Psychiatric Disability on the Rise

December 01, 2002 | Bipolar Disorder [1], Schizophrenia [2], Dependent Personality Disorder [3], Major Depressive Disorder [4], Addiction [5]

There is no doubt that the number of applications for disability is rising. How should psychiatrists deal with patients who ask for disability without compromising the therapeutic alliance or the goals of therapy?

If you have noticed a rise in the number of patients seeking mental health disability benefits, it is not your imagination. Mental health is the fastest growing sector of the federal disability recipient pool and continues to grow steadily (Social Security Advisory Board [SSAB], 2001). Mental impairment accounted for 22% of state agency disability awards in 1999, double the percentage it was in 1980 (SSAB, 2001). Unemployment, other financial stressors and the success of public outreach efforts by the Social Security Administration (SSA) are all possible reasons for this increase (Leo, 2002).

"My impression is that over the last five years, there has been a rise of about 30%" in the number of patients seeking federal and/or employer-sponsored disability, said Marc Graff, M.D., a psychiatrist with Kaiser Permanente in Reseda, Calif. He told Psychiatric Times, "A greater percentage of my time and effort has been spent on that, more than before."

Graff believes the increase may be due to several factors: the destigmatization of mental illness and a societal trend toward bureaucratization; patients are less intimidated by paperwork than in the past and are willing to aggressively advocate for themselves; and a shift among Americans toward greater emotional investment in their jobs and careers. With this investment in career as a defining emotional focus, disruptions and conflicts in the workplace are more commonly experienced as consuming and even disabling. "Work is the major issue in people's lives," said Graff. "Workplace issues and problems have increasingly become the reason people come in."

While the number of patients seeking psychiatric disability has risen, Graff said patients seeking disability present with the same disorders as always--major depression and bipolar disorder. Despite the growing prevalence of disability petitions, many doctors are ill-equipped to properly fill out disability forms, much less to deal with the dynamic issues that can arise. The need for expertise is especially keen in university hospital clinics and community mental health centers. The low socioeconomic status of patients in these settings, coupled with the severity of their illness, substantially boosts the likelihood that they will be applying for disability benefits (Mischoulon, 1999).

"We don't like conflicts with our patients, and we want to be helpful," said Kelly Clark, M.D., a psychiatrist with the University of Massachusetts Medical School. She told PT, "If we're not clear about the difference between wants, benefits and needs, and how much power and control we do and do not have over the disability determination, we can cause harm to the patient's life, as well as irreparable harm to the therapeutic alliance."

Understanding the Process

According to Clark, one of the most common and problematic mistakes her colleagues make is failing to understand the limits of their influence. "We don't determine disability, just as we don't determine competency," said Clark, who is also a reviewer for Peer Review Analysis, an agency that conducts specialty-matched independent peer reviews. "It's a legal definition, not a clinical one."

Unfortunately, some clinicians mistakenly believe that a note from them virtually guarantees approval of a disability application--a belief that is often transmitted to patients. Similarly, Clark has seen her share of patients who show up armed with disability forms and the expectation that she will support their application. "I have lost patients because I've been unwilling to advocate for their desires regarding disability," Clark said.

Disability payments may be significantly delayed or even denied if a physician does not understand the idiosyncratic and often labyrinthine criteria of public and private disability plans. Problems also can arise if the physician, deliberately or inadvertently, does not provide enough relevant information to give a full understanding of the patient's clinical status. For example, a patient with bipolar disorder may be energetic and productive during a manic episode and clearly not meet disability criteria. Unless the treating psychiatrist also provides the patient's level of functioning during a depressive episode, reviewers will not gain a full understanding of the patient's average
level of functioning, which may be quite poor. Clinical data about the side effects of a given medication are also important, particularly if the patient is employed in an occupation that puts them or others at risk of physical injury. **Therapeutic Alliance**

Doctors' attitudes toward disability payments can significantly affect the therapeutic alliance as well as the outcome of the disability process. For example, patients with schizophrenia may be seen as deserving of disability payments, while patients with Axis II difficulties may not be, particularly if they evoke strong countertransference in their clinicians.

