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LITIGATING DISABILITY INSURANCE CLAIMS INVOLVING POST-TRAUMATIC STRESS DISORDER

Defense Strategies and Techniques

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I. INTRODUCTION

Post-Traumatic Stress Disorder (PTSD) is an anxiety disorder that is based on how an individual responds to a traumatic event. There is no known diagnostic test for PTSD and no physical manifestation of the illness that readily permits its diagnosis. PTSD therefore is a self-reported (or "subjective") disorder that is diagnosed by way of history and interview, rather than by physical examination or through lab work and tests.

Without objective medical evidence to confirm that a person suffers from PTSD, the potential for fraudulent disability claims is great. However, the illness is real. Indeed, the *American Psychiatric Association* added PTSD to the third edition of its *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) in 1980. The illness also is common, with some researchers estimating that about 4 percent of the population will experience symptoms of PTSD in a given year.[1]

The effects of PTSD often are genuinely and severely disabling. Nevertheless, there are virtually no published decisions that involve disability insurance claims attributed to PTSD. Any litigator who handles a disability insurance claim that involves PTSD therefore must have a working understanding of the illness. They also must develop a plan for testing both the legitimacy of the insured's diagnosis and his or her proof of functional impairment.

Given the nature of PTSD, those plans should almost always include a fact-intensive evaluation of the insured's risk of relapse. Depending on the facts of a particular case, a disability insurance claim involving PTSD also can raise questions about the meaning of the phrase "own occupation." In addition, the facts of a particular case can sometimes raise significant questions under the Americans with Disabilities Act (ADA). Disability insurance claims involving PTSD therefore can present a unique challenge to defense lawyers by requiring them to litigate a collection of issues that the courts have yet to fully resolve.

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[1] *Anxiety Disorders: Post-Traumatic Stress Disorder*, National Institute of Mental Health.

II. LITIGATOR'S GUIDE TO POST-TRAUMATIC STRESS DISORDER.

PTSD is a psychiatric illness that can occur after someone experiences or witnesses a traumatic event. Most people who are exposed to a traumatic stressor experience some of the symptoms of PTSD in the days and weeks following exposure. However, a much smaller percentage go on to develop some form of PTSD, and approximately 30 percent of those people will develop a chronic form of the disorder that persists throughout their lifetime.

Although the *American Psychiatric Association* first added PTSD to the DSM-III in 1980, PTSD is not a new disorder. To the contrary, there are written accounts of similar symptoms in ancient times, and historical medical literature from the Civil War refers to a similar disorder as "DaCosta's Syndrome."

PTSD also has been called "shell shock" and "battle fatigue syndrome." As those names suggest, it once was thought to be mostly a disorder affecting war veterans who had been involved in heavy combat. To be certain, PTSD is more common among combat veterans.[2] However, as many as 70 percent of adults in the United States have experienced at least one major trauma in their lives, and many of them have suffered from the emotional reactions that are called PTSD.[3]

There is no precise explanation for why some people who experience trauma have little difficulty while others suffer for years afterwards. By definition, though, people who suffer from PTSD often "re-live" the traumatic event through recurrent memories, dreams, or flashback episodes. They also show signs of avoidance and hyperarousal. The symptoms of PTSD therefore include panic attacks, depression, suicidal thoughts, feelings of alienation and isolation, feelings of mistrust and betrayal, anger, irritability and other problems that severely impair an individual's daily functioning.

A. Diagnostic Criteria.[4] In the initial DSM-III formulation, the diagnostic criteria for PTSD required some traumatic event or catastrophic stressor that was outside the range of usual human experience. However, the DSM-III diagnostic criteria for PTSD were revised in DSM-III-R (1987) and DSM-IV (1994), and a very similar syndrome is classified in ICD-10. As a result, the diagnostic criteria for PTSD now include a history of exposure to a more broadly-defined "traumatic event," as well as symptoms from each of three symptom clusters.

1. Stressor Criterion. Under the current diagnostic criteria, the underlying "traumatic event" need not have been outside the range of usual human experience. To the contrary, they require only that the person have been exposed to a catastrophic event involving actual or threatened death or injury, or a threat to the physical integrity of himself, herself or others. In addition, the person's subjective response while exposed to that traumatic event must have been marked by intense fear, helplessness, or horror.

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[2] One study concludes that 30.9 percent of male and 26.9 percent of female Vietnam theater veterans will suffer from PTSD at some point in their lives. *Ronald C. Kessler, et al., "Posttraumatic Stress Disorder in the National Comorbidity Survey," Archives of General Psychiatry* 52(12): 1048-1060 (December 1995).
[3] *Edna B. Foa, et al., "Expert Concensus Treatment Guidelines for Posttraumatic Stress Disorder: A Guide for Patients and Families," J. Clin. Psychiatry* 1999:60 (suppl. 16).
[4] Developed from *Post-Traumatic Stress Disorder: An Overview, National Center for Post-Traumatic Stress Disorder, Department of Veterans Affairs*.

The classic examples of traumatic events that cause PTSD relate to military service in a combat setting. However, published decisions that involve other issues (such as a criminal defendant's mental capacity, a personal injury plaintiff's claim for emotional distress, etc.) reveal a more common set of traumatic events that can give rise to PTSD: being injured by a falling object[5]; surviving a fire[6]; being physically restrained during an arrest[7]; kidnapping[8]; surviving a collision between train and car[9]; witnessing one parent shoot at the other[10]; witnessing a murder[11]; witnessing a suicide[12]; being sexually assaulted[13]; being sexually harassed at work.[14]

2. Intrusive Recollection Criterion. For individuals with PTSD, the traumatic event is a dominating and enduring psychological experience that retains its power to evoke power, terror, dread, grief, or despair. The most distinctive and readily identifiable symptom of PTSD involves the experience of daytime fantasies, traumatic nightmares, and psychotic reenactments of the traumatic event. In addition, certain stimuli can trigger recollections of the event and evoke mental images, emotional responses and psychological reactions associated with the related trauma.

