gious/spiritual ritual for professionally accepted diagnostic methods or therapeutic practice."

Consider a psychiatrist who offers treatment specializing in couples' therapy but, similar to the allegations in this case, has a religious objection to homosexual relationships. If practicing in California, solo or sharing the office with another psychiatrist of similar belief, the psychiatrist could be held liable if a gay couple seeking therapy is instead referred to another physician. The ruling by the California Supreme Court in this case could compel the psychiatrist to treat the couple despite religious objection. If the psychiatrist holds homosexual relationships to be immoral, would the psychiatrist offer a gay couple adequate treatment? Although the referral of this couple to a psychiatrist without these beliefs might be in the best interest of the patients, both the California Supreme Court and the American Psychiatric Association envision a professional practice in which such a referral would be unnecessary.

Ruling on Social Security Benefits

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The Legal Standard for Ruling on Social Security Benefits Is Delineated by Federal Statutes, Including Use of a "Special Technique"

In *Kohler v. Astrue*, 546 F.3d 260 (2nd Cir. 2008), the U.S. Court of Appeals for the Second Circuit considered the decision by the U.S. District Court for the Northern District of New York, in which the district court affirmed the Social Security Administration's denial of Social Security Disability Insurance (SSDI) and Supplemental Security Insurance (SSI) benefits to the plaintiff.

Facts of the Case

Kathy Kohler had a history of treatment of bipolar disorder since 1992 (or earlier). In that year, she was hospitalized for mania twice in about a month and improved with medications both times. Four years later, she moved to rural, upstate New York, where she received outpatient treatment at North Star Behavioral Health Services. Dr. Naveen Achar was her treating physician of record, but the clinician with whom she had the most frequent contact was Lorna Jewell, APRN. In 1998, Ms. Kohler was hospitalized for a week with lithium toxicity. In 2001, she had a manic episode but was not hospitalized. During an evaluation two weeks later, Ms. Jewell thought Ms. Kohler was "approaching hypomania," possibly triggered by emotional stress.

Ms. Kohler's work history had declined markedly after 1991. She went from working 30 hours a week as a house cleaner between 1982 and 1991 to five hours a week as a babysitter from 1996 to 2005, when the case was heard. She had not held steady, long-term employment since 1991.

Ms. Kohler's first application for SSDI and SSI benefits in March 2002 was initially denied, but the decision was vacated and remanded by the district court on technical grounds in October 2004. The administrative law judge (ALJ) again denied Ms. Kohler's application at a second hearing in February 2005, and the district court upheld the decision in November 2006. Ms. Kohler then appealed to the U.S. Court of Appeals for the Second Circuit.

Three mental health professionals evaluated Ms. Kohler regarding her capacity to work. In June 2002, Dr. Terri Bruni, a state agency psychologist, found that Ms. Kohler had "moderate" limitation for difficulties in maintaining social functioning. She also found Ms. Kohler to be "moderately limited" in:

> . . . (1) ability to maintain attention and concentration for extended periods, (2) ability to complete a normal workday and work week without interruptions from psychologically-based symptoms, and to perform at a consistent pace without an unreasonable number and length of rest periods, and (3) ability to interact appropriately with the general public [*Kohler*, p 264].

Dr. Brett Hartman, a psychologist, and Dr. Achar evaluated her within a period of two weeks in October 2003. Each concluded Ms. Kohler had no to mild limitations in all areas of functioning evaluated, although Dr. Hartman noted that Ms. Kohler "would appear to have mild to moderate problems performing a variety of complex tasks independently given her mild intellectual deficits" (*Kohler*, p 263). All three professionals agreed Ms. Kohler had bipolar disorder with episodes of mania and depression.

In coming to his decision, the ALJ reviewed medical reports, including evaluations by Dr. Achar and treatment notes by Ms. Jewell, and agreed that Ms. Kohler had bipolar disorder. However, he found "no treating reports which would suggest that the claimant experiences more than occasional problems in social and occupational functioning" (*Kohler*, p 268), and concluded Ms. Kohler had the "residual functional capacity" to perform her past relevant work, and that a finding of "not disabled" was therefore required.

Ruling and Reasoning

The U.S. Court of Appeals for the Second Circuit vacated the ruling of the district court and remanded the case, instructing that court to remand to the commissioner of Social Security for further proceedings.

This decision was based on an examination of whether there was support for the commissioner's decision and whether the correct legal standards had been applied. The first task was for Ms. Kohler to prove she was disabled within the meaning of the Social Security Act (20 C.F.R. § 404.1520, *et seq*. (2003)). The evaluation for disability utilizes a five-step framework:

> Is the claimant employed?
>
> If not, does the claimant have a "severe impairment" that has limited the claimant's capacity to work for a period of time sufficient to satisfy the duration requirement?
>
> If an impairment exists, is it equal to one in Appendix 1 of § 404.1520 and does it meet the duration requirement?
>
> Does the claimant have the residual functional capacity to do "past relevant work"?
>
> If not, can the claimant adjust to other work? If not, the claimant is found to be disabled.

The regulations also require the application of a "special technique" at the second and third steps of the five-step framework to determine the severity of mental impairments in accordance with 20 C.F.R. § 404.1520a (2003). This technique requires that if the claimant has a "medically determinable mental impairment" that causes functional limitations, the degree of such limitations will be rated in four broad areas of functioning: "activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation" (20 C.F.R. § 1520a(c)(3) (2003)). A rating of "none" or "mild" in the first three areas, in addition to no decompensation, means the claimant is not entitled to benefits. Notably, the regulations mandate that this process of evaluating eligibility be documented, including a specific finding as to the degree of limitation in each of the functional areas.

