Veterans Affairs Disability Compensation: A Case Study in Countertherapeutic Jurisprudence

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This article examines the disability compensation programs and health care system of the Department of Veterans Affairs (VA) from the perspective of therapeutic jurisprudence scholarship. VA psychiatric patients have unambiguous financial incentives to endlessly litigate disability claims, to seek lengthy hospitalization rather than outpatient treatment, and to be ill, disabled, and unemployed. These countertherapeutic incentives reward incapacitation, encourage perceiving oneself as sick, diminish personal responsibility, taint treatment relationships, and lead to disparaging perceptions of VA patients. In addition, such perceptions produce moral dilemmas that arise from mutual distrust and frustration when patients and caregivers have antagonistic goals for the clinical encounter. Changes in disability determination procedures, compensation levels, and patterns of payment for treatment could give VA patients and caregivers a "healthier" health care system that encourages personal responsibility and promotes respectful attitudes toward patients. In the absence of such changes, an awareness of countertherapeutic financial incentives can help clinicians distinguish between psychopathological behavior and the pursuit of a rational income strategy, and can help practitioners recognize that apparently deceitful or litigious behavior represents a reasonable response to the economic contingencies that VA patients face.

Over the past decade, legal scholars increasingly have recognized that laws and regulations governing mental disability and the related civil and criminal issues may themselves be agents for psychotherapeutic change.[1–3] Writers on the subject of "therapeutic jurisprudence" view laws, administrative procedures, regulations, legal decision-makers,[4] and the "players"[5] in legal proceedings as "social forces that often produce therapeutic or antitherapeutic consequences," and ask "whether the law's antitherapeutic consequences can be reduced and its therapeutic consequences enhanced" while attaining the aims of justice (p 762).[6]

Most therapeutic jurisprudence schol-

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arship has focused on "traditional" mental disability law issues such as civil commitment, refusal of psychotropic medication, competency, and the insanity defense.[1] However, the therapeutic jurisprudence heuristic also has proved valuable for evaluating sometimes subtle[4] emotional consequences of health care financing,[7] jury service,[8] and child abuse reporting laws,[9] and for analyzing the behavioral effects of personal injury litigation,[10, 11] workers' compensation rules,[12] and disability law.[13] In these latter areas, writers have criticized laws and regulations that provide financial incentives for plaintiffs or claimants to remain ill and to disavow responsibility for their emotional problems, and have recommended changes when "legal arrangements can be corrected with little or no impact on justice considerations" (pp 32–33).[12]

This article turns the therapeutic jurisprudence "lens" on Department of Veterans Affairs (VA) programs for providing psychiatric care and mental disability compensation to former members of the armed services. The following section discusses VA acute care psychiatric inpatients, the financial incentives they encounter, and the effects of those incentives on their behavior and self-perceptions and on their caregivers. Next, the article discusses the concept of a therapeutic law and evaluates the VA mental disability rules in light of that discussion. The final section describes proposed changes in the financial incentives and rules governing disability determination that would greatly improve the therapeutic effectiveness of VA psychiatric care and the fairness of disability compensation.

Veterans, VA Health Care, and Disability Benefits

Demographic Background Current eligibility rules generally limit use of VA medical facilities to veterans who are either poor (in 1994, those couples with annual income below about $19,000) or service-connected (SC) (i.e., who have medical—including psychiatric—problems acquired during, or directly related to, military service).[14, 15] Psychiatric hospitalization and outpatient treatment constitute a major portion of the care administered at the VA's 171 medical centers. According to one recent estimate, about 40 percent of the 2,800,000 veterans treated annually at VA facilities receive psychiatric care.[16] One-seventh of all SC veterans have a primary psychiatric disability, and a third of the VA's hospital beds are dedicated to psychiatric care.[17] VA patients account for one-ninth of our nation's daily inpatient psychiatric census.[18]

