Report of the Commission on the Evaluation of Pain*

The following is a reprint of the report to Congress transmitted by the Department of Health and Human Services in response to a provision of the Social Security Disability Benefits Reform Act of 1984 (Public Law 98–460). It also includes some of the report's appendix material. The congressional mandate called for a study, performed in consultation with the National Academy of Sciences, of how pain is evaluated in determining disability under titles II and XVI of the Social Security Act and for recommendations on how pain should be considered in evaluating disability under these programs. In addition to several recommendations for improvements in interviewing, applications, questionnaires, and development practices in "pain" cases by including pain specialists for consultative examinations, the Commission strongly advocated experiments to determine if individuals with impairment due primarily to pain can be reactivated and vocationally rehabilitated under appropriate programs or if such individuals should be allowed disability benefits.

Executive Summary

Since the early 1980's, an increasing number of court cases presented challenges to existing Social Security Administration (SSA) policy on the evaluation of pain as a factor in determining disability. Thus, attention was focused on the need for a careful review and evaluation of that policy.

During the congressional deliberations on H.R. 3755 (Public Law (P.L.) 98–460, The Social Security Disability Benefits Reform Act of 1984), several Members noted the influence the Federal courts were exercising in defining various pain standards in the disability program. The decisions regarding pain varied considerably from circuit to circuit, and primarily addressed how a claimant's allegation of pain was to be assessed and evaluated in deciding whether a claimant was under a disability. Some Members were concerned that the court opinions had gone beyond what the Congress had intended by giving too much weight to allegations, thereby redefining the concept of disability. These Members believed that the court pain standards were improper and beyond the intent of Congress. Other Members were concerned that SSA had been too restrictive in its interpretation of how to evaluate pain, thereby wrongly denying benefits. At the same time, the Congress recognized the need to express clear congressional intent and did so by authorizing a statutory standard for the evaluation of pain to apply to all disability decisions during the period in which SSA policy could be evaluated in the light of adjudicative experience and current medical knowledge.

Thus, section 3 of P.L. 98–460 incorporated the existing SSA policy for the evaluation of pain into the statute for the first time, but with a "sunset" date of December 31, 1986. At the same time, section 3 required the Secretary of Health and Human Services to appoint a Commission on the Evaluation of Pain to study, in consultation with the National Academy of Sciences (NAS), the evaluation of pain in determining eligibility for disability benefits under titles II and XVI of the Social Security Act, as amended, and to make recommendations on how pain should be considered in the evaluation of disability under these programs. The Secretary must report the Commission's findings to the Senate Finance Committee and to the Committee on Ways and Means of the House of Representatives.

A 20-member Commission, with collective expertise in the fields of medicine, law, insurance, and disability program administration with significant concentration

*For an unabridged copy of the report, containing all the appendices in their entirety, specify the above title and direct your request to the Office of Public Inquiries, Social Security Administration, Room 4100 Annex, 6401 Security Boulevard, Baltimore, Maryland 21235. Orders may also be initiated by calling (301) 594-7700.

of expertise in the field of clinical pain, was appointed on April 1, 1985. The members of the Commission [who are identified on the next page] have devoted considerable personal time and effort to provide a thorough and objective review of the issues raised by the Congress and others, and have consulted with the NAS to enable them to carry out their charge, and with SSA to ensure the practical application of their findings and recommendations.

The Commission has carefully studied the social security disability programs, the policies and procedures with respect to the disability evaluation process in general, and the evaluation of pain in determining disability in particular. The Commission has also, with the aid of the consultative services of the NAS, reviewed extensive literature on pain and disability and heard expert testimony on the latest methodologies for the measurement of pain and pain behavior. The collective observations and conclusions of the Commission are reflected in the appended summary of the Commission's Findings and Recommendations and discussed in detail in the formal Report.

Social Security Act Pain Standard

Under existing social security law, in order for pain to be considered in evaluating disability, there must first be a medically determinable physical or mental impairment which could reasonably be expected to produce pain. Once such an impairment is established, SSA will consider statements from the individual, his or her doctor, and others concerning any restrictions caused by pain. If, however, there is no underlying physical or psychiatric impairment which could reasonably explain the pain, then disability cannot be established.

Defining Pain

Pain is a complex experience, embracing physical, mental, social, and behavioral processes which compromises the quality of life of many individuals. The Commission acknowledges the difference between two categories of pain, acute and chronic. As a symptom, acute pain is handled relatively well under current law. The problem is in the evaluation of individuals with chronic pain. In those individuals with objective laboratory and clinical evidence of a physical or mental impairment which could reasonably be expected to cause the pain alleged, evaluation proceeds in the manner by which all other symptoms are handled. However, there is now a recognized chronic pain syndrome (CPS) in which the pain persists beyond the expected healing time of the injury or illness and in which there is a lack of objective laboratory and clinical evidence of physical impairment which could reasonably cause the reported pain. Numerous medical, psychological, sociological, and economic factors contribute to this syndrome. The Commission addressed the differences between claimants with chronic pain and those with CPS and recognized that SSA's adjudicative problems were due in part to a lack of a systematic evaluation approach to such claimants and in part to the complexity of addressing a subjective experience such as pain in the evaluation of disability.

As a preliminary to its full discussion of the evaluation of pain and pain behavior in determining disability, the Commission defined four groups of chronic pain claimants: (a) chronic pain, inability to cope, insufficient documented impairment (chronic pain syndrome)—not covered by current law; (b) chronic pain, competent coping, insufficient documented impairment—not covered by current law; (c) chronic pain, inability to cope, documented impairment sufficient—covered by current law, and (d) chronic pain, competent coping, documented impairment sufficient—covered by current law. The Commission recognized the problems of all claimants with chronic pain, but was particularly concerned with the adjudicative problems raised by the first two groups.

