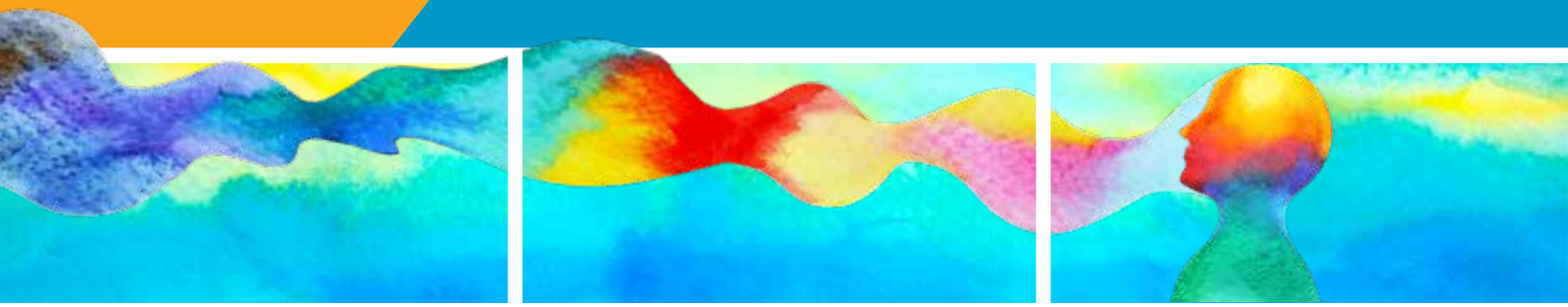

Seven Key Questions to Check for Plausibility in Mental Health Claims

By Johannes Schmidt, Gen Re, Cologne

Do you recognise this situation? You are assessing a Disability claim for a mental health condition and wondering whether the reported severity of symptoms claimed is accurate. Unfortunately, the majority of mental health conditions have no diagnostic imaging results or biological markers to ensure an appropriate diagnosis is made.

For example, depression is often diagnosed as a catch-all based on self-reported symptoms that may simply be expected reactions to life events or stressors. While it is relatively easy for a "major depressive episode" to be coded on the basis of subjective information using the ICD-10 criteria, this category is actually intended for cases in which those affected can no longer cope with their everyday life,[1] e.g. neglecting their personal hygiene, being unable to get out of bed, feeling emotionally flattened (experiencing neither joy nor sadness), having suicidal thoughts, and/or generally being urgently in need of medication and psychotherapeutic help.

There is a need for tools to assist claims assessors in the assessment of complex claims when no diagnostic criteria otherwise exist to confirm the plausibility and severity of the claimed impairment. These indicators include things like a glimpse into an insured's everyday life, including hobbies and volunteer efforts, along with the frequency and severity of symptoms claimed during doctor visits.

This article summarizes seven important aspects to keep in mind when assessing mental health claims, based on current empirical evidence.[2] Important to preface is none of the aspects mentioned should be considered in isolation. Mental health conditions must always be considered as a part of the individual's whole being.

Achieving Fairness

Ultimately the key driver of good claims management should always be fairness, i.e. paying out legitimate claims and defending against illegitimate claims. This is, of course, in the best interests of the industry and of the individuals filing claims, but it is also well understood to be better for claimants who are actually suffering from serious (mental) impairments.

So, how can fairness be achieved? One answer is consistency analysis and plausibility testing:

- *Consistency analysis* refers to verification efforts performed throughout the claims process at varyous points confirming statements made and information provided.
- *Plausibility testing* refers to whether inconsistency between statements, behaviors, activity level, and evidentiary requirements exists.

Given the fraud reported in the insurance industry, part of claims assessment requires one to understand the difference between deliberate "malingering" and unintentional magnification of symptoms.

"Malingering" refers to the *deliberate* creation, faking, or extension of discomfort to achieve a specific goal.[3] The individual is aware of the deception, for which there must be an external incentive. In the context of Disability Insurance this may be the receipt of financial benefit, which is why claims assessors must always query non-medical and motivational factors.

On the other hand, some magnification of symptoms can be considered a situation-appropriate response in the context of a medical or expert examination.[4] It is perfectly normal to want to convince a doctor or assessor of the presence of existing complaints by emphasizing or even slightly exaggerating the

presentation of the complaint. This often happens unconsciously. In addition, an altered self-perception (e.g. unrealistically negative self-assessment) can also be a component of a mental disorder such as depression, without the insured person intentionally being deceitful about the degree of his or her impairments.