The diagnostic criteria require some history of such intrusive recollections. Specifically, they provide that a person with PTSD must persistently re-experience the traumatic event in one of the following ways:

- recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions;
- recurrent distressing dreams of the event;
- acting or feeling as if the traumatic event were recurring (include a sense of re-living the experience, illusions, hallucinations, and dissociative flashback episodes);
- intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event; or
- physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

3. Avoidant/Numbing Criterion. Persons with PTSD develop behavioral, cognitive or emotional strategies to reduce the likelihood that they will be exposed to the stimuli that produce intrusive recollections and to minimize the intensity of their psychological response to those stimuli. The diagnostic criteria therefore require some

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[5] *Smith v. K-Mart Corp*., 117 F.3d 19 (1st Cir. 1999).
[6] *Campbell v. Coyle*, 260 F.3d 531 (6th Cir. 2001).
[7] *Davis v. Rennie*, 264 F.3d 86 (1st Cir. 2001).
[8] *Walsh v. Walsh*, 221 F.3d 204 (1st Cir. 2000).
[9] *Marschand v. Norfolk & Western Rwy. Co.*, 81 F.3d 714 (7th Cir. 1996).
[10] *Morgan v. Krenke*, 232 F.3d 562 (7th Cir. 2000).
[11] *U.S. v. Johnson*, 46 F.3d 1166 (D.C.Cir. 1995).
[12] *Kidwell v. Dept. of the Army*, 140 F.3d 791 (D.C.Cir. 1995).
[13] *Dykstra v. U.S. Bureau of Prisons*, 140 F.3d 791 (8th Cir. 1998); *Nichols v. American National Insurance*, 154 F.3d 875 (8th Cir. 1998).
[14] *Reinhold v. Commonwealth of Virginia*, 151 F.3d 172 (4th Cir. 1998); *Murray v. Chicago Transit Authority*, 252 F.3d 880 (7th Cir. 2001); *Jenson v. Eveleth Taconite Co.*, 130 F.3d 1287 (8th Cir. 1997); *Gotthardt v. National Railroad*, 191 F.3d 1148 (9th Cir. 1999).

history of persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, as indicated by three (or more) of the following:

- efforts to avoid thoughts, feelings, or conversations associated with the trauma;
- efforts to avoid activities, places, or people that arouse recollections of the trauma;
- inability to recall an important aspect of the trauma;
- markedly diminished interest or participation in significant activities;
- feeling of detachment or estrangement from others;
- restricted range of affect (e.g., unable to have loving feelings); and
- sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

4. Hyperarousal Criterion. Persons who suffer from PTSD often exhibit symptoms that resemble those found in people with panic and generalized anxiety disorders. However, they commonly display signs of hypervigilance and startle that are unique to PTSD. The diagnostic criteria for PTSD therefore require some history of persistent symptoms of increased arousal that were not present before the trauma, as indicated by two (or more) of the following:

- difficulty falling or staying asleep;
- irritability or outbursts of anger;
- difficulty concentrating;
- hypervigilance; and
- exaggerated startle response.

5. Duration Criterion. The length of time for which psychological disturbances last after a trauma can vary greatly. Some people have few or no long-lasting effects, while others may continue to have problems for months or even years after the trauma and will not get better without professional treatment.

If a person's symptoms last for less than one month but are more severe than what most people experience after a traumatic event, the duration of their disorder is too brief to be considered PTSD. Rather, it is more likely that they are suffering from an acute stress disorder that can increase the risk of later developing PTSD.[15]

Under the diagnostic criteria for PTSD, the symptoms in each symptom cluster must last for longer than one month. If they last only between one and three months, the condition is considered acute PTSD. If the symptoms persist for more than three months, the diagnostic criteria consider the condition to be chronic PTSD.

6. Significance Criterion. Under the DSM-IV, a person cannot suffer from PTSD unless they experience significant distress or impairment in their social, occupational or other important areas of functioning. By definition, then, a person who legitimately suffers from PTSD must have some form of functional impairment.

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[15] *Edna B. Foa, et al., "Expert Concensus Treatment Guidelines for Posttraumatic Stress Disorder: A Guide for Patients and Families," J. Clin. Psychiatry* 1999:60 (suppl. 16).

B. Secondary and Associated Symptoms.[16] Secondary symptoms are problems that are attributable to the primary symptoms of PTSD. For example, a person who wants to avoid talking about a traumatic event might sever ties with friends and become both lonely and depressed. As time passes, more and more secondary symptoms may emerge. Ultimately, those secondary symptoms may become more troubling and disabling than the original symptoms of PTSD. Associated symptoms are problems that do not directly relate to being overwhelmed with fear, but happen because of other things that were going on at the time of the trauma. For example, a person who is psychologically traumatized by a car accident might also get physically injured, then get depressed because their physical injury makes them unable to work or leave the house.

There are numerous problems that can be secondary or associated symptoms of PTSD. Some examples include: depression; despair and hopelessness; loss of important beliefs; aggressive behavior toward self or others; self-blame, guilt and shame; problems in relationships with people; feeling detached or disconnected from others; getting into arguments and fights with people; less interest or participation in things the person used to like to do; social isolation; problems with identity; feeling permanently damaged; problems with self-esteem; physical health symptoms and problems; alcohol and/or drug abuse.

PTSD also is associated with an increased likelihood of several co-occurring psychiatric disorders. In one study, 88 percent of men and 79 percent of women with PTSD met the diagnostic criteria for a second psychiatric disorder.[17] The DSM-IV therefore calls for a differential diagnosis with a variety of disorders, including: adjustment disorder, symptoms of avoidance, numbing, and increased arousal that are present before exposure to the stressor, another mental disorder (e.g., Brief Psychotic Disorder, Conversion Disorder, Major Depressive Disorder): Acute Stress Disorder; Obsessive-Compulsive Disorder; Schizophrenia; other Psychotic Disorders; Mood Disorder with Psychotic Features; Delirium; Substance-Induced Disorders; Psychotic Disorders Due to a General Medical Condition; and Malingering.

The co-occurring disorders most prevalent among men with PTSD were alcohol abuse or dependence (51.9 percent), major depressive episode (47.9 percent), conduct disorder (43.3 percent), and drug abuse and dependence (34.5 percent). The disorders most frequently co-occurring for women with PTSD were major depressive disorder (48.5 percent), simple phobia (29 percent), social phobia (28.4 percent) and alcohol abuse or dependence (27.9 percent).

C. Treatment Options and Prognosis. The available research suggests that roughly 30 percent of those people who have PTSD develop a chronic form that persists throughout their lifetimes.[18] The course of chronic PTSD usually has periods of symptom exacerbation and remission. However, some individuals may experience severe symptoms that are unremitting.

