

MENTAL BLOCK: THE CHALLENGES AWAITING A MENTALLY IMPAIRED CLAIMANT WHEN APPLYING FOR SOCIAL SECURITY DISABILITY BENEFITS

INTRODUCTION

Nora Lewis has not always been this way.¹ There was a time when the only thing on Nora's mind was whether she had spent too much money on her daughter's birthday present. But now things have changed. Today, she wonders why she is alive, and she wishes that she were not. Three months ago, Nora was diagnosed with bipolar disorder with schizoaffective features, a diagnosis which explains her inability to get out of bed and the frequent hallucinations she experiences. Her illness has interfered with her ability to function—so much so that it has forced Nora and her twelve-year-old daughter to move in with Nora's grandparents.

Nora applied for Social Security disability benefits in December 2004 and appeared at a hearing three years later. Two years ago, she was notified by letter that her request for disability benefits had been denied because her medical records indicate that she experiences brief periods of functioning while on medication. Nora is scared and confused, and she does not know what she is going to do. Instead of birthday presents, her thoughts now turn to suicide.

This Note examines the Social Security disability adjudication process for mentally impaired claimants. Part I discusses the history of mental illness and society's opinions of the mentally ill from both three-hundred years ago and today. Part II gives a brief overview of the process of applying for disability insurance benefits and Supplemental Security Income and also addresses the common hurdles that a claimant with mental impairments will face before benefits will be awarded. Part III addresses the documentation that a claimant submits in support of the disability allegations and the effect that each piece of evidence has on a disability determination. Part IV discusses the significance of Global Assessment of Functioning ("GAF") ratings and how these assessments are weighed, specifically focusing on the approaches taken by the Third, Sixth, and Tenth Circuits. Finally, Part V outlines a proposal for an Administrative Law Judge's consideration of GAF evaluations.

¹ Nora's mental impairments and her experiences with the disability adjudication process are based on those of a real-life claimant; her name, however, has been changed to protect her confidentiality. The Administrative Law Judge's ("ALJ") decision cannot be cited to, as it is unpublished and contains the claimant's Social Security number. Her story is used with the permission of her legal representative, and the ALJ's opinion is on file with the author.

I. THE MISPERCEPTION OF MENTAL ILLNESS

A. *Mental Illness in the 1700s*

Only a few centuries ago, the local jails were used to confine not only the criminally guilty, but also individuals with mental diseases.²

In 1725 the [New York City] town marshal, Robert Crannell, Jr., was paid two shillings six pence a week by the churchwardens “for to Subsist Robert Bullman a Madman in Prison.” Not infrequently the unfortunate person spent decades incarcerated like a common criminal. But when some hope was held out for his recovery, only temporary confinement was ordered. In 1720, for example, the same marshal was given the custody of one Henry Dove, “a Dangerous Madman, untill he shall Recover his senses.”³

In addition to confinement in a jail cell, the mentally ill were also subjected to inhumane treatment, even when, instead of being imprisoned, the individual was admitted into a psychiatric institution.⁴

Clifford Whittingham Beers experienced this firsthand.⁵ Beers, a Yale University graduate and businessman, suffered a mental breakdown after becoming obsessed with the fear that he, like his brother, had epilepsy.⁶ After jumping from a four-story window in an attempt to end his life, Beers was admitted to several psychiatric institutions.⁷ During his hospital admissions, Beers

was treated in the harsh and crude way that was all too prevalent at that time. He was beaten mercilessly, choked, spat upon and reviled by attendants, imprisoned for long periods in dark, dank padded cells, and forced to suffer the agony of a strait-jacket for as many as twenty-one consecutive nights. . . .

A large measure of this treatment had its source in the prevailing ignorance concerning insanity—ignorance not only of proper therapeutics, but of the very nature of mental disorder. . . . It was still regarded less as an illness than as a family disgrace and as a frightful visitation for some evil or sin committed by the victim.⁸

Indeed, the twenty-first century has brought about positive changes in the treatment of the mentally ill, as few have the opinion that these individuals should be incarcerated and/or treated cruelly. While our care

² ALBERT DEUTSCH, *THE MENTALLY ILL IN AMERICA* 41 (Columbia Univ. Press 1949) (1937).

³ *Id.* at 42 (citation omitted).

⁴ *Id.* at 303.

⁵ *Id.* at 302.

⁶ *Id.*

⁷ *Id.* at 302–03.

⁸ *Id.* at 303–04.

of the mentally ill has evolved substantially since the 1700s, our feelings and opinions of them, however, remain the same.⁹

B. Mental Illness Today

A recent study conducted by sociology professor Jason Schnittker of the University of Pennsylvania assessed the extent to which society's view of mental illness had changed during the previous ten years.¹⁰ This study found that "even though more Americans today believe that mental illness has a genetic basis . . . they remain just as intolerant toward some mentally ill patients, especially schizophrenics, as they've ever been."¹¹ Although Americans now view alcoholism differently, our views toward other mental diseases, such as schizophrenia, have not changed.¹² "[M]ost Americans don't want to work with them, help them, or even associate with them,"¹³ and the study concluded that it is unlikely that such bias will ever go away.¹⁴

A similar study at the University of North Carolina at Chapel Hill came to the same conclusion¹⁵:

People with psychiatric disabilities are arguably doubly marginal—unwelcome in both the nondisabled and the disabled communities. They were included only grudgingly under provisions of the Americans with Disabilities Act (Bell 1997). Recent Equal Employment Opportunities Commission rulings requiring workplace accommodation for people with psychiatric conditions have evoked an unsympathetic response, which was epitomized by a *New York Times* story that ran under the headline, "Just What the Government Ordered: Breaks for Mental Illness," with a subhead that declared, "Employers are Terrified."¹⁶

⁹ See, e.g., Sue E. Estroff et al., *Pathways to Disability Income Among Persons with Severe, Persistent Psychiatric Disorders*, 75 MILBANK Q. 495, 496 (1997); Tim Hyland, *Americans Still Wary of Mentally Ill*, PENN CURRENT (Univ. of Pa., Phila., Pa.), Sept. 18, 2008, at 2, available at <http://www.upenn.edu/pennnews/current/research/091808.html> (discussing Jason Schnittker, *An Uncertain Revolution: Why the Rise of a Genetic Model of Mental Illness Has Not Increased Tolerance*, 67 SOC. SCI. & MED. 1370, 1380 (2008)).

¹⁰ Schnittker, *supra* note 9, at 1370–71.

¹¹ Hyland, *supra* note 9, at 2.

¹² *Id.*

¹³ *Id.*

¹⁴ *Id.*

¹⁵ Estroff et al., *supra* note 9, at 496.

¹⁶ *Id.* at 496 (citing Christopher G. Bell, *The Americans with Disabilities Act, Mental Disability, and Work*, in MENTAL DISORDER, WORK DISABILITY, AND THE LAW 203 (Richard J. Bonnie & John Monahan eds., 1997); Sheryl Gay Stolberg, *Breaks for Mental Illness: Just What the Government Ordered*, N.Y. TIMES, May 4, 1997, § 4, at 1).

The existence of such intolerance is surprising, as mental illness is becoming increasingly prevalent in the United States.¹⁷ According to the National Institute of Mental Health, there are numerous Americans suffering with some form of mental disease.¹⁸ A recent study found that 26.2 percent of American adults “suffer from a diagnosable mental disorder.”¹⁹ When this figure was applied to the 2004 U.S. Census population, it was determined that approximately 57.7 million people currently living in the United States are mentally ill.²⁰

Mental disease does not appear to be a rare or novel condition of which society is completely ignorant. In fact, the University of Pennsylvania study actually suggests that there have been vast improvements in the mindset and treatment of mental disease over the past three centuries.²¹ Nonetheless, the mentally impaired continue to be treated as a substandard class in many instances.²² Few are immune to this bias, and the Social Security Administration has begun to reflect this bias in its disability determinations.²³ As the trends of the disability adjudication process are analyzed herein, it becomes evident that mentally ill claimants face numerous disadvantages when applying for Social Security disability benefits.

II. THE MENTALLY ILL AND THE DISABILITY ADJUDICATION PROCESS

When an individual can no longer sustain full-time employment because of a physical and/or mental impairment, that person may be entitled to Social Security disability benefits provided through the Social Security Administration.²⁴ Such an individual may be eligible for disability insurance benefits if the claimant worked for a statutory period of time and paid into the Social Security system.²⁵ For someone who does not meet those requirements, that person may be eligible for

¹⁷ Nat'l Inst. of Mental Health, Statistics, <http://www.nimh.nih.gov/health/topics/statistics/index.shtml> (last visited Apr. 15, 2010).