This means mental health claims without any inconsistencies whatsoever are few and far between. Here it is important to weigh things in the overall context - if nine arguments speak for the plausibility of the presentation and only one argument against, that one should not be overweighted. In addition, a doctor should always assess whether abnormalities can be medically explained and are part of the disorder.

Seven Questions to Assess Consistency and Plausibility

1. Are there discrepancies between the reported frequency and intensity of symptoms and the vagueness of the complaints?

Even if psychometric tests are considered by some to be important, the diagnostic interview with the insured person remains a core element of psychiatric diagnosis. An important part of this is the history of condition, in which the individual states the specific complaints and limitations he or she experiences, when and how these developed, whether there are phases of improvement or regression, and what his/her concept of the disorder looks like (i.e. can he/she accept that the complaints could possibly have a mental rather than physical cause).

It may not be plausible, for example, to hear the insured person state complaints or symptoms of high intensity and frequency and be unable to reference them in any detail when asked. Therefore, it's important to seek clarification from the insured person via *concrete* examples of his/her complaints to ensure not only generalized statements (e.g. "everything hurts" or "I don't do anything anymore") are offered. Tele-assessment of claims can be useful here to gather concrete everyday examples of the complaints explained.

One of the benefits of tele-assessment in the claims process is it allows the claims assessor to gain better insight into the reported symptoms and ask better questions. For example, if the claimant:

- *only* presents symptoms that are difficult to objectify, such as fatigue or exhaustion, or
- reports symptoms that do not change over time or cannot be influenced by therapeutic measures, or
- gives "textbook-like" description of symptoms.

An assessor could ask questions such as: Can you tell me if you're more fatigued doing housework chores like laundry, or walking the dog (assuming one has a dog)? This helps to understand how much activity an individual endures and where the difficulties come into play.

2. Are there discrepancies between major subjective complaints (including via self-assessment questionnaires) and the recognizable physical and psychological impairments in the examination?

In addition to the diagnostic interview, clinical findings including behavioural observation are an important component of psychiatric diagnostics. Virtual therapy may mask some of the important observations and impressions clinicians otherwise note in inpatient therapy, for example, facial expressions and gestures, affect, mood, body tension, and psychomotor activity. The claims assessor should read all information prior to scheduling a tele-assessment or in-person interview with the claimant to prepare questions that may help resolve the inconsistencies. For example, laughing or crying would be rather atypical for a severe depressive disorder since it typically corresponds with flat affect (e.g. incapable of mood fluctuation). Another example is the insured's ability to concentrate and respond consistently for the duration of the assessment or interview, despite reporting symptoms of increased exhaustion, fatigue, or loss of concentration.

Naturally, one must keep in mind that the clinical picture is highly dependent on the type of disorder and each insured may not have all the symptom manifestations. For example, if someone suffers from panic attacks (or other anxiety disorders), it is not very likely that these will reveal themselves during the clinical assessment. Here, it would not be unusual if the psychopathological findings are unremarkable as symptoms may only be triggered by specific environmental or situational contexts. However, there are disorders in which "external" abnormalities are typical. For example, in addition to the possibility of erratic or irrational thinking in severe depression and schizophrenia, post-traumatic stress disorders (PTSD) should also be mentioned here. Those affected typically avoid addressing the trauma they have experienced, displaying hyperarousal (e.g. increased jumpiness and irritability, excessive vigilance) and often become recognizably agitated and frightened (e.g. trembling, red blotches) when the conversation is directed towards the traumatic event.

Sometimes a claimant/insured is convinced his/her impairment is physically based and thus the resulting description of symptoms manifest themselves in a physical fashion. What can claims assessors do to ferret out whether the underlying

condition is mental health or physically related? Claims assessors can compare complaints with the recognizable physical-psychological impairment in various pain disorders. Do the functional impairments complained of or demonstrated during the examination correlate with the gait pattern, the pain behaviour, apparent spontaneous movements, and external appearance (e.g. the apparent musculature)?

3. Are there any discrepancies between the patient's own statements and the information provided by others (including the records)?

Comparing current information with that recorded previously can be a useful exercise. The plausibility of the presentation increases if the information provided by the insured person is consistent across several points in time and different examiners. There are also "patient biographies" which are typical for certain disorders. Let's take somatization, for example, where a great many medical reports can often be found. This results from psychological explanations typically being rejected by the affected person at the beginning, meaning a large number of (potentially unnecessary) organic clarifications take place with different therapists from various disciplines. In cases where symptoms may have a medical (non-psychiatric) explanation, it is important that all differential medical diagnoses are investigated to ensure that the final diagnosis is accurate and the treatment optimal.