PTSD is treated by a variety of forms of psychotherapy and drug therapy. There is no definitive treatment and no cure. However, some treatments appear to offer promise, such as

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[16] Developed from *Effects of Traumatic Experiences, National Center for Post-Traumatic Stress Disorder, Department of Veterans Affairs.*
[17] *What is Post-Traumatic Stress Disorder?, A National Center for PTSD Fact Sheet, National Center for Post-Traumatic Stress Disorder, Department of Veterans Affairs.*
[18] *What is Post-Traumatic Stress Disorder?, A National Center for PTSD Fact Sheet, National Center for Post-Traumatic Stress Disorder, Department of Veterans Affairs.*

cognitive-behavioral therapy, group therapy, and exposure therapy (in which the patient repeatedly relives the traumatic event under controlled conditions to help him or her work through the trauma).

The most widely-used drug treatments for PTSD are serotonin reuptake inhibitors, such as Prozac and Zoloft. Importantly, though, recent research has identified certain biological changes associated with PTSD. Accordingly, researchers are now exploring the utility of drugs that target those biological changes.

III. DEFENSE STRATEGIES AND TECHNIQUES.

Most disability income insurance policies have an elimination (or "waiting") period that must be exhausted before the insured becomes eligible to receive benefits. The length of such elimination periods varies. However, the presence of an elimination period will largely eliminate claims for acute stress disorders (PTSD symptoms lasting less than 1 month) and acute PTSD (symptoms lasting between 1 and 3 months).

Attorneys in the disability insurance field therefore are substantially more likely to encounter benefit claims involving chronic PTSD (symptoms lasting more than 3 months). As noted above, some individuals with chronic PTSD experience severe symptoms that are unremitting. However, chronic PTSD usually involves periods when the symptoms are aggravated, as well as periods when the symptoms subside. Accordingly, attorneys who handle disability insurance litigation involving PTSD will most often encounter a set of facts in which the insured alternates between periods of full functioning and periods of apparent disability.

In all such cases, the defense attorney should examine the file and consult qualified experts to determine whether the insured was properly diagnosed with PTSD. In addition, they should attempt to identify the stimuli which exacerbate the insured's symptoms and prepare to show at least one of the following: (1) that the insured can perform the substantial and material duties of his or her occupation without encountering those stimuli; (2) that the insured's risk of a relapse upon returning to work is speculative; or (3) that the insured's historical response to those stimuli does not include symptoms which interfere with his or her performance of the substantial and material duties of his or her occupation.

A. Challenge the Insured's Proof of Sickness. As a general rule, each party in a lawsuit has the burden of proving the existence (or nonexistence) of every fact that is essential to the claim or defense he or she is asserting. With regard to claims for insurance coverage, it therefore is axiomatic that the insured has the burden of establishing that the occurrence which forms the basis of the coverage claim falls within the basic scope of insurance coverage.[19]

The typical disability income insurance policy provides for benefits only if the insured's disability is attributable to some "Sickness" or "Injury." Consequently, the insured cannot establish his or her eligibility for benefits without offering some proof of the Sickness or Injury to which he or she attributes the alleged disability.

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[19] See, e.g., *Weil v. Federal Kemper Life Assurance Co.* (1994) 7 Cal.4th 125, 148.

By nature of the condition, it often is extremely difficult for an insured to prove that he or she suffers from PTSD. Simply stated, there is no single diagnostic test for PTSD, and it often is confused with a host of other secondary and associated symptoms. Recognizing that fact, some cases involving other self-reported disabilities suggest that courts will require lesser proof of the insured's Sickness. However, other courts have been persuaded that the absence of a definitive diagnosis is enough to justify the denial of a claim for disability benefits.

1. Must the Insured Have a Definitive Diagnosis? In *Yeager v. Reliance Standard Life Insurance Company*,[20] an industrial nurse filed a claim for disability benefits under a group plan issued by Reliance Standard, claiming that she was disabled as a result of fibromyalgia, chronic low back pain, arthritis, fatigue and carpal tunnel syndrome. Three of her treating physicians supported her claim for benefits by offering opinions that she was not capable of performing the material duties of her occupation. All three physicians also identified fibromyalgia as the "probable diagnosis" of her condition. However, they each acknowledged an absence of objective findings to support the insured's subjective complaints, and none of them definitively diagnosed her to be suffering from fibromyalgia.

The insurer denied the claim for benefits because there was insufficient proof that the insured was totally disabled within the meaning of the policy. In the subsequent lawsuit, the Court reasoned that:

> "The Plan required plaintiff to submit satisfactory proof that she could not perform the material duties of her regular occupation, and defendant had received no medical evidence of any physical condition or anatomic abnormality that would cause plaintiff to be totally disabled. The disabling condition on which plaintiff based her claim for disability benefits is fibromyalgia, but no doctor ever actually definitively diagnosed plaintiff as having this condition. . . . In the absence of any definitive anatomical explanation of plaintiff's symptoms, we cannot find that the administrator's decision to deny benefits was arbitrary and capricious."[21]

The *Yeager* court therefore found the lack of a definitive diagnosis of the insured's condition to be fatal to her claim, even though three of her treating physicians had agreed that she was totally disabled.[22]

Other cases involving challenges to the insured's proof of an underlying Sickness have produced similar results.[23] However, the notion that insureds must present

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[20] 88 F.3d 376 (6th Cir. 1996).
[21] Id., at 381-382.
[22] See also, *Ellis v. Metropolitan Life Insurance Co.*, 126 F.3d 228 (4th Cir. 1997) [despite primary treating physician's diagnosis of somatic dysfunction, denial of claim not arbitrary and capricious when all treating physicians unable to arrive at a consensus on a diagnosis of the claimant's condition).
[23] 23 See, e.g., *Steinman v. Long Term Disability Plan of the May Department Stores Co.*, 863 F.Supp. 994 (E.D.Mo. 1994) [summary judgment proper in absence of objective evidence supporting a diagnosis of chemical sensitivity that would form a basis of total disability]; *Donato v. Metropolitan Life Insurance Company*, 19 F.3d 375 (7th Cir. 1994) [claim denial neither arbitrary nor capricious when disability

objective medical evidence of the Sickness allegedly causing their disability has not been universally accepted. Thus, while at least one court has reasoned that requiring the insured to present objective medical evidence of a Sickness is consistent with the goal of providing disability benefits only to those individuals who "truly merit such benefits,"[24] other courts have reasoned that "medical conditions that do not give rise to hard laboratory facts or data may still be cognizable claims."[25] The prevailing view therefore appears to be that, when the underlying sickness is universally recognized as being severely disabling but has no known etiology, "it would defeat the legitimate expectations of [plan participants] to require those with [the condition] to make a showing of such etiology a condition of eligibility for LTD benefits."[26]

2. Medical Experts and the Need for an IME. In *Gawrysh v. C.N.A. Insurance Company*,[27] the insured described herself as suffering from chronic fatigue, sinus problems, severe headaches and depression. Her primary treating physician offered that she suffered from chronic fatigue syndrome and other infirmities, including sinusitus with intractable headache, recurrent sinus infections and bronchitis. After obtaining the insured's medical records, the insurer's claim specialist found that the insured's maladies did not meet the diagnostic criteria for CFS. The claim specialist therefore denied the insured's claim for benefits because there was no objective medical documentation to support her claim of disability.

