Social Security Claims of Psychiatric Disability: Elements of Case Adjudication and the Role of Primary Care Physicians

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When first introduced into law, social security was designed to safeguard economic security for U.S. citizens who were retired or disabled. Primary care physicians are often contacted by the Social Security Administration (SSA) to provide clinical information about the impairments affecting their patients who have applied for disability. The disability determination process is often elusive to physicians. This article is written to describe the process involved in adjudicating disability claims according to SSA standards. Because psychiatric disturbances constitute the largest reason for applications for disability, this article addresses the sorts of information required of clinicians that would expedite disability adjudication of claims involving psychiatric disorders. Practical suggestions are offered for clinicians to employ when preparing medical reports. The potential impact of the disability claim on the doctor-patient relationship is also discussed.

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Franklin D. Roosevelt signed the original Social Security Act in 1935, creating a system of economic security for U.S. citizens. Congress signed amendments to the original proposal, rendering several changes and broadening the duties of the Social Security Administration (SSA). Disabled Americans did not become eligible to receive social security disability benefits until 1956. Currently, the system provides continued income to retired workers, disabled individuals unable to work, and families of workers who have died.

The 2 disability programs available through the Social Security Act include the Social Security Disability Insurance (SSDI) program (Title II, originated in 1956) and the Supplemental Security Income (SSI) program (Title XVI, originated in 1972). The programs share some common features. In general, similar rules are applied in both programs to determine if an individual meets the disability requirement to qualify for them. Certain differences, however, exist between these programs. SSDI benefits are directly supported by funds obtained from one's prior work, whereas SSI benefits are supported by general revenue funds of the U.S. Treasury. SSI programs are available to individuals who have no prior, or only limited, work histories in which to have accumulated SSDI benefits. In addition, medical coverage is provided for individuals under Titles II and XVI. People receiving SSDI benefits for 24 months become eligible for Medicare. Those receiving SSI are immediately eligible for health insurance through Medicaid.

SSI (Title XVI) is a program that provides monthly payments to disabled individuals who have limited income and few additional assets. It is possible for individuals receiving SSDI (Title II) benefits to simultaneously receive SSI benefits, if the amount of SSDI monthly benefits is small. SSI benefits are also provided to persons over 65, the blind, and children who meet the income restrictions.

According to the SSA, impairments can be physical and/or mental in nature. In fact, psychiatric disturbances have become the largest single reason for disability awards.[1,2] Primary care physicians often provide for patients with psychiatric disturbances, either solely or in conjunction with psychiatrists and other mental health providers. Consequently, primary care physicians are frequently contacted to provide clinical information to the SSA so that determinations of disability eligibility can be made. It is imperative that physicians understand the disability determinations process and their roles and responsibilities in providing the medical evidence/clinical information that is required to make disability determinations.[3]

EVALUATION OF DISABILITY CLAIMS

Because of the diversity of impairments that can qualify one for a disability, the SSA has established a legal paradigm with which to make determinations of disability fairly and equitably. This paradigm is depicted in Table 1 and described below.

Each state employs disability review specialists, i.e., psychiatrists or licensed psychologists, who review claims of psychiatric disability. Disability determinations are based solely on a chart review; the patient is never interviewed

Table 1. Sequential Evaluation Process Employed by Disability Adjudicators[a]

Step 1.	Is the claimant engaging in substantial gainful activity?
Yes:	Claim denied
No:	Proceed to Step 2.
Step 2.	Is the claimant's impairment severe?
Yes:	Proceed to Step 3.
No:	Claim denied
Step 3.	Does the claimant's impairment (or impairments) meet or equal any listing of impairments?
Yes:	Claim allowed
No:	Proceed to Step 4.
Step 4.	Does the individual have an impairment (or impairments) that prevents past relevant work?
Yes:	Proceed to Step 5.
No:	Claim denied
Step 5.	Does the claimant's impairment (or impairments) preclude the ability to perform other work?
Yes:	Claim allowed
No:	Claim denied

[a]Adapted from the Social Security Administration.[4]

Table 2. A Social Security Administration (SSA) Listing of Psychiatric Impairments[a]

Organic mental disorders
Schizophrenic, paranoid, and other psychotic disorders
Affective disorders
Mental retardation
Anxiety-related disorders
Somatoform disorders
Personality disorders
Substance addiction disorders
Autistic disorder and other pervasive developmental disorders

[a]This listing represents psychiatric impairments considered severe by the SSA. Adapted from the Social Security Administration[4] and the Office of the Federal Register.[5]

directly by the disability review specialist. The reviewer may make inquiries of treating sources into pertinent clinical findings, sometimes request additional information, and, ultimately, adjudicate the cases.