At the request of SSA, the Commission considered whether psychogenic pain disorder is descriptive of individuals in these groups. Using the definition of psychogenic pain found in the **Diagnostic and Statistical Manual of Mental Disorders, Third Edition** (DSM III), the Commission questioned several expert witnesses about psychogenic pain and concluded that it is not the same as chronic pain or chronic pain syndrome. The Commission found that chronic pain and chronic pain syndrome are not psychiatric disorders. Thus, while there was agreement that psychogenic pain, as defined in DSM III, can appropriately be evaluated as a mental disorder, the Commission believes that chronic pain and chronic pain syndrome cannot.

Statutory Standard

The Commission reviewed the current information about clinical pain states, pain measurement, and the relationship of pain to disability in the context of the existing social security disability programs and, specifically, the recently enacted statutory standard for the evaluation of pain in determining disability. The Commission found that the current statutory language adequately and appropriately calls attention to the necessity of considering pain in adjudicating disability cases. Although some members believed that the statutory standard might be improved, the consensus was that any modification would be premature without more specific data about pain and disability. Thus, the Commission recommends that the statutory standard be extended until additional data are obtained.

Need to Assess Magnitude of Problem

The Commission recognized that the Social Security Act requires that an individual have a medically determin-

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able impairment which can reasonably be expected to produce the alleged pain. The Commission also recognized that there are individuals who allege significant restrictions because of pain and who demonstrate chronic illness behavior who are currently not eligible under the Act because they have insufficient documented findings to substantiate the degree of pain alleged. However, the Commission found there is insufficient data on the magnitude of this group of claimants with pain who seek social security disability benefits or the number of individuals who are denied on the basis of insufficient documented findings. Therefore, the Commission recommends that SSA create a dedicated data management system to monitor both allowances and selected sample denials in which pain forms a substantial element of the claim and to follow such cases at each stage of the disability process.

Consultation with the National Academy of Sciences

The Commission could not fully determine the magnitude of the problem of pain and the evaluation of pain in the social security disability claimant population in the time allotted without the aid of the NAS. The Institute of Medicine (IOM) of the NAS contracted for a review of the published literature on pain and disability and arranged for a panel presentation on the possible impact payment of disability benefits, particularly for disability on the basis of pain, would have on chronic pain behavior and on the rehabilitation of claimants with chronic pain. On September 30, 1985, at the recommendation of this Commission, SSA contracted with the IOM for a major study on the relationship of pain, chronic illness behavior, and disability to supplement the Commission's work. The Commission recommends funding of the most promising areas of research in the field of chronic pain and its assessment identified by the IOM study.

Improvement of SSA Development of Pain in Disability Claims

The Commission notes that, within the construct of the existing administrative and program structure, there are a number of steps SSA can and must take to improve and refine existing procedures for claims development and adjudication where pain is a factor. These include improved training of personnel at all adjudicative levels, redesign of disability applications to collect more information about pain and pain behavior, development of more efficient data gathering forms and questionnaires, increased use of personal interviews and face-to-face examinations earlier in the decisionmaking process, and use of trained pain specialists, where possible, in the examination and evaluation of claims where pain is a significant factor in the claimant's allegations. The adoption of these steps will provide SSA with better information about the claimant's pain from the claimant, his or her treating and consulting sources, and others, as well as provide a better data base for management information. The Commission specifically recommends that SSA obtain the consultative services of experts in the design and testing of forms and questionnaires to ensure the appropriateness of the final design. The Commission believes that while many of these actions can be initiated by SSA under existing administrative authority, sufficient funds should be made available to allow these changes to be rapidly incorporated into current disability program policy and procedures.

Availability of Methods to Measure Pain

The Commission holds that pain is a complex experience with social and psychological factors complicating attempts at measurement. The Commission recognizes that the assessment of claimants with chronic pain requires a multidimensional approach to allow for correlation of functional limitations with reported pain and that SSA is necessarily limited to relying on observations of pain behavior by physicians, State and SSA interviewers, and the claimant's own reports of his or her pain. At the same time, there is a clear Commission consensus that malingering is not a significant problem and thaat increased attention to subjective evidence in the evaluation of the existence and nature of pain will not significantly alter the ability of trained professionals, medical and other, to recognize malingering where it is present.

A Listing Category For Impairment Due Primarily to Pain

The Commission considered at length the appropriateness of establishing a listing level category for impairment due primarily to pain for evaluation of individuals who have minimal or no physical findings and who would not be found disabled under existing law, but who show significant chronic illness behavior. Thus, the Commission developed a set of criteria descriptive of individuals where pain is the primary impairment. The members did not agree that this set of criteria necessarily accurately or best described disability as defined by the Social Security Act. Discussion on this issue was intense and extended, with some members wanting to recommend the proposed criteria be adopted by SSA as a new disability listing without further study or delay. Although a minority of members drafted a separate opinion in support of this position (see page 121 [of the full report]), the majority believed that there was insufficient data for such a recommendation.

Therefore, the Commission recommends that, concurrent with an assessment of the magnitude of the problem, the criteria developed by the Commission be used to select participants for an experiment or experiments to determine whether the set of criteria, in fact, correctly defines dis-

ability, and that such an experiment or experiments include a rehabilitation/reactivation experiment.

Rehabilitation/Reactivation Experiment

Although there are several provisions in the social security law which encourage rehabilitation, the Commission was generally critical of the rehabilitation aspects of the disability programs and considers these provisions inadequate to overcome the inherent financial and social advantages to continued entitlement to benefits. The Commission strongly recommends that there be an experiment or experiments to study whether there should be a disability category for impairment due primarily to pain and to assess the feasibility, efficacy, and cost effectiveness of rehabilitation. The Commission believes such an experiment or experiments should incorporate the criteria developed by the Commission to evaluate the desirability of incorporating those or similar criteria into the "Listing of Impairments." Further, the Commission recommends that the experiment or experiments provide a time-limited monthly stipend equal to the monthly disability benefit the person would have received had disability benefits been awarded as an incentive for participation.