When reviewing that claims specialist's decision, the court first noted that diagnosing chronic fatigue syndrome is "not a simple matter." It then explained that no single test for the diagnosis of CFS exists and that the formal diagnostic criteria require physicians to rule out other clinically defined causes of chronic fatigue by using a variety of tests. On the facts before it, the court found the evidence to indicate that the insured's symptoms were "debilitating and were consistent with chronic fatigue syndrome." The court commented that:

> "Rather than punishing [the insured] for the inability of medicine to specifically pinpoint the cause of her debilitating fatigue, C.N.A. should have hired experts or used its own doctors to examine [the insured] to determine the cause and degree of her fatigue."

Significantly, the insurer in *Gawrysh* never had outside experts examine the insured or make any effort to establish the severity and cause of her fatigue. Instead, it utilized

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attributed to alleged chemical hypersensitivity identified by questionable medical theory and suspect medical evaluation, testing and documentation].

[24] *Davis v. U.S. West Inc.*, 1996 WL 673148 at *12 (Neb. 1996).

[25] *Duncan v. Continental Casualty Co.*, 1997 WL88374 at *5 (N.D.Cal. 1997).

[26] *Mitchell v. Eastman Kodak Co.*, 113 F.3d 433, 443 (3rd Cir. 1997) [arbitrary and capricious to deny benefit claim for a lack of clinical evidence regarding the etiology of the insured's CFS]; see also, *Clausen v. Standard Insurance Company*, 961 F.Supp. 1446, 1456 (D.Colo. 1997) ["Standard's attempt to ignore the CFS diagnosis of Clausen's treating physicians and to require, instead, that Clausen provide 'objective' evidence of a distinct 'physical disease' runs afoul of established law in this circuit."]; *Duncan, supra*, at *5 ["Continental may not deny Duncan's claim because her physician cannot provide physiological proof where the physical condition is such that physiological proof is not available."].

[27] 1998 WL 329719 (N.D. Ill. 1998).

only a claims specialist who had no apparent medical training or experience. The court therefore held that the insurer's denial of the insured's benefit claim had been arbitrary and capricious.

In contrast, the insurer in *Greene v. Metropolitan Life Insurance Company*[28] collected the medical records regarding an insured who claimed to suffer from CFS and forwarded them to an outside medical consultant for review. Ultimately, that medical consultant concluded that the available information did not allow for an independent confirmation of the CFS diagnosis. The lawsuit that followed the insurer's denial of the benefit claim therefore presented a classic "battle of the experts." Stated differently, the court was being asked to decide whether to believe the insured's doctor [who diagnosed CFS] or the insurer's medical consultant [who found no support for that diagnosis]. In the end, though, the court found that the "arbitrary and capricious" standard of review prescribed by ERISA[29] prevented it from "injecting its own judgment into the case to vacate a claim fiduciary's prior determination."[30]

Despite the outcome in *Greene*, it is clear that hiring a medical expert to review the available records and/or examine the insured who attributes disability to a self-reported condition is not always enough – even in an ERISA case in which the claim review fiduciary has discretion. In *Monroe v. Pacific Telesis Group Comprehensive Disability Benefits Plan*[31], for example, the insured sought disability benefits after her rheumatologist diagnosed her to be suffering from "profound fibromyalgia." In response, the plan had the insured examined by an internist who found no objective evidence to substantiate her reported symptoms. The plan then denied the claim for benefits, and the insured filed suit.

Unlike the court in *Greene*, the *Monroe* court held that the plan's claims decision had been arbitrary and capricious. In part, the court based its decision on the presence of some objective evidence supporting the claim of fibromyalgia (ie., an abnormal sleep study and record of certain trigger points). However, the court also was persuaded by the plan's failure to have the insured examined by a rheumatologist, as well as the fact that the plan's physician was not a "fibromyalgia expert."[32]

Again, there are not yet any published decisions involving disability insurance claims attributed to PTSD. However, PTSD is largely viewed as a self-reported condition that cannot be established by objective medical evidence. The published cases involving disability insurance claims for other self-reported conditions (such as fibromyalgia and chronic fatigue syndrome) therefore counsel that the claimant's medical records should be reviewed by an appropriate expert before any claims decision is made.

To be certain, the available medical records may often omit certain information that is necessary to confirm a diagnosis of PTSD. Insurers (and their counsel) therefore should also consider arranging for an independent medical examination that will permit a

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[28] 28 924 F.Supp. 351 (D.R.I. 1996).
[29] See, *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).
[30] *Greene, supra*, 924 F.Supp. at 360.
[31] 971 F.Supp. 1310 (C.D.Cal. 1997).
[32] *Id*., at 1315.

qualified expert to supplement the available medical records with a comprehensive interview of the disability claimant.

B. Assessing Functional Capacity. Under the terms of most disability income insurance policies, the insured cannot establish a "total disability" simply by presenting evidence that he or she has a Sickness or suffered some Injury. Rather, the terms of most disability income insurance policies define the phrase "totally disabled" to mean that, due to Injuries or Sickness, the insured has an incapacity to perform the substantial or material duties of an "Occupation." To establish a total disability within the meaning of such policies, the insured therefore must establish both a Sickness (or Injury) and a resulting incapacity to perform the substantial or material duties of an occupation. For that reason, the policy can be said to prescribe a functional test for determining whether the insured is "totally disabled."

Under such a functional test, the Ninth Circuit[33] has explained that:

> "The mere existence of an impairment is insufficient proof of disability. A claimant bears the burden of proving that an impairment is disabling." Accordingly, proof of a Sickness or Injury alone is not enough. Rather, "the focus of the analysis is on the degree to which the physical impairment has hindered a worker's earning capacity."[34]

Numerous cases involving disabilities attributed to other self-reported conditions recognize that concept.[35] In addition, at least one case under the *Americans with Disabilities Act* has held that a person suffering from PTSD still must provide some evidence that his condition substantially impairs working or some other major life activity.[36] Thus far, though, the reported cases show little agreement as to the type and character of evidence necessary to show that a self-reported condition is, in fact, disabling.