A large fraction of VA acute care psychiatric inpatients are middle-aged men who served during the Vietnam era.[19, 20] Many of these men entered military service as teenagers after dropping out of high school,[21, 22] experienced childhood abuse,[22] and/or had behavioral problems as children.[23] Many enlisted or were drafted at a time when persons with college prospects or other social advantages tried to avoid military service. Vietnam-era clinicians believed that trouble adapting to combat generally reflected preenlistment psychosocial problems rather

than war-related stress,[24] and that a "significant increase in psychological awareness of the military command" had kept the rate of actual "psychiatric casualties . . .surprisingly low" (pp 482–3).[25] The majority of psychiatric evacuees to a hospital ship had what Strange[24] termed "pseudo-combat fatigue." These soldiers had childhood histories of poor impulse control, as well as social, family, and school problems; they rarely had been given positions of responsibility in combat; their recoveries were slow, and their symptoms frequently worsened when returning to duty was scheduled.[26, 27]

The optimism of 25 years ago contrasts with the present-day recognition that a substantial fraction of Vietnam veterans suffer from serious emotional problems.[23] Vietnam combat veterans have an increased likelihood of heavy drinking,[28] arrests, and convictions.[29, 30] Those who witnessed or participated in atrocities have had the greatest problems with post-service emotional adjustment.[29, 30]

Given the above described eligibility requirements and the availability to most Americans of employment-related health care coverage, one would anticipate that the veterans who use VA acute care psychiatric inpatient services would include an overrepresentation of individuals who are unemployed, have limited social support, and are destitute. In addition, the VA's special programs to provide housing and assistance for homeless veterans serve a population especially in need of psychiatric care.[31] A large number of VA psychiatric inpatients are or recently have been homeless,[32] and homeless veterans are disproportionately admitted for inpatient psychiatric care.[33] VA psychiatric inpatients thus are drawn from that portion of the population whose potential work-related income has been most affected by the disappearance of manufacturing and other high-paying jobs traditionally performed by unskilled men with limited educations.

Table 1
Ratings and Compensation for Single Veterans with Psychiatric Disabilities,[39] December 1995

Level, %	Definition	Monthly Compensation, $
0	Symptoms without impairment	0
10	Mild impairment	91.00
30	Definite impairment	266.00
50	Considerable impairment	542.00
70	Severe impairment	862.00
100	Total impairment	1,870.00

Incentives for Establishing Psychiatric SC Disability SC disabilities often make veterans eligible for cash compensation in addition to free VA medical care. In 1991, the VA disbursed $9.6 billion in SC compensation to 2,179,000 veterans, of whom 293,000 had a primary psychiatric disability.[34, 35] The amount of money granted to veterans reflects VA Regional Office Rating Boards' judgments about the severity of impairment.[36–38] Table 1 summarizes the rating schedule for single veterans with psychiatric disabilities[39] along with compensation levels as of December 1995.

Veterans receive additional compensation for dependents, and compensation is

increased annually to adjust for inflation. SC disability payments are tax exempt.[38] A single veteran with 100 percent SC disability benefits therefore receives more after-tax income, for example, than a single working resident of southwestern Ohio who earns $29,000 a year; if this income is supplemented by Social Security disability payments, its total value exceeds taxed annual income of $44,000.

As of November 1995, the national average nonfarm wage was $11.58 per hour[40] (approximately $24,000 per year), a figure that includes earnings of high school graduates and those with additional education. The laws regulating the provision of treatment and SC disability compensation thus create important financial opportunities for veterans whose employment prospects offer lower potential financial rewards than does 100 percent SC (disability) status. Moreover, securing SC status entitles veterans to vocational rehabilitation services, as well as to free treatment rendered by the VA itself or by private practitioners who are paid by the VA.[41] It is therefore not surprising that most hospitalized Vietnam combat veterans apply for SC disability compensation;[42] for them, as for many persons with chronic mental illnesses, claiming disability, seeking compensation, and/or protecting entitlement to compensation may not signify immorality or laziness, but the pursuit of a rational income strategy. Estroff[43] illustrated this issue by quoting one veteran's assessment of his situation: "I can't be sure about working but I can be sure about the VA. All I have to do is keep being me and not working. So I guess I'm better off just leaving well enough alone" (p 71).