Consequences of Granting or Denying Disability

The Commission is concerned that there are possible adverse consequences of awarding or denying disability benefits that cannot be ignored in evaluating whether there should be a Listing category for impairment due primarily to pain. Many experienced Commission members indicated that the availability of public and private disability programs, financial and other, are sometimes strong disincentives to rehabilitation and return to work. On the other hand, income from these benefit programs is often a major factor in an individual's maintaining self and family without economic deprivation and attendant potential health-jeopardizing stresses. Finally, award of disability benefits is often used as a substitute compensation for unemployment, creating a "sick" person out of one who could be at least partially productive. The Commission believes this often results in health care overutilization and recommends that alternative programs for the support of the occupationally disabled be explored.

Findings

Chronic Pain and Chronic Pain Syndrome Are Inadequately Understood

(1) Pain is a complex experience, embracing physical, mental, social, and behavioral processes, which compromises the quality of life of many Americans. Chronic pain and its consequences are inadequately understood by patients, the health care system, the public generally, and the Social Security Administration.

(2) There are two basic categories of pain, acute and chronic. The distinctions between the two are important for proper assessment of disability. Acute pain, that is pain of recent onset and probable limited duration, is dealt with relatively well under current law. The problem is chronic pain—that is, constant or intermittent pain of long duration or pain which persists past healing.

(3) Chronic pain patients may usefully be categorized according to two interrelated variables. The first is the extent of pathology—that is, the degree of identifiable body damage. The second is the behavior of the individual which may be influenced by personal response and adaptation—that is, the extent to which the individual is able to deal effectively with his or her pain or responds to advice and information about the pain from the health care system, past experience, or significant persons in his or her environment. Together these two factors are powerful predictors of a person's potential capability to function and for return to work.

(4) Chronic pain syndrome is a complex condition which has physical, mental, and social components. Both chronic pain and chronic pain syndrome can be defined in terms of duration and persistence in relation to the extent of demonstrated and observable pathology. However, chronic pain syndrome, as opposed to chronic pain, has the added component of certain recognizable psychological and socioeconomic influences. While there may be some blurring of the boundaries between chronic pain and chronic pain syndrome, the characteristic psychological and sociological behavior patterns inherent in chronic pain syndrome provide a basis for trained clinicians to distinguish between the two conditions, and to differentiate the chronic pain syndrome from malingering and from serious emotional disorders. Chronic pain and the chronic pain syndrome are the primary focus of this report.

Incidence of Malingering

(5) There is a clear consensus that malingering is not a significant problem, that it can be diagnosed by trained professionals, medical and other, and that increased attention to subjective evidence in the evaluation of the existence and nature of pain will not significantly alter this.

Unavailability of Methodologies For Measuring Pain

(6) Numerous attempts have been made to try to develop methodologies for measuring pain objectively. This is, as yet, not possible because pain is inherently a subjective personal experience and we are necessarily limited to observations of pain behavior, including the person's reports.

With acute pain, attempts at measurement have met with some success, at least in experimental settings and in a limited number of clinical settings where patients have been taught to describe the quality and intensity of pain and their degree of relief, using measurement tools that have established validity. Chronic pain, however, is a more complex entity, with additional social and psychological factors requiring a multidimensional approach to assess the person's report of pain.

Inadequacy of Data Base on Disability Due Primarily to Pain

(7) There is no existing system to "track" claimants with chronic pain in the current disability evaluation process. System management lacks longitudinal data for both awards and denials broken down by such factors as type of impairment, adjudicative stage, and demographics.

Evaluation of Pain in Determining Disability Under Social Security

(8) There is a lack of knowledge on the part of health care professionals generally about chronic pain and chronic pain syndrome and about their impact on the disability system. The complexity of the problem of chronic pain has generated predictable administrative difficulties, including incomplete data gathering and inconsistent decisionmaking. Participants in the social security process, including social security initial decisionmakers and appellate adjudicators, consulting physicians, and others, do not have adequate guidance about pain and pain behavior or the distinction between acute and chronic pain or chronic pain and chronic pain syndrome.

(9) The current disability system reflects the difficulties and uncertainties encountered by the medical profession in dealing with pain. The existing social security disability regulations appropriately include pain as a symptom to be fully assessed in evaluating disability. The regulations also deal adequately with pain as a component of certain listings and in other cases where pain is reasonably consistent with identified physical and mental impairments. In contrast, the Social Security Act does not allow a finding of disability when impairment is due primarily to pain which cannot be related to a medically determinable condition, especially where a claimant's pain reports may not correlate highly with physical findings.

Retention of a Statutory Standard

(10) The introduction of a statutory requirement for the consideration of pain in evaluating disability has promoted a uniformity of adjudication at all levels within the Social Security Administration and in the courts which did not previously exist. The presence of the statutory standard is, by itself, a positive step. However, the standard will "sunset" on December 31, 1986, unless some action is taken. The expectation of the Congress was that this Commission would be able to complete its mandated study of the issues, evaluate the appropriateness of the standard, and recommend extension, modification, or termination in time for the Congress to act prior to the sunset date. In view of the complexity of the issues, the Commission realized that this expectation was overly optimistic. It was the considered opinion of the Commission that the current statutory language adequately and appropriately calls attention to the necessity of considering pain in adjudicating disability claims and that there is no need for clarification or modification of the statutory language at this time. Any proposed modification would, therefore, be premature in light of the clear need for additional data.

Consequences of Awarding or Denying Disability

(11) The Commission believes that in some instances the availability of public or private disability and medical benefits are disincentives and may influence the persistence and continuation of pain behavior. A requirement of objective medical evidence encourages excessive and often fruitless pursuit of such evidence. The pursuit itself then risks promoting iatrogenically induced complications and further claimant commitment to a self-image as a disabled person. In other instances, however, income from public or private disability and medical benefits is the major factor insulating the recipient (and his or her family) from economic deprivation and attendant potential health-jeopardizing stresses. Further, the granting of disability benefits often is used as a substitute compensation for unemployment resulting from occupational disability. As such it creates a "sick" person out of one who could be at least partially productive. As medical disability is far more expensive than occupational disability, requiring continued health care overutilization to continue to prove disability, alternative programs for support of the occupationally disabled should be explored.