Where permissible and with appropriate consent agreements in place, securing corroborating evidence through employer/familial interviews may be appropriate.

4. Are there discrepancies between reported severity of symptoms and the observed level of psychosocial functioning in everyday life?

It's really important for the claims assessor to be able to marry the insured's functional capacity to the material and substantial duties performed just prior to his/her claimed date of loss. This can take place in an array of fashions but the key here is to understand what an insured CAN do versus CAN'T do. Since mental health problems do not usually manifest themselves exclusively at work, comparing daily activity levels with reported occupational limitations is a central aspect of psychiatric plausibility checks. For this, it is therefore important to obtain information about the insured person's daily routine. This may be obtained from the data in medical reports and expert opinions, but tele-assessments, activity diaries, and online research (e.g. social media sites) can also be useful sources.

One aspect that must be taken into account is that even people suffering from only moderate depressive disorders usually have difficulties coping with everyday life.[5] Important questions in this context would be:

- When do you wake up and when do you get up?
- What do your morning rituals look like (including personal hygiene)?
- Who takes care of the household? Which parts do you take over?
- What leisure activities and hobbies do you pursue?
- Who does the shopping and who takes care of the children (or relatives in need of care)?
- What activities do you do outside the house, including socialization?
- Which other activities fill your day?
- When do you go to bed and when do you fall asleep?

It's important to also lend consideration to the insured's premorbid level of function. For example, if an insured lived a private or relatively introverted lifestyle prior to his/her claimed date of loss and reports doing so at time of claim this would not be an inconsistency.

Furthermore, generalized statements such as "I don't do anything anymore" or "I simply watch tv all day" really require more understanding. Claims assessors should probe more to understand the answers to the questions noted above to gain greater insight to what the insured CAN do. In such cases it is worth asking for concrete examples and, if possible, have the person describe their daily routine from A to Z.

5. Are there discrepancies between the extent of the complaints described and the intensity of the use of therapeutic help?

The relationship between the severity of functional limitations and how therapeutic measures have been adopted must be regarded as quite delicate. For example, it can speak against the claimed severity of limitations if a patient is diagnosed with a severe depressive episode but receives neither antidepressant medication (or only an inadequate dose, or herbal preparation such as St. John's Wort) nor undergoes outpatient or inpatient psychotherapy, even though such treatment is the gold standard and indicated for severe depression.[6] However, it's always necessary to consider the reasons why. For example:

- Was medical treatment recommended by a doctor but refused by the insured
- Were adverse reactions experienced to the medication prescribed
- Are medications being adjusted (e.g. tapering vs. increasing or changed altogether)
- Were no antidepressants prescribed.

In the latter case, this may speak to inappropriate care and treatment as outlined by both general practitioners and psychiatrists. If the insured person refused to take medication, the claims assessor really needs to understand the rationale why. There could be an array of very valid reasons including one's religious beliefs, cultural differences that exist around the world, and even prior concerns about the use of prescription medications. Claims assessors should ask questions of both the insured and the treating specialist to truly understand the root cause of the insured's concerns and the alternative approaches available. Were the symptoms and their degree of impairment not significant enough for the insured person to feel the need to take medication, or do they possibly hold concerns about the use of chronic medication or the potential side effects? In this case, psychoeducation would be necessary to explain the cost-benefit risk involved and alternative medications and therapies should be explored by a suitably qualified specialist. Or are there difficulties accessing treatment due to limited specialist availability or long wait times for appointments? Here modern approaches such as online (e)CBT, virtual reality, and other innovations may offer an alternative to traditional treatment or may help bridge the gap while waiting for face-to-face therapy.

Conversely, it speaks for the plausibility of the complaint of a severe depressive disorder if an affected person, for example, accepts inpatient (especially psychiatric) hospital stays and receives antidepressants.

Panic disorders often have corresponding physical symptoms that may be observed if medical attention is sought immediately. This aids in the understanding of the condition's claimed severity, the frequency and duration of the symptoms, and the corresponding treatment regimen recommended. It also offers the claims assessor insight into what might have led to the onset or triggering event of the panic attack. Some of the symptoms may include a racing heart, sweating, trembling, shortness of breath, tightness in the chest, nausea, dizziness and take a typical course (sudden occurrence, attacks increasing in intensity within about 10 minutes and usually lasting about 30 minutes),[7] but may also be deeply disturbing events for those affected, especially when they first occur – fears of dying often accompany a panic attack. These symptoms, if medically detailed through clinical notes or emergent care treatment, often lend credence to the plausibility of the correct diagnosis being established.