The SSA regards *disability* as the inability to engage in any substantial gainful activity (SGA) due to a medically determinable physical and/or mental impairment.[4] Thus, for example, it is not sufficient that a claimant carries the diagnosis of major depression—he or she must have corroborating clinical data to substantiate this allegation. In addition, the impairment cannot be transient, but must be present for a continuous period of at least 12 months.[4]

First, the individual's earnings are reviewed. If the claimant is performing work and earning wages, a determination is made as to whether the wages are deemed substantial. Under new rules enacted as of January 1, 2001, an average monthly wage of more than $740 is considered substantial. Rules may be set forth by the SSA to allow for yearly automatic adjustments in the amount of the average monthly wage based on the national average wage index.* No matter what the individual reports his or her physical or mental impairment to be, it is not considered a severe disability unless it prevents an individual from being a productive member of the work force. For those individuals who are not currently working for substantial gain, the next step is to evaluate the severity of the alleged impairment.

Not all medical impairments are considered severe enough to result in a disability. Severe impairments are those that are expected to last for prolonged periods and that compromise individuals' ability to provide economic security for themselves and their families. On the other hand, some psychiatric disorders, e.g., adjustment disorders, are relatively brief in nature with the proper medical treatment or may have little functional impact. If an individual has a less severe impairment of this nature, the claim is denied at this point.

If the impairment is considered to be severe enough to interfere with basic work activities, then in the third step, a determination is made as to whether the alleged psychiatric condition falls under the regulatory Listings of Mental Impairments.[5,6] The SSA has established a "listing of impairments" encompassing medical conditions that, in the absence of substantial gainful activity, would allow for a presumption of disability by adjudicators. The listings are organized into 13 body systems. Impairments are described in terms of symptoms, signs, and laboratory findings. Those psychiatric disorders considered to be severe impairments by the SSA are summarized in Table 2. The criteria for meeting the definitions of such impairments are based largely on *Diagnostic and Statistical Manual of Mental Disorders* (DSM) criteria.[7] If the signs, symptoms, and findings in a patient's file are commensurate with those called for in the appropriate listing, the claim is allowed, avoiding any additional time or cost for further evaluation. In such cases, the claimant is awarded benefits. The severity criteria for schizophrenia are provided as an illustration in Table 3.

In many instances, an individual will be awarded benefits because the alleged psychiatric impairment consists of features that are equivalent to the level of severity and duration of a listed impairment. Thus, a psychotic disorder that does not precisely satisfy the criteria for schizophrenia, e.g., schizoaffective disorder, can nonetheless result in an allowance. Again, in such cases, the claimant is judged to be disabled and awarded benefits.

If the impairment is not found to "meet or equal" those on the listing of impairments, the fourth and fifth steps of the evaluation process are undertaken. At these steps, consideration is given to vocational factors. An assessment of those factors thought to be functionally relevant to maintaining and sustaining work are considered. Thus, in step 4, a determination is made as to whether the claimant can

*These rules apply only to individuals with impairments other than blindness.

Table 3. Severity Criteria for Schizophrenia and Other Psychotic Disorders[a]

1) Presence of continuous or intermittent psychotic symptoms, with deterioration from prior level of functioning
2) Medical documentation of one or more of the following:
   a) Delusions
   b) Hallucinations
   c) Catatonia
   d) Grossly disorganized behavior
   e) Incoherence, illogical thought processes, poverty of speech
   and one of the following:
      (1) Blunted affect
      (2) Flattened affect
      (3) Inappropriate affect
      (4) Emotional withdrawal
      (5) Isolation
   AND
3) Medical documentation of two of the following:
   a) Marked limitations in activities of daily living
   b) Marked difficulties in social functioning
   c) Marked difficulties in maintaining concentration, persistence in activity, or pace
   d) Repeated episodes of decompensation
   OR
4) Medical documentation of an attenuated psychotic disorder of at least 2 years' duration, and one of the following:
   a) Repeated episodes of decompensation
   b) Marginal adjustment in which mental demands or environmental changes would result in decompensation
   c) Inability to live outside of a highly structured, supportive living arrangement

[a]Adapted from Social Security Administration publication 64-039, pp. 106–107.[4]

return to prior work. If so deemed, the claim is denied. If not, the determination is made as to whether the claimant can perform any work in the national economy (step 5). If so, the claim is denied. If not, the claim can be allowed based on vocational factors.