Overall, on the basis of the available information, the Commission is unable to generalize on the number of claimants in either group, the magnitude of the conflicting pressures, or on the consequences of awarding or denying benefits to social security claimants.

Request For Special Study to be Conducted by The National Academy of Sciences

(12) The limited time span allotted for the Commission is not sufficient to fully explore the complete subject of pain and disability. However, the Institute of Medicine of the National Academy of Sciences does have the capability to do additional work that the Commission views as nec-

essary to meet its professional responsibility to fully explore the interrelationship between pain, chronic illness behavior, and disability.

Recommendations

Need For Additional Training and Redesign of Forms and Questionnaires

(1) The early stages of the disability claims procedure should be redesigned to adduce better information about pain and pain behavior. Several specific steps should be pursued toward this objective. These include:

(a) Additional training focused on issues of pain to be provided to State disability determination services employees, to administrative law judges, and to others within the social security disability system, in order to instruct government personnel about issues raised by pain complaints;
(b) Redesign of Social Security Administration application forms to alert interviewers and/or adjudicators to cases where pain is a substantial element and development of questionnaires to collect more information about pain at the earliest opportunity. The initial application form should have a new section providing the claimant a clear occasion to detail the pain, when present. Questionnaires and forms sent to treating and consulting physicians and, where appropriate, to the applicant, his or her family, friends, and other potential sources, should also have additional provision for eliciting detailed descriptions of pain behaviors, when applicable.

Need For Input by Specialists in Pain Behavior and Pain Management

(2) Whenever possible, additional use should be made of pain specialists as consultative examiners in appropriate cases. Unless specifically trained, health care professionals are not pain experts for this purpose.

Need For Face-to-Face Interview in Pain Cases

(3) Personal interviews or face-to-face examinations at the State disability determination services level should be required earlier in the decisionmaking process in pain cases to enable first hand personal evaluation to supplement paper reviews and telephone interviews.

Medical-Vocational Assessment of Impairment Due Primarily to Pain

(4) For more accurate consideration of cases in which pain is a substantial element but the impairment does not meet or equal any Listing, the "sequential evaluation process" (20 CFR 404.1520/416.920) ought to take greater account of the ways in which pain can inhibit functional capacity. This should be accomplished in two ways:

(a) Improve the definition of "residual functional capacity" (20 CFR 404.1545 **et seq.**) to consider explicitly the possible restrictions created by pain upon a claimant's ability to carry out the strength-related demands of basic work activities, i.e., sitting, walking, standing, lifting, carrying, pushing, pulling. Regulations should require disability decisionmakers to consider in detail whether the reported pain interferes with ability to undertake physical exertion and should rely, as much as is practicable, on observations of the claimant's performance of the basic strength-related demands of work activities or comparable activities. Work evaluation should be used where indicated.
(b) Pain should also be more fully incorporated into the analysis of nonexertional employment-related limitations, i.e., mental, sensory, and environmental limitations. The notes and examples accompanying the **Medical-Vocational Guidelines** (20 CFR 404. subpart P, appendix 2, section 200.00), as well as in the main portion of subpart P, should be expanded to elaborate instances where reported pain, especially in concert with other limitations, whether exertional, mental, sensory, environmental, postural, etc., can be significant in the medical and vocational analysis of disability.

Need to Specifically Address the Issue of Pain in Decisionmaking and in Decision Rationale

(5) Regulations should require decisionmakers at each stage and at all levels of adjudication of a disability case to specifically address the issue of pain whenever it is raised by the claimant or the record, and to state explicitly all findings and the basis for such findings regarding the nature, extent, and severity of pain.

Remand of Certain Cases at Administrative Law Judge Level

(6) In any case where disabling pain is alleged for the first time at the administrative law judge (ALJ) stage, and the ALJ is unable to otherwise dispose of the case (e.g., by awarding benefits on medical or medical-vocational grounds or denying benefits based on the claimant's failure to satisfy the nonmedical eligibility requirements), the ALJ should be required to remand the case back to the State disability determination services for further development and evaluation by a physician of the record regarding pain.

Need to Assess the Magnitude of the Problem

(7) There should be an experiment or experiments to assess the magnitude of the problem of disability evalua-

tion where impairment is alleged due primarily to pain and to evaluate whether there should be a Listing category for "impairment due primarily to pain."

Need to Assess the Feasibility and Cost Effectiveness of Rehabilitation

(8) SSA should continue to foster studies directed toward elucidating objective methods for identifying chronic pain as disabling in the absence of objective evidence of physical or mental impairment which could reasonably be expected to cause the reported pain. The results of any experiment(s) carried out pursuant to this Commission's recommendations should be used to determine how pain should be evaluated in determining whether chronic pain is disabling and in making disability determinations.

Need to Develop Criteria For Determining Disability Where Impairment Is Due Primarily to Pain

(9) Any experiment(s) to determine the magnitude of the problem of evaluating pain where the alleged impairment is due primarily to pain should include a study of the feasibility, efficacy, and cost effectiveness of reactivation and rehabilitation.

Proposal For Extension of Statutory Standard

(10) The current statutory standard for the evaluation of pain should be extended without modification for the duration of the experiment(s) being recommended by this Commission and for one year thereafter. Any modification in the statutory language should only be made after additional data are acquired as a result of the study being conducted by the Institute of Medicine of the National Academy of Sciences and through the experimental process.

Development of Improved Data Base

(11) The Social Security Administration should create a dedicated data management system to monitor cases in which pain forms a substantial element of the claim. Detailed accounts should be maintained of the numbers and disposition of pain cases at each stage of the disability process. Allowances, as well as selected sample denials, should be monitored for subsequent developments over an extended period of time. The case records should include data on impairments, hospitalizations, other benefit programs applied for, and subsequent work history. All experiment cases should be included in the followup.