A psychiatrist who has a long-term therapeutic relationship with a patient may feel pressure--either internal or from the patient--to advocate for disability, even if they do not believe the patient is disabled, for fear of harming the therapeutic alliance. Conversely, over-involvement in the role of patient advocate can muddy doctor-patient boundaries and encourage an inappropriate degree of dependency.

Treating clinicians may be legitimately concerned that receipt of disability benefits might encourage and/or reinforce dependency and interfere with a patient's incentive to make and retain therapeutic gains. Working with disability benefit recipients has "helped me to appreciate the adverse effect that idleness has on people," David Mischoulon, M.D., Ph.D., a psychiatrist at Massachusetts General Hospital in Boston, told *PT*. "It made me realize how bad it is when people get paid to be sick. It really becomes part of them, it consolidates the 'I am a mental patient and nothing else' identity."

The needs of employers also play a major role when it comes to determining if a patient is ready to go back to work. Employers "want to have their people return to work promptly, but they don't want people to come back who are unable to handle the work," Graff explained. He recalled the case of an employee on psychiatric disability for recurrent major depression with psychotic features. "The workplace didn't want him back until he was more or less perfect," he said. Ironically, the issue that most concerned the patient's employers was the fact that his medication was somewhat sedating. "They didn't get that he was psychotic."

Clark believes many problems in the therapeutic relationship can be avoided, or at least minimized, if doctor and patient openly discuss their views of the patient's perceived disability. "Discussion of disability allows you to really assess objectively, as well as to get the patients' sense of their strengths and weaknesses," said Clark, who always fills out disability forms with the patient during the regular office visit. "Often, people don't list their strengths particularly well." In addition, filling out the form together discourages patient passivity and removes the appearance of secrecy.

Graff thinks there is a dynamic tension between patients' expectations and the privileges doctors actually have. "If you're a doctor, you can do things that other people can't do," he said. "I can write a note that basically can cost someone thousands of dollars ... Doctors are given this power. In return, people come up to you and ask, or even demand, that you give them what they want." Graff said several patients each day ask him to fill out disability forms. There are so many that "What is that piece of paper in your hand?" has become a commonplace question during office visits.

Graff does not think patients seeking disability benefits are more entitled than other patients, but believes patients in general feel increasingly entitled and have greater expectations of treaters. In the case of those seeking disability, an attitude of entitlement can strain the therapeutic relationship, particularly if the clinician does not believe the patient is disabled but is "playing the system" for the sake of financial gain.

It has been theorized that disability-seeking behavior "may also represent a characterological trait, particularly in those who are less disabled Further research may help clarify whether disability is an independent entity, or a form of a mixed personality disorder" (Mischoulon, 1999). **Talking to Patients**

The task of talking to patients applying for disability can be a delicate one. Unwanted changes in job responsibilities or conflicts with supervisors or co-workers frequently are cited by these patients, who often are surprised to learn the actual degree of disability required to meet the eligibility criteria of federal agencies and/or private employers. For example, patients may mistakenly believe they are entitled to disability benefits if they are unable to perform job responsibilities in their given field. In fact, SSA regulations (2002) define disability as "the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." Clark said, "There are patients who feel they should be [judged] disabled if they can't do the job of their choice."

Consequently, familiarity with disability guidelines can serve to give these patients a realistic sense of the chances that their application will be approved and can create an opportunity to generate alternative, empowering solutions. Similarly, questions about specific job responsibilities can
pinpoint areas of strength, as well as difficulty. Mischoulon suggests that clinicians adopt a stance of cautious pessimism when talking with patients about the probability of receiving benefits (Mischoulon, 2002). If a psychiatrist does not believe their patient is disabled, Mischoulon suggests that the clinician share this impression with the patient. Specifically, Mischoulon recommends that the psychiatrist tell the patient that they believe the petition for disability to be an indirect way of getting personal needs met. Remaining empathic with the patient’s wish to be taken care of while inviting them to actively participate in generating alternative ways to get needs met can go a long way toward preserving the therapeutic alliance while maintaining focus on negotiated treatment goals. If a patient is deemed eligible for benefits, work should continue to maintain clinical momentum, which, for seriously and chronically ill patients, may mean working toward a return to baseline functioning. Clark does not discuss disability as a permanent situation with patients, even if their prognosis is poor. "My goal is to get them to the highest level of functioning," she explained.

References:


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