

Disability and Psychotherapy: A Response to Bursztajn *et al.*

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In their recent Analysis and Commentary article Bursztajn and colleagues argue persuasively that to provide comprehensive independent medical evaluations (IMEs), forensic psychiatrists must take into account the managed care context of a claimant's case. The author of this article agrees with that assessment, but adds that another significant problem in his practice occurs when disability claimants who have severe disabling personality disorders resist psychotherapy and when, as is often the case, there are no experienced psychotherapists available to provide the needed treatment.

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Bursztajn and his colleagues¹ recently argued that forensic psychiatrists performing independent medical evaluations (IME's) for insurance companies must take the managed care setting of the treatment into account. They present case examples to illustrate their points. The common denominator in the examples is an inadequate psychiatric evaluation before the IME, caused frequently by economic disincentives to refer the patient to a specialist, as well as by the patient's resistance to psychiatric referral, which is too often taken at face value. The authors suggest that patients' fears of stigmatization by psychiatric referral may be reinforced by treaters' ready acceptance of patients' rejection of referral. The authors argue that there should be public policy solutions that shift the paradigm from limiting care toward limiting disability.

Bursztajn and Barsky² list five factors that cause claimants to reject psychiatric referral: (1) the social stigma of a psychiatric diagnosis; (2) damage to the patient's self-esteem from such a diagnosis; (3) the patient's misunderstanding of the role of emotions in physical discomfort; (4) the patient's feeling of rejection by the referring physician; and (5) the effects of the psychiatric illness itself. Other barriers suggested by Bursztajn and Barsky include the physician's re-

luctance to refer and the barriers created by the mental health system.

I would like to address another problem involving psychiatric IME's. My practice involves almost exclusively patients with own-occupation policies (in which insured persons are considered disabled if they cannot perform the exact same duties as before they became disabled and make almost as much money—typically 80%). The premiums for such policies are high; but so are the disability payments. In my experience, such claimants have usually seen psychiatrists and are usually on appropriate medication. Since the claimants are usually considered disabled at the time of the IME, medications alone have not been effective. Own-occupation claimants typically have been high functioning before becoming disabled and are less likely to accept a psychological (as opposed to a biological) psychiatric diagnosis than are claimants holding regular disability insurance. As a result of their resistance to accepting a psychological diagnosis (typically on Axis II), such claimants are frequently resistant to accepting psychotherapy.

Case Example

Mr. A. was a 48-year-old sales representative who received a diagnosis of bipolar disorder after he sought psychiatric help for what he thought was attention deficit disorder. He was upset at the bipolar diagnosis, because he felt that it meant that he was not in control or responsible for his actions. He had been treated with a variety of antidepressant and mood-stabilizing medications, with only partial con-

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trol, in part due to inconsistent compliance because of reported side effects to every medication and denial of illness. He refused even to try different medications. It was the opinion of both the examiner and treating psychiatrist that further improvement would require intensive, confrontational psychotherapy to address Mr. A.'s characterological disorder (including avoidant, obsessive, and borderline features). His parents had made it clear that having a mental disorder was unacceptable. His father had stopped working at age 50 without any apparent disability, and Mr. A. had a history of low self-confidence and anger that predated the emergence of any affective symptoms.

The examiner was asked to re-evaluate Mr. A. one year later. The patient continued to report significant symptoms of bipolar disorder, but blamed all his problems on his medications. He had been seeing his treating psychiatrist only once every two to three months for 15-minute medication checks. He had seen a counselor twice, but stopped going; he also attended one meeting of a bipolar disorder support group, but did not return. When the examiner again discussed the benefits of psychotherapy, Mr. A. became angry and accused the examiner of blaming him for his problems. The examiner again opined that Mr. A. was disabled and that without intensive, confrontational psychotherapy by an experienced therapist, Mr. A.'s disability would persist. A request by the author to determine whether Mr. A. had continued to refuse psychotherapy and whether he continued to receive disability payments was declined by the insurance company, based on assertions of confidentiality.

Sederer and Clemens³ report that untreated mental illness costs U.S. corporations billions of dollars each year. The cost of psychiatric disability claims is estimated at \$150 billion a year. Half of all long-term disability claims involve a contributing mental disorder. Sederer and Clemens' article focuses on persuading business executives to upgrade their employees' mental health coverage.

However, providers of disability insurance are different from those who provide health insurance. They must make their own decisions about awarding disability payments. What should be the responsibility of such a company when an insured individual refuses to cooperate with treatment recommended by treaters and independent evaluators?

There is some support in the clinical and legal literature for declining to provide financial support for patients who refuse to cooperate with recommended treatment. Appelbaum⁴ argues that as society scrutinizes the dollars spent on health care more closely, we can anticipate an increased reluctance to pay for repeated, costly hospitalizations that are precipitated by a failure to abide by recommendations for outpatient care. He reports that Congress has considered a proposal that would require states to implement systems of outpatient commitment to qualify for federal funding of programs for homeless persons. Most outpatient civil commitment statutes already require that voluntary outpatient treatment has failed, and as a result the patient has needed repeated hospitalizations.⁵

The federal Social Security Act⁶ has a requirement that before *grand mal* epilepsy can be considered a disabling condition, the seizures must be documented by electroencephalogram and detailed description at least once a month, despite eight months of prescribed treatment. The regulation states that these criteria "can be applied only if the impairment persists despite the fact that the individual is following prescribed anticonvulsive treatment." This provision was applied in the case of Timothy Brown, who claimed disability due to mental retardation and epilepsy. His application for Supplementary Security Income (SSI) was denied because of a finding that he was not disabled within the meaning of the Social Security Act. He appealed to the federal court for the Western District of Pennsylvania, which held that although his retardation did not render him disabled, the opinion that his seizure disorder did not meet the applicable listing was not supported by substantial evidence; it found for Brown. On appeal, the Third Circuit⁷ held that there was abundant evidence that Brown's serum anticonvulsant levels were therapeutically inadequate, due to his failure to comply with the therapeutic regimen, and he therefore failed to meet criteria for disability, as defined by the law. It reversed the lower court, thus affirming the denial of benefits.

In *Blum v. Yaretsky*,⁸ a nursing home's utilization review committee determined that patient Yaretsky and other residents no longer required skilled nursing care, and notified local Medicaid officials of a proposed transfer to a facility providing less intensive care. Yaretsky resisted the transfer, and the facility staff notified him that his benefits at the skilled nurs-

ing facility level would be discontinued unless he accepted the transfer. The challenge was to the transfer decision without sufficient due process. The patients did not challenge the threat to adjust benefits, and the Supreme Court therefore did not address it. This decision illustrates the use of threats of withdrawal of support for patients who decline to follow clinical recommendations.

The trend in this country since the 1970s has been to emphasize the rights of mental patients, both protections against unwarranted deprivations of liberty and rights to treatment. Parity is clearly the biggest social and political issue for mental health professionals and advocates alike. Much less attention has been paid to the patient's responsibilities.⁹ It is the author's contention that if patients refuse to cooperate with treatment that is essential to overcome a disability, the insurer should no longer have an obligation to provide disability payments. And, even if they go to psychotherapy sessions, they should have an obligation to participate effectively (as judged by the therapist) to continue to receive disability payments.

Unfortunately, even if a high-functioning insured individual with a significant personality dis-

order contributing to a disability is willing to participate actively in psychotherapy, the current managed care system does not permit the type of intensive, confrontational psychotherapy by experienced therapists that is required for such patients. It seems that disability providers themselves should be willing to support such treatment, perhaps by tying some of their disability payments to payment for psychotherapy.

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