Followup Study by the Institute of Medicine of the National Academy of Sciences

(12) The Institute of Medicine (IOM) of the National Academy of Sciences should be contracted to do a followup study in the areas of the intersection of medical illness and the symptom that is pain; the distinction between chronic and acute pain; how chronic pain develops; the development of chronic illness behavior as a result of chronic pain; specific interactions of chronic pain, disability, and the determination of disability; avenues of research that might lead to a usable form of pain measurement; and what rehabilitation measures are suggested for dealing with individuals with chronic pain and chronic illness behavior. On September 30, 1985, the IOM was contracted to perform the above study and to report to the Social Security Administration in December 1986.

Followup Commission to Assess the Results of the Experiment(s) and the National Academy of Sciences Study

(13) Congress and the Department of Health and Human Services should appoint a new Commission as soon as feasible after the conclusion of the experiment(s) to assess the success of the criteria for determining disability based on impairment due primarily to pain and of the rehabilitation program, to review the findings of the study being conducted by the Institute of Medicine of the National Academy of Sciences, to survey the interim progress in evaluating pain, and to reaffirm the national focus upon the issue of pain. The new Commission should include one or more members with expertise in the deliberations, findings, and recommendations of this Commission and with the findings and results of the study being conducted by the IOM on the intersection of pain and disability.

Defining Pain

The Commission recognizes two basic categories of pain, acute and chronic. The distinctions between the two are important for proper assessment of disability and are described in detail below. Acute pain is relatively well understood and is dealt with relatively well by current law. The problem is in the evaluation of individuals with chronic pain and, more specifically, the chronic pain syndrome (CPS).

To ensure uniform understanding, the Commission defined and described pain, and chronic pain states in particular, and agreed to a system of classification for individuals with chronic pain. Although the definitions and classifications used by the Commission may not conform precisely to some which have been used by various researchers, the Commission's definitions and classifications formed the basis for its deliberations and the discussions in Part Three of this report and are, therefore, presented

here as background for the reader.

Understanding and Defining Pain

The most common conception of the pain process begins with the stimulation of certain specialized nerve endings. The stimulation can be a discrete, localized pin prick or a widespread impact; it may be a "pure pain" event or it may be accompanied by sensations of cold, pressure, etc.; it may occur in the skin or deep within the body.

Whatever the variations of noxious stimulation, the sensation is transmitted from nerve cell to nerve cell via complex and still incompletely understood electrochemical mechanisms, to the spinal cord and ultimately to the brain. The messages carried by the nerve cells may be blocked (such as by narcotics), superseded (such as when a pain message is overwhelmed by a higher priority impulse, like fright) or, occasionally, lost or garbled in transition.

When the signal through the neurons reaches a central point (in some instances this occurs in the brain, but other types of pain are received lower in the spinal cord), it is interpreted as a pain message, and an appropriate physical response is triggered. Where the stimulus is a complex one (e.g., involving both pain and fright), the interpretation will be complex as well and the "pain" component of the stimulus might not be recognized as primary.

This model of the pain process, of pain nociception being the brain's interpretation of a complicated message transmitted to it by the nerves in response to an external stimulus, is the generally accepted one, and it works well enough to explain the process when there is a pain stimulus. However, there are a number of conditions involving body damage where there is no pain stimulus at all, and there are others where a pain stimulus occurs without the brain perceiving it. Moreover, a pain stimulus does not always indicate a threat to tissue or body damage, as when a set of muscles receives an unusual amount of use and is "sore" the next day. Thus, even without beginning to consider the so-called "psychological" issues, it is clear that the common model of the pain process has many limitations. For purposes of assessing disability, and especially for shaping the response of the legal system to the problem of pain, some refinements are, therefore, necessary.

First, it is important to differentiate "pain" from "suffering." The greater the pain the more it is believed to cause suffering. However, some pain, like that of childbirth, can be extremely severe and yet be considered rewarding. People may tolerate great pain without reporting suffering particularly if they know that it does not have dire meaning, that it can be relieved, or that it will be short-lived. On the other hand, individuals will report suffering with pain that others might consider minor if the pain is believed to signal dire consequences (such as cancer), if the pain is perceived as never-ending, or if no relief seems possible. In all these situations, individuals perceive pain as a threat to their continued existence—not merely to their lives or their bodies, but to their integrity as persons. That this is the relationship of pain to suffering is strongly suggested by the fact that suffering can be relieved **in the face of continued pain,** by making the source of the pain known, changing its meaning, and demonstrating that it can be controlled and that an end is in sight.

Pain and suffering tend to evoke virtually identical behaviors. As a consequence, both the suffering individual who reports pain and the observer who would evaluate it are faced with trying to differentiate pain behaviors (discussed below) from suffering behaviors. In the case of pain behaviors which are reasonably consistent with significant physical findings, reversal of those behaviors awaits resolution of the underlying medical problem and, very frequently, overcoming the effects of deactivation and overguarding engendered by treatment and the passage of time since onset. In the case of suffering behaviors associated with reports of pain, but in which physical findings are lacking or insufficient to account for the pain alleged, resolution of the problem concerns clarification to the suffering individual that the pain which he or she is experiencing does not inevitably constitute a threat to his or her continued existence. In effect, it is postulated that, in the latter situation, the individual is confounding pain with suffering and does so largely under the mistaken impression that there is no resolution; that their future is threatened indefinitely. "Clarification," however, inevitably involves far more than transmission of information. The long-suffering pain patient has a pervasive repertoire of mental and physical consequences, including the adverse effects of deactivation and overguarding, which, for their reversal, will require systematic and extensive intervention.

This is not to say that suffering is any less intense or less real than pain, merely that it is a broader concept, and that it often confuses the precision of "pain" perception and reporting. Second, the degree of pain caused by a particular stimulus varies enormously from individual to individual. As elaborated in the discussion on the measurement of pain in Part Three of this report (see page 88 [of the full report]), current science offers no objective evidence of the existence or extent of a person's pain. We can observe tissue damage, and under some circumstances we can even measure the nerve impulse arising from stimulation of the pain receptors. We can also observe a person's reactions to the stimuli, but there is no direct external way to interpret that experience as "pain" or to compare objectively one painful experience to the next or one person's pain to another's. What we can objectively observe, and what does serve as the basis for medical and legal inferences, is "pain behaviors."

