In contrast to the defendant’s right for discovery to support a fair defense, the court acknowledged, quoting a variety of sources, that sexual assault victims have the rights to be treated with compassion, to be free from harassment, to be minimally inconvenienced, to receive information about the case, and to participate in proceedings. The New Jersey Supreme Court noted that in managing a request for additional discovery, the rights of defendants and victims should be balanced.

The New Jersey Supreme Court used these principles to establish the framework for maintaining the rights of the defendants and the victims. Under the framework, there were two options for obtaining records: a formal motion and an informal path. Under the formal pathway, the victim would have to be notified, and the motion would satisfy a two-part standard. The first stage would require the defendant to show “(1) that there is a substantial, particularized need for such access; (2) that the information sought is relevant and material; and (3) that the information is not available through less intrusive means” (Chambers, p 29). If the three prongs are met by a preponderance of the evidence, the defendant is entitled to have a judge conduct an in camera inspection. The defense counsel should not be present, and the judge must determine whether to “pierce” mental health privilege, redact the preincident records, and make them available.

Alternatively, a defendant can informally seek access to the records. Through this path, the victim would still be notified. Defense counsel would send a letter to an assistant prosecutor, stating what kinds of records were sought, the substantial need, and that the victim had the right to not participate in the investigation. The letter must inform the victim that disclosure is voluntary.

Regarding the request made in this case, the New Jersey Supreme Court vacated the trial court’s orders and remanded for further proceedings to be guided by the framework established in this opinion. The New Jersey Supreme Court stated that as the record stood, there was not enough to support the substantial need for the mental health documentation. On remand, defense counsel was permitted to supplement the record to demonstrate the substantial need. The New Jersey Supreme Court could not determine if there were a less intrusive means to access the information, and recommended that the defense speak with additional family members and friends, or investigate the victim’s social media, for more information regarding the victim’s alleged mental illness.

Discussion

The framework established in State v. Chambers highlights the importance of balancing the rights of the victim with the rights of the defendant in allegations of sexual assault. The court in State v. Chambers creates a procedural and analytical framework that supports a “heightened discovery standard” in order for medical and psychiatric records to be obtained by the defense. Medical records, and especially mental health records, have long been considered private information. This notion was codified with the Health Insurance Portability and Accountability Act of 1996. In the interest of pursuing justice, however, in certain circumstances, it is reasonable and acceptable to “pierce” mental health patient-provider confidentiality to assure a fair and meaningful defense.

Disability Determinations and Chronic Mental Illness

Gregory Singleton, MD
Fellow in Forensic Psychiatry

Ahmad Adi, MD, MPH
Assistant Professor, Department of Psychiatry
Associate Program Director, Forensic Psychiatry Fellowship

Richard Martinez, MD, MH
Robert D. Miller Professor of Forensic Psychiatry
Director, Forensic Psychiatry Services and Training

Department of Psychiatry
Division of Forensic Psychiatry
University of Colorado Anschutz Medical Campus
Aurora, Colorado

Subjective Statements of Symptoms and Treating Psychiatrists’ Opinions Are Important in Disability Determinations in Chronic Mental Illness

DOI:10.29158/JAAPL.230096L3-23

Key words: mental illness; disability; subjective symptoms; major depressive disorder; Social Security

In Shelley C. v. Comm’r Soc. Sec. Admin., 61 F.4th 341 (4th Cir. 2023), Shelley Cannon appealed the order of the U.S. District Court for the District of South Carolina affirming the Social Security Administration’s denial of her Social Security Disability Insurance (SSDI) following a formal hearing by an Administrative Law

Volume 51, Number 4, 2023

597
Judge (ALJ). The Fourth Circuit Court of Appeals held that the ALJ erred by “extending little weight” to the opinion of Ms. Cannon’s treating psychiatrist, “improperly disregarding” Ms. Cannon’s subjective statements, and not considering the “unique nature” of chronic depression. The Fourth Circuit reversed and remanded the district court and ALJ’s decisions with instructions to grant Ms. Cannon disability benefits.