If any doubts remain regarding treatment and compliance, these should be explored with the treating specialist. In some cases, a review by an Independent Medical Examiner or Insurance Medical Advisor may be beneficial.

6. Are there discrepancies between the apparent clinical picture and the results of self-report scales and/or psychometric tests (including specific complaint validation tests)?

The use of psychometric tests for the diagnosis of mental disorders and for the assessment of occupational performance is a controversial issue. However, there is agreement that the diagnostic interview is central and that tests are only supplementary instruments. Psychometric tests do not objectify or prove anything, but only provide indications and are rarely meaningful when considered in isolation.

That said, psychometric tests do create an additional database that can be compared with other findings as part of the plausibility check. If, for example, an insured person claims that he or she is unable to concentrate for more than 30 minutes at a time, this can be verified not only clinically (e.g. if symptoms of exhaustion and fatigue were revealed during an examination lasting several hours), but also through performance in concentration and attention tests such as the d2 Test of Attention-Revised (d2-R).[8] Again, it should be noted that abnormal test results must never be interpreted in isolation but,

rather, should be weighted in the overall context of findings (e.g. psychopathological findings, medical history, daily activities etc.).

Test results should also never be accepted uncritically. For example, it may be an indication of malingering if the insured person almost exclusively achieves extreme values (e.g. percentile rank PR < 1 or > 99, T values T < 20 or > 80), if there are contradictory results between tests that measure the same trait (e.g. both testing attention), or if the results vary greatly with repeated measuring.

As well as unspecific complaint validation tests, tests have also been specially developed to test a participant's willingness to exert maximum effort and motivation to take the test. *Performance validity tests*[9] such as the Test of Memory Malingering (TOMM)[10] pursue different approaches which will not be discussed here as they can in principle be trained and thus falsified. An indication of this could be if someone performs below the guessing probability or exhibits a certain level of errors in such tests which superficially appear to be difficult but can be mastered even by severely impaired patients (principle of concealed ease).[11]

In addition to performance validity tests, there are also so-called *symptom validity tests*,[12] which do not test the willingness of a test person to make an effort but, rather, the plausibility of their reported complaints. These tests, such as the Structured Interview of Reported Symptoms – 2 (SIRS-2)[13] or the Self-Report Symptom Inventory (SRSI),[14] also take different approaches. For example, it is tested whether a participant complains of a variety of complaints that would be very atypical for the disorder in question, whether unlikely symptom combinations are complained of, or whether obvious complaints are affirmed but subtle ones are denied.

Such tests are an important, complementary component block in distinguishing between deliberate malingering and unintentional magnification of symptoms and contribute to more valid assessments that do not rely solely on experience-based expert judgement.

"... There is little evidence that clinicians – unaided by specialized tests – can reliably distinguish malingerers from persons actually suffering from a mental disease or defect. One recent study found that psychiatrists working in a state forensic facility, relying on interviews and file data, failed to identify 50 percent of malingerers detected through specialized testing..."[15]

Therefore, it makes sense not to rely on one's experience, but to use all available diagnostic instruments.

However, if used, validation tests should be performed and evaluated by experienced clinical neuropsychologists. In addition, as the validity of a single test is limited, several tests should be used to measure the same characteristic and the test results compared with the other findings (psychopathological findings, daily structure, preliminary findings in the file, etc.) before a conclusion is drawn.[16]

For more information on psychometric, performance validity, and symptom validity tests, please feel free to get in touch with me or your chief medical officer.

7. Are there discrepancies between the medications reportedly being taken and a lack of evidence in the blood serum?

Laboratory tests are a final component in the validation of complaints. For example, it speaks in favour of the complaint presentation and to compliance if the specified antidepressant medication can be detected in the blood serum. The evaluation of such findings belongs in the hands of experts. Since different psychotropic drugs are broken down at different rates and some affected persons are so-called ultrarapid metabolizers,[17] it makes a difference whether the medication presented cannot be detected in the therapeutically effective range in the blood serum or not at all. If an insured claims to be taking a certain medication on a daily basis and then it cannot be detected at all, this can speak against the plausibility of the claim. The availability and suitability of such tests differs from market to market. We advise you to speak to local experts if you are unsure whether blood serum testing is appropriate.

Conclusion

In the field of mental health claims, numerous options are available to help establish the plausibility of an insured person's claim and enable valid decisions to be made. The seven factors described here in detail can provide claims assessors with important insight. However, you should always bear in mind that each claim should be evaluated on its own unique set of circumstance much like each puzzle piece must always be assessed as a whole and never in isolation from the others.