Individuals over age 55 are considered by the SSA to have "advanced age" and to be adversely affected by vocational factors, i.e., they are less adaptable to newer work experiences. Consequently, individuals over age 55 are not expected to be able to take on work that is different from past relevant work. Thus, if deemed to be incapable of returning to prior work (step 4), individuals with "advanced age" are deemed to be disabled and are awarded benefits.[8]

FUNCTIONAL ASSESSMENT OF CLAIMANTS WITH PSYCHIATRIC DISORDERS

The subjective nature of many psychiatric complaints makes it impossible to apply the same sorts of laboratory or clinical standards applicable to many other medical conditions, e.g., cardiac or pulmonary conditions. It becomes very difficult to define disability for psychiatric disorders and to operationalize assessment of psychiatric impairments for programmatic purposes.[9] Therefore, greater emphasis is placed on history, signs, and symptoms with the assessment of psychiatric disturbances. Ultimately, the adjudication of psychiatric disability is fundamentally a vocational issue rather than a medical one.

Thus, when a psychiatric disability is alleged, adjudicators must evaluate the evidence gathered in the claim along certain key areas of functioning to make a determination of the claimant's capacity for work. As summarized in Table 3 (item 3), the SSA considers 4 functional areas necessary to perform work: (1) activities of daily living (ADLs); (2) social functioning; (3) concentration, persistence, or pace; and (4) episodes of decompensation. The treating source may be limited in the amount of information he or she has about an individual's ability to perform these tasks appropriately. Some evidence will need to come directly from the claimant or from an independent third party source that is impartial (it is hoped) to the outcome of the claim. Nonetheless, it is helpful if primary care physicians can speak to these functional areas by deriving information from careful clinical inquiry and/or direct observation. Marked impairments in any *two* of these or extreme impairments in any *one* of these will designate a severe impairment, thereby prompting allowance of the disability claim.

Activities of daily living refer to activities such as personal grooming and hygiene, ability to maintain a household by cleaning, shopping for groceries, and paying bills on time, and effective use of support services in the community such as public transportation or emergency services. Ability to perform household tasks would suggest an ability to perform simple, repetitive tasks.

An individual also needs to be able to interact with others in the community and work force in a manner appropriate to the demands of the work setting. Thus, issues regarding ability to maintain eye contact, interact appropriately, listen and respond to others, and maintain appropriate boundaries (e.g. physical space) are all relevant. Concerns arise when there are issues regarding inappropriate distress and anxiety around others, bizarre speech, hostility and aggression, etc. Individuals need to demonstrate an ability to perform their ADLs and appropriate social interactions with some degree of independence and sustainability.

To perform in a work environment, individuals need sufficient concentration to complete simple tasks in a timely manner as well as an ability to adapt to the stress of new or additional demands placed on them. Formal mental status exam or psychological testing can provide some useful information about concentration, e.g., serial 7 calculation, spelling "world" backwards, and so on. However, even results of cognitive assessments must be considered along with the other evidence in the case file. Other information about an individual's current and previous work and academic history and performance is important evidence to consider in determining an individual's ability to maintain concentration and sustain function. For some people, the stress of a structured work environment may cause a worsening in their symptoms or deterioration from a previously attained level of independent functioning. Hints of this

Table 4. Areas of Functioning Examined by Disability Adjudicators to Determine Disability Eligibility[a]

Understanding and memory
The ability to:
Remember locations and worklike procedures
Understand and remember very simple instructions
Sustain concentration and persistence
The ability to:
Carry out simple instructions and repetitive tasks
Maintain attention and concentration
Perform activities within a schedule
Maintain regular attendance
Be punctual within customary tolerances
Sustain a routine without special supervision and frequent redirection
Work in coordination with or proximity to others without being distracted
Make simple work-related decisions
Social interaction
The ability to:
Ask simple questions or request assistance
Accept instructions
Respond appropriately to feedback from supervisors
Get along with coworkers or peers
Avoid distraction of others
Relate with others without exhibiting behavioral extremes
Adaptation
The ability to:
Respond appropriately to changes in the work setting
Adapt to changes in the work routine
Be aware of normal hazards
Take appropriate precautions

[a]Based on Enelow,[10] the Office of the Federal Register,[11] and Folsom et al.[12]

decline are suggested by histories of marginal functioning or the requirement of intensive supervision in order to maintain functioning, e.g., having a job coach.

