

14. Listing 112.08: Personality Disorders (Children)

See the comments under adult Listing 12.08. Part Ⓐ of this listing is the same as 12.08, except for an additional part Ⓐ7, mentioning perfectionism and inflexibility, which are abnormalities associated with obsessive-compulsive personality disorder.

a. Listing Level Severity

Personality disorders in children that meet the listing are manifested by pervasive, inflexible, and maladaptive personality traits, which are typical of the child's long-term functioning and not limited to discrete episodes of illness. The required level of severity is met when both Ⓐ and Ⓑ are satisfied.

Ⓐ Deeply ingrained, maladaptive patterns of behavior, associated with one of the following:
1. Seclusiveness or autistic thinking.
2. Pathologically inappropriate suspiciousness or hostility.
3. Oddities of thought, perception, speech, and behavior.
4. Persistent disturbances of mood or affect.
5. Pathological dependence, passivity, or aggressiveness.
6. Intense and unstable interpersonal relationships and impulsive and exploitative behavior.
7. Pathological perfectionism and inflexibility.

Ⓑ For older infants and toddlers (ages one and two), the condition results in at least one of the appropriate age-group criteria in part Ⓑ1 of Listing 112.02. For children (ages three through 17), the condition results in at least two of the appropriate age-group criteria in part Ⓑ2 of 112.02.

15. Listing 12.09: Substance Addiction Disorders (Adults)

Substance addiction disorders are evaluated under whatever listings are most appropriate to the complications produced by the abuse of drugs. Alcohol abuse is a frequent cause of complications. Chronic cocaine use can cause significant mental abnormalities (such as personality changes and paranoia).

Federal law prohibits payment of SSDI or SSI benefits and Medicare or Medicaid coverage based on those benefits to people who are disabled because of drug addiction and/or alcoholism (DAA) to the extent that their problems would be reversible by ceasing the addictive activity. In other words, you can be disabled because of irreversible organ damage caused by DAA. See Chapter 11 regarding how the SSA evaluates DAA.

Many claimants with DAA have other mental disorders, and questions arise concerning the relative contributions of drugs and alcohol versus the other mental disorder. For example, how does one evaluate a claimant with chronic schizophrenia who also abuses cocaine? Which symptoms are due to drug use and which are related to schizophrenia? How do the drugs increase the severity of the schizophrenic symptoms? How much improvement in the schizophrenia would one see if the drug abuse ended? These cases require expert judgment and are susceptible to error. If possible, records from a time the claimant was free of alcohol or drugs would be very helpful. To the extent that the SSA lacks reasonable certainty as to the contribution of DAA to a mental or physical disorder, the benefit of the doubt would generally go to the claimant.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have behavioral changes or physical changes associated with the regular use of substances that affect the central nervous system. The required level of severity is met when any of the following parts (Ⓐ through Ⓘ) is satisfied.

Ⓐ Organic mental disorders. Evaluate under Listing 12.02.
Ⓑ Depressive syndrome. Evaluate under Listing 12.04.
Ⓒ Anxiety disorders. Evaluate under Listing 12.06.
Ⓓ Personality disorders. Evaluate under Listing 12.08.
Ⓔ Peripheral neuropathies. Evaluate under Listing 11.14 (CD Part 11).
Ⓕ Liver damage. Evaluate under Listing 5.05 (CD Part 5).

Ⓖ Gastritis. Evaluate under Listing 5.04 (CD Part 5).
Ⓗ Pancreatitis. Evaluate under Listing 5.08 (CD Part 5).
Ⓘ Seizures. Evaluate under Listing 11.02 or Listing 11.03 (CD Part 11).

b. Residual Functional Capacity

Residual functional capacity must be determined on an individual basis, depending on the types of abnormalities and functional limitations present. See the discussion of RFC under the particular listing used to evaluate the claim.