¹⁸ Roughly one in every four adults has a mental condition. *Id.*

¹⁹ *Id.*

²⁰ *Id.*

²¹ Schnittker, *supra* note 9, at 1371.

²² Estroff et al., *supra* note 9, at 496.

²³ *Id.* at 495–96 (citing Robert A. Rosenblatt, *Social Security Plans New Tests of Disability Pay*, L.A. TIMES, Mar. 17, 1996, at A1).

²⁴ SOC. SEC. ADMIN., DISABILITY BENEFITS 4 (2009) [hereinafter SOC. SEC. ADMIN., DISABILITY], available at <http://www.ssa.gov/pubs/10029.pdf>. Providing disability benefits for individuals with mental impairments costs approximately \$12 billion each year. J. Reich, *DSM-III Diagnoses in Social Security Disability Applicants Referred for Psychiatric Evaluations*, 47 J. CLINICAL PSYCHIATRY 81, 81 (1986).

²⁵ 20 C.F.R. §§ 404.130, .315(a) (2009); SOC. SEC. ADMIN., DISABILITY, *supra* note 24, at 5.

Supplemental Security Income based on the claimant's limited income and resources.²⁶

To begin the long process of obtaining disability benefits,²⁷ an initial application must first be filed;²⁸ if denied, the claimant may appeal by filing a Request for Reconsideration of the initial decision.²⁹ If denied again, the claimant may then request a hearing before an Administrative Law Judge ("ALJ").³⁰

When determining whether a claimant is disabled, the ALJ follows a five-step sequential evaluation process.³¹ The first step requires the ALJ to consider whether the claimant is currently engaged in "substantial gainful activity."³² If the claimant is sustaining full-time

²⁶ 20 C.F.R. §§ 416.202, .1201 (2009); SOC. SEC. ADMIN., SUPPLEMENTAL SECURITY INCOME 5 (2007), available at <http://www.ssa.gov/pubs/11000.pdf>.

²⁷ It can often take three years or longer before a claimant will receive a final adjudication to a request for Social Security disability benefits. The national average waiting period for a hearing to be scheduled before an Administrative Law Judge ("ALJ") alone is 500 days. *Eliminating the Social Security Disability Backlog: Hearing Before the H. Comm. on Ways and Means*, 111th Cong. 9, 106 (2009) (statement of Dr. McDermott, chairman of the Subcomm. on Income Security and Family Support, and statement of Peggy Hathaway, Vice President, United Spinal Association).

²⁸ 20 C.F.R. § 404.603 (2009).

²⁹ *Id.* § 404.900(a)(2); SOC. SEC. ADMIN., THE APPEALS PROCESS 1 (2008) [hereinafter SOC. SEC. ADMIN., APPEALS], available at <http://www.socialsecurity.gov/pubs/10041.pdf>. About 71% of claimants from years 2005 to 2008 were denied Social Security disability benefits after filing an initial application. Delaware Online, Shut Out of Social Security: A Special Report, <http://php.delawareonline.com/federal/alj.php?queryName=byState> (last visited Apr. 15, 2010) (determining percentage from combined initial denials of all fifty states and Washington, D.C.). Tennessee has the highest denial rate—about 92.8%. *Id.*

³⁰ 20 C.F.R. § 404.900(3) (2009); see also U.S. Dep't of Labor, Who Are ALJs and How Are They Appointed?, <http://www.oalj.dol.gov/FAQ4.HTM> (last visited Apr. 15, 2010) ("The position of Administrative Law Judge (ALJ), originally called hearing examiner, was created by the Administrative Procedure Act of 1946, Public Law 79-404. The Act insures fairness and due process in Federal agency rule making and adjudication proceedings. It provides those parties whose affairs are controlled or regulated by agencies of the Federal Government an opportunity for a formal hearing on the record before an impartial hearing officer. . . . [T]he Administrative Procedure Act includes provisions that give administrative law judges protections from improper influences and ensure independence when conducting formal proceedings, interpreting the law, and applying agency regulations in the course of administrative hearings.").

A hearing before an ALJ gives the claimant the opportunity to speak to the ALJ personally and explain why he is disabled and unable to work. This is an advantage over the initial and reconsideration levels, where decisions are based solely on the claimant's medical records. SOC. SEC. ADMIN., APPEALS, *supra* note 29, at 1–2.

³¹ 20 C.F.R. § 404.1520 (2009).

³² *Id.* § 404.1520(a)(4)(i). Substantial gainful activity is "work activity that involves doing significant physical or mental activities" that the claimant does for pay or profit. *Id.* § 404.1572(a)–(b). "A person who is earning more than a certain monthly amount (net of impairment-related work expenses) is ordinarily considered to be engaging in SGA." Soc. Sec. Admin., Substantial Gainful Activity, <http://www.socialsecurity.gov/OACT/COLA/>

work at the time of the hearing, the ALJ will find the claimant not disabled.³³ If, however, the claimant is not engaged in substantial gainful activity, the ALJ then begins step two by considering the claimant's alleged impairments and the severity of those conditions.³⁴ In addition, the ALJ also determines the length of time that the impairment is expected to last; unless the impairment is expected to result in death, it must continue or be expected to continue for at least twelve consecutive months.³⁵ Third, once alleged impairments have been substantiated, the ALJ will then determine whether those impairments meet or equal a Social Security listing.³⁶ Currently, there are 114 sub-categories of physical³⁷ and nine sub-categories of mental listings that a claimant can potentially meet.³⁸ If the listing requirements are satisfied, the claimant

sga.html (last visited Apr. 15, 2010). In 2010, for a non-blind claimant, up to \$1,000 gross could be earned without adversely affecting the claimant's application for disability benefits. *Id.*

³³ 20 C.F.R. § 404.1520(a)(4)(i) (2009).

³⁴ See *id.* § 404.1520(a)(4), (a)(4)(ii). An impairment "is not severe if it does not significantly limit your physical or mental ability to do basic work activities." *Id.* § 404.1521(a). The ALJ will examine the record to determine whether an impairment is severe. *Id.* § 404.1520(a)(4)(ii). Typically, the record will contain treatment notes, test results, and physician opinions, which the claimant is responsible for submitting to the ALJ. *Id.* § 404.1512(b)–(c). "Basic work activities" include understanding, use of judgment, responding appropriately to supervision and co-workers, and dealing with changes in a routine work setting. *Id.* § 1521(b).

³⁵ *Id.* § 404.1509.

³⁶ *Id.* § 404.1520(a)(4)(iii); see also Soc. Sec. Admin., Disability Evaluations Under Social Security (Sept. 2008), <http://www.ssa.gov/disability/professionals/bluebook/listing-impairments.htm> (last visited Apr. 15, 2010) ("The Listing of Impairments describes, for each major body system, impairments considered severe enough to prevent an individual from doing any gainful activity Most of the listed impairments are permanent or expected to result in death, or the listing includes a specific statement of duration is made. For all other listings, the evidence must show that the impairment has lasted or is expected to last for a continuous period of at least 12 months.").

³⁷ The primary categories for physical impairments include the musculoskeletal system, special senses and speech, respiratory system, cardiovascular system, digestive system, genitourinary impairments, hematological disorders, skin disorders, endocrine system, impairments that affect multiple body systems, neurological, malignant neoplastic diseases, and immune system disorders. 20 C.F.R. pt. 404, subpt. P, app. 1, §§ 1.00–12.00 (2009).

³⁸ The nine Social Security mental listings are: organic mental disorders; schizophrenic, paranoid, and other psychotic disorders; affective disorders; mental retardation; anxiety-related disorders; somatoform disorders; personality disorders; substance addiction disorders; and autistic disorder and other pervasive developmental disorders. *Id.* § 12.02–12.10.