Essential to the ability to work is the determination of one's ability to tolerate the increased mental and emotional demands associated with competitive work. Because this can be difficult to ascertain solely by a paper review, disability examiners often look to the frequency and duration of periods of decompensation in order to assess the severity of a particular psychiatric impairment. Thus, for example, adjudicators often look to the number and duration of psychiatric hospitalizations. A claimant who has been hospitalized once or twice in 1 year is considered to have a moderate impairment. One who has been hospitalized 3 times for extended duration in 1 year would be considered to have marked impairments, while one who has been hospitalized 4 or more times in 1 year would be considered to have an extreme degree of limitation in this functional limitation. Fewer hospitalizations of lengthy stays are accounted for as are more frequent episodes of shorter duration.

VOCATIONAL FACTORS

Clinicians typically focus on pathology, the manifestations of a disease process and how it may adversely influence functioning, i.e., what one *cannot* do. Even the DSM incorporates the requirement of "impairments in social, occupational, and interpersonal functioning" in its criteria of psychiatric disorders. In contrast, when a psychiatric allegation is reviewed for eligibility for disability, adjudicators focus on what the individual *can* do despite the alleged impairment. Thus, adjudicators evaluate whether the claimant still possesses those skills deemed to be important to perform even the most rudimentary work within the national economy. Requisite skills required for rudimentary work are summarized in Table 4.[10,11]

If one's claim for disability is denied, it has been determined that despite the alleged psychiatric disorder, the individual possesses residual mental capacities to perform these skills. On the other hand, psychiatric disorders producing deficiencies in any 2 of the areas listed would result in an allowance of the disability claim.

Assessments of the individual's capabilities are determined after considering all of the available evidence in his or her record. Often the claimant's treating source(s) will have provided an opinion about what tasks the claimant can still perform. However, it is not the physician's statements alone that are the basis for the determination. Additional evidence considered is that obtained from the claimant and other nonmedical sources who may have knowledge about an individual's remaining capabilities to function in the workplace. In preparing reports to the SSA on behalf of a patient, primary care physicians ought to consider the guidelines and suggestions outlined below.

GUIDELINES FOR COMPLETION OF PSYCHIATRIC ASSESSMENTS

Primary care physicians are likely to be solicited by the SSA to provide clinical information so that determinations of disability can be made even if the primary care physician is not solely, or even primarily, involved in the treatment of the alleged psychiatric disorder. Failure to provide requested information will delay the processing and evaluation of claims for disability or may even result in a denial of a claim if the necessary clinical information has not been provided. Therefore, a physician has a duty as the patient's advocate to provide accurate and timely information to assist the adjudicator in making the most appropriate determination.

Information will be similarly requested from others involved in the care of the patient, e.g., psychiatrists, psychologists, social workers, or those who have extensive contact with the claimant, e.g., former employers, and teachers.[13] All of the information gathered is examined and weighed in making a determination of eligibility for disability. The legal framework maintained by the SSA specifies that only certain sources contacted for evidence contained in the claimant's file are considered

Table 5. Sources of Information Frequently Contacted by the Social Security Administration (SSA) for Claim Development[a]

Claimant
Psychiatrist[a]
Primary care physician[a]
Therapist (if other than psychiatrist)
Licensed psychologists[a]
Social workers
Pastoral counselors
Speech and language pathologists[a]
Neuropsychologists[a]
Occupational therapists
Physical therapists
Chiropractors
Vocational rehabilitation counselors
Employers
Intensive case managers
Supervisors in a group home
Others (relatives, friends, landlords, etc)

[a]Sources the SSA considers medically acceptable. Adapted from the Office of the Federal Register.[13]

Table 6. Clinical Information Required[a]

Psychiatric diagnosis
Ruled-out diagnoses
Psychiatric symptoms
Nature and frequency of treatment
Medications
Psychotherapy/counseling
Hospitalizations
Compliance with treatment
Response to treatment
Mental status examination
Appearance
Speech
Mood and affect
Thought form (goal-directed, tangentiality, flight of ideas, circumstantiality)
Thought content
Perception disturbances (illusions, hallucinations)
Cognitive functioning
Orientation
Registration
Recall
Concentration
Execution of simple commands
Abstraction
Judgment

[a]Based on Folsom et al.[12]

acceptable medical sources (see Table 5). However, even information provided by other sources, e.g., social workers and family members, are considered, as these sources may supplement data provided by clinicians. These sources may have an opportunity to elaborate on adaptive functions observed in the claimant that a clinician may not have had sufficient exposure to.