16. Listing 112.09: Psychoactive Substance Dependence Disorders (Children)

See Chapter 11 regarding prohibition of disability payments for drug addiction and/or alcoholism (DAA). Because this listing is for substance addiction alone—the very thing federal law prohibits as being the basis for disability—it cannot be used to find a child disabled. Instead, the SSA would decide if the child's substance dependence is severe enough to satisfy the listing. If not, the claim would be denied. If the impairment is severe enough to meet the listing, the SSA would then decide that the DAA was material to the finding of disability and would deny it anyway because the child can't be allowed benefits for substance dependence. This is bureaucracy at its finest. However, to the extent that a child has a mental or physical disorder that would remain after cessation of DAA (even if the DAA originally caused the problem), he or she could still be found disabled under the appropriate other listing, but not this one.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listing, it must be manifested by a cluster of cognitive, behavioral, and physiologic symptoms that indicate impaired control of psychoactive substance use, along with continued use of the substance despite adverse consequences. Part Ⓐ is for diagnostic purposes; part Ⓑ is for evaluation of functional severity. The required level of severity is met when both Ⓐ and Ⓑ are satisfied.

Ⓐ Medically documented findings of at least four of the following:

1. Substance taken in larger amounts or over a longer period than intended with a great deal of time spent in recovering from its effects.
2. Two or more unsuccessful efforts to cut down or control use.
3. Frequent intoxication or withdrawal symptoms interfering with major role obligations.
4. Continued use despite persistent or recurring social, psychological, or physical problems.
5. Tolerance, as characterized by the requirement for markedly increased amounts of substance in order to achieve intoxication.
6. Substance taken to relieve or avoid withdrawal symptoms.

Ⓑ For older infants and toddlers (ages one and two), the condition results in at least one of the appropriate age-group criteria in part Ⓑ1 of Listing 112.02. For children (ages three through 17), the condition results in at least two of the appropriate age-group criteria in part Ⓑ2 of 112.02.

17. Listing 12.10: Autistic Disorder and Other Pervasive Developmental Disorders (Adults)

Autism (autistic disorder) is a form of pervasive developmental disorder, for which there are a number of specific diagnostic criteria. Although this listing concerns autism in adults, the diagnosis is based on childhood developmental abnormalities, as you'll see mentioned below. Basically, autism may be associated with:

- *Severe deficits in social interaction.* Lack of nonverbal behaviors usually present in social interactions, such as gestures, body postures, and facial expressions; failure to develop social relationships with other children the same age (peers); lack of spontaneous sharing of enjoyment or interests with other people; lack of sharing emotions with others (lack of emotional or social reciprocity).
- *Severe impairments in communication.* Delay or lack of development of spoken language with no attempt to compensate by other means of communication. For example, a normal deaf child will attempt to learn and communicate with sign language, but an autistic child will not.

Other communication abnormalities may involve inability to start or keep up a conversation with others even if speech ability is present; repetitive use of language or personalized (idiosyncratic) language; lack of socially imitative play or make-believe play that would normally be appropriate to the child's level of development.

- *The persistent repetition of senseless acts or interests (stereotyped behavior).* Preoccupation with restricted interests; insistence on sticking to certain unnecessary routines or rituals; stereotyped mannerisms; and an abnormal interest (preoccupation) with the parts of objects.
- *Abnormal functioning before age three years.* Abnormal functioning or delayed development in the following:
  1. social interaction
  2. language as used in social communication, or
  3. play involving imagination or symbolism.

Not all of the above abnormalities of autism need to be present for a diagnosis of the disorder. Part Ⓐ of the listing concerns establishing the diagnosis of a pervasive developmental disorder. "Qualitative deficits" mentioned in part Ⓐ refers to an identifiable problem being present, and not level of functional severity, which is evaluated under part Ⓑ.

Autism is an extremely severe mental disorder with a poor prognosis. Part Ⓐ1 is specifically for autism. If a claimant actually has autism, it is virtually certain they will be given an allowance under this listing. Denial of a claimant with autism should cause the question to be raised that either the determination of denial is wrong or that the diagnosis of autism is wrong. For example, it would be unusual for someone with autism to not have marked limitations in daily activities (part Ⓑ1) or social functioning (part Ⓑ2).