Each listing consists of requirements which the claimant must meet; the listings are divided into paragraph A criteria (a set of medical findings) and paragraph B and C criteria (a set of impairment-related functional limitations). *Id.* § 12.00(A). To meet the requirements of paragraph A, the claimant must show the presence of a particular mental disorder through specific symptoms, signs, and laboratory findings. These findings,

will be adjudicated disabled.³⁹ Fourth, the ALJ will consider the claimant's residual functional capacity ("RFC") and his past relevant work.⁴⁰ For the fifth and final step, the ALJ reviews the claimant's RFC, age, education, and work experience to determine whether the individual can make an adjustment to other types of work if he no longer can perform his past work.⁴¹

A. What Is So Special About Mental Cases?

1. The Nature of Mental Disease

As previously noted, before an award of benefits will be made, the claimant must first show that the impairment has lasted or is expected to last at least twelve months.⁴² When a claimant has a chronic physical impairment—such as congestive heart failure or degenerative disc disease, which can be confirmed through objective medical testing—it is not significantly difficult to convince an ALJ that the limitations caused by this condition will likely persist for one year or longer. With physical diseases, surgical intervention or pain management may be required, and although limitations may improve after such treatment, the

however, must substantiate the existence of the disease according to Social Security's definition. *Id.*

Paragraphs B and C require a showing of "impairment-related functional limitations that are incompatible with the ability to do any gainful activity." *Id.* For example, in order to meet the criteria in paragraph B for Anxiety Related Disorders, the claimant must show at least two of the following (unless he can show a complete inability to function independently outside his home): marked restriction of activities of daily living; marked difficulties in maintaining social functioning; marked difficulties in maintaining concentration, persistence, or pace; or repeated episodes of decompensation, each of extended duration. *Id.* § 12.06(B).

³⁹ *Id.* § 1520(a)(4)(iii).

⁴⁰ *Id.* § 404.1520(a)(4)(iv). An RFC assessment is the most a claimant can do despite his limitations; the ALJ bases this assessment on the relevant evidence in the record. *Id.* § 404.1545(a)(1).

Ordinarily, RFC is the individual's maximum remaining ability to do sustained work activities in an ordinary work setting on a regular and continuing basis, and the RFC assessment must include a discussion of the individual's abilities on that basis. A "regular and continuing basis" means 8 hours a day, for 5 days a week, or an equivalent work schedule.

Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims, 61 Fed. Reg. 34,475 (July 2, 1996). Based on this rule, unless the ALJ can find that the claimant is capable of sustaining a forty-hour work-week, the ALJ must award disability benefits. *See* 20 C.F.R. § 404.1520(a)(4)(iv)–(v) (2009).

The past relevant work that the ALJ considers is the substantial gainful activity that the claimant has done within the previous fifteen years and that was done long enough for the claimant to learn how to do it. *Id.* § 404.1565(a).

⁴¹ *Id.* § 404.1520(a)(4)(v).

⁴² *Id.* § 1509.

claimant is unlikely to make a complete return to the physical state that was previously occupied.

With mental illness, however, there is a strong likelihood that the claimant's symptoms will worsen and then improve on a regular basis.⁴³ Individuals with bipolar disorder, for example, often experience periods of full functioning only to be followed by episodes of decompensation.⁴⁴ Bipolar disorder has been described as

a long-term condition that requires lifelong treatment, even during periods when you feel better. . . . Effective and appropriate treatment is vital for reducing the frequency and severity of manic and depressive episodes and allowing you to live a more balanced and enjoyable life. Maintenance treatment—continued treatment during periods of remission—also is important. People who skip maintenance treatment are at high risk of a relapse of their symptoms or having minor episodes turn into full-blown mania or depression.⁴⁵

As with many mental diseases, the severity of the symptoms may not be continuous for a twelve-month period.⁴⁶ Again, it is quite common for an individual suffering with severe mental limitations to regain an ability to function effectively for a period of time.⁴⁷ During this time, the

⁴³ David Mischoulon, *An Approach to the Patient Seeking Psychiatric Disability Benefits*, 23 ACAD. PSYCHIATRY 128, 131 (1999). It is estimated that approximately 5.7 million American adults, or about 2.6 percent of the U.S. population age 18 and older are personally affected by bipolar disorder in any given year. Nat'l Inst. of Mental Health, *The Numbers Count: Mental Disorders in America*, <http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml#KesslerPrevalence> (last visited Apr. 15, 2010) (extrapolating from Ronald C. Kessler et al., *Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 ARCHIVES OF GEN. PSYCHIATRY 617, 620 (2005)).

⁴⁴ Mayo Clinic, *Bipolar Disorder*, <http://www.mayoclinic.com/health/bipolar-disorder/DS00356> (last visited Apr. 15, 2010).

⁴⁵ *Bipolar Depression Symptoms, Treatments and Drugs*, <http://bipolardepression.com> (last visited Apr. 15, 2010).

⁴⁶ See Mischoulon, *supra* note 43, at 131 (“[D]etermination of psychiatric disability is not simple, largely because determination involves a prediction of the future. Outpatient clinic assessments may not reflect the true extent of disability. Disability may fluctuate with time, as seen in patients with bipolar disorder who may be very productive during a manic or hypomanic phase, but very unproductive during a depressed phase. Emphasis may be placed on subjective (nonmeasurable) rather than objective (measurable) impairments. Histories presented may not be corroborated, and patients may exaggerate or falsify their symptoms. Sadly, a few cases can cloud the fact that people do become disabled from psychiatric illness.” (citing H.A. Pineus et al., *Determining Disability Due to Mental Impairment: APA's Evaluation of Social Security Administration Guidelines*, 148 AM. J. PSYCHIATRY 1037, 1042 (1991); C.R. Brewin et al., *The Assessment of Psychiatric Disability in the Community: A Comparison of Clinical, Staff, and Family Interviews*, 157 BRIT. J. PSYCHIATRY 671 (1990); H. Massel et al., *Evaluating the Capacity to Work of the Mentally Ill*, 53 PSYCHIATRY 31 (1990); Mansel Aylward & John J. Locascio, *Problems in the Assessment of Psychosomatic Conditions in Social Security Benefits and Related Commercial Schemes*, 39 J. PSYCHOSOMATIC RES. 755, 757–58 (1995))).

⁴⁷ *Id.*

claimant may feel well enough to return to work only to deteriorate at a later date.⁴⁸ This individual, however, cannot be expected to be reliable in sustaining full-time employment. Nonetheless, ALJs frequently deny a mentally impaired claimant because the mental limitations were briefly interrupted with periods of functioning.⁴⁹

2. Ability to Function with Medication but Failure to Maintain Treatment

If psychiatric treatment notes indicate that a claimant's functioning has improved with medication or that the claimant has been noncompliant with treatment, an ALJ will repeatedly deny a claimant on the basis that the claimant can sustain full-time employment when taking medication on a regular basis.⁵⁰ When such a situation is present, the ALJ has a legitimate ground to deny benefits⁵¹ because such a claimant is likely to perform successfully in a work environment as long as the medication continues to suppress the symptoms.

Often, however, the ALJ fails to take into consideration that a symptom of mental illness is voluntary noncompliance with medication.⁵² This often occurs because those with mental health issues feel the disgrace that comes with their diagnosis.⁵³ Once medicated, the claimant

⁴⁸ *See id.*

⁴⁹ *See, e.g.,* Barnhart v. Walton, 535 U.S. 212 (U.S. 2002) (upholding the SSA's denial of benefits to a mentally ill claimant who managed to work for a brief period after 11 months of disability, since the Court ruled the Agency's twelve month requirement was a permissible statutory interpretation).

⁵⁰ *See* 20 C.F.R. § 404.1530(b) (2009).

⁵¹ *Id.*

⁵² *See* Mark Olsson et al., *Predicting Medication Noncompliance After Hospital Discharge Among Patients with Schizophrenia*, 51 PSYCHIATRIC SERVS. 216, 221 (2000).

⁵³ Sarah, a twenty-six year old college graduate with psychosis and multiple personality disorder, explained the stigma of her mental disease and how it affected her life:

I worry a lot about, you know, asking my mom for so much support, because she does have limited resources. And for that I thought it was acceptable to take some sort of help, because otherwise it was going to come out of her pocket. And you know, it's such an ordeal to get approved for stuff like that. You have to basically say, "I'm incompetent to be a person." You know, I mean, you really have to declare yourself a complete basket case, and that's very upsetting, you know. Nobody likes to say, you know, "I can't cope and I won't be able to cope for a while." I don't like thinking of myself as a disabled person. On the other hand, had my parents not taken me in, I literally would have been homeless. I didn't have a home anymore. I didn't have anybody else to take care of me. . . .

God, you know, if there were any alternative, if there were any way to have handled a job, I definitely would have gone for that instead. I don't think anybody gets on disability because they're too lazy, because it's too much of a job to get the disability. . . . Well, for one thing, they make you feel like you're a, you're trying to cheat somebody out of something when you're applying.