Upon review of the ALJ's decision on Ms. Kohler's case, the court of appeals found that the ALJ failed to adhere to the regulations, and his written decision did not reflect application of the special technique. The court concluded that the ALJ "does not appear to have evaluated each of the four functional areas, and did not record specific findings as to Ms. Kohler's degree of limitation in any of the areas" (*Kohler*, p 267). The court was frustrated by the failure of the ALJ to adhere to regulations. In addition, the court observed that the ALJ did not "conduct a distinct analysis that would permit adequate review on appeal even without the requisite findings" (*Kohler*, p 267). It referred to precedent and reported that other courts of appeals have remanded cases in which the ALJ did not follow established regulations for evaluation of disability, even if such noncompliance was ultimately harmless.

In supporting its opinion that a thorough analysis of the case was not conducted, the court observed that the ALJ tended to "overlook or mischaracterize" evidence, to Ms. Kohler's disadvantage, and stated several examples to support its view. These include the observation that the ALJ did not mention Dr. Bruni's evaluation that found "moderate" limitation in social functioning and the rather cursory attention paid to Ms. Jewell's notes. The court acknowledged that the ALJ was not required to give strong consideration to Ms. Jewell's notes because she was not a "treating source" by definition (20 CFR 404.1502 (2002)), but opined that he should have given it "some extra consideration," since Ms. Jewell was the main treatment provider for Ms. Kohler in the "very rural North Country." The court also noted that, in other cases in which the ALJ had similarly failed to consider "relevant probative evidence," it had remanded.

Discussion

This interesting case highlights the importance of following through with established protocol for evaluating eligibility for SSDI. Even when it appears clear that an individual would not be eligible for

disability, any deviation from the mandated protocol, no matter how minor, may lead to the remanding of the case.

It is heartening to note that the court gave weight, not only to formal assessments by the treating psychiatrist, but also to information about clinical presentation and treatment by other clinicians involved, even when a clinician is not a treating source. Although these opinions may not carry "controlling weight" as they are not from the treating source, they usually carry significant weight and may even be entitled to more weight than the opinion of the treating source if that opinion does not meet certain specified criteria. The treating source in this case would be a licensed physician/psychiatrist, not an APRN. The court was unhappy with the ALJ for not giving adequate consideration to an assessment from a state agency psychologist and to progress notes from Ms. Kohler's psychiatric APRN. The ALJ's apparent dismissal of these reports gave an appearance of a biased view that led to denial of benefits.

The opinion of the treating psychiatrist carries controlling weight with regard to disability eligibility determinations. This fact may not be immediately apparent, given the high number of psychiatrically disabled individuals denied benefits. Those who are well enough to understand the system appeal the denial and subsequently fall into a large pool of individuals in limbo, waiting for the final determination of their applications. The sad reality of this case is how long it has dragged on; six years after the initial application, the case is still unresolved.

Duty to Warn Clarified

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The Kentucky Supreme Court Interprets When a Threat Is Communicated and the Meaning of an Actual Threat

In *DeVasier v. James*, 278 S.W.3d 625 (Kentucky 2009), the Supreme Court of Kentucky affirmed the court of appeals' decision concluding that the trial court should have directed a verdict in favor of Dr. William James, the psychiatrist defendant, because he owed no duty to warn or take precautions regarding a man he evaluated in an emergency department. In so doing, the court analyzed the statutory definitions of "communicated to a qualified mental health professional" and "an actual threat" contained in Ky. Rev. Stat. Ann. § 202A.400 (Michie 1995), both broadening and narrowing physician liability in duty-to-warn cases in Kentucky.

Facts of the Case

In July of 1995, Kenneitha Crady attempted to end an eight-year romantic relationship with her boyfriend Rene Cissell. Mr. Cissell had recently been violent with Ms. Crady on several occasions, including on July 12, when he crashed his car into a car carrying Ms. Crady, and on July 18, when he held a knife to her throat causing a small cut. At the time, Mr. Cissell was noted to be "depressed, irritable, abusing drugs, and increasingly angry" (*DeVasier*, p 628). After the knife incident, Mr. Cissell's sister, Georgia Yount, and Ms. Crady took Mr. Cissell for a crisis evaluation at a local outpatient psychiatric facility. Although he was given a follow-up counseling appointment for the next day, Ms. Crady and Ms. Yount were worried enough about his increasing anxiety that they took him instead to the psychiatric emergency department at the University of Louisville Hospital.

Mr. Cissell was first evaluated by an intake nurse, who was told about the recent violence. After that evaluation, the nurse charted that Mr. Cissell was a "man in crisis" and, based upon what Ms. Yount and Ms. Crady reported, the nurse charted that Mr. Cissell had "homicidal ideation." The nurse placed Mr. Cissell in the locked waiting room for further examination. His next evaluation was by a licensed clinical social worker, whom Mr. Cissell told that he "loved Crady, and that he did not want to harm her but was afraid that he could not control himself" (*Devasier*, p 633). The social worker then conferred with the attending psychiatrist, Dr. James, who performed the final evaluation. Dr. James decided against hospitalization by civil commitment for Mr. Cissell and allowed him to leave with his sister and Ms. Crady. Ms. Crady was present during all three evaluations.

After attending the counseling session, which had been scheduled the day before, Mr. Cissell and Ms. Crady got into another altercation. The police were