Developmental disorders other than autism are also considered under part Ⓐ2 of the listing, but are much less likely to be allowances than autistic disorder.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, it must be characterized by qualitative deficits in your 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 parts Ⓐ and Ⓑ are satisfied.

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

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

18. Listing 112.10: Autistic Disorder and Other Pervasive Developmental Disorders (Children)

Autism (autistic disorder) is not mental retardation. Autism is a form of pervasive developmental disorder, for which there are a number of specific diagnostic criteria. Basically, autism may be associated with:

- *Severe deficits in social interaction.* Examples include a lack of nonverbal behaviors usually present in social interactions, such as gestures, body postures, and facial expressions; failure to develop social relationships with other children the same age (peers); lack of spontaneous sharing of enjoyment or interests with other

people; and lack of sharing emotions with others (lack of emotional or social reciprocity).

- *Severe impairments in communication.* Delay or lack of development of spoken language with no attempt to compensate by other means of communication. For example, a normal deaf child will attempt to learn and communicate with sign language, but an autistic child will not. Other communication abnormalities may involve inability to start or keep up a conversation with others even if speech ability is present; repetitive use of language or personalized (idiosyncratic) language; lack of socially imitative play or make-believe play that would normally be appropriate to the child's level of development.
- *The persistent repetition of senseless acts or interests (stereotyped behavior).* Examples include preoccupation with restricted interests; insistence on sticking to certain unnecessary routines or rituals; stereotyped mannerisms; and an abnormal interest (preoccupation) with the parts of objects.
- *Abnormal functioning before age three.* Abnormal functioning or delayed development in the following: (1) social interaction, (2) language as used in social communication, or (3) play involving imagination or symbolism.

Not all of the above abnormalities of autism need to be present for a diagnosis of the disorder. Qualitative deficits refer to an identifiable problem being present and not level of functional severity, which is evaluated under part Ⓑ.

Autism is an extremely severe mental disorder with a poor prognosis. If a claimant actually has autism, it is virtually certain he will be found disabled under this listing. Denial of a claimant with autism should mean that either the determination of denial is wrong or that the diagnosis of autism is wrong. Developmental disorders other than autism are also considered here, but are much less likely to be allowances than autistic disorder. Children less than one year old who have developmental disorders are evaluated under Listing 112.12.

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, it must be 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 is met when both Ⓐ and Ⓑ are satisfied.

Ⓐ Medically documented findings of 1 or 2:

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

Ⓑ For older infants and toddlers (ages one and two), the condition results in at least one of the appropriate age-group criteria in part Ⓑ1 of Listing 112.02. For children (ages three through 17), the condition results in at least two of the appropriate age-group criteria in part Ⓑ2 of 112.02.

19. Listing 112.11: Attention Deficit Hyperactivity Disorder (Children)

Attention deficit hyperactivity disorder (ADHD) is a common childhood disorder. It is characterized by impulsive behavior, difficulty maintaining attention, and hyperactivity. Of course, these characteristics are to some extent natural in a young child and should not be confused with ADHD. ADHD children will not sit still very long and are into everything. If of school age, they typically have difficulty completing their lessons because they can't maintain their attention long enough. Consequently, their grades suffer. They impulsively respond to every little distraction.

The cause of ADHD is unknown, but there is evidence of abnormal brain function. Mental retardation is not an expected part of ADHD and it is controversial whether IQs in these children are lower than normal children matched for other similarities

(age, socioeconomic condition, and the like). IQ scores obtained from hyperactive, inattentive children are not valid, if the child displays these abnormalities during the test enough to affect the results. If IQ or other testing is done, the psychologist administering the test must be skilled in maintaining the child's attention and effort.