Pain can also be categorized on the basis of its presumed site of origin and the terms "somatogenic" and "psychogenic" have been used as discussed below.

"Somatogenic" refers to pain generated by tissue damage, prompted by injury or disease. Although most significant physical impairments generate corresponding emotional stress, this category of pain is relatively familiar and straightforward. It can often, however, produce erroneous diagnoses, because the origin of a pain stimulus in a particular part of the body usually, but not always, evidences tissue damage. Professionals and lay persons alike may fail to recognize that "hurt" and "harm" are not the same.

"Psychogenic pain" refers to a specific diagnostic entry in the **Psychiatric Diagnostic and Statistical Manual III** (DSM III). In general this term is difficult to define with disagreement among experts being common. The Commission questioned several expert witnesses about the "psychogenic pain" diagnosis and concluded that individuals with "psychogenic pain" by any commonly accepted definition constitute a very small number. Further, such persons come under the existing mental impairment listing for somatoform disorder used by the Social Security Administration. In contrast, the Commission believes that the mental impairment listing for somatoform disorders does not accurately describe individuals with chronic pain discussed in the following subsection. The Commission held that the medical conditions in groups A and B are not solely psychiatric impairments.

Social conditioning, reenforcing or minimizing pain behaviors and coloring their expression, is a powerful influence. Iatrogenic influences, too, can muddy the neat body/mind distinction, as failed treatment regimens (surgery, drugs, prolonged inactivity) generate their own pains in pursuit of a cure for others.

In the case of chronic pain, the issue can be looked at in another way. It may be useful to distinguish between "having" something (e.g., the body "has" an impairment) and "doing" something (e.g., the individual displays or emits pain behaviors). Pain behaviors have often been interpreted to mean the individual "has" an impairment. And that is often, particularly in acute pain, the case. But it is essential to recognize that those same pain behaviors, however they originated, may now be occurring for other reasons; reasons, for example, reflecting the effects of disuse, the confounding of suffering with pain, or as a consequence of conditioning effects produced by the environment and people around the individual.

The Commission wishes to emphasize the fact that no one can know the pain of another person. Only pain behaviors, not pain itself, are observable to the outsider. Pain behaviors comprise verbal and nonverbal expressions or actions indicating that pain is being experienced. Obvious verbal expressions of pain include moans, gasps, and overt statements or complaints of pain. Facial expressions, guarded movements, limping and the like are also pain behaviors, as is the use of a cane or other assistive device. The alterations in muscle deployment, changes in stance, gait, and body motions are also found when pain is present. Similarly, broader activities, such as frequent reliance upon the health care system (e.g., repeated seeking of medication, surgery, or other therapy) or avoidance of erstwhile pleasurable events can be understood, in the appropriate context, as pain behaviors.

The special importance of pain behaviors is twofold. First is the fact that pain behaviors are our only way of assessing a person's pain. Because science has developed no laboratory tests for identifying and measuring pain, the only available substitute is careful observation of a wide range of behaviors.

The second factor is that pain behaviors are subject to influence by a variety of factors in addition to pain stimuli, making the assessment of pain particularly complex. It is noteworthy, in particular, that many pain behaviors are least partially under the conscious control of the individual. Individuals vary substantially in their utilization of the repertoire of pain behaviors, and evidence also indicates that there are demonstrable social boundaries giving some groups (defined, for example, by ethnicity, gender, or age) greater "permission" to express their pain in the overt ways of pain behavior. Pain behaviors are also influenced by the effects of the naturally occurring learning process, which automatically accompanies any experience. This becomes a very important issue in considering chronic pain.

The temporal aspect of pain is another obvious basis for classification, and, again, two categories are generally recognized. "Acute" pain is pain of recent onset, most commonly associated with a discrete injury or other trauma. In the absence of residual structural defect or systemic disease, acute pain should subside as the healing process continues—ordinarily less than six months and usually less than one month. Recurring or episodic acute pain is generally associated with identifiable systemic disease, and intermittent bouts of more intense acute pain are punctuated by periods of remission. However, when pain recurs with sufficient frequency over long periods of time, its effects on the individual may be the same as pain that is constantly present for the same duration.

"Chronic" pain is constant or intermittent pain lasting for long periods of time. Six months is a commonly employed duration. Such pain may be associated with a residual structural defect that persists long after the acute episode. An example would be the pain produced by the pressure of an intervertebral disk against a nerve root that remains long after the injury that led to the disk protrusion. Or pain may persist beyond the anticipated healing time of an injury, or beyond the active state of a disease, and be difficult to explain. Indeed, there may be no objective medical evidence of a physical or mental abnormality which could reasonably be expected to generate pain of the nature and intensity experienced, yet alterations of stance, gait, or body mechanics may clearly signify that pain is present. Unlike acute pain, which may be concep-

tualized as a warning that something is wrong and is therefore often a useful symptom, chronic pain may become a problem in its own right—a symptom but not necessarily of an underlying impairment.

The existing "Listing of Impairments" incorporates acute pain as an element in many of the categories. (For example, 1.02—rheumatoid arthritis, 4.00E—chest pain of cardiac origin, 10.10—obesity.) Not all pain, however, is amenable to categorization in this way. Some pains (for example, migraine headaches or "phantom limb" pain) generate little or no objective medical evidence. Moreover, where the pain outlasts the apparent physical abnormality, the current Listings do not establish a distinct category recognizing this condition as a discrete impairment.

