

Commentary: Challenges in Providing Psychiatric Disability Evaluations

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Christopher *et al.*, in their study of differences between general psychiatrists and forensic psychiatrists in the evaluation of psychiatric disability relative to Social Security Disability Insurance claims, have provided useful information regarding statistically significant differences in practice and beliefs. Despite the relatively small number of participants in this unique survey study, the authors have identified important sources of potential bias among both general and forensic psychiatrists. The study also highlights the profound disconnect between the historically prevalent medical model of disability, in which treating clinicians are considered experts in assessing disability, and the actuality that most general and forensic psychiatrists lack training in disability evaluations. This misperception creates additional practical and ethics-related problems for clinicians when their patients file disability claims.

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Christopher *et al.*¹ have conducted a much-needed investigation into practice patterns and perceptions of role, objectivity, and dual agency in the disability evaluation process and whether these aspects differ between general and forensic psychiatrists. Although the actual number of psychiatrists who responded to the survey was relatively small, the authors have reported some interesting and at times disturbing findings. Among the many important aspects of the process of disability evaluations touched on by the authors, two stand out as deserving further discussion: the various types of bias in disability identified as influencing both forensic and general psychiatrists, and the profound disconnect between the historically prevalent medical model of disability and the reality of psychiatric training and expertise.

The relationship between psychiatric illness and disability is neither well studied nor well understood. The less well understood a phenomenon, the more easily personal, professional, and social biases influence the perceptions of those who attempt to evaluate the phenomenon. This is certainly true of disability benefits providers, public and private, who tend to regard claims for benefits on the basis of psychiatric disorders with greater distrust and skepticism than they do claims for physical illnesses. It is also

true of physicians, including psychiatrists, on whom disability benefit providers depend for information to make disability determinations.

American society promotes a strong work ethic: those who can work are expected to work. We as a society have also decided that we should provide financial support to individuals who cannot work because they are disabled. These social values create a dynamic tension that is not easily addressed by disability benefit providers, workers, or their physicians. The high moral and social value placed on gainful employment has made disability due to illness one of the few socially sanctioned, legitimate pathways for withdrawing from the workplace. When individuals apply for public disability benefits through the Social Security Administration (SSA), they must provide medical documentation of their impairments. When psychiatric disability claims are filed, psychiatrists are asked to provide the documentation of the individual's impairments and disabilities. Although psychiatrists providing first-line disability evaluations are not the arbiters of SSA disability determinations, their opinions carry great weight.

Multiple influences can result in bias in psychiatrists' disability evaluations, especially of their own patients. Of these, the potential influence of dual agency in psychiatric disability evaluations cannot be overstated. The authors note that among other problems, treating clinicians must contend with pressure and resentment from patients if the clinicians choose

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not to complete disability forms or disagree with the patient's own assessment of degree of disability.

When faced with difficult clinical situations involving disability, most treating psychiatrists struggle with determining what their role should be and with adopting that role while attempting to maintain the therapeutic alliance. Individuals may wish to withdraw temporarily or permanently from the workplace for many reasons besides psychiatric illness. Psychiatrists do not typically advise a patient to leave work and seek disability benefits, except under the most extreme circumstances. The more common progression to a medical disability involves a patient who makes the determination that he is disabled and needs to withdraw from the workplace and then presents the necessary paperwork to the treating clinician. When the clinician completes the paperwork, the patient typically summarizes the process as follows: "My doctor said I am disabled and shouldn't work."

Christopher *et al.* report that approximately 70 percent of both general and forensic clinicians believe that completing Social Security Disability Insurance (SSDI) evaluations is part of their role as treatment providers. Approximately one quarter of both groups also reported that they complete the forms to maintain the therapeutic alliance. Of those who do complete forms, most identify themselves as the patient's advocate. The study also reports that a significant proportion, particularly of general clinicians, feel pressured by their patients to complete the forms. A minority of both general (14%) and forensic (20%) clinicians indicated that they had endorsed disability in a patient whom they believed was able to work.

These findings reflect the difficulties in managing a complex clinical situation in which so many potential biases may be active. For example, confronting patients about self-assessments of disability is highly problematic, even if the clinician suspects that the self-assessment is exaggerated or just plain wrong. Aside from the potential of damaging the therapeutic relationship, treating clinicians are not in a position to argue with patients' assessments, since they rarely have all the information necessary to correlate the severity of symptoms with specific functional impairments relative to the patient's job. Moreover, most patients who present with a self-assessment of disability are in emotional distress, and it may not be clear whether that distress is impairing functions necessary for work.