Veterans learn about gaining service connection from fellow patients and benefits counselors, and sometimes present "themselves to psychiatric examiners having read printed symptom checklists describing the diagnostic features of the disorder for which they seek compensation"[41] (p 1119). Examiner concern about false claims of psychiatric illness has risen since the VA recognized posttraumatic stress disorder (PTSD) as a compensable condition[44] following the disorder's listing in the American Psychiatric Association's 1980 diagnostic manual (DSM-III).[45] Although some veterans obtain service connection in a relatively brief time, for many the disability process spans several years. Regional Office Rating Boards make decisions about a veteran's initial claim after reviewing findings from medical disability examinations and records of military service, employment, and medical treatment.[38, 46] Veterans may appeal these initial decisions to the local board and then to the Board of Veterans Appeals (BVA). If these steps fail, they may ask the BVA to reconsider, ask the Court of Veterans Appeals (CVA) to review decisions, or initiate new claims at the Regional Office. Recent enactments allows attorneys to charge veterans "reasonable fees" for assistance in reopening claims or appealing rating decisions.[36, 38] A veteran may resubmit his claim indefinitely, and each time he adduces new supportive evidence he receives the same procedural opportunities granted to initial claimants, including the right to appeal rating decisions.[36]

Among such "new evidence" may be records of recent psychiatric hospitalizations and outpatient treatment,[36] so that a veteran's postmilitary clinical course and receipt of mental health care count as factors that may increase or decrease his disability rating—and cash compensation. Rating examiners review recent medical records and conduct reevaluations of veterans with "nonstatic" psychiatric disabilities at roughly two-year intervals,[38] and the examiners' reports may provide local adjudication boards the grounds for changing a disability rating. Disability that has persisted for 20 years is not subject to further review,[47] but until then veterans live with the knowledge that their income may be altered by the contents of their treatment records.

Incentives to Become Hospitalized Veterans who are partially (i.e., less than 100%) disabled and are hospitalized for more than 20 days for SC problems are deemed totally disabled for that month, and are compensated at the 100 per cent SC rate.[48] Unlike their private practice counterparts, the VA's salaried physicians do not face pressure from third-party payers to discharge patients quickly;[16] patients, who pay nothing themselves for hospital care, have no financial incentive to leave. VA psychiatric hospitalizations thus tend generally to be lengthy,[49, 50] and to be lengthier for partially disabled veterans.[48]

Chronically mentally ill persons seek hospitalization for reasons unrelated to their need for psychiatric treatment, finding public sector hospitals attractive sources of structure, emotional support, protection, nourishment, and shelter.[51] Many patients lack the support of caring family members or get into conflicts with those with whom they live. Those single men who are not homeless often live in lonely, destitute circumstances. Being in the hospital assures them that their basic physical needs are satisfied. Their own ability to establish relationships and occupy their time is supplemented by structured recreational and therapeutic activity and the companionship of other patients, clergymen, and hospital staff.

Psychiatric publications contain numerous discussions of the powerful emotions evoked by VA medical centers. Veterans who served in combat have a special affinity for VA care.[52] For some patients, the VA is a source of emotional as well as physical nurturance; for others, it represents an uncaring parent and thus helps to channel and organize overwhelming feelings of shame and rage.[53] Faced with severe difficulties in meeting the demands of civilian life, some veterans welcome the chance to reassume the security and comfort of their past affiliations with the service.[54] In addition, service organizations recognize their past service to country, and the concern and respectful treatment of medical staff give them a sense of being valued. Coming to the hospital, being among fellow veterans, and exchanging stories gives former warriors a chance to reexperience what for many was the most meaningful part of their lives.[27]

Effects of Financial Incentives The classic notion of "financial incentive" addresses itself to a rational actor who is able to calculate future personal advantage and behave accordingly. Although

some might believe that financial incentives are irrelevant to psychiatric patients ("crazy people"), most people who suffer from psychiatric disorders—including severe thought and mood disorders—act rationally most of the time, competently manage their own affairs, and "make many reasonable decisions unaffected by psychotic thinking" (p 1235).[55] VA patients who need psychiatric care achieve global functioning scores similar to those of nonpsychiatric VA patients.[56] While psychiatric patients generally cannot help being ill, they have a substantial amount of influence over the course and severity of their disorder (just as do most patients with nonpsychiatric medical disorders). Most psychiatric disorders thus affect rationality only modestly,[57] and certainly do not affect it seriously enough for monetary incentives to be irrelevant. The minority of patients whose rationality is often impaired still have extended periods of time (e.g., when treated with medication) when they think rationally and make logical (although sometimes unwise) choices. Moreover, severely disturbed patients often have family members who are not ill and who can be expected to act in ways that take financial implications into account.