1. The Need for Objective Medical Evidence. In an unreported decision, the court in *Duncan v. Continental Casualty Co.*[37] considered the disability benefit claim of an insured who had been diagnosed with fibromyalgia. The insurer had denied the claim because there was no objective medical evidence of a condition severe enough to have caused a disability. When reviewing that decision de novo, the court first noted that the policy made no reference to the "objective medical evidence" described in the insured's denial letter. It then concluded that, unless the requirement of "objective medical evidence" was made "clear, plain and conspicuous enough [in the policy] to negate

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[33] *Matthews v. Shalala*, 10 F.3d 678, 680 (9th Cir. 1993).
[34] *St. Industrial Ins. System v. Bokelman*, 113 Nev. 1116, 946 P.2d 179, 182 (1997).
[35] See, e.g., *Greene, supra*, 924 F.Supp. at 360 [". . . whether or not Greene could perform her job duties was the relevant question in determining her eligibility under the disability plan, not simply being diagnosed with CFS."]; *Renfro v. UNUM Life Insurance Company of America*, 920 F.Supp. 831, 838 (C.D.Tenn. 1996) [". . . the issue before the plan administrator was, as it is before this court, whether any condition or combination of conditions suffered by the [claimant] is disabling within the meaning of the applicable plan language. A list of diagnosed conditions, standing alone, does not satisfy the burden of making such a showing of disability."].
[36] *Hamilton v. Southwestern Bell*, 136 F.3d 1047 (5th Cir. 1998).
[37] 1997 WL88374 (N.D.Cal. 1997).

laymen objectively reasonable expectations of coverage," the insurer's claim decision could not be sustained under any standard of review.[38]

In a slightly different context, the court in *Sansavera v. E.I. Du Pont De Nemours & Co., Inc.*[39] reached a similar conclusion. In that case, the plan denied a claim for long term disability benefits because the insured failed to provide objective medical evidence that he was permanently incapacitated by CFS. However, the court found the plan's requirement that the applicant demonstrate with medical certainty that a disability will be permanent to be unreasonable when:

> ". . . [as] is especially true in the case of an applicant diagnosed with CFS . . . there is currently no method of determining whether a person will ever recover from CFS, nor is there any treatment that has been proven [effective] in overcoming this illness. Because Sansevera has been suffering from CFS from February of 1990 and has not shown any sign of improvement, it is unreasonable to deny him benefits simply because he cannot prove with medical certainty that he will never recover." [40]

Two years later – in a case involving the very same long term disability plan -- the same court reached the opposite conclusion. Specifically, the court in *Pokol v. E.I. Du Pont De Nemours & Co., Inc.*[41] held that, because the plan expressly gave the administrator discretionary authority to construe its terms and conditions, it was neither irrational nor unreasonable for the administrator to interpret the language "satisfactory medical evidence" to require "objective medical evidence."[42]

Other courts have employed similar reasoning to uphold an insurer's denial of a subjective disability claim for a lack of objective medical evidence about the insured's functional capacity.[43] Still others have reasoned that a lack of objective medical evidence to prove the insured's functional impairment "cannot constitute substantial evidence that [the insured] was not disabled."[44] Collectively, then, the cases involving subjective disability claims suggest that the required proof and likely outcome can be as dependent upon the choice of forum as any differences in the facts or available evidence.

2. Minimize the Risk of Relapse. Under the DSM-IV, a person cannot suffer from PTSD unless they experience significant distress or impairment in their social,

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[38] *Id.*, at *4.
[39] 963 F.Supp. 1361 (D.N.J. 1997).
[40] *Id.*, at 114-115.
[41] *Pokol v. E.I. DuPont De Nemours & Co., Inc.*, 963 F.Supp. 1361 (D.N.J. 1997).
[42] *Id.*, at 1372.
[43] See, e.g., *Finster v. Metropolitan Life Insurance Co.*, 927 F.Supp. 201 (N.D.Tex. 1996) [summary judgment granted to insurer because plaintiff did not provide objective medical evidence that reported back pain was disabling]; *Conlev v. Pitney Bowes, Inc.*, 1997 WL 580533 (E.D.Mo. 1997) [judgment for insurer after trial because plaintiff's complaints of subjective back pain not supported by objective medical findings].
[44] *Clausen, supra*, 961 F.Supp. at 1457, citing *Sisco v.U.S. Department of Health and Human Services,* 10 F.3d 739 (10th Cir. 1993).

occupational or other important areas of functioning. By some estimates, though, as much as 5 percent of the American population currently suffers from PTSD.[45] It therefore stands to reason that many people who suffer from PTSD either receive effective treatment or, by reason of avoidance mechanisms, are otherwise are able to continue functioning in their occupational lives.

From a psychiatric perspective, such avoidance mechanisms are mere behavioral, cognitive or emotional strategies that are calculated to reduce the likelihood of exposure to stimuli that produce intrusive recollections or to minimize the intensity of the psychological response to those stimuli.

Stated differently, they are characteristic of PTSD and do nothing to suggest that the person has been cured. From a disability insurer's perspective, however, those avoidance mechanisms can empower a person suffering from PTSD to lead what appears to be a near normal life. In other words, they can allow someone with PTSD to engage in activities that seemingly contradict their claim of disability. Logically, advocates for people with PTSD can be expected to address that apparent inconsistency by describing the claimant's functional capacity as the fragile product of an avoidance mechanism that would quickly be destroyed by exposure to thoughts, feelings, activities, places or people which arouse recollections of the trauma. In turn, they may reason that the claimant necessarily is disabled because he or she has a genuine risk of relapse upon returning to the workplace.

Unfortunately, there are no published decisions that comprehensively analyze a claim of disability which is based on the risk of a relapse. There are, however, two unreported cases that suggest the risk of relapse (or the risk of exposure to stressors that evoke harmful behaviors) may not be enough to establish disability.

The first case is an unreported decision entitled *Levitt v. UNUM*.[46] The plaintiff in Levitt was an anesthesiologist who elected not to return to his occupation for fear that he would return to illegal substance abuse. The Court first noted that the anesthesiologist had successfully undergone treatment for chemical dependency. It then reasoned that:

> "The carrier has no obligation to pay any more or less than its obliged to under the contract, whatever sympathies they may have for an insured[.] . . . Is it possible that he will relapse? Yes, it is possible. Is that sufficient to make the carrier obliged to pay him benefits? It is not. . . . He has, to his credit, made a successful adjustment to the issue of his drug problem. But he is in such a situation, in the court's view, that he is not disabled from practicing anesthesiology. He may, as a matter of prudence, decide not to. That's his choice. But, again, it doesn't become the carrier's obligation to subsidize that."