Estroff et al., *supra* note 9, at 501-02.

typically begins to feel better.⁵⁴ This euphoric state, however, then causes the claimant to think, “I don’t need this medication. I feel fine. There’s nothing wrong with me.”⁵⁵ Shortly thereafter, the claimant stops taking his medication and begins to experience the debilitating symptoms that caused the initial need for the medication.⁵⁶ Sadly, it becomes a vicious cycle. In fact, the Mayo Clinic advises its schizophrenic patients of the challenges that await while on the road to recovery.⁵⁷

[I]t’s often difficult for people with schizophrenia to stick to their treatment plans. You may believe that you don’t need medications or other treatment. Also, if you’re not thinking clearly, you may forget to take your medications or to go to therapy appointments. . . . Even with good treatment, you may have a relapse.⁵⁸

Voluntary noncompliance with medication is a commonly recognized symptom in the mental health arena.⁵⁹ Robert Heinssen, Ph.D., of the National Institute of Mental Health, has faced such challenges while treating a patient to whom he refers as “Ms. J.”⁶⁰ According to Dr. Heinssen, Ms. J. has suffered with schizophrenia for over fifteen years.⁶¹ During this time, she has been admitted to psychiatric facilities on a regular basis and has been prescribed numerous antipsychotic medications. “The reasons Ms. J. gave for stopping her medications included . . . a belief that ‘I should be able to make it on my own,’ and difficulty remembering dosing times.”⁶²

Dr. Heinssen also noted that “her lingering reservations about prophylactic pharmacotherapy threatened her commitment to long-term medication compliance.”⁶³ In addition, a study performed by the Institute for Health at Rutgers University found that “one in five patients with schizophrenia reported missing one week or more of oral antipsychotic medications during the first three months after hospital discharge.”⁶⁴

⁵⁴ Mayo Clinic, Schizophrenia, <http://www.mayoclinic.com/health/schizophrenia/DS00196/DSECTION=treatments-and-drugs> (last visited Apr. 15, 2010).

⁵⁵ *See id.*

⁵⁶ OhioHealth, Schizophrenia, <http://www.ohiohealth.com/blank.cfm?print=yes&id=6&action=detail&ref=1081> (last visited Apr. 15, 2010) (citing Mayo Clinic, Schizophrenia, *supra* note 54).

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ *See* Robert K. Heinssen, *Improving Medication Compliance of a Patient with Schizophrenia Through Collaborative Behavioral Therapy*, 53 PSYCHIATRIC SERVS. 255, 255 (2002).

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*

⁶⁴ Olfson et al., *supra* note 52, at 221. It was also noted that “patients whose families refuse[] to participate in treatment” and those “who have difficulty recognizing their own symptoms” are at high risk for medication noncompliance. *Id.*

Despite documented research that a claimant's failure to comply with recommended treatment is actually a symptom of the disease, ALJs continue to deny benefits on this basis.⁶⁵ While an ALJ can legitimately deny a physically impaired claimant who refuses to follow physician treatment plans,⁶⁶ a claimant with a mental condition presents a unique situation which should be considered further. A claimant with a mental impairment—as opposed to a physical one—has significant chemical imbalances in the brain that affect the claimant's ability to make rational decisions,⁶⁷ such as the need to take medication regularly. This is a facet of mental disease which the ALJ should be required to take into consideration when determining whether the claimant is entitled to disability benefits instead of mechanically denying the claimant because of noncompliance with medication.

3. Noncompliance with Recommended Treatment Due to Financial Inability

Although ALJs typically deny claimants with mental or physical impairments due to noncompliance with medical treatment, many ALJs do not adequately attempt to determine the reasons for the noncompliance;⁶⁸ instead, if treatment notes reflect noncompliance, the ALJ now has a regulatory-supported basis for denial.⁶⁹ While there are compelling public policy reasons for denying a non-compliant claimant, such as a desire to deter willful disobedience of a treating physician's recommendations, there are also a myriad of justifiable reasons why a claimant may be in noncompliance. These permissible reasons should include a lack of health insurance or an inability to afford the co-pay for medications.⁷⁰

⁶⁵ See 20 C.F.R. § 404.1530(b) (2009).

⁶⁶ *Id.*

⁶⁷ *E.g.*, Mayo Clinic, Bipolar Disorder, <http://www.mayoclinic.com/health/bipolar-disorder/DS00356/DSECTION=causes> (last visited Apr. 15, 2010); Mayo Clinic, Schizophrenia, *supra* note 54.

⁶⁸ For example, in *Simons v. Heckler*, a district judge reversed the ALJ's denial of benefits to a mentally ill claimant when the ALJ had based that denial on claimant's refusal, without satisfactory explanation, to seek treatment. The judge explained that excuses that "may seem irrational" can be consistent with the symptoms of the applicant's mental illness, indicating that ALJs should examine whether refusals are caused by the illness itself. 567 F. Supp. 440, 444 (E.D. Pa. 1983); *see also* *Benedict v. Heckler*, 593 F. Supp. 755, 761 (E.D.N.Y. 1984) (explaining that denial of benefits to mentally ill claimants because their refusal of treatment is unreasonable "mocks the idea of disability based on mental impairments").

⁶⁹ 20 C.F.R. § 404.1530(b) (2009).

⁷⁰ Many claimants find themselves without health insurance when their disability forces them to quit or when they are fired from their jobs. Without full-time employment, it is extremely difficult for an insurance company to provide adequate health care coverage.

Atypical issues arise when a claimant with mental impairments has not complied with prescribed treatment, and the ALJ should bear the burden of determining the reasons underlying noncompliance before the claimant can be denied. Additional investigation is needed because the reason for noncompliance may not always be evident. For example, even when a claimant is covered by health insurance, it may not provide adequate coverage when the claimant suffers with a mental disorder.⁷¹

Health insurance coverage for psychiatric illnesses, when available, may have high deductibles and copayments, limited visits, or other restrictions that are not equal to the benefits for other medical disorders. . . . The newer medications that can be so helpful for most patients are unfortunately more expensive than the older ones.⁷²

If a claimant is in noncompliance with recommended treatment due to financial difficulties and has made a good-faith attempt to treat the condition, the claimant should not be penalized due to reasons beyond the claimant's control. Unfortunately, ALJs can continue to fault claimants because of noncompliance, even when reasonable efforts have been made. To prevent an unjust outcome, a burden should be placed on the ALJ to question the claimant regarding any notations of noncompliance in the record while the claimant is testifying at his hearing. If the claimant provides an objectively reasonable explanation, the ALJ should be prohibited from basing a denial on noncompliance.

III. PROVING A MENTAL IMPAIRMENT EXISTS

To convince an ALJ that an award of benefits should be made, the claimant must begin by showing that the mental disorder significantly limits the claimant's ability to perform basic work activities.⁷³ Again, mental disorders are unique in the disability circuit when compared to physical conditions. The strongest evidence a claimant can offer when applying for disability benefits is objective evidence, such as a MRI report or X-ray findings.⁷⁴ Few ALJs will argue with a heart catheterization showing Coronary Artery Disease or a CT scan of the

Furthermore, as claimants find themselves unemployed, they are forced to rely on family for support, further depleting financial resources. See Estroff et al., *supra* note 9, at 502.

⁷¹ Peter J. Weiden et al., *Expert Consensus Treatment Guidelines for Schizophrenia: A Guide for Patients and Families*, 60 J. CLIN. PSYCHIATRY 73, 76 (Supp. 11 1999).

⁷² *Id.*

⁷³ 20 C.F.R. § 404.1520(c) (2009). If significant limitation is established, the ALJ will find the claimant's limitations to be "severe." See *id.* §§ 404.1520(c), 416.920(c) (2009). A "slight abnormality" that has only a "minimal effect" on the claimant's ability to work is considered "not severe." *Id.* §§ 404.1521(a), 416.921(a); Soc. Sec. Rul. 85-28; Titles II and XVI: Considering Allegations of Pain and Other Symptoms in Determining Whether a Medically Determinable Impairment Is Severe, 61 Fed. Reg. 34,468, 34,470 (July 2, 1996).

⁷⁴ See *Titles II and XVI: Considering Allegations of Pain and Other Symptoms*, 61 Fed. Reg. at 34,469.

abdomen revealing an inoperable aneurysm. In this regard, physically impaired claimants have an advantage over the mentally impaired, as test results can definitively confirm or deny the existence of a debilitating condition.