Despite the presence of clear financial incentives to be ill, the author's experience suggests that the overwhelming majority of VA psychiatric inpatients need some form of psychiatric treatment and have serious emotional problems. They do not simply misuse hospitals and deceive their caretakers. Rather, financial incentives insidiously alter patients' perceptions of their problems, taint relationships with health care professionals, and contaminate patients' views of themselves.

As Hyer and colleagues point out,[58] patient behavior that occurs with distinctive frequency in the VA medical system—reviewing one's medical chart, petitioning to have records revised, exchanging advice about increasing disability ratings, arguing with clinicians about test results, or refusing evaluations out of fear that a change in diagnosis might reduce compensation[59]—reflects *requirements* of the compensation system, in which "patients who are seeking compensation are required to be legalistic, vigilant, and knowledgeable about their claims" (p 254).[58] In a study that documented associations between positive response to PTSD treatment and lower rates of alcohol consumption, Perconte and Griger[60] observed that veterans who did poorly "tended to verbalize their discomfort and dysfunctions more frequently and more emphatically during therapy. . .to externalize responsibility for their maladaptive behaviors, and. . .to be most comfortable with the role or designation of 'disabled'" (p 562). Noting that "these veterans did not appear to observing clinicians to be any more dysfunctional than those veterans who were successfully treated" (p 562), the authors questioned whether "overreporting" reflected greater distress or compensation-seeking. Hyer and colleagues also suspect that Vietnam veterans "overreport" their symptoms of PTSD because the VA rewards psychopathology with financial compensation. "Not to view this as an important influence is unrealistic" (p

485).[51] Pervasive exaggeration leads VA clinicians to mistake complaining and overreporting for symptoms of PTSD itself.[58]

Pary and colleagues[48] describe ways that partially disabled patients prolong hospitalizations beyond 20 days to obtain 100 percent SC compensation for a month, and conclude that "[t]he system of monetary rewards. . .appears to prolong inpatient stays" (p 845). They tactfully advise VA physicians to prepare themselves for conflicts with irate patients who "may have expectations for hospital stays different from their own" (p 845). With unusual bluntness and candor, psychiatrists who organized a 1990 discussion of "The Problem Patient in VA Psychiatric Services" wrote that patients receive "varying degrees of veterans' pensions which may support pathological life-styles. . .. [I]t is a fair observation that certain problematic aspects in the VA system are experienced to a much higher degree than elsewhere, including extraordinary rates of alcohol and drug abuse and character disorder in patients who are adversarial, highly demanding, and have a strong sense of entitlement."[62]

Professional publications also discuss malingering behaviors and clinicians' responses that are peculiar to the VA system. In one report, 5.6 percent of psychiatric patients admitted over a five-month period feigned PTSD; none had seen combat, and some had not served in Vietnam.[45] Clinicians sometimes prove to patients that they have fabricated war experiences by using military records to show that the patients hadn't served where they claimed they had.[63, 64] A veteran who had undergone several VA psychiatric hospitalizations, and was thus familiar with the complaints of Vietnam veterans being treated for PTSD, used his knowledge of symptoms to obtain controlled substances and shelter from duped staff.[65]

A substantial portion of an oft cited text's chapter on malingered PTSD[66] specifically discusses Vietnam veterans with claimed emotional disorders. Suspicion about financial motives, skeptical attitudes,[67] and cynicism about patients[68, 69] are very common among current and former VA professional staff. Financial incentives also affect treatment relationships in ways that cannot be quantified scientifically and thus are mentioned only in passing in scientific publications. Ambiguity about patients' motives can lead to inappropriate treatment and needless exposure to medication side effects, or to reluctance to provide indicated treatment. It can also have discouraging interpersonal side effects: clinicians know that professional disbelief can cause further harm to trauma victims,[70] but they also recognize that undervaluing the truth in a treatment relationship may waste patients' and clinicians' time and make meaningful therapy impossible.[71] Estroff[43] quotes members of a community treatment organization who wrote to VA authorities to complain about their difficulties working with veterans "not because of the disabilities and disorders they possess, but because of the large veteran's disability pensions that they have and are receiving. . .. Over and over again we have heard these men talk of their unwillingness to participate in em-

ployment efforts because they do receive the money" (p 72).