The Court in *Levitt* therefore focused on the claimant's capacity to perform the duties of his occupation and held that, even if based on the sound advice of his treating

[45] Edna B. Foa, et al., "Expert Concensus Treatment Guidelines for Posttraumatic Stress Disorder: A Guide for Patients and Families," *J. Clin. Psychiatry* 1999:60 (suppl. 16).
[46] No. L93-2434 (slip. op., D.Md. July 19, 1994).

physicians, his decision to give up the practice of anesthesiology did not render him disabled.

The second case is entitled *Laucks v. Provident Companies*[47] and, like the *Levitt* case, is an unreported decision that involved an anesthesiologist with an addiction to drugs. During trial, the anesthesiologist in *Laucks* presented medical evidence that he remained at risk for relapse if he were to return to his anesthesia practice. The insurer presented other testimony that, while the doctor's decision not to return to his anesthesia practice may have been prudent, he was capable of performing the substantial and material duties of his occupation. After viewing that evidence, the Court in *Laucks* expressly rejected the notion that the claimant's addiction permanently prevented his return to the practice of anesthesia. It then concluded that, "although there may well be cases where addicted and recovering anesthesiologists can never return to the O.R. and are therefore disabled within the policy language here, it is my view that Dr. Laucks is not one of them."

Absent more definitive authorities on the risk of relapse, insurers (and their counsel) who face disability claims involving PTSD would be well-advised to carefully review the available information to identify the claimant's stressors (the stimuli that arouse recollections of the trauma) and the emotional responses they have historically caused. Indeed, there are several cases which suggest the risk of relapse presents a triable issue of fact that precludes summary judgment.[48] Insurers and their counsel therefore should prepare themselves to make a fact-intensive showing that the insured can perform the substantial and material duties of his or her occupation without encountering those stimuli or that the risk of relapse is speculative because the insured's emotional response to those stimuli is not uniformly disabling.

3. Are the Stressor's Unique to a Specific Place of Employment? A physician who has PTSD from his or her service as a medic on a field of battle may have so many stimuli associated with victims of traumatic injuries that he or she cannot return to a practice in emergency room medicine. However, a secretary who has PTSD because she was raped may only have an emotional response when she is alone with her boss – a man who closely resembles her rapist. Under those facts, the physician probably can demonstrate that his PTSD impairs his ability to perform the substantial and material duties of his regular occupation (emergency room physician) in any setting. In contrast, the rape victim may be fully capable of performing secretarial work, provided that she works for someone who does not resemble her rapist.

Several cases will assist the insurer in demonstrating that an insured's ability to perform the substantial and material duties of his or her occupation in a different setting disproves a claim of total disability. In 1994, for example, the *Southern District of New York*[49] held that "occupation" is not as narrow as the insured's particular job, but means "a position of same general character as the insured's previous job, with similar duties

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[47] 97-CV-1507 (U.S.D.C., Md.D. Pa., Oct. 28, 1999), Slip. Op.
[48] *Brosnan v. Provident Life and Accident Life Ins. Co.*, 31 F.Supp.2d 460, 465, fn. 6 (E.D.Pa. 1998); *Hinchman v. General American Ins. Co.*, IP 96-0578-C-B/S, slip op. (S.D.Ind., April 4, 1998); *Krisa v. The Equitable Life Assurance Society*, 113 F.Supp.2d 694, 699 (E.D.Pa. 2000).
[49] *Dawes v. First UNUM Life Ins. Co.*, 851 F.Supp. 118, 122 (S.D.N.Y. 1994).

and requirements." Likewise, the Ninth Circuit has held that an insured is not disabled if she can work in her own occupation for another employer.[50]

Other cases from around the country follow the view that an insured's "occupation" is broader than his or her "job."[51] Therefore, when the facts of a particular case suggest that the insured's stressors relate to a specific individual, place or task, disability insurers and their counsel should consider whether the insured is capable of performing the substantial and material duties of his or her occupation in another setting. If so, the policy language regarding "own occupation" may provide them with an additional defense.

4. Must the Employer Make Reasonable Accommodations? Congress enacted the *Americans with Disabilities Act* (ADA) for the stated purpose of providing "a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities."[52] Toward that end, the ADA prohibits certain forms of employment discrimination against qualified individuals with disabilities.[53] The ADA also mandates that employers make "reasonable accommodations" so that qualified individuals with a disability[54] can perform the essential functions of their employment in spite of their disabilities.[55]

Disability insurance claimants often ignore that change in federal law. Indeed, a claim that the insured is eligible for benefits under the policy simply because he or she is unable to perform his duties "in the usual or customary way" would improperly expand the risk that the insurer promised to insure.[56] Were the rule otherwise, a disability insurance claimant could take advantage of federally-mandated accommodations by his employer to actually perform the substantial and material duties of his former occupation without any loss of income and, at the same time, claim eligibility for full benefits under the policy.

In short, Congress' enactment of the ADA changed the nature of the workplace by requiring employers to take reasonable steps that allow an employee to carry out the substantial and material functions of his or her occupation despite a disability.[57] Insurers and their counsel therefore should consider whether the ADA requires the claimant's

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[50] *Bendixen v. Standard Ins. Co.*, 185 F.3d 939 (9th Cir. 1999).
[51] See, e.g., *Ceasar v. Hartford Life*, 947 F.Supp. 204 (D.C.S.C. 1996) [plaintiff's job was narrower than his occupation]; See also, *Ehrensaft v. Dimension Works Inc. Long Term Disability Plan*, 120 F.Supp.2d 1253, 1259 (D.Na. 2000) [". . . the evaluation of disability should be made in light of the usual duties of that occupation and not depend on ad hoc peculiarities of a specific job or the requirements of a particular employer who may require activities beyond that generally contemplated by the `occupation'. "]; *Harbron v. Standard Ins. Co.*, 1999 U.S. Dist. LEXIS 9720 at *1 (N.D.Ill. June 18, 1999) [employee must be unable to perform his own occupation, not just for his present employer, but for any employer].
[52] 42 U.S.C. §12101(b)(1).
[53] See, e.g., 42 U.S.C. §12112(a).
[54] The ADA defines the phrase "qualified individual with a disability" to mean an individual with a disability who "can perform the essential functions of the employment position that such individual holds or desires," with or without "reasonable accommodations." 42 U.S.C. §12111(8).
[55] 42 U.S.C. §12111(9).
[56] *Hackethal v. National Casualty Company* (1987) 189 Cal.App.3d 1102, 1109.
[57] 42 U.S.C. §12111(8).

employer to make accommodations which will allow him or her to return to work without risk of exposure to the stressors that produce the disabling symptoms associated with PTSD. If so, the insured may not be disabled.