With mental impairments, however, medical science has yet to produce a purely objective method that can fully substantiate an allegation of an existing mental illness.⁷⁵ Because there is a lack of advanced medical technology for confirming a mental diagnosis, ALJs are forced to rely on psychiatric treatment notes, medical opinions of treating physicians, and GAF assessments.⁷⁶

A. Psychiatric Treatment Notes and Clinician Opinions

To confirm the existence of a mental impairment, the ALJ will often begin by reviewing the record to see whether the claimant is getting ongoing psychiatric treatment.⁷⁷ If so, the treatment notes should then reveal the specific treatment undergone by the claimant as well as diagnoses. The ALJ will also look for such information when the claimant is asserting disability based on a physical impairment, but once again, mentally ill claimants present distinctive challenges.

In order to prove disability, the claimant bears the burden of submitting medical evidence which supports the claimant's allegations.⁷⁸ When a mental disability is alleged, the claimant will typically submit treatment notes and/or hospital records from admissions to substantiate the disability.⁷⁹

But before an ALJ will even consider such evidence, the ALJ must be persuaded that the treatment has been provided by an "acceptable medical source."⁸⁰ If the ALJ believes that the evidence does not

⁷⁵ When considering subjective evidence such as a claimant's symptoms, the ALJ will then make a credibility determination. Titles II and XVI: Symptoms, Medically Determinable Physical and Mental Impairments, and Exertional and Nonexertional Limitations, 61 Fed. Reg. 34,488, 34,489 (July 2, 1996); Titles II and XVI: Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements, 61 Fed. Reg. 34,483, 34,485 (July 2, 1996).

⁷⁶ *Id.*

⁷⁷ See *infra* Part III.B. for discussion concerning Global Assessment of Functioning ("GAF") ratings. "A GAF score may help an ALJ assess mental RFC, but it is not raw medical data. Rather, it allows a mental health professional to turn medical signs and symptoms into a general assessment, understandable by a lay person, of an individual's mental functioning." *Kornecky v. Comm'r of Soc. Sec.*, 167 Fed. App'x 496, 503 n.7 (6th Cir. 2006) (citing AM. PSYCHIATRIC ASSOC., DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed., text rev. 2000)).

⁷⁸ 20 C.F.R. § 404.1512(a), (c) (2009).

⁷⁹ *Id.* § 404.1512(b)(2).

⁸⁰ Social Security regulations distinguish between an "acceptable medical source" and "other sources." 20 C.F.R. § 404.1513(a), (d) (2009); Titles II and XVI: Considering

originate from such a source, the evidence does not have to be considered, regardless of how comprehensive it is.⁸¹ In regard to mental health providers, Social Security Rules provide that the only acceptable medical sources that the ALJ may consider are psychiatrists and licensed psychologists.⁸² All other providers, such as Licensed Clinical Social Workers and therapists, are considered “other sources,”⁸³ and evidence from these providers “may be based on special knowledge of the individual and may provide insight into the severity of the impairment(s) and how it affects the individual’s ability to function.”⁸⁴ An ALJ is not required to consider opinions,⁸⁵ diagnoses, or prognoses from these sources.⁸⁶ This is very important, as medical opinions of an “acceptable medical source” are entitled to substantial deference, and if not contradicted, controlling weight must be given.⁸⁷

A problem arises under these rules because many mental-health specialists keep poor treatment notes, particularly psychiatrists who are one of the few “acceptable medical sources.”⁸⁸ This is because

Opinions and Other Evidence from Sources Who Are Not “Acceptable Medical Sources” in Disability Claims, 71 Fed. Reg. 45,593, 45,594 (Aug. 9, 2006).

⁸¹ *Titles II and XVI: Considering Opinions and Other Evidence*, 71 Fed. Reg. at 45,594.

⁸² *Id.*

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ Medical opinions are “judgments about the nature and severity of . . . impairment(s), including . . . symptoms, diagnosis and prognosis, what [one] can still do despite impairment(s), and [an individual’s] physical or mental restrictions.” 20 C.F.R. § 404.1527(a)(2) (2009). A treating source will often have more than one medical opinion, including “at least one diagnosis, a prognosis, and an opinion about what the individual can still do.” *Titles II and XVI: Giving Controlling Weight to Treating Source Medical Opinions*, 61 Fed. Reg. 34,490, 34,491 (July 2, 1996). It is important to note that a mental health professional’s opinion toward disability may affect the opinions rendered.

For example, a practitioner with strong beliefs about personal responsibility may be opposed, on principle, to disability seeking, and may view the patient as being rewarded for idleness. Conversely, a practitioner with more liberal beliefs may be inclined to sympathize with a disability-seeking patient. Psychiatrists need to be aware of their personal and political values and not allow them to cloud their clinical judgment.

Mischoulon, *supra* note 43, at 131 (citing Elliott M. Heiman & Stephen B. Shanfield, *Psychiatric Disability Assessment: Clarification of Problems*, 19 COMP. PSYCHIATRY 449 (1978)).

⁸⁶ 20 C.F.R. § 404.1513 (2009); *Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not “Acceptable Medical Sources” in Disability Claims*, 71 Fed. Reg. 45,593, 45,594 (Aug. 9, 2006).

⁸⁷ 20 C.F.R. § 404.1527(d)(2) (2009).

⁸⁸ E-mail from Dennis Pash, Attorney, Dale L. Buchanan & Assoc., to author (Nov. 24, 2008, 05:59 EST) (on file with author) (“These treatment notes have [two] problems—being scant and being often unreadable (and ALJs often declare the records invalid or not useful in spite of seeking clarification or transcription).”).

psychiatrists primarily meet with patients only when a change in medication is needed or for follow-up appointments.⁸⁹ This appears to be the trend among mental-health providers, as the Palo Alto Medical Foundation, a multi-specialty health care provider, acknowledges that

[a]ll of our doctors do see some patients for therapy, but this is a smaller part of their practice since most of their time is used for medication evaluations and follow up. We have a team of highly qualified psychotherapists, including licensed clinical social workers, who do the bulk of psychotherapy⁹⁰

Because psychiatrists predominantly meet with patients for medication purposes, psychiatric treatment notes seldom note a claimant's ability, or lack thereof, to perform daily activities or function in a potentially stressful environment. Instead, such treatment notes contain general notations, such as "patient functioning well on medication" or "Seroquel made her feel like she was under water. Trazodone was substituted." These statements, although helpful, do not provide adequate insight into the claimant's ability to successfully function in a work environment.⁹¹

In order to get a complete picture of the claimant's daily struggles, treatment notes from talk therapy sessions are typically more helpful, as those tend to provide a more detailed description of the claimant's symptoms and functioning levels.⁹² Having this consistent one-on-one contact with the patient, the mental-health provider often makes preliminary diagnoses based on the symptoms that have been discussed and observed.⁹³ Talk therapy sessions are, however, predominately conducted by therapists or licensed clinical social workers who are not "acceptable medical sources" under Social Security regulations;⁹⁴ thus, the ALJ is not required to consider this potentially comprehensive evidence.⁹⁵

This is a common challenge that many mentally disabled claimants face while seeking disability benefits. These claimants are often treated by a licensed clinical social worker for weekly therapy sessions and meet

⁸⁹ *Id.*; Palo Alto Medical Found., Psychiatry & Behavioral Health, <http://pamf.org/psychiatry/services/faq.html> (last visited Apr. 15, 2010) (follow "Why don't [sic] your psychiatrist see more patients for therapy?" hyperlink).

⁹⁰ Palo Alto Medical Found., *supra* note 89.

⁹¹ See 20 C.F.R. § 404.1513(c)(2) (2009).

⁹² Mayo Clinic, Psychotherapy, <http://www.mayoclinic.com/health/psychotherapy/MY00186> (last visited Apr. 15, 2010).

⁹³ *Id.*

⁹⁴ JEROME D. FRANK & JULIA B. FRANK, PERSUASION & HEALING: A COMPARATIVE STUDY OF PSYCHOTHERAPY 15 (3d ed. 1993).

⁹⁵ *Cf.* 20 C.F.R. § 404.1513(a) (2009) (distinguishing between an "acceptable medical source" and "other sources"); Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not "Acceptable Medical Sources" in Disability Claims, 71 Fed. Reg. 45,593, 45,594 (Aug. 9, 2006) (same).

with the overseeing psychiatrist only when medication changes are necessary.⁹⁶ Upon applying for disability benefits, the claimant will then submit the treatment notes of the therapist with no guarantee that the ALJ will actually consider the diagnoses and opinions found therein.⁹⁷

This Social Security rule⁹⁸ should be repealed to ensure that all relevant evidence will be considered, regardless of whether the source is a psychiatrist or therapist. In its place, a rule requiring the ALJ to consider the opinions of all mental health providers should be promulgated, especially when the provider and the claimant have had an ongoing treating relationship as evidenced by the record.