Patients regularly ask to be hospitalized because they are lonely, cold, hungry, or sought by criminal associates or police—reasons that have little to do with the legitimate uses of inpatient psychiatric facilities. (Patients know better than to declare these motives when they seek admission: they tell doctors that they will commit suicide or harm someone else if not admitted.) As one patient, who was admitted because of difficulty coping with the demands of his wife and children, explained to the author, going to a hotel would serve the same functions for him as did the hospital, but "this is free and I'm entitled to it." At some VA centers, patients who manage to gain entrance to hospitals with little overt psychopathology, yet insisting they need to remain there, are said to be taking "V-A-cations." Pankrantz and Jackson found that "wandering patients"—persons with admissions to four or more different VA hospitals in one year—accounted for 2.8 percent of all psychiatric admissions to VA facilities in 1988–1992.[72] This figure probably represents a small fraction of the psychiatric patients who obtain other forms of inappropriate admissions.

VA hospitals also struggle with patients who have chronic, severe mental illnesses, who respond to treatment when hospitalized, who stop taking their medications shortly after discharge, and who soon need rehospitalization.[20] Increasing numbers of patients repeatedly produce or exacerbate their psychiatric symptoms with drugs or alcohol;[20, 73] sometimes their habits are funded by their disability funds. For VA patients and their families, the "revolving door" syndrome[74] often has emotional and financial rewards: troublesome relatives are hospitalized, and families get the veterans' SC disability income without having to provide for or help clinicians deal with their relatives' problems in living.

Even more tragic is the effect of financial incentives on veterans' self-perceptions. Veteran disability claimants sometimes reason that because violence, interpersonal problems, or substance abuse may result from PTSD, those difficulties are evidence of having the disorder even when the cardinal symptoms of PTSD are not obvious.[41] Years of unemployment often convince them they cannot work. Disability compensation systems induce claimants to interpret any difficulty as a "health" problem, and provide income sources that induce claimants to interpret their ability and motivation for work as reflective of a medical condition. In other words, explains Estroff,[43] "Not working is seen as both symptom and proof of *their* disabilities and deficits" (p 70). Some clinicians share this perception, and often recommend that patients solve problems in ways that reinforce it. Psychiatric examiners may be moved to increase disability status out of pity for veterans combined with pressure from claimants or others who believe that a SC disorder is causing the veterans' problems.[41]

For some veterans, becoming "100 percent SC" vindicates their past sacrifices to country and fully justifies poor social and work function. However, periodic review of their disability causes some patients so

much anxiety that they need and seek hospitalization (which may help demonstrate to review boards and themselves that they remain disabled). In civil litigation for psychological injuries, claimants have their day in court, receive a lump sum reward if legal action is successful, and then go on with their lives. Medicolegal studies show that litigation about physical or emotional injuries is itself stressful;[75] if functioning can improve after litigation has ended, it is most likely to do so if the duration of litigation is relatively short.[76] The VA's claim system represents a worst-possible scenario, inasmuch as a veteran can reapply for compensation endlessly, and his compensation may be decreased in the absence of continued evidence of disability.

Countertherapeutic Incentives

Most economists and policy analysts would agree that the VA's system of health care and compensation gives psychiatric patients exactly the wrong kinds of financial incentives, and conservative pundits and politicians who decry "welfare queens" may also take offense at a system that reward poor people for not functioning productively and for being ill. Yet it is not easy to establish why the VA's compensation system is "countertherapeutic." The Greek word *therapeutikos* is derived from a verb meaning "to minister to" or "to serve."[77] Many intelligent and well-meaning clinicians inside and outside the VA would argue that they are ministering to their patients when they help or encourage them to obtain disability compensation. Disability compensation is a benefit promised to veterans injured in the line of duty, a benefit to which they are entitled by law. A steady income greatly reduces the life stress of persons who are mentally disabled and who have dismal financial and occupational prospects. Poverty and loneliness are well-documented causes of emotional distress. If giving unfortunate veterans money or letting them spend some time in a supportive emotional environment makes them feel better, how could it be countertherapeutic?