IV. PRACTICAL TIPS.

A. Make No Claims Decision Without Medical Review or an IME. For reasons discussed earlier, an insurer's failure to retain an expert to review the insured's medical records or have the insured examined by a qualified medical practitioner can prompt the finder of fact to conclude that its denial of a subjective disability claim was arbitrary and capricious.[58] In contrast, an insurer's reliance on the opinions of qualified experts can demonstrate that its claims decision was reasonable, even when the insured's treating physicians disagree with those experts.[59] Insurers therefore should defer any decision on a subjective disability claim until the insured's medical records have been reviewed and/or the insured has been examined by a qualified medical expert.

In that regard, care must be taken to select appropriate medical experts.[60] Those experts also should be asked to comment separately on the genuineness of the insured's underlying condition and his or her functional capacity. Doing so could reveal that the insured's self-reported condition escapes a definitive diagnosis.[61] It also could enable the insurer to enhance its position before the jury by permitting it to acknowledge the insured's self-reported condition as genuine while, at the same time, challenging only the level of functional impairment related to that condition.

B. Conduct the Insured's Deposition Early in the Lawsuit. In most cases, it is best to conduct the insured's deposition during the earliest stages of discovery. Delays allow the insured and his or her attorney more time to consider the facts, research the proof that must be made to prevail at trial, and become more "educated" about the potentially dispositive issues.

During the insured's deposition, the insurer's attorney should authenticate as many of the claim forms, written communications and other documents (such as attending physician statements) as he or she can. Naturally, the authentication of those documents will assist the insurer when it sets out to prepare a motion for summary judgment. At the same time, though, many of the documents in the insurer's claim file will include statements the insured made about his or her condition, the symptoms related to that condition, and the activities in which he or she engaged on a daily basis. Reviewing those documents with the insured will invite him or her to verify the severity of the subjective disorder and resulting level of functional impairment.

The insurer's attorney also can use the review of those documents as an opportunity to establish other important facts. For example, it can be used to ask the insured to confirm the presence (or absence) of those symptoms which are necessary to meet the diagnostic criteria for PTSD. It also can solicit damaging testimony about the insured's daily activities which are

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[58] See, *Garwysh, supra*, 1998 WL 329719 (N.D.Ill. 1998).
[59] See, *Greene, supra*, 924 F.Supp. at 360.
[60] See, *Monroe, supra*, 971 F.Supp. 1310 (C.D. Cal. 1997).
[61] See, *Yeager, supra*, 88 F.3d 376 (6th Cir. 1996); See also, note 22 and related text.

inconsistent with those captured on videotape by a surveillance team, as well as admissions about the insured's functional capacity which are consistent with the demands of the occupation in question.

C. Cross-Examine the Treating Doctors in Deposition. After developing a full evidentiary record of the insured's reported symptoms and actual level of functioning, the insurer's attorney should depose each of the insured's treating physicians. At a minimum, those depositions should be used to establish the limits of each physician's expertise. However, the focus of those depositions should otherwise be kept on the certainty with which the physician diagnosed the insured's condition, the facts upon which each physician based his or her assessment of the insured's functional capacity, and any historical information that suggests the insured has a genuine risk of relapse.

The decision in *Renfro v. UNUM Life Insurance Co. of America*[62] provides an excellent illustration of one insurer's successful use of that strategy. In that case, the claimant initially filed a claim due to major depression. After the policy's two year benefit period for mental-nervous conditions expired, she asserted that she remained totally disabled from multiple causes. The insured supported her claim for benefits with a variety of medical evidence. For example, the report from her allergist indicated that she was very sensitive to certain chemicals. Based upon that report, the insured's treating internist concluded that the insured's allergies and asthma made her sensitive to perfume and other materials common in the work place and therefore unable to work.[63]

In addition, the insured's chiropractor and physical therapist both reported that the insured suffered from arthralgias, myalgias, weakness and other medical problems that contributed to her inability to work. After reviewing the insured's medical records, though, the insurer found nothing from a physical standpoint to support her claim of disability. The insured thereaafter consulted a pulmonologist, who reported that her breathing difficulties were neither psychological nor the product of malingering.[64]

The insurer next conducted an IME which produced a finding that the insured's asthma was, at best, mild. The IME doctor further offered that the insured's sensitivity to chemicals could be controlled with the aggressive use of an anti-inflammatory drug.[65] He also suggested that her alleged disability was functional (i.e., the product of secondary gain), rather than the result of a true asthma condition.[66] The insurer therefore denied the benefit claim.

In the ensuing ERISA lawsuit, the court examined the insurer's claims decision under the de novo standard of review.[67] It commenced its analysis by noting that the treating psychiatrist had only provided evidence of the insured's mental disability and had disclaimed any expertise concerning allergies. It then noted that the treating allergist had diagnosed several conditions,

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[62] 920 F.Supp. 831 (C.D.Tenn. 1996).
[63] *Id.*, at 834.
[64] *Id.*, at 835.
[65] *Id.*, at 836.
[66] *Id.*, at 837.
[67] *Id.*, at 838.

but had not attributed the insured's disability to any of them. The court next dismissed the opinions of the insured's chiropractor and physical therapist because neither of them had the expertise to diagnose an infectious or environmental illness.[68] As a result, the treating internist's opinion (attributing the alleged disability to "very, very severe asthma") was the only competent medical evidence to support the disability claim.

After isolating the court's attention on the internist's opinion, the insurer offered evidence of clinical tests which had contradicted the internist's opinion. It also demonstrated that the insured's own allergist did not suggest that allergies contributed to her disabilities. The court therefore upheld the insurer's denial of the benefit claim.[69]

In most cases, treating physicians also will acknowledge that their assessment of the insured's functional capacity was based largely on the insured's subjective complaints. Insurers who possess compelling surveillance videotape therefore should consider asking the treating physicians to view those videotapes during deposition, then soliciting either an admission that the insured's functional capacity may be greater than reported or at least a concession that their assessment of the insured's functional capacity is based on incomplete information.