However, as this study demonstrates, in validating claims for disability, many psychiatrists may be confused about their ethics-based obligations. Both general and forensic psychiatrists reported that filling out forms, even when they do not believe their patients are disabled, is a form of patient advocacy. The obligation to advocate for one's patient is actually an obligation to advocate in the interest of the patient's health. It is not simply an obligation to comply with a patient's wishes, especially if those wishes are detrimental to his health. For example, a physician would not prescribe a dangerous and unnecessary medication simply because the patient requested it.

When a patient makes a disability claim and asks his psychiatrist to endorse the claim by documenting impairments and disability, psychiatrists should think carefully about the true meaning of patient advocacy. SSDI benefits require that the patient be totally and permanently disabled. Permanent disability status is typically not good for anyone's mental health. Once an individual considers himself permanently disabled, a downward spiral in mental health is unavoidable.

Psychiatrists' ethics-related obligations for advocacy in these disability claims may be better fulfilled by directly, empathically, and nonjudgmentally confronting their patients' self-assessments of disability. Offering to work with the patient to explore how best to maintain functioning, even in circumstances of psychiatric illness or occupational stress that may cause emotional distress, can be extremely difficult and may disrupt the therapeutic alliance. However, it can also serve to strengthen it, if the patient comes to understand that his psychiatrist is trying to prevent additional or further psychiatric harm. That a minority from both the general and the forensic psychiatric groups acknowledged identifying a patient as disabled despite believing otherwise indicates how difficult such a confrontation may be.

Christopher *et al.* suggest that even a higher awareness of these conflicts may not be enough to counter the problems inherent in dual agency and patient advocacy in disability claims. They found that forensically trained clinicians were more sensitive to the conflicts associated with dual agency in providing disability evaluations for one's own patients. This observation corresponds with two other findings: that forensically trained psychiatrists tended to feel less pressured to complete evaluation forms and that they were significantly less likely to agree to perform

evaluations on their own patients. This finding is gratifying in light of efforts to raise awareness of the potential complexity and ethics-related problems involved in disability evaluations. Nevertheless, forensically trained psychiatrists still felt always or usually pressured to complete forms, did not consistently obtain informed consent, and primarily identified themselves as advocates when performing disability evaluations. Thus, even forensically trained psychiatrists who are familiar with dual-agency conflicts struggle with wearing two hats² when performing disability assessments.

The findings of Christopher *et al.* are consistent with concerns raised by others in regard to SSDI evaluations³ and workers' compensation claims.⁴ If an employee makes a workers' compensation claim involving psychiatric injury or illness, he is referred to a psychiatrist, who generally provides initial evaluation, treatment, and reevaluation of the claimant, including opinions regarding disability. The information is provided directly to the adjudicating board and is considered heavily weighted evidence. The combination of sympathy toward the patient claimant, as well as the tendency to justify ongoing treatment, renders clinicians especially vulnerable to bias in these workers' compensation cases.

Another important problem that the authors identified is the lack of knowledge regarding the SSDI process and, by implication, of other types of disability evaluations. This finding highlights the need for psychiatrists to gain a better understanding of the various disability benefit systems. The study evaluated only SSDI determinations. The initial stages of the SSDI determinations rely almost entirely on information provided by the treating psychiatrist. Independent evaluations are obtained only when the information is not provided by the treating psychiatrist or is incomplete or nonresponsive.

The authors found that forensically trained clinicians were more likely to be aware of the weight of their evaluations than were the general clinicians. However, general clinicians are more likely to fill out SSDI claim forms (in this study, 83.1% of general clinicians asked to fill out forms versus 62.5% of forensic clinicians). In addition, Christopher *et al.* found that general psychiatrists were significantly more likely than forensically trained psychiatrists to believe that the SSA gives more weight to the opinions of independent examiners.

It is disturbing to find that many general psychiatrists are unfamiliar with the importance of their role in the SSDI adjudication process. Their underestimation of the importance of their evaluations may lead, as the authors point out, to misrepresenting patients' impairments, believing that somewhere in the process an independent evaluator will set the record straight. It also raises concerns about the conflict inherent in placing psychiatrists in dual roles: one in which they act as mediators between disability evaluations and the complex bureaucracies that determine who will receive benefits and the other in which they fulfill their own belief, also documented in this study, that completing these evaluations is part of their obligation to their patients.