About the author

Johannes Schmidt *(Psychologist, M.Sc.) is an experienced psychological assessor who has been working in the Claims Management Team Cologne since 2018. In addition to his numerous lectures and articles, his focus is on the examination of complex and legally contentious medical issues.*

Tel. +49 221 9738 478
johannes.schmidt@genre.com

Endnotes

1 Dilling, H., & Freyberger, H. (2019). Pocket guide to the ICD-10 classification of mental disorders: based on JE Cooper's pocket guide. Bern: Hogrefe; pp. 135-136.

2 Widder, B., & Schneider, W. (2021). New AWMF guideline on the assessment of mental and psychosomatic disorders. Der Nervenarzt, 92(1), 36-43.

3 QC30 Malingering. International Classification of Diseases (11th ed., April 2019). World Health Organization. Retrieved November 5, 2019.

4 Rogers, R. (2018). Current status of clinical assessment of response styles. In: Rogers R, Bender SD (Eds.) Clinical assessment of malingering and deception., ed 4. New York, Guilford Press; pp 571-591.

5 Dilling, H., & Freyberger, H. (2019). Pocket guide to the ICD-10 classification of mental disorders: based on JE Cooper's pocket guide. Bern: Hogrefe; pp. 135-136.

6 National Institute for Clinical Excellence (NICE). (2017). Depression in adults: recognition and management. 2009. https://www.nice.org.uk/guidance/cg90; last accessed 22 November 2021.

7 https://www.awmf.org/uploads/tx_szleitlinien/051-028l_S3_Behandlung-von-Angststoerungen_2021-06.pdf; p. 17; last accessed 15 November 2021.

8 https://www.hogrefe.com/uk/shop/d2-test-of-attention-revised.html; last accessed 19 January 2022.

9 Lippa, S. M. (2018). Performance validity testing in neuropsychology: A clinical guide, critical review, and update on a rapidly evolving literature. The Clinical Neuropsychologist, 32(3), 391-421.

10 https://www.testzentrale.de/shop/test-of-memory-malingering.html; last accessed 19 January 2022.

11 Dohrenbusch, R., & Torras, R. A. (2017). Principles and methods of complaint validation. PSYCH up2date, 11(04), 359-374.

12 Lockhart, J., & Satya-Murti, S. (2015). Symptom exaggeration and symptom validity testing in persons with medically unexplained neurologic presentations. Neurology. Clinical practice, 5(1), 17-24.

13 Kocsis, R. N., PhD (2011). The Structured Interview of Reported Symptoms 2nd Edition (SIRS-2): The New Benchmark towards the Assessment of Malingering, Journal of Forensic Psychology Practice, 11:1, 73-81, DOI: 10.1080/15228932.2011.521726.

14 Merten, T., Merckelbach, H., Giger, P., & Stevens, A. (2016). The Self-Report Symptom Inventory (SRSI): A new instrument for the assessment of distorted symptom endorsement. Psychological Injury and Law, 9(2), 102-111.

15 Miller, H.A. (2005). The Miller-Forensic Assessment of Symptoms Test (M-FAST): Test Generalizability and Utility Across Race, Literacy, and Clinical Opinion, Journal of Criminal Justice and Behavior. https://www.swiss-insurance-medicine.ch/storage/app/media/Downloads/Dokumente/Bildung/Tagungen/Jahrestagung/2019/7plohmanninternet21032019sim20jahrestagungaggravation20aus20neuropsychologischer20sicht1.pdf; last accessed 19 January 2022.

16 Berthelson L., Mulchan S.S., Odland A.P., Miller L.J., Mittenberg W. (2013). False positive diagnosis of malingering due to the use of multiple effort tests. Brain Inj.27(7-8):909-16. doi: 10.3109/02699052.2013.793400. epub 2013 Jun 19. PMID: 23782260.

17 An ultrarapid metabolizer (UM) is a drug metabolism phenotype that describes the ability to metabolize a drug at much faster rates than expected. (2004). Ultrarapid Metabolizer. In: Encyclopedic Reference of Molecular Pharmacology. Springer, Berlin, Heidelberg. https://doi.org/10.1007/3-540-29832-0_1702; last accessed 19 January 2022.

The people behind the promise®

genre.com | genre.com/perspective | Twitter: @Gen_Re

General Reinsurance AG
Theodor-Heuss-Ring 11
50668 Cologne
Tel. +49 221 9738 01
Fax +49 221 9738 494