B. GAF Ratings

In 1952, the American Psychiatric Association published the Diagnostic and Statistical Manual of Mental Disorders⁹⁹ (“DSM”), “the standard classification of mental disorders used by mental health professionals in the United States.”¹⁰⁰ The DSM has been referred to as

⁹⁶ There are, however, few mental health professionals who feel experienced enough to give an opinion regarding a patient’s ability to maintain a full-time work schedule.

Psychiatrists need to learn how to respond appropriately to petitions for psychiatric disability benefits. Unfortunately, most psychiatric residency training programs do not include disability assessment in their didactic curricula, and supervising psychiatrists may be reluctant to address the subject during supervision of residents. This shortcoming may stem from a general unfamiliarity with the mechanics of a disability assessment and the countertransference issues that frequently arise when a patient presents with a disability petition. Consequently, the discomfort with disability assessment may be perpetuated to the next generation of psychiatrists, as the psychiatric resident may feel anxious, frustrated, and inadequately supported when called upon to perform a disability evaluation. This inadequacy may cause the resident to feel resentful or hostile, and present a threat to the doctor-patient alliance.

Mischoulon, *supra* note 43, at 128–29 (citing Allen J. Enelow, *Psychiatric Disorders and Work Function*, 21 PSYCHIATRIC ANNALS 27 (1991)).

⁹⁷ See 20 C.F.R. § 404.1513(a).

⁹⁸ *Id.*

⁹⁹ Am. Psychiatric Assoc., Post-World War II, http://www.psych.org/MainMenu/Research/DSMIV/History_1/PostWarClassifications.aspx (last visited Apr. 15, 2010). Since 1952, there have been five revisions to the DSM. *Id.*; Am. Psychiatric Assoc., Development of DSM-III, http://www.psych.org/MainMenu/Research/DSMIV/History_1/DevelopmentofDSMIII.aspx (last visited Apr. 15, 2010). The most recent revision was the DSM-IV, which was published in 1994. AM. PSYCHIATRIC ASSOC., *supra* note 77; Am. Psychiatric Assoc., DSM-III-R and DSM-IV, http://www.psych.org/MainMenu/Research/DSMIV/History_1/DSMIIIandDSMIV.aspx (last visited Apr. 15, 2010). The DSM-V is due for publication in May 2013. Am. Psychiatric Assoc., DSM-V: The Future Manual, <http://www.psych.org/MainMenu/Research/DSMIV/DSMV.aspx> (last visited Apr. 15, 2010).

¹⁰⁰ Am. Psychiatric Assoc., Diagnostic and Statistical Manual, <http://www.psych.org/MainMenu/Research/DSMIV.aspx> (last visited Apr. 15, 2010) [hereinafter Am. Psychiatric Assoc., DSM].

“the psychiatric bible,”¹⁰¹ and is consulted by practitioners in different psychiatric specialty fields, such as biological, psychodynamic, cognitive, behavioral, interpersonal, and family systems.¹⁰²

As a result of reliance on the DSM, diagnoses and prognoses from psychiatric treating sources fall into one of five axes:

- Axis I Mental Disorders
- Axis II Developmental Disorders and Personality Disorders
- Axis III Physical Disorders and Conditions
- Axis IV Severity of Psychosocial Stressors
- Axis V Global Assessment of Functioning.¹⁰³

Axis V, GAF, has become an important aspect in the treatment of psychiatric disorders and in the adjudication of disability benefits.¹⁰⁴ A GAF is a number on a scale of 1–100¹⁰⁵ that indicates “the clinician’s judgment of the individual’s overall level of functioning[, and] is to be rated with respect only to psychological, social, and occupational functioning.”¹⁰⁶

IV. THE IMPACT OF THE GAF IN THE DISABILITY REALM

Although the GAF has been an aspect of the mental health profession for quite some time,¹⁰⁷ courts appear to be at odds as to what to do with it. Since a GAF is a “judgment of the individual’s overall level of functioning,”¹⁰⁸ does this mean that it is the equivalent of a medical opinion? If so, the score is entitled to substantial deference at the least.¹⁰⁹ Or is a GAF just another piece of evidence to be considered in combination with the record? The Social Security Administration has not directly answered this question, but has taken the stance that a claimant’s GAF score “does not have a direct correlation to the severity requirements.”¹¹⁰ The Social Security Administration does, however,

¹⁰¹ See HERB KUTCHINS & STUART A. KIRK, MAKING US CRAZY: DSM: THE PSYCHIATRIC BIBLE AND THE CREATION OF MENTAL DISORDERS (1997).

¹⁰² Am. Psychiatric Assoc., DSM, *supra* note 100.

¹⁰³ AM. PSYCHIATRIC ASSOC., *supra* note 77, at 27.

¹⁰⁴ See *id.* at 32.

¹⁰⁵ See *infra* Addendum. The GAF scale ranges from 1 (severe limitations as evidenced by a continuous likelihood of harming self or others) to 100 (no limitations in the ability to function). *Id.*

¹⁰⁶ AM. PSYCHIATRIC ASSOC., *supra* note 77, at 32.

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ 20 C.F.R. § 404.1527(d)(2). This is only the case if the GAF assessment is provided by an “acceptable medical source.” If not, the score does not have to be considered. *Id.* § 404.1513(a), (d); Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not “Acceptable Medical Sources” in Disability Claims, 71 Fed. Reg. 45,593, 45,594 (Aug. 9, 2006).

¹¹⁰ Revised Medical Criteria for Evaluating Mental Disorders and Traumatic Brain Injury, 65 Fed. Reg. 50,746, 50,764–65 (Aug. 21, 2000).

acknowledge it as the medical tool used by clinicians to “assess current treatment needs and provide a prognosis.”¹¹¹

Because there is not a direct and definitive answer to whether a GAF is a medical opinion, different circuits have taken differing—and conflicting—approaches.

A. The Sixth Circuit: A GAF Is Not a Medical Opinion

The Sixth Circuit has consistently held that a GAF is not a medical opinion entitled to substantial deference.¹¹² In 1996, the Circuit held that a GAF is “a subjective determination” that must be supported by the entire record in order to be considered.¹¹³ The Circuit affirmed its decision seven years later in *Howard v. Commissioner of Social Security*.¹¹⁴ There, Ms. Howard had filed suit in federal court, requesting that the ALJ’s decision be reversed for several reasons, one of which was the ALJ’s failure to consider her GAF scores on four different occasions.¹¹⁵ She claimed that this failure had caused the ALJ’s RFC to be inaccurate.¹¹⁶ The court stated that “[w]hile a GAF score may be of considerable help to the ALJ in formulating the RFC, it is not essential to the RFC’s accuracy. Thus, the ALJ’s failure to reference the GAF score in the RFC, standing alone, does not make the RFC inaccurate.”¹¹⁷

More recently, the Circuit has specifically stated that “[a] GAF score may help an ALJ assess mental RFC, but it is not raw medical data. Rather, it allows a mental health professional to turn medical signs and symptoms into a general assessment, understandable by a lay person, of an individual’s mental functioning.”¹¹⁸ Again, the Circuit described a GAF as “a clinician’s subjective rating.”¹¹⁹

B. The Third Circuit: A GAF Is a Medical Opinion

In contrast, Third Circuit case law specifically requires an ALJ to “consider all the evidence and give some reason for discounting the

¹¹¹ *Id.* at 50,764.

¹¹² *See, e.g.*, *Kornecky v. Comm’r of Soc. Sec.*, 167 Fed. App’x 496, 503 n.7 (6th Cir. 2006); *Howard v. Comm’r of Soc. Sec.*, 276 F.3d 235, 241 (6th Cir. 2002) (citing *Hardaway v. Sec’y of Health & Human Servs.*, 823 F.2d 922, 927 (6th Cir. 1987)).

¹¹³ *Rutter v. Comm’r of Soc. Sec.*, No. 95-1581, 1996 U.S. App. LEXIS 19136, at *4–5 (6th Cir. July 15, 1996).

¹¹⁴ *Howard*, 276 F.3d at 241.

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ *Id.*

¹¹⁸ *Kornecky*, 167 Fed. App’x at 503 n.7.