Generally, information provided by acceptable medical sources is often compared for consistency. A patient who presents with very mild symptoms with one source, but marked symptoms with another source, raises questions about the degree of severity and pervasiveness of his or her symptoms. While the information provided by the specialist is weighed more than that of the generalist, other factors determine whether clinical information is weighed differently. One factor often considered is the frequency of contact with the patient. Thus, the clinical information provided by the primary care physician who sees the patient monthly may be weighed more than that of the psychiatrist who sees the patient for less frequent medication evaluations.[13]

The clinical information requested from the primary care physician is listed in Table 6. It is imperative that the patient's condition is described clearly and that jargon is avoided.[12] For example, it is unhelpful to the claimant if he or she is described as "anxious." Rather, if a patient is treated for anxiety, the clinician should specify the symptoms of the anxiety, precipitants for the anxiety, duration of episodes of anxiety, mitigating factors, the way one manages the anxiety, and the impact of the anxiety on one's overall functioning. Failure to provide specific findings can lead to delays in the processing of claims or result in a decision to deny the disability claim.

Similarly, detailed descriptions of the patient's symptoms are warranted as it becomes necessary to characterize how the symptom impacts on the individual's functioning. Thus, indicating that a patient is "delusional" would signal a pathologic process, but does not add anything to clarification of the patient's adaptation or functional abilities. After all, it is conceivable that delusional individuals, e.g., individuals affected with delusional disorder,[7] can remain quite functional. Symptoms of delusions require detail about the content, nature, and pervasiveness of the delusions and how these impact the patient's functioning, ability to relate with others, and the rigidity with which such beliefs are maintained. Again, without such descriptions, attempts will have to be undertaken by disability determinations experts to clarify these issues with further inquiries of the clinician and requests for copies of medical records. At times, an independent examination with a psychiatric or psychological consultant may be required to clarify aspects of the claimant's history, symptoms, mental status, and adaptive functioning.

Medications and other treatment interventions warrant elaboration. Attention should be given to descriptions of medications that have the potential of adversely impacting work function. A detailed mental status examination is required. The components of the mental status examination warranting description include patient appearance, speech, mood, form of thought, thought content, and perceptual disturbances. Formal measures of the patient's ability to manipulate information, e.g., the Folstein Mini-Mental Status Examination,[14] are very useful indicators of the patient's cognitive abilities, which are necessary to perform simple, repetitive work.

Aside from the pertinent clinical information requested, primary care physicians can be particularly helpful if they can provide information regarding the

Table 7. Functional Adaptations About Which Clinicians Are Encouraged to Elaborate[a]

I. Estimate degree of restriction of claimant's daily activities:
Ability to attend meetings (eg, church, lodge, social clubs, etc)
Work around the house
Clean
Wash dishes
Launder clothes
Pay bills
Manage money
Shop (eg, for groceries)
Prepare meals
Socialize with friends and neighbors
Drive or use public transportation
II. Estimate degree of impairment of the claimant's ability to relate to other people, eg,
Maintain appropriate interpersonal space
Maintain eye contact, engage others, relate in a socially appropriate manner
Maintain appropriate speech
Maintain courtesy
Adapt to, or adjust to, social settings
Willingness to listen to and comply with a supervisor's suggestions, or to improve job performance
III. Estimate degree of impairment of the claimant's ability to concentrate, maintain persistence and pace, eg,
Process information concerning work duties for satisfactory job performance
Perform required jobs with minimal supervision
Faithfully arrive at work daily and conform to work schedules
Withstand pressure and remain calm in crucial and decisive situations
Demonstrate initiative, ie, readiness and ability to attain goals and to achieve
Adapt to changes in work settings

[a]Based on Enelow,[10] the Office of the Federal Register,[11] and Folsom et al.[12]

Table 8. Factors That Raise Questions About the Credibility of Alleged Impairments

Noncompliance with treatment
Alcohol/substance abuse histories
Positive review of psychiatric symptoms
Vague symptoms
Inconsistency in reporting symptoms
Symptoms that are not consistent with features of the pathologic features of Axis I disorders
Continued impairments (or worsening) of symptoms despite reasonable treatment

claimant's adaptive functioning, aspects of which are summarized in Table 7.[12] This information can be obtained from direct observations of the patient and/or careful inquiry of the patient and collateral informants. Bear in mind that adjudicators need to establish a link between impairments in functioning and the prevailing psychiatric disorder. For example, a claimant may suggest that he or she is "unable to leave home." The cause of the inability to leave home is critical for the disability determinations process. Thus, one's inability to function outside the home due to a psychotic process is more significant than one's choice to be reclusive or a lack of transportation.