Facts of the Case

On August 23, 2016, Ms. Cannon applied for SSDI benefits, claiming disabilities due to her diagnoses of major depressive disorder (MDD), anxiety disorder, and attention-deficit/hyperactivity disorder (ADHD). Ms. Cannon’s depression started when she was 18 years old. In 1999, she started seeing her psychiatrist, Dr. Beale. Over the course of her treatment, Dr. Beale prescribed multiple medication combinations to address Ms. Cannon’s “severe mental health impairments,” which, when they helped, provided only brief respite. Ms. Cannon also participated in psychotherapy with Hillary Bernstein. Both Dr. Beale’s and Ms. Bernstein’s notes describe chronic, recurring episodes of severe depression with occasional, temporary periods of a few weeks during which her mood was improved. On July 30, 2016, Ms. Cannon attempted suicide by intentionally overdosing on medications. Following the overdose, Dr. Beale increased the frequency of his appointments with Ms. Cannon, and he recommended either electroconvulsive therapy or transcranial magnetic stimulation (TMS). Ms. Cannon opted for the latter and underwent 36 TMS treatments in May 2017. Her symptoms improved significantly, but after a few weeks her severe depression returned. Shortly after the suicide attempt, Ms. Cannon left her job as a preschool’s Director of Religious Activities and applied for SSDI benefits.

Ms. Cannon provided multiple subjective statements to the SSA describing her symptoms, including difficulty getting out of bed, low energy, substantial difficulty with daily tasks, frequent crying spells, trouble interacting with family and friends, and loss of enjoyment in former hobbies and interests. Two psychiatrists consulted by the government reviewed Ms. Cannon’s records but did not examine her; both opined that she was not disabled and that she can perform simple work tasks. During her official hearing with the ALJ on August 7, 2018, Ms. Cannon reiterated her subjective experience of symptoms, and the ALJ requested a consultative examination. The consultation was completed by Dr. Custer, who diagnosed Ms. Cannon with depression. He noted that she had some difficulties with complex instructions, interacting with supervisors, and adapting to changes in a work setting. Dr. Beale, Ms. Cannon’s treating psychiatrist, submitted a medical opinion letter supporting her disability claim in which he summarized her treatment history, symptom severity, and his conclusion that her conditions would worsen with the stress of any employment.

On February 12, 2019, the ALJ denied Ms. Cannon’s application for SSDI benefits on the grounds that her “severe mental impairments” did not meet the disability criteria for mental disorders, and that she retained sufficient ability to perform some tasks adequately enough for some form of employment. The decision was affirmed by the district court on appeal. Ms. Cannon subsequently appealed to the Fourth Circuit.

Ruling and Reasoning

The Fourth Circuit Court of Appeals considered whether the ALJ had erred by giving little weight to the opinion of Dr. Beale and disregarding Ms. Cannon’s subjective complaints because of “their alleged inconsistency” with objective evidence in her medical records. The Fourth Circuit found that the ALJ had erred on both counts. Additionally, the court of appeals determined that the ALJ erred by not properly considering the unique nature of Ms. Cannon’s major depression diagnosis. The ALJ’s decision was reversed and remanded with instructions to grant SSDI benefits to Ms. Cannon.

In its reasoning, the court of appeals relied upon previous case law regarding review of ALJ findings. The court first considered Hancock v. Astrue, 667 F.3d 470 (4th Cir. 2012), which recognized its authority to review the SSA Commissioner’s denial of benefits under 42 U.S.C.A. § 405(g) (2020). The court then relied upon Johnson v. Barnhart, 434 F.3d 650 (4th Cir. 2005), which held that the reviewing court must defer to the decision of the ALJ if it was supported by “substantial evidence” and reached after applying the “correct legal standard.” Additionally, the court will not “reevaluate conflicting evidence, make credibility determinations, or substitute our judgment for that of the [ALJ]” in reviewing for substantial error (Johnson, p 653). Finally, the court considered whether the ALJ in Ms. Cannon’s case looked at all the appropriate evidence and adequately
explained the decision to credit or discredit certain evidence based on *Milburn Colliery Co. v. Hicks*, 138 F.3d 524 (4th Cir. 1998).