One special type of pain that occupied much of the Commission's attention is the condition labeled CPS. CPS is a complex condition which has physical, mental, and social components. Both chronic pain and CPS can be defined in terms of duration and persistence in relation to the extent of demonstrated and observable pathology. Both may or may not have emotional components. However, CPS, as opposed to chronic pain, has the added component of certain recognizable psychological and socioeconomic influences. Some individuals with chronic pain may not be disabled and other persons with disability due primarily to pain may not have emotional impairments. While there may be some blurring of the boundaries between chronic pain and CPS, the characteristic psychological and sociological behavior patterns inherent in CPS provide a basis for trained clinicians to distinguish between the two conditions and to differentiate the CPS from malingering and from serious emotional disorders.

The typical CPS claimant might be a middle-aged man who, having worked in manual labor all his life, suffers a severe back injury in a fall. He is out of work for a recovery period of 4 months, but the pain persists despite apparent tissue healing. Additional conservative treatment is unproductive, and a more invasive therapeutic regimen of analgesics and surgery proceeds. A year after the originating fall, he is still out of work, still experiencing no abatement of the pain, and well entrenched in a lifestyle of inactivity, pain, and disability.

The stereotypical CPS claimant is not a hypochondriac, a malingerer, or a hysteric. He is not "making up" the pain, not cynically plotting strategies for unwarranted receipt of disability benefits. Instead, his pain is real and very unpleasant, but also very complicated.

The CPS claimant is caught in the web of effects which result from the influence of conditioning or experience. "Illness behaviors" are rewarded and the incentives for recovery are inadequate. There are multiple variations of this theme: for some, the continuation of pain is rewarded by increased concern and solicitousness from spouse and family; for others pain provides a "legitimate" rationale for quitting an unpleasant work environment; for still others, the luxury of concerted medical attention is a powerful lure.

In all these instances, there is a profound but subconscious feedback process in which suffering or pain behaviors occur in large part because the individual's system has come to anticipate that multifarious "good things" happen when he emits pain behaviors, and that relatively "bad things" are in prospect when he recovers. The conditioning is automatic if circumstances are favorable and does not require even the awareness, let alone the intent, of the individual.

Without corrective action, a CPS individual slips ever deeper into a rut over time. The pain never abates, and the status of "pain disabled" provides a certain legitimacy and, sometimes, a steady income. As long as the incentive structure remains unaltered, the prospects for spontaneous recovery are remote.

The Commission believes, however, that CPS is treatable and need not be a permanent condition. While a few individuals will improve spontaneously, others need the assistance of the concerted rehabilitation efforts of trained professionals. Such rehabilitation efforts include those of complex behavior modification training.

Classification of Individuals with Chronic Pain

The Commission specifically addressed itself to the problem of evaluating disability in individuals who allege chronic pain. Such individuals live a life in which pain is always a factor, either because of its continuous nature or because, while the pain may sometimes ease, it always returns. The Commission believes that persons with chronic pain can be classified into four groups.

Group A—Chronic Pain, Inability to Cope—Insufficient Documented Impairment (Not Covered by Current Law)

Group A individuals have little in the way of medically documented findings, but their complaints of pain are prominent. They develop changes in behavior and mode of living which are due to the physical, emotional, and mode of living which are due to the physical, emotional, and social effects of their pain. They frequently misuse drugs. They require what appears to be an inordinate amount of medical care; they have hospitalizations and surgeries in search of relief and are often made worse. They do not uphold their family roles and are no longer socially active. In addition, they may be depressed or have other psychological problems. These alterations in function may be of sufficient severity to reduce the Group A individual's residual functional capacity, thereby affecting his or her ability to work. Such persons are unable

to function primarily because of their chronic illness behavior and the attendant loss of competent coping mechanisms rather than because of underlying pathological conditions. These persons have what is known as the chronic pain syndrome (CPS). It should be clearly understood that although emotional or psychological factors are important components of the CPS, these individuals do not have, nor are they disabled by, "psychogenic," unreal, or imaginary pain. The Commission holds that CPS is not a psychiatric diagnosis.

For pain to be considered in the evaluation of disability for social security purposes, the law specifies that there must be a medically determinable condition that can reasonably be expected to produce the pain. Persons in Group A (with CPS) are not usually found disabled because the documented pathological condition or impairment is not one which would reasonably be expected to produce the pain alleged.

Group B—Chronic Pain, Competent Coping—Insufficient Documented Impairment (Not Covered by Current Law)

Group B individuals exhibit some similar characteristics to those in Group A. They too lack medically documented findings to account for their pain, yet they may allege disability due primarily to pain. Despite their pain they continue to function well in emotional and social spheres. They do not have CPS. While they are functional their endurance may be compromised both by their pain and by their poor pacing skills. They can sit or stand, but not for periods sufficiently long to be productive. They can walk, but only for short distances before their pain causes them to stop. They may be able to carry heavy loads or do heavy work, but only briefly. Such persons have usually continued to work for many years despite their pain, but physical alterations in habitus, posture, gait, or work related motions or effort can be demonstrated. Their pain may ultimately cause them to stop working. Because of the pain standard in the present law, as with individuals in Group A, they do not qualify for disability benefits under the social security or supplemental security income programs.

Group C—Chronic Pain, Inability to Cope—Documented Impairment Sufficient (Covered by Current Law)

Group C individuals have medically determinable conditions, such as rheumatoid arthritis, which fully account for their pain. However, like Group A individuals, they also have severe difficulties with emotional and social functioning arising from their illness—the ability to cope with the pain and to deal with the problems created by the chronic illness has been lost. It is difficult to know to what degree these difficulties relate to either the underlying impairment or to the pain. They are unable to work both because of the physical consequences of their impairment and because of its social and emotional consequences. Their behavior is similar to individuals with CPS (Group A), except that Group C individuals also have medically determinable impairments which could reasonably be expected to produce the pain alleged. These individuals do not generally present a problem in the assessment of disability under the Social Security Act. For disability assessment purposes their pain can be considered along with their impairment.

Group D—Chronic Pain, Competent Coping—Documented Impairment Sufficient (Covered by Current Law)

Group D individuals, like those in Group C, have medically documented impairments that could reasonably be expected to produce pain. Group D individuals, however, have good emotional and social functioning. They cope competently with their pain and the problems created by their impairment and may continue to work. These persons may qualify for social security benefits because of their medically documented impairment.