There is, of course, a close association between the term "therapeutic" and the practice of medicine. Many persons are attracted to medicine with the hope that they can lessen others' misery, yet doctors' training provides many opportunities to witness ways that well-intentioned diagnostic procedures or medical treatments themselves cause or prolong suffering. In such cases, doctors typically justify the short-term discomfort they cause on utilitarian grounds; for example, doctors might argue that the discomfort suffered by patient undergoing surgery to remove cancer is less than the benefit—the chance to be free of disease.[78] Treatment, if painful, should serve the therapeutic purpose of allowing patients to reach longer term goals and enhancing possibilities for enjoyment of the future. Conversely, it may be countertherapeutic to intervene in a way that alleviates immediate discomfort if doing so forecloses much more important future opportunities.

A utilitarian calculus, however, does not tell us why veterans' incentives to achieve disability status are countertherapeutic. For many mentally ill veterans,

one can argue convincingly that their future opportunities are meager, and that they might well find a guaranteed income and a comfortable "retirement" from the demands of work fulfilling (just as many senior citizens do).

A better approach to the problem recognizes that self-determination is the starting point for medical decision-making.[79, 80] When physicians intentionally impose suffering in the belief that "it's worth it," they may feel that they have provided a full justification for causing the suffering. However, a cost-benefit assessment provides only a scientific grounding for recommending a course of care. Current ethical and legal norms for the undertaking of medical care make the physician's and patient's consent the *sine qua non* of medical treatment.[79, 80] Such norms place medical care within the broad framework of human interactions that affirm and protect individuals' dignity and autonomy and subordinate applications of medical therapeutic knowledge to a broad ethical theory that governs all aspects of interpersonal obligation.

Therapeutic jurisprudence scholars have offered a number of justifications for the ethical and legal principle that, when improving well-being conflicts with preserving autonomy, autonomy should win. Schopp,[81] for example, explains that informed consent requirements in a "patient-centered model of health care" help insure that medical care will constitute an exercise of individual "sovereignty through an autonomous act" (p 36). The ability to perform autonomous acts reflects a set of qualities that we associate with persons who are self-governing, a concept that includes thinking about our motives and goals, self-reliance, self-control, independence, and accountability for our acts. In turn, certain types of acts can promote or undermine the development of these traits and can increase or decrease the likelihood that individuals will qualify as "sovereign," that is, will be eligible to exercise their autonomous rights. Thoughtful clinicians should ultimately concern themselves with their patients' capacities to act autonomously, because these capacities are what enable persons to achieve their wishes. Moreover, in a society that regards independence and liberty as fundamental personal rights, the development of autonomous virtues is central to a patient's ability to respect himself and to command the respect of others. From this standpoint, incentives to be sick and unable to support oneself are damaging to patients and represent the antithesis of any health-care enterprise that takes a comprehensive view of patients' well-being.

The notion that being responsible for oneself supersedes other ends (such as lessening discomfort) finds other expressions in the therapeutic jurisprudence literature. Shuman[82] has argued that the liability of tortfeasors should reflect their efforts to diminish the likelihood of causing others injury, in particular by recognizing that seeking mental health treatment to diminish their accident proneness after major life stressors constitutes an aspect of exercising due care. Such recognition would (at least in theory) encourage persons who suffer from impaired concentration or responsiveness to take steps to reduce their chances of ac-

cidently harming others. Wexler and Winick[3] have argued that allowing sex offenders to plea bargain or plead "no contest" to charges may promote cognitive distortion and refusal to acknowledge the nature of their acts, thereby lessening the offenders' likelihood of reforming.

Research on the impact of legal decisions suggests that nonmaterial factors predict respect for legal processes and obedience to the law's dictates. Citizens' feelings about legal decisions reflect not the outcome of a particular case so much as their perception that they were treated fairly and that legal procedures in general are fair. People are affected by how decisions are made more than by the results of those decisions, and individuals' respect for the law is diminished to the extent that they perceive legal authorities as less than legitimate.[83] The importance of these findings for the VA disability system is that the rage and resentment that veterans express toward the VA may stem from perceiving that system as providing rewards for successful dissembling and manipulation, and not, as many have believed, from the VA's refusal to award benefits or provide services.