The authors are to be applauded for including discussion of the training in disability evaluations in their study. They are correct in their conclusion that clinical experience alone does not provide adequate preparation for assessing disability. They cite two studies that indicated training in conducting disability evaluations to be almost universally lacking in psychiatric residencies.^{5,6} Senior psychiatry residents report low confidence in their ability to assess disability accurately and identify a need for more training on evaluating disability.⁶

As the study noted, forensic psychiatrists may be more sensitized to dual-agency and ethics-related conflicts, but they are not necessarily better trained in assessing disability than are general clinicians. My experience suggests that many forensic fellowships struggle to find opportunities to provide disability training to forensic fellows. Most criminal forensic evaluations occur in institutional facilities, where evaluatees are literally captive populations. In contrast, civil forensic evaluations, including those for disability, cannot be accessed consistently for teaching or training purposes.

Both general and forensic psychiatrists typically lack adequate training in assessing disability and have limited understanding of disability benefit systems. Moreover, as Christopher *et al.* have demonstrated, both groups, to a greater or lesser degree, are subject to pressures and influences that may bias their assessments. This realization raises a broader question: why do private and public disability benefit providers preferentially seek information from treating clinicians on which to base disability determinations?

The belief that treating physicians, including psychiatrists, are the best sources of information for

these complex assessments has arisen for a variety of reasons, the most significant of which is the widespread medical model of disability. Social Security disability programs typify the use of this model, and Christopher *et al.* rightly raise concerns about its utility. In this model, disability is conceptualized as a problem whose locus resides in the individual. It is assumed to be caused by disease, trauma, or some other health condition. Thus, the role of the treating physician or psychiatrist and the information he provides is central to the disability determination.

In contrast, the social model of disability, which has become increasingly widespread over past years, proposes that disability results from a combination of an environment that fails to accommodate persons with impairments and negative attitudes toward such persons. Disability is defined as an interaction of an individual's impairments, job description, and the perceptions of others. The Americans With Disabilities Act (ADA)⁷ is an example of this more nuanced approach to the assessment of disability, and, as in ADA claims, the role of the treating psychiatrist is less clear. For example, physicians' expertise regarding illness and impairments is still required, but the evaluation of work environments and their success or failure in accommodating persons with impairments is not necessarily a medical opinion.

The pervasive use of the medical model of disability assures that disability benefits systems will continue to rely on physicians to provide information critical to the adjudication of claims. Christopher *et al.* point out that treating clinicians, some of whom may not be aware of the risk of dual agency and who almost certainly have not received any specialized training in either disability evaluations or in understanding their role in the disability systems, will be the primary source of information for disability determination adjudicators. Thus, in claims involving psychiatric illness, psychiatrists have accepted, although often uncomfortably, the role of mediators of this complex process between patients and disability benefits systems.

However, there is a profound disconnect between the paternalistic medical model of disability determination and the reality of psychiatric training. Both forensic and general psychiatrists should be aware of the gap between the nonmedical world's expectations and our own clinical training and vulnerabilities. The inherent conflicts of dual agency create problems in maintaining a treatment alliance and

providing objective information to disability benefit adjudicators. In addition, a lack of familiarity with disability determination systems can result in uncertainty regarding role, creating the potential for more bias. Most physicians, including psychiatrists, when uncertain about their role, fall back on clinical training and side with their patients.

The gap between what psychiatrists are assumed to know about disability and disability systems and what they actually know calls for extra vigilance in conducting disability evaluations, especially for their own patients. Close self scrutiny and observation should accompany disability evaluations precisely because structure, training, and familiarity with the needs and objectives of the third party who solicited the evaluation are minimal. The concerns that these evaluations raise cast light on the influence of a wide array of biases that can result, as Christopher *et al.* found, in psychiatrists documenting disability for their own patients, even when they believe none exists. One hopes that this is as rare an occurrence as the study seems to indicate.

Psychiatric disability evaluations occur at the poorly understood intersection of the worlds of psychiatric illness and impairment, competitive employment, and disability determination bureaucracies. More structured education in conducting disability evaluations is needed. Christopher *et al.* call for better education for general and forensic psychiatrists who perform psychiatric disability evaluations. They suggest the development of a formal curriculum on this topic in psychiatric residencies and forensic fellowships. These are excellent recommendations.

As we know however, residency and fellowship training provide the basis and the beginning of clinical expertise. Psychiatrists might therefore take a page from disability determination administrators and managers and attorneys who litigate disputed disability claims. These groups have professional organizations that provide extensive continuing education opportunities devoted to understanding disability systems, claims, and the complexities surrounding disability benefit administration and litigation. Psychiatric organizations such as the American Psychiatric Association should prioritize the development of continuing medical education in disability evaluation training. Increasing knowledge and expertise can only improve the quality of psychiatric disability evaluations and assist both forensic and general psy-

chiatrists in managing the complex practical problems and ethics-related concerns associated with them.

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