¹¹⁹ *Id.*

evidence she rejects.”¹²⁰ Within the Third Circuit, the Eastern District of Pennsylvania has taken the approach that a GAF is a medical opinion because it is widely used by mental health professionals.¹²¹

In *Dougherty v. Barnhart*, Ms. Dougherty applied for disability benefits, alleging disability due to bipolar disorder, anxiety, and other physical impairments.¹²² After being denied by the ALJ, and having that decision later affirmed by the Social Security Administration’s Appeals Council, Ms. Dougherty filed a complaint against the Commissioner in federal district court.¹²³ Ms. Dougherty argued that her mental impairments were disabling, which was supported by several GAFs found in the record that the ALJ failed to consider.¹²⁴ Conversely, the Commissioner argued that the scores were not supported by the evidence and that Ms. Dougherty was “attempting to rely upon isolated GAF results.”¹²⁵ The court was unconvinced by the Commissioner’s arguments and held that, because a GAF is a piece of medical evidence that has been relied upon by the mental health profession and is reliable, it “must be addressed by an ALJ in making a determination regarding a claimant’s disability.”¹²⁶

The court’s decision was supported by numerous cases in support of its holding that a GAF is a medical opinion. In *Escardille v. Barnhart*, an ALJ’s unfavorable decision was reversed because the ALJ failed to mention the claimant’s GAF score of 50.¹²⁷ In its holding, the district court found that the score “constituted a specific medical finding that [the claimant] was unable to perform competitive work.”¹²⁸ In *Colon v. Barnhart*, the Eastern District of Pennsylvania once again held that “in light of Plaintiff’s total GAF score history, the ALJ was required to discuss his reasons for not even considering the two GAF scores of 50, leading up to the disability determination in this case.”¹²⁹ The court also reprimanded the ALJ for “cherry-picking” the higher GAF scores while completely disregarding the lower scores.¹³⁰ In *Span ex rel. R.C. v.*

¹²⁰ *Adorno v. Shalala*, 40 F.3d 43, 48 (3d Cir. 1994) (citing *Stewart v. Sec’y of Health, Educ., & Welfare*, 714 F.2d 287, 290 (3d Cir. 1983)).

¹²¹ *Dougherty v. Barnhart*, No. 05-5383, 2006 U.S. Dist. LEXIS 58562, at *28 (E.D. Pa. Aug. 21, 2006).

¹²² *Id.* at *1–2.

¹²³ *Id.* at *1–3.

¹²⁴ *Id.* at *13. Ms. Dougherty was given a GAF of 40 on three occasions, including a GAF of 55 and 60. *Id.* A score of 50 or lower is considered disabling. *Id.* at *31 n.5; *infra* Addendum.

¹²⁵ *Dougherty*, 2006 U.S. Dist. LEXIS 58562, at *28.

¹²⁶ *Id.*

¹²⁷ No. 02-2930, 2003 WL 21499999, at *7 (E.D. Pa. June 24, 2003).

¹²⁸ *Id.*

¹²⁹ 424 F. Supp. 2d. 805, 813 (E.D. Pa. 2006).

¹³⁰ *Id.* at 813–15.

Barnhart, the ALJ's decision was reversed and remanded because the written opinion did not indicate that the GAFs found in the record were considered; instead, the scores were merely listed in the opinion and the ALJ then adopted a doctor's opinion that the claimant was not disabled.¹³¹

C. The Tenth Circuit: A GAF Is a Medical Opinion, but on Second Thought, Maybe It Is Not

Some circuits, such as the Tenth Circuit, cannot decide whether a GAF is a medical opinion. This has resulted in conflicting opinions,¹³² leaving mentally ill claimants even more confused as to how supportive a GAF actually is to the disability claim.

In 2007, the Tenth Circuit remanded a decision because the ALJ failed to analyze the GAF "as the *opinion* of a treating physician as required by the regulations and our case law,"¹³³ and then subsequently held that a GAF is merely a piece of evidence to be considered with the rest of the record.¹³⁴ The Circuit has also held that "[s]tanding alone, a low GAF score does not necessarily evidence an impairment seriously interfering with a claimant's ability to work. The claimant's impairment, for example, might lie solely within the social, rather than the occupational sphere."¹³⁵

As a general rule, however, the Tenth Circuit has stated that an ALJ's written opinion "must demonstrate that the ALJ [has] considered all of the evidence," but discussion of every piece of evidence is not required; the ALJ is only required to refer to the "uncontroverted evidence he chooses not to rely upon, as well as significantly probative evidence he rejects."¹³⁶

V. THE THIRD CIRCUIT IS RIGHT: A GAF IS A MEDICAL OPINION ENTITLED TO SUBSTANTIAL DEFERENCE

A GAF is a medical opinion by its very nature. It is a "clinician's *judgment* of the individual's overall level of functioning."¹³⁷ According to

¹³¹ No. 02-CV-7399, 2004 U.S. Dist. LEXIS 12221, at *22, 29 (E.D. Pa. May 21, 2004).

¹³² Compare *Petree v. Astrue*, 260 Fed. App'x 33, 42 (10th Cir. 2007) ("[A] low GAF score does not alone determine disability, but is instead a piece of evidence to be considered with the rest of the record."), with *Lee v. Barnhart*, 117 Fed. App'x 674, 678 (10th Cir. 2004) ("[T]he GAF score should not have been ignored.")

¹³³ *Givens v. Astrue*, 251 Fed. App'x 561, 567 (10th Cir. 2007) (emphasis added).

¹³⁴ *Petree*, 260 Fed. App'x at 42.

¹³⁵ *Lee*, 117 Fed. App'x at 678 (citing *Eden v. Barnhart*, 109 Fed. App'x 311, 314 (10th Cir. 2004)).

¹³⁶ *Clifton v. Chater*, 79 F.3d 1007, 1009–10 (10th Cir. 1996) (citing *Vincent ex rel. Vincent v. Heckler*, 739 F.2d 1393, 1394–95 (9th Cir. 1984)).

¹³⁷ AM. PSYCHIATRIC ASSOC., *supra* note 77, at 32 (emphasis added).

Social Security's own rules, a medical opinion is a "*judgment*[]" about the nature and severity of [an individual's] impairment(s), including [his] symptoms, diagnosis and prognosis, what [he] can still do despite impairment(s), and [his] physical or mental restrictions."¹³⁸ Social Security's definition of a medical opinion describes a GAF perfectly. When determining a patient's GAF, the clinician is opining on the patient's highest and lowest ability to function socially, psychologically, and *occupationally*.¹³⁹

Moreover, mental health professionals "consider the GAF to be a key part of any outcomes assessment program. . . . [T]he information obtained through the GAF 'is useful in planning treatment and measuring its impact and in predicting outcome.'"¹⁴⁰ The GAF scale is not a new invention that has not been tested for reliability.¹⁴¹ "[T]he GAF probably is the single most widely used rating scale to assess impairment among patients with psychiatric . . . disorders."¹⁴²

This Note urges the Social Security Administration to promulgate a rule specifying that a GAF is a medical opinion. Because a GAF is a medical opinion and is widely relied upon by mental health clinicians and researchers when making determinations of functioning, the Social Security Administration should take its rule one step further by creating an inference of disability upon evidence of consistently poor GAF assessments.

When the record contains a string of GAF scores—the majority of which are disabling—an inference of disability should occur. The ALJ should then look to the remaining evidence and make a determination as to whether the record, in its totality, supports or rebuts the inference. If the treatment notes and opinions do not adequately rebut the inference created by the string of poor GAF scores, the ALJ must award disability benefits.

Such a standard is necessary for several reasons. First, mental disorders present many challenges for an ALJ when trying to make a

¹³⁸ 20 C.F.R. § 404.1527(a)(2) (2009) (emphasis added).

¹³⁹ Rudolf Moos et al., *Global Assessment of Functioning (GAF) Ratings: Determinants and Role as Predictors of One-Year Treatment Outcomes*, 56 J. CLINICAL PSYCHOL., 449, 450 (2000) [hereinafter Moos et al., *GAF Outcomes*].

¹⁴⁰ Rudolf Moos et al., *Global Assessment of Functioning Ratings and the Allocation and Outcomes of Mental Health Services*, 53 PSYCHIATRIC SERVS. 730, 730 (2002) [hereinafter Moos et al., *Ratings, Allocation, and Outcomes*] (citing Pamela Moriearty et al., *Incorporating Results of a Provider Attitudes Survey in Development of an Outcomes Assessment Program*, 14 AM. J. MED. QUALITY 178 (1999); M. Tracie Shea, *Core Battery Conference: Assessment of Change in Personality Disorders*, in MEASURING PATIENT CHANGES IN MOOD, ANXIETY, AND PERSONALITY DISORDERS 389 (Hans H. Strupp et al. eds., 1997); AM. PSYCHIATRIC ASSOC., *supra* note 77).

¹⁴¹ AM. PSYCHIATRIC ASSOC., *supra* note 77, at 32.