The Moral Ends of Mental Health Care

Definitions of mental health and the goals of psychiatric treatment are somewhat elusive. But if we identify the aims of the variety of treatments psychiatry now offers with the goal of fostering autonomy and personal responsibility, we can make sense of Freud's terse statement[84] of what "a normal person should be able to do. . . '*Lieben und arbeiten*' (to love and to work)" (pp 264–5). Mental health professionals have long recognized that patients with severe mental disorders need psychosocial rehabilitation that focuses less on a patient's individual psychopathology than on his progress in becoming a well functioning member of the community.[85, 86] Work was a centerpiece of 19th-century moral treatment for mental disorders,[87] and Freud noted in *Civilization and Its Discontents*[88] that work has greater effect than any other technique in attaching an individual closely to reality, "for his work at least gives him a secure place in a portion of reality, in the human community" (p 27). Optimism about ability to work remains a core component of late 20th-century psychosocial rehabilitation.[85] Research over the last decade justifies this optimism, with findings that proper psychosocial care allows half of patients with schizophrenia to achieve substantial long-term recovery, including return to gainful employment.[87, 89]

Remunerated work gives individuals the means to obtain goods and services, a daily structure that improves personal organization, opportunities for social contact, defined social roles, and the expectation that they participate in society as competent adults.[85] In an article arguing that psychiatric inpatients have a constitutional right to remunerated work, Perlin[86] summarizes the extensive mental health literature attesting to the moral therapeutic value of work and cites several studies[90, 91] that document the benefits of gainful employment for severely disturbed persons. The Fountain House[92] believes work "must underlie, pervade,

and inform" all aspects of psychosocial rehabilitation; "[w]ork, especially the opportunity to aspire to and achieve gainful employment, is a deeply generative and reintegrative force in the life of every human being" (p 67).

Unemployment doubles the likelihood of death in middle-age men, with deaths from accidents, suicide, and violence accounting for much of the increased risk.[93] Unemployed men experience deterioration in physical health and even more serious psychiatric consequences: "anxiety, depression, neurotic disorders, poor self-esteem and disturbed sleep patterns. . . . The psychological damage stems mainly from loss of status, purpose, social contacts, income, and a sense of belonging and mattering. Unemployment also brings stigma, humiliation and a reduced scope for making decisions" (p 972).[93] A so-called "treatment system" that makes work financially unattractive thus acts counter to psychiatry's therapeutic goals. So does a treatment system that gratifies short-term physical and emotional desires without encouraging patients to develop the psychological resources to satisfy those desires independently.

Implications and Proposed Solutions

The countertherapeutic incentives of the VA's system of disability compensation are not unique. Critics of government entitlement programs have argued effectively that many well intended policies inadvertently reward dependency, cause serious social disruption, and ultimately harm the programs' supposed beneficiaries.[94–96] Satel[97] and the U.S. General Accounting Office[98] have described how Social Security Disability Income determinations and payments reward addicts for using of illicit drugs, and Wilkinson[12] has described how workers' compensation litigation encourages self-perceptions of illness and disability.

Unfortunately, mental health administrators and front-line clinicians tend to interpret and to respond to all patients' problems "clinically." Thus, although the impact of the VA's compensation-related incentives is well known to VA clinicians and has been documented extensively in mental health professionals' academic publications, that literature tends to conceptualize the resulting difficulties as mental health issues. In addition, clinicians do not want to appear critical of their patients' motives, and feel awkward about confronting financial issues forthrightly.[99] Professional publications suggest that financially motivated exaggeration is itself a "symptom" exhibited by veterans,[61] refer to methods of detecting malingering as efforts to "diagnose" a "disorder,"[45] and conceptualize "confronting" patients about their true military histories as part of their "management"[71] or "treatment."[63]

As Estroff[43] points out, however, misuse of the clinical perspective can dangerously distort our understanding of processes that are "social, structural, economic, political and outside the control of admittedly impaired persons" (p 73). A therapeutic jurisprudence perspective might help administrators and policy makers bridge the conceptual gap between the design of disability legislation

and its effects on potential beneficiaries and those who treat them. By recognizing that laws and regulations can promote or impede competent social functioning, clinicians may be less tempted to regard subsistence strategies as psychiatric symptoms. If patients find financial incentives seductive and behave accordingly, it is disrespectful to patients to pathologize such behavior. Clinicians and administrators also must concede that moral dilemmas created by economic and social forces may not "respond" to "clinical interventions," and that health care systems with countertherapeutic incentives can make treatment impossible.