A common error clinicians make is failing to distinguish between symptoms (e.g., the patient reports impaired concentration) and clinically observed data (e.g., the ability or inability to attend to the flow of inquiry during sessions or the ability to perform formal cognitive assessments).[12] Often, valuable information can be gleaned from inquiry into the activities that make up the patient's day. Thus, if the patient reports that he or she spends much of the day reading or watching television, inquiry should be made into the patient's ability to attend to what is read or viewed on TV, i.e., whether the patient can comprehend what is read or follow a story line.

Adjudicators must assess the credibility of a claim of disability. "Red flags" (see Table 8) of credibility arise with claimants who present with poorly defined symptoms, vague symptoms, diffuse symptoms, and symptoms that do not appear to interfere with basic functioning. In such cases, there are concerns that the alleged difficulties may arise from some other factor, e.g., substance abuse or malingering. Decisions in favor of disability allowances are never made for patients suspected of malingering. In addition, failure to comply with advised treatment that presumably will result in improved health and improved adaptive functioning, thus restoring one's capacity to work, will result in a denial of a disability claim.[15] The credibility of the clinician is not called into question, but a poorly prepared medical report can contribute to ambiguities in the file under review and can delay the processing of the claim.

The use of drugs and alcohol often coexists with and confounds the symptoms of other psychiatric disorders. For example, anxiety can be quite distressing and incapacitating for patients. Yet, the anxiety may arise from the use of certain illicit substances (e.g., stimulants such as cocaine, amphetamines, or withdrawal from other illicit substances such as heroin, alcohol, and benzodiazepines). Therefore, the adverse impact on work capacity brought on by the use of substances may be more directly related to impairments in functional capacities. While individuals with significant substance dependence may be impaired in their abilities to maintain productive work for sustained periods, an administrative decision was made to avoid allowances of primary substance dependence disorders.[16] The enactment of public law 104-121 prohibited awarding SSI or SSDI benefits to individuals with alcohol and/or substance dependence and abuse. In addition, benefits were terminated for individuals who had previously been awarded benefits for addictions.[17] Many of those individuals whose benefits were terminated were allowed to reapply for disability based on a different illness, but awards were only provided to those whose illness was not a direct result from, or exacerbated by, ongoing drug and alcohol use. Nonetheless, an individual with a primary psychiatric disorder and comorbid substance use disorder can be deemed eligible for disability. In such cases, a designated representative payee may be warranted to safeguard against mismanagement of disbursements and misappro-

Table 9. Clarifying the Relationship Between Substance Abuse and Other Psychiatric Disorders[a]

Physicians are required to assess the following:
Have there been periods of abstinence?
Do the symptoms abate shortly after cessation of substance use?
Do the symptoms abate during periods of abstinence?
Do the symptoms recur during periods of relapse?
Did the symptoms occur or arise only after periods of protracted use?

[a]Adapted from the Office of the Federal Register.[16]

priation of funds for purposes of acquiring alcohol and illicit substances.[18,19]

Clinicians can be most helpful if they can clarify whether the psychiatric symptoms result from or arise from the substance dependence. Clinicians may be asked to evaluate the relationship between substance abuse and other psychiatric impairments. Suggested means of clarifying the relationship are summarized in Table 9.

POTENTIAL PITFALLS TO THE DOCTOR-PATIENT RELATIONSHIP

Several issues have to be addressed with the patient who intends to file a claim for social security disability to avoid potential disruptions to the doctor-patient relationship.[20] First, the physician must ensure that a signed release of information is obtained *before* any information is disclosed to the SSA. Similarly, the limits of confidentiality would need to be disclosed to the patient, particularly in light of the fact that the SSA may request copies of treatment notes, results of toxicology screens, details of past work and current work (if any), and so on. Addressing this matter directly avoids the potential for confrontations regarding disclosure of "sensitive" information after it has been provided to the SSA.

It may be prudent for physicians to discuss the process by which disability determinations are made. It is important to reinforce the idea that the primary care physician does not make the decision about disability eligibility. Rather, the patient should be informed that the decision is made by adjudicators and possibly judges and courts if appeals are undertaken. In addition, patients should be apprised that the primary care physician is but one source contacted by the SSA for clinical information. The physician's clinical information is considered in light of all of the other information provided from other sources.