¹⁴² Moos et al., *GAF Outcomes*, *supra* note 139, at 450.

determination of disability. An inference takes the guess work out of the process and also protects a mentally disabled claimant from being denied erroneously. Second, a GAF assessment is a medical opinion regarding the claimant's ability to function in everyday activities, which the clinician—in his expertise—has based on diagnoses, prior treatment and hospital admissions, and prognoses. Third, a GAF assessment is an extremely useful tool in disability adjudication because an ALJ is not a medical expert and cannot be expected to review treatment notes and make a determination of functioning. Instead, the ALJ must rely on the assessment of a medical expert who has had one-on-one contact with the claimant and has assessed the claimant's limitations and provided a prognosis.

Furthermore, a GAF is the best standard that the medical profession has to offer when providing evidence for a disability determination due to mental disease. Until medical technology can create a specialized test that can definitively confirm a diagnosis of bipolar disorder or manic depression, the ALJ will be forced to rely on treatment notes and medical opinions. The claimant should not be penalized for a lack of advanced medical technology.

Although a GAF rating has proven to be a helpful tool in painting the big picture of an individual's ability to function, there are noted problems with its application when assessing whether a claimant is disabled. One such problem is that GAFs can be misleading because they require a prediction of a claimant's functioning.¹⁴³ A high GAF could be noted for several reasons, such as a sheltered work or home environment.¹⁴⁴ If the demands of a full-time job were placed on a claimant, a GAF could rapidly decline. In addition, a single poor GAF does not equal disability, as the majority of Americans have poor GAF days from time-to-time.

Another alleged problem with GAFs has been noted by the Sixth Circuit: a GAF is a "subjective determination" by a clinician and thus should not be entitled to great weight in disability adjudication.¹⁴⁵ A GAF is not subjective, however, because an independent medical expert is assessing the claimant's functioning, not the claimant himself.¹⁴⁶ Such

¹⁴³ See generally David A. Patterson & Myung-Shin Lee, *Field Trial of the Global Assessment of Functioning Scale—Modified*, 152 AM. J. PSYCHIATRY 1386 (1995) (finding degree of social support to be one of several factors that accounts for variance in GAF scores).

¹⁴⁴ See *id.*

¹⁴⁵ *Kornecky v. Comm'r of Soc. Sec.*, 167 Fed. App'x 496, 503 n.7 (6th Cir. 2006); *Rutter v. Comm'r of Soc. Sec.*, No. 95-1581, 1996 U.S. App. LEXIS 19136, at *4 (6th Cir. July 15, 1996).

¹⁴⁶ An opinion is subjective when it is "[b]ased on an *individual's* perceptions, feelings, or intentions." BLACK'S LAW DICTIONARY 1561 (9th ed. 2009) (emphasis added).

an assessment is more than merely writing down the claimant's subjective complaints in the treatment notes, although it appears that some courts have made the assumption that a GAF is solely based on the claimant's complaints.¹⁴⁷ This assumption, however, is inaccurate. A study of the reliability of GAF assessments found that the "GAF ratings obtained during treatment were only minimally associated with self-reported symptom outcomes."¹⁴⁸ Furthermore, this argument does not change the fact that a GAF evaluation is a medical *judgment* assessed by a medical professional,¹⁴⁹ and as such is entitled to deference.

The American Psychiatric Association has also observed problems with GAF assessments, resulting in a published clarification as to how a GAF should be used within the mental health profession:

Lack of detail in the instructions regarding application of the Global Assessment of Functioning (GAF) rating have led to misinterpretations of how to apply the GAF. One source of confusion is how to operationalize the current time frame for the GAF. Does it strictly refer to how that patient appears and functions during the evaluation procedure? This interpretation might result in a misleadingly high GAF, given that some individuals may experience transient improvement in anticipation of receiving help. For clarity, the text now includes a sentence that states in order to account for day-to-day variability in functioning, the GAF rating for the current period is sometimes operationalized as the lowest level of functioning for the past week.

Another source of confusion involves how to integrate the potentially disparate contributions of psychiatric symptomatology and functioning to the final GAF score. For example, for a patient who is a significant danger to self (justifying a GAF below 20) but is otherwise functioning well at work and with his family (reflecting a GAF above 60), what should the final GAF be? Some GAF users mistakenly average the two together, resulting in a GAF around 40. In fact, the final correct GAF score should always reflect the lower of the two (i.e., in this case, the GAF should be below 20, despite the higher social and occupational functioning).¹⁵⁰

Because a GAF assessment is made by an independent medical expert, it does not satisfy the definition of "subjective." A GAF assessment cannot be classified as objective, however, because while it is made by a clinician, that person may or may not be a disinterested party "[w]ithout bias or prejudice." *See id.*

¹⁴⁷ *Kornecky*, 167 Fed. App'x at 503 n.7; *Rutter*, 1996 U.S. App. LEXIS 19136, at *4–5.

¹⁴⁸ Moos et al., *Ratings, Allocation, and Outcomes*, *supra* note 140, at 731.

¹⁴⁹ *Id.* at 730.

¹⁵⁰ Am. Psychiatric Assoc., Clarification of the Procedure for Making an Axis V Global Assessment of Functioning Rating, <http://www.psych.org/MainMenu/Research/DSMIV/DSMIVTR/DSMIVvsDSMIVTR/SummaryofPracticeRelevantChangestotheDSMIVTR/GAFProcedures.aspx> (last visited Apr. 15, 2010) (internal quotation marks omitted).

Because of this problem, a low GAF score may have been assessed because of social functioning limitations only and therefore may not be a strong indicator of an inability to function in an occupational setting.¹⁵¹ The American Psychiatric Association illustrated this problem by noting that a person could be “a significant danger” to himself “but is otherwise functioning well at work.”¹⁵² While this seems counterintuitive, as common sense argues that someone who is overtaken with thoughts of suicide would have a difficult time functioning adequately at work, it is possible that a claimant could function for short periods of time under such circumstances. The suicidal ideation, however, would inevitably take over the thought-process, affecting concentration, persistence, and pace. A Boston University study found that people with mental disabilities are predisposed to significant challenges in a work setting when trying to screen out environmental stimuli, sustain concentration, maintain stamina, handle time pressures and multiple tasks, interact with others, and respond to negative feedback or change.¹⁵³

Regardless of whether the GAF is based on limitations in social functioning, a continuous disability in a claimant’s ability to perform activities of daily living will unavoidably extend the limitations to his ability to concentrate, to maintain appropriate social interaction, and to perform the duties required of a full-time job. As such, the problems reported with GAFs do not outweigh their benefits. A GAF is a clinician’s judgment based completely on a claimant’s ability to function; this goes to the heart of whether an individual is capable of sustaining full-time work. It is a reliable, trusted opinion that is entitled to substantial deference and an inference of disability when evidenced by the record.

CONCLUSION

Despite the fact that numerous malingering claimants file false disability claims each year, the majority of disability claims—like Nora’s—are filed by claimants who suffer from legitimate mental impairments. These claimants are denied relief, however, because the focus in disability adjudication has shifted from the forest to the trees. Instead of keeping the big picture in mind, ALJs have become cynical and disheartened with the disability process and have allowed this to skew their judgment, particularly when dealing with the mentally impaired. Yet in spite of their flaws, America’s Social Security disability programs continue to provide a better way of life for millions of people;

¹⁵¹ *Id.*

¹⁵² *Id.*

¹⁵³ Boston Univ. Ctr. for Psychiatric Rehabilitation, *How Does Mental Illness Interfere with Work Performance?*, <http://www.bu.edu/cpr/reasaccom/employ-func.html> (summarizing L.L. Mancuso, *Reasonable Accommodations for Workers with Psychiatric Disabilities*, 14 *PSYCHOSOCIAL REHAB. J.* 3 (1990)).

with improvement, Franklin D. Roosevelt's vision of a program that provides economic security for the nation's disabled will become a reality.¹⁵⁴

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¹⁵⁴ See SOC. SEC. ADMIN., MANAGEMENT'S DISCUSSION AND ANALYSIS 1 (1998), available at <http://www.socialsecurity.gov/finance/1998/98md&a1.pdf>.

ADDENDUM: GLOBAL ASSESSMENT OF FUNCTIONING SCALE*

91–100	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
81–90	Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).
71–80	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).
61–70	Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social occupational, or school functioning (e.g., occasional truancy or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
51–60	Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).
41–50	Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).
31–40	Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
21–30	Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly

* AM. PSYCHIATRIC ASSOC., *supra* note 77, at 34.

	inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).
11–20	Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).
1–10	Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.