Therapeutic jurisprudence can reinforce biopsychosocial conceptualizations of health and illness by broadening administrators' awareness of the sources of patients' problematic behavior and by helping clinicians accurately delineate the problems for which their interventions have potential effectiveness. Efforts toward helping patients solve problems must begin with an honest recognition of what those problems really are, a recognition that some problems that at first appear to be "clinical" are not, and a realization that those problems may more properly be addressed by administrative, regulatory, or legislative action.

Winick[7] has proposed that construction of health care delivery systems be guided by the therapeutic principles outlined in the previous section. "In designing the health delivery system,. . .[w]e should- . . .build in appropriate incentives for the proper utilization of preventative approaches, for patients to assume responsibility for their own health, and for efficient and effective use of services generally" (p 53). He points out that constructing systems so that patients have choice and control can increase the effectiveness of treatment, encourage efficient use of services, promote a sense of autonomy, and improve consumer satisfaction.

The VA's health care and psychiatric disability system frequently violates Winick's suggestions. This is especially sad because the VA has a good record of delivering satisfactory medical services inexpensively.[14] Some conceptually simple changes in regulations and procedures would give VA patients incentives to use treatment resources more effectively and efficiently, remove incentives for patients to be ill, and create a treatment environment that promotes autonomy rather than entitlement. Such changes might include the following:

1. Give veterans the same sort of finality in their disability determination process as civil litigants have. Both veterans and VA rating agencies deserve clear incentives to make accurate disability ratings and to end the claims process at some point. Once a veteran is determined to deserve compensation and accepts a disability payment for psychological injury, his compensation level should be fixed permanently. As in civil litigation, the amount of compensation would need to reflect the possibility that a veteran's condition might worsen or improve over the course of his life. Disability payments could be lump sum distributions, or the current practice of monthly payments could be maintained. In either case, the knowledge that disability judgments, once accepted, would be final would give

veterans, caregivers, and VA agencies a strong interest in documenting disability accurately (perhaps using psychophysiological measures[100]), making realistic assessments of prognosis, and making the disability determination process fair. Under this system, psychiatrically disabled veterans would run the risk that their emotional problems might worsen and that they therefore might accept a level of compensation below what they would receive under the current adjustable-payment system. But in exchange for accepting this risk, veterans would receive the benefit of knowing that working and recovering would not reduce their income and that they won't have to spend the rest of their lives convincing skeptical caregivers that they really are ill.

2. Make the amount of disability compensation bear a realistic relationship to individual veterans' actual loss of earning potential, just as it would in the course of civil litigation. Disabled veterans should not have their problems compounded by countertherapeutic incentives not to work, and it is unfair to offer them potential disability payments that are far higher than what they might expect to earn had they no disability, but the same educational backgrounds and personal histories. A compensation scheme that incorporated actual earning potential might give higher payments to college graduates with sophisticated job skills than to unskilled persons without high school diplomas, and this might cause resentment or jealousy. However, such a scheme would realistically reflect the exigencies of the contemporary workplace and the actual losses that veterans' disabilities have caused them, and would convey the implicit message that compensation implies genuine loss and is not a reward for past service to country.

3. Eliminate the financial reward for being hospitalized over 20 days, and have veterans take some financial responsibility for their own medical care. Asking patients to do this would provide them and their families with incentives to use treatment resources efficiently and would provide incentives for them to use other resources (e.g., increased family support or hotels) when these could meet patients' needs. Even if this produced no cost savings, it would yield important moral and psychotherapeutic benefits: having patients help pay for care attests to our respect for their autonomy and our faith that they can take some responsibility for themselves and their treatment, even if they are disabled. Patients' copayments would also be concrete reminders that while medical treatment is a SC veteran's entitlement, it also is a service produced by and purchased from health care professionals. The dollar copayment amount could be related to a patient's SC plus other income (information already used by the VA to establish eligibility), so that incentives to make wise use of services would not fall disproportionately on poorer patients. Copayments for inpatient care, outpatient treatment, and medication could be set at levels that reflect the relative costs and intensities of these various types of treatments. Payments for treatment could be deducted from veterans' future disability checks or bank accounts, so that veterans would be certain that

their financial responsibilities would be realized.

Veterans deserve these changes in disability compensation rules, and they deserve respectfully delivered psychiatric care that unambiguously encourages them to improve their social functioning and that honors their humanity.

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