Outcomes of the disability determination may also have an impact on the doctor-patient relationship.[20] Ambivalence may arise in response to a favorable decision. Despite the fact that an allowance would mean access to resources of financial support and medical insurance, it may also stir feelings of dependency, inadequacy, shame, perhaps interpretations of loss of self-sufficiency, etc. On the other hand, an unfavorable decision may be interpreted negatively, e.g., a withholding of needed resources or the perception that the patient is "not cared about." It is difficult to be angry with a decision maker whom the patient never sees, thus such feelings may be directed instead at the treating physician. Hence, the patient may harbor beliefs that "if the doctor really cared," he or she would have made a stronger case on the patient's behalf. Thus, discussions between the physician and patient may diffuse the tensions that arise from such beliefs about and reactions to the decision-making process.

Primary care physicians may feel particularly pressured if the patient already has legal counsel involved in the disability claim. Attorneys working on behalf of the disability claimant often receive contingency fees for favorable decisions or reversals of previously unfavorable disability determinations. Consequently, the attorney protecting the best interest of the client will also attempt to present a level of disability that would result in the highest award being granted. While productivity and return to employment may be in the best interest of the patient, thereby reducing feelings of dependency, passivity, and inefficacy, the attorney may inadvertently reinforce the notion of the patient's disability. After all, the attorney is not considering the clinical well-being of the patient, but rather, the monetary or compensatory benefits available to the claimant under the law.

Attorney involvement in a patient's disability claim may further heighten the anxieties of a treating physician. Without conferring with the attorney, the physician may be reluctant to clarify issues regarding the claimant's alleged disability and functional impairments, fearing that this may incur legal repercussions. It is reasonable for the primary care physician to obtain written permission from the patient to consult and confer with the attorney involved in the claim. In this way, the physician can be certain that the clinical best interest of the patient is also being sought.

Societal values emphasize the distinction between those deserving individuals who are too sick to work and those who will not work. Thus, the individual perceived to have relatively mild symptoms but who dramatizes symptoms may trigger marked countertransference reactions in treating sources, e.g., of manipulating or "cheating the system."[21] The nature of the disability program intrinsically creates incentives for claimants to maximize monetary gains by emphasizing functional limitations and overstating the severity of illnesses.[22]

The pursuit of disability may provide patients with primary gains, i.e., being taken care of and avoiding distress associated with having to meet the expectations of work, as well as secondary gains, i.e., financial support. Primary care physicians may harbor resentment and other feelings by the prospect of being pulled into the position of rewarding idleness, inactivity, and dependency. Inattention to such reactions may lead primary care physicians to underestimate the severity of the claimant's symptoms, distance themselves from the patient, and undermine

treatment. In such situations, enlisting the support of a psychiatric consultant may help to clarify the severity and functional impact of the patient's claims of disability. SSA would also require the consultant's report.

Even though the nature of the claimant's impairments may preclude any meaningful participation in productive work, clinicians may have concerns about the unstructured time patients may experience when receiving disability benefits. There may be concerns that treatment endeavors, e.g., social skills training, learning to work through anxiety one experiences around others, and development of autonomy and self-sufficiency, may be undermined. Directly addressing such concerns with the patient may be quite meaningful and therapeutic. Open discussions may be the basis for introducing the need for developing vocational training and work preparatory skills. In some cases, the increased time available to the patient may justify pursuit of more intensive treatment, psychotherapy, group therapy, day treatment, etc.

CONCLUSION

The values of responsibility and compassion compel civilized societies to provide protection and financial support for its disabled members.[22] The determination of disability eligibility is complex, involving a paper review of medical evidence gathered from a number of medical and nonmedical sources. Unfortunately, there is a dearth of available resources and training on the processes involved in disability eligibility assessment and the information required of clinicians in order for those assessments to be made. Because of the subjective nature of many psychiatric complaints, the determination of disability eligibility relies largely upon making determinations of the claimant's functional capabilities.[10] Primary care physicians can reduce some of the potential uncertainties surrounding making such determinations and expedite the processing of claims if they are able to provide pertinent clinical information and avoid potential pitfalls of ambiguous information and unclear diagnoses, symptoms, and signs.