D. Moving for Summary Judgment. Through the use of qualified medical experts, independent medical examinations, surveillance, and effective cross-examination, disability insurers and their attorneys often can assemble a wealth of evidence to refute the insured's claim that a self-reported condition is disabling. Accordingly, the mere fact that the insured has made subjective complaints of a disabling Sickness or Injury should not dissuade the insurer from filing a motion for summary judgment.

To be certain, the insured's subjective complaints may ultimately reflect on his or her motivation to return to work. However, the credibility of those complaints is immaterial to a motion for summary judgment in a subjective disability case. Specifically, the policy's definition of "total disability" usually provides for an objective test which focuses on the insured's ability to return to some form of gainful employment. The central issue therefore is one that requires medical evidence, rather than an insured's subjective, unqualified opinion.

In most cases, the subjective disability claimant lacks sufficient medical expertise to offer an opinion about his or her functional capacity. For that reason, the insured's subjective complaints should have no bearing on his or her eligibility for benefits. Stated differently, the insured's subjective complaints of a self-reported condition and/or disabling symptoms cannot constitute substantial evidence that the underlying condition is, in fact, disabling. Instead, the

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[68] In cases involving Social Security benefits, the Ninth Circuit has unambiguously held that a chiropractor is "not considered an acceptable medical source. Although a claimant is free to offer chiropractic evidence to help the Secretary understand his inability to work, there is no requirement that the Secretary accept or specifically refute such evidence." *Bunnell v. Sullivan*, 912 F.2d 1149, 1152 (9th Cir. 1990), rev'd on other grounds, 947 F.2d 341 (9th Cir. 1991) (en banc); see also, 20 C.F.R. §404.1513(a) and (e) [distinguishing between "acceptable medical sources" and "other sources," and listing chiropractors under "other sources"].

[69] *Renfro, supra*, 920 F.Supp. at 838.

resolution of that issue must turn on medical evidence developed from a variety of other sources.[70]

E. Trial Tactics. Subjective disability claims often involve a complex set of medical opinions about conditions with which most jurors have little experience. When preparing to try a case involving a subjective disability claim, the primary goal of the insurer's attorney therefore should be to simplify that evidence so that the jury can more readily apply it to the applicable legal standards.

A significant portion of that work must be completed before trial actually begins. For example, the insurer's attorney should consider filing pre-trial motions to exclude the opinions of any treating physician who lacks the expertise necessary to diagnose the insured's self-reported condition or assess his or her functional capacity. Doing so will minimize the amount of testimony the jury hears about the various maladies from which the insured may suffer. It also should limit the insured's evidence at trial to the competent medical evidence required to sustain his or her burden of proof.

Of course, the insurer has no reason to expect a favorable outcome at trial unless it has assembled medical evidence of its own to suggest either that the insured's self-reported condition is not genuine or that the insured's functional capacity is not sufficiently impaired. However, its trial counsel should seize every opportunity to establish common ground between its medical experts and the insured's treating physicians, so that the points of dispute (and issues to be resolved by the jury) are more clearly defined.

In most cases, insurers who have retained qualified medical experts and allowed them to perform appropriate tests to comprehensively examine the nature and extent of the insured's alleged disability can rely on the testimony of those experts to demonstrate that their opinions are more compelling than those of the insured's treating physicians. The insurer's ability to make that showing also can be enhanced by evidence (such as excerpts from surveillance videotapes) which directly contradicts the insured's subjective complaints. Indeed, the treating physicians' opinions often are based on those subjective complaints. As a result, evidence that the insured is capable of tasks he or she told doctors were impossible to perform can undermine the foundation of the treating physicians' opinions.

Absent compelling evidence, though, insurers must be careful not to ask that the jury decide whether the insured's subjective complaints are credible. Rather, they should explain why the evidence which contradicts those subjective complaints is more reliable, then ask that the jury consider only the competent evidence of the insured's functional capacity. Otherwise, jurors may presume the insurer believes the insured to be a liar and reach a decision for reasons unrelated to the evidence presented at trial.

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[70] A plaintiff must come forward with sufficient competent evidence to find permanent disability. See, e.g., *Nevada Industrial Commission v. Hildebrand*, 675 P.2d 401, 454 (Nev. 1984) ["Hildebrand could not, by her own assertion, show a . . . permanent total disability."]; See also, *Chapaz v. Golden Nugget*, 822 P.2d 1114, 1118 (Nev. 1991) [competent medical authority is required to establish that an injured worker is unable to return to his pre-injury employment].

POHLS ASSOCIATES

V. CONCLUSION

The prospect of litigating a benefit dispute against someone who suffers from PTSD can be daunting. Regardless of whether the claimant attributes his or her condition to military service or some other traumatic event, they will endear themselves to the trier of fact by presenting themselves as survivors who must silently suffer from their memories of the underlying event for the rest of their lives.

Proof that those memories are triggered by something in the insured's occupation will present insurers and their counsel with another challenge. Specifically, that proof will allow the insured's attorney to suggest that the insurer will not pay benefits under the policy unless the insured puts himself or herself in harm's way. Any insurer who litigates a disability insurance claim involving PTSD therefore should take care to fully investigate the facts and test their legal defenses before trial becomes inevitable.

Although the case law involving subjective disability claims is largely unsettled, several decisions hold promise for an analytical approach that will assist insurers in exposing fraudulent claims. Specifically, some cases hold that the insured must present evidence of a definitive diagnosis regarding their self-reported condition, and others suggest that objective medical evidence is required to establish the condition and related functional impairment. For now, though, an insurer's ability to use those decisions to achieve favorable outcomes appears to be more a matter of forum-selection than anything else.

As a result, disability insurers and their trial counsel should stick to the basics and apply more traditional principles of insurance coverage analysis to disability claims that involve self-reported conditions. In particular, they should develop an evidentiary record concerning the Sickness or Injury to which the insured attributes his or her disability, then insist that the insured meet his or her burden of proving that Sickness or Injury to exist. They also should develop an evidentiary record concerning the insured's functional capacity and use it to challenge the insured's proof of functional impairment.

Insurers who opt not to assemble that evidence are left to make claims decisions on the basis of conclusory opinions by medical professionals who often believe either that self-reported conditions do not exist or are not disabling. In the end, though, the party who assembles evidence to support the medical experts' opinions will prevail. Disability insurers who remain focused on the need for that evidence during the claims administration and litigation stage of subjective disability claims therefore fare much better than those which do not.

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