Treatment of ADHD usually consists of behavior therapy (which must also involve the parents) and drugs. Various drugs used include certain kinds of antidepressants, dextroamphetamine, and methylphenidate (Ritalin). The side effects of drugs should be taken into account during disability determination. It is important to the nondrug part of treatment that the child's environment be highly organized (structured) both at home and at school if possible. Treatments like restriction of sugar, dosing with megavitamins, or dietary restrictions are not effective.

If a child has all three of the mental status abnormalities of marked inattention, marked impulsiveness, and marked hyperactivity, in addition to certain functional restrictions, then allowance level severity is present. Most children with ADHD are not disabled—the listing applies only to the most severe cases of ADHD.

a. Listing Level Severity

Part Ⓐ of the listing is used to establish the presence of the attention deficit hyperactivity disorder (ADHD). Part Ⓑ of the listing is used to establish functional severity. The required level of severity is met when both Ⓐ and Ⓑ are satisfied.

Ⓐ Medically documented findings of all three of the following:
1. Marked inattention.
2. Marked impulsiveness.
3. Marked hyperactivity.

Ⓑ For older infants and toddlers (ages one and two), the condition results in at least one of the appropriate age-group criteria in part Ⓑ1 of Listing 112.02. For children (ages three through 17), the condition results in at least two of the appropriate age-group criteria in part Ⓑ2 of 112.02.

20. Listing 112.12: Developmental and Emotional Disorders of Newborns and Younger Infants (Birth to Attainment of Age One) (Children)

Any type of physical or mental medical disorder can be used to satisfy this listing in children under age one year. Potential causes of marked developmental or emotional disorders include malformations of the brain at birth, infections of the brain, strokes, genetic disorders of brain metabolism, or any other disorder affecting the brain function. Autism and other pervasive developmental disorders in children under age one year are also evaluated under this listing. See comments under child Listing 112.10 for more information about autism.

A child's developmental level is measured with tests designed for that purpose, such as the Bayley Scales of Infant Development that yields a developmental quotient (DQ). Not all parts of the listing require formal testing, but it may be necessary to obtain accurate results in unclear cases—of which there are many. In cases of obvious marked severity based on clinical observations by a doctor and supported by parental and other information, formal testing is not required. The need for specific formal testing is a matter of medical judgment in each individual claim.

a. Listing Level Severity

Developmental or emotional disorders of infancy are evidenced by a deficit or lag in the areas of motor, cognitive/communicative, or social functioning. These disorders may be related either to organic or to functional factors or to a combination of these factors. The required level of severity is met when Ⓐ, Ⓑ, Ⓒ, Ⓓ, or Ⓔ are satisfied.

Ⓐ Cognitive/communicative functioning generally acquired by children no more than one-half the child's chronological age, as documented by appropriate medical findings (in infants under six months, markedly diminished variation in the production or imitation of sounds and severe feeding abnormality, such as problems with sucking, swallowing, or chewing) including, if necessary, a standardized test.

Ⓑ Motor development generally acquired by children no more than one-half the child's chronological

age, documented by appropriate medical findings, including if necessary, a standardized test.

Ⓒ Apathy, overexcitability, or fearfulness, demonstrated by an absent or grossly excessive response to one of the following:

1. Visual stimulation.
2. Hearing stimulation.
3. Touch stimulation.

Ⓓ Failure to sustain social interaction on an ongoing, reciprocal basis as evidenced by:

1. Inability by six months to participate in vocal, visual, and movement (motoric) social exchanges (including facial expressions).
2. Failure by nine months to communicate basic emotional responses, such as cuddling or exhibiting protest or anger.
3. Failure to attend to the caregiver's voice or face or to explore an inanimate object for a period of time appropriate to the infant's age.

Ⓔ Attainment of development or function generally acquired by children no more than two-thirds of the child's chronological age in two or more areas (i.e., cognitive/communicative, motor, and social), documented by appropriate medical findings, including, if necessary, standardized testing. ■