Recognition of both the impact of seeking disability and the outcomes of disability determinations on the therapeutic relationship and potential therapeutic gains is essential. Attrition from treatment may be a consequence of receiving disability disbursements.[23] In some situations, allowances of disability can be made contingent upon the pursuit of ongoing therapy and treatment compliance.[24] However, the utility of, and ethical issues arising from, such practices warrants further attention.[19,25] In addition, vocational rehabilitation may be mandated for individuals allowed disability benefits, so that the patient will be working toward acquiring those skills necessary for future work potential. In this way, the pursuit of disability benefits does not become an end in itself, but a means to improve the rehabilitation of the patient with a psychiatric disorder.[26]

REFERENCES

1. Social Security Advisory Board. Charting the future of social security's disability programs: the need for fundamental change. Washington, DC: Social Security Advisory Board; 2001
2. Kochhar S, Scott CG. Disability patterns among SSI recipients. Soc Secur Bull 1995;58:3–14
3. Druss BG, Marcus SC, Rosenheck RA, et al. Understanding disability in mental and general medical conditions. Am J Psychiatry 2000;157: 1485–1491
4. Social Security Administration. Disability evaluation under social security. Washington, DC: Social Security Administration; 2001. SSA publication 64-039
5. Office of the Federal Register. Code of Federal Regulations. Title 20, Part 404, Subpart P, Appendix 1. Washington, DC: US Government Printing Office; 2000
6. US Dept Health, Education, and Welfare. Disability Evaluation Under Social Security: A Handbook for Physicians. Washington, DC: US Government Printing Office; 1979
7. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC: American Psychiatric Association; 1994
8. Office of the Federal Register. Code of Federal Regulations. Title 20, Part 416, Section 963, paragraphs C and D. Washington, DC: US Government Printing Office; 2000
9. Pincus HA, Kennedy C, Simmens SJ, et al. Determining disability due to mental impairment: APA's evaluation of social security administration guidelines. Am J Psychiatry 1991;148:1037–1043
10. Enelow AJ. Psychiatric disorders and work function. Psychiatr Ann 1991; 21:27–35
11. Office of the Federal Register. Code of Federal Regulations. Title 20, Part 416, Section 945. Washington, DC: US Government Printing Office; 2000
12. Folsom J, Lipsett MM, Raskin DE, and the American Psychiatric Association's Committee on Rehabilitation. Guidelines for psychiatric evaluation of social security disability claimants. Hosp Community Psychiatry 1983;34:1044–1051
13. Office of the Federal Register. Code of Federal Regulations. Title 20, Part 416, Section 927. Washington, DC: US Government Printing Office; 2000
14. Folstein MF, Folstein SE, McHugh PR. Mini-mental state: a practical method for grading the cognitive state of patients for the clinician. J Psychiatr Res 1975;12:189–198
15. Office of the Federal Register. Code of Federal Regulations. Title 20, Part 416, Section 930. Washington, DC: US Government Printing Office; 2000
16. Office of the Federal Register. Code of Federal Regulations. Title 20, Part 416, Section 935. Washington, DC: US Government Printing Office; 2000
17. Rosenheck R. Disability payments and chemical dependence: conflicting values and uncertain effects. Psychiatr Serv 1997;48:789–791
18. Rosen MI, Rosenheck R. Substance use and assignment of representative payees. Psychiatr Serv 1999;50:95–98
19. Satel SL. When disability benefits make patients sicker. N Engl J Med 1995;333:794–796
20. Mischoulon D. An approach to the patient seeking psychiatric disability benefits. Acad Psychiatry 1999;23:128–136
21. Heiman EM, Shanfield SB. Psychiatric disability assessment: clarification of problems. Compr Psychiatry 1978;19:449–454
22. Fontana A, Rosenheck R. Effects of compensation-seeking on treatment outcomes among veterans with posttraumatic stress disorder. J Nerv Ment Dis 1998;186:223–230
23. Satel S, Reuter P, Hartley D, et al. Influence of retroactive disability payments on recipients' compliance with substance abuse treatment. Psychiatr Serv 1997;48:796–799
24. Shaner A, Roberts LJ, Eckman TA, et al. Monetary reinforcement of abstinence from cocaine among mentally ill patients with cocaine dependence. Psychiatr Serv 1997;48:807–810
25. Ries RK, Dyck DG. Representative payee practices of community mental health centers in Washington state. Psychiatr Serv 1997;48:811–814
26. Donegan KR, Palmer-Erbs VK. Promoting the importance of work for persons with psychiatric disabilities: the role of the psychiatric nurse. J Psychosoc Nurs Ment Health Serv 1998;36:13–23