The court reasoned that the ALJ must follow the “treating physician rule” which requires that greater or “controlling” weight be assigned to the opinion of the treating physician unless there is “persuasive contradictory evidence” in the record (*Shelley C.*, pp 353-4). If the ALJ assigns lower weight to the treating physician’s opinion, under 20 C.F.R. § 404.1527(c)(1)-(6) (2017), the ALJ must address six factors when providing the rationale for the decision: the length of the physician’s treatment relationship with the claimant; the frequency of examinations; the nature and extent of the treatment relationship; whether the medical evidence in the record supports the physician’s opinion; the consistency of the physician’s opinion with the entirety of the record; and the treating physician’s specialization. The Fourth Circuit found that the ALJ failed to both adequately explain the rationale for discounting Dr. Beale’s opinion and to address all six factors after doing so, and that the “decision to allot ‘little weight’ to Dr. Beale’s opinion was erroneous” (*Shelley C.*, p 355). Additionally, the court held that the ALJ inappropriately afforded more weight to Ms. Cannon’s nonexamining physicians’ opinion than to her treating physician’s.

The Fourth Circuit also evaluated Ms. Cannon’s assertion that the ALJ did not give adequate attention to her subjective complaints when it found a lack of objective evidence in her treatment record. The court agreed with Ms. Cannon. In doing so, it relied upon *Arakas v. Comm’r Soc. Sec. Admin.*, 983 F.3d 83 (4th Cir. 2020), in which it held that an ALJ could not use the absence of objective medical evidence to discount subjective reports of symptoms of “fibromyalgia or some other disease that does not produce such evidence” (*Arakas*, p 97). In Ms. Cannon’s case, the Fourth Circuit held “that depression — particularly chronic depression — is one of those other diseases . . . [S]ymptoms of MDD, like those of fibromyalgia, are ‘entirely subjective’” (*Shelley C.*, p 361). The court concluded that the ALJ erred by improperly increasing Ms. Cannon’s burden of proof when it failed to treat her subjective statements as substantiation of her impairments.

Discussion

The decision in *Shelley C.* has implications for forensic psychiatrists and treating psychiatrists. For treating psychiatrists, the decision underscores the importance of obtaining a thorough symptom history, including subjective statements, over the course of the treatment relationship. Comprehensive documentation that details a patient’s self-reported symptoms in addition to objective measures, treatment history, and response to various interventions, may be invaluable in the patient’s ability to advocate for SSDI benefits.

Forensic psychiatrists are frequently asked to review records and opine on a disability claimant’s impairments. The *Shelley C.* decision highlights the importance of thoroughly reviewing the treating psychiatrist’s records and carefully considering them when formulating an opinion. If possible, the forensic psychiatrist should communicate directly with the treating psychiatrist to clarify any apparent inconsistencies in the record. Finally, assuming one has the opportunity, the forensic psychiatrist will obtain a more comprehensive understanding of the patient’s impairments and functional status by completing a psychiatric evaluation in addition to reviewing available records.

**Expert Witness Testimony on the Ultimate Issue**

Eric Lesch, MD
*Fellow in Forensic Psychiatry*

Christopher Marett, MD, MPH
*Associate Professor of Psychiatry*

Director of Forensic Psychiatry

Program Director, Forensic Psychiatry Fellowship

Department of Psychiatry and Behavioral Neuroscience
University of Cincinnati College of Medicine
Cincinnati, Ohio

**Expert Witness Testimony to Defendant’s Knowledge of Wrongfulness at the Time of the Offense Inadmissible in Federal Insanity Trial**

DOI:10.29158/JAAPL.230097-23

**Key words:** federal insanity; ultimate issue; wrongfulness; expert witness; testimony

In *United States v. Turner*, 61 F.4th 866 (11th Cir. 2023), the Eleventh Circuit Court of Appeals held that the lower court abused its discretion in allowing a psychologist to testify to the defendant’s ability to appreciate the nature and quality or