The Commission was particularly concerned with the problems raised by the first two groups: Group A—CPS, chronic pain, inability to cope, little in the way of documented impairment; Group B—chronic pain, competent coping, little in the way of documented impairment.

Malingering

In defining chronic pain, and in subsequent discussions concerning the ramifications of establishing a category of impairment for claimants whose impairment is due primarily to pain, the Commission members discussed at some length the concern as to whether malingerers can be distinguished from individuals who are truly impaired due primarily to pain. The medical experts on the Commission held that malingering can be recognized by trained health care professionals who can distinguish malingerers from claimants with credible allegations of pain. The essence of the medical experts' position is reflected in the following description of malingering and in methods for distinguishing malingerers from other claimants.

The Commission holds that malingering is the conscious and deliberate feigning of an illness or disability for gain. The essential feature of malingering is the voluntary production and presentation of false or grossly exaggerated physical or mental symptoms in pursuit of a goal. The goal frequently involves the prospect of financial reward (such as payment of social security disability benefits) or avoidance of unpleasant work or duty. Although malingering often has a negative connotation, for example, it is

popularly associated with faking illness or injury to avoid military duty, under some circumstances malingering may be adaptive behavior, as when a wartime captive feigns illness to avoid additional harsh treatment from the enemy.

In considering the likelihood of malingering as a factor in allegations of pain which are not substantiated by objective medical signs and findings, the Commission is aware that there are certain advantages to being sick—increased attention, control of others, freedom from responsibilities, etc. Usually, however, these secondary gains are not part of the individual's illness, but arise after the illness is established. Further, the Commission observed that the fact that the individual can achieve certain advantages from the illness does not mean that he or she is malingering.

At the same time, the Commission recognizes that the presence of an obviously recognizable goal, whether financial, emotional, or social, which can be achieved by the individual as a result of the illness behavior may give rise to suspicion that malingering may be a factor in the allegations of pain, particularly when the medical evidence submitted in support of the individual's social security disability claim fails to support the allegations of severe, disabling pain and the evidence in file reflects a lack of cooperation with the diagnostic evaluation and prescribed treatment regimen.

The Commission explored the issue of malingering in great depth. The members questioned witnesses closely about malingering and scrutinized their own experiences. A clear consensus developed that malingering is not a significant problem for the social security disability system for two reasons: numbers and identifiability. First, the Commission concluded that there are simply not very many malingerers in the social security disability applicant population. Second, the members expressed confidence that trained professionals, medical and other, could identify malingerers using appropriate medical and psychological tests and that careful review of the entire disability file, including the history, objective physical and mental findings, and statements from the claimant, his or her treating sources, and others would provide proper safeguards.

Commission Discussion Areas

In the course of its study, the Commission has not been blind to the problems facing the social security administrators and has paid special attention to the discussions on the current policies and procedures promulgated by the Social Security Administration with respect to the evaluation of pain in adjudicating disability claims. In its meetings, the commission defined major areas of concern and carefully considered each of these areas individually and in relationship to each other. Commission discussions were often lengthy and highly charged, reflecting the sensitive nature of the issues and the personal experiences and opinions of the members.

This section of the report reflects the major areas considered by the Commission. In combination, they reflect the scope of the Commission's discussions, observations, and findings. For ready reference, the specific findings and recommendations resulting from the Commission discussion appear at the end of each subsection.

Summary of Discussion Subjects

Statutory Standard

The Commission was asked to address the adequacy of the statutory language for evaluation of pain and to recommend to the Secretary of Health and Human Services whether that standard should be allowed to "sunset" on December 31, 1986, or should be extended, or [be] extended with modification.

Lack of Knowledge: Inadequate Tools and Techniques

The Commission observed that there is a general lack of knowledge and understanding of chronic pain and chronic pain behavior which is reflected in the lack of adequate Social Security Administration tools and techniques for obtaining information about pain.

Lack of Reliable Method For Measurement of Pain

The Commission considered whether [there is] a valid and reliable method of measuring pain for purposes of assessing impairment due primarily to pain exists.

Facilities to Evaluate Pain

The Commission considered whether specialized pain centers should be used by the Social Security Administration to provide a comprehensive assessment of claimants alleging impairment due primarily to pain. Specifically, the Commission addressed the questions of availability, reliability, and required specifications for such facilities.

Consequences of Granting or Denying Benefits

The Commission weighed the consequences of granting disability benefits versus denying disability benefits in the context of the Social Security Administration's dual and competing responsibilities to protect the interests of claimants and the integrity of the Disability [Insurance] Trust Fund and Federal general revenues.

Reactivation/Rehabilitation Experiment

The Commission discussed the value of a reactivation and rehabilitation program as a necessary step in assessing impairment due primarily to pain.

Statutory Pain Standard

The Commission was asked to comment on the adequacy of the statutory language for evaluation of pain and to recommend to the Secretary of Health and Human Services whether that standard should be allowed to "sunset" on December 31, 1986, or should be extended, or be extended with modification.

> "An individual's statement as to pain or other symptoms shall not alone be conclusive evidence of disability as defined in this section; there must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, which show the existence of a medical impairment that results from anatomical, physiological, or psychological abnormalities which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all evidence required to be furnished under this paragraph (including statements of the individual or his physician as to the intensity and persistence of such pain or other symptoms which may reasonably be accepted as consistent with the medical signs and findings), would lead to a conclusion that the individual is under a disability. Objective medical evidence of pain or other symptoms established by medically acceptable clinical or laboratory techniques (for example, deteriorating nerve or muscle tissue) must be considered in reaching a conclusion as to whether the individual is under a disability."
>
> October 9, 1984
> Public Law 98–460, Section 3(a)(1)

In October 1984, the Congress enacted the above statutory language with the explicit provision that the standard would apply to **all** decisions made prior to January 1, 1987. The new temporary statutory standard codified existing Regulation and policy with respect to the evaluation of pain in determining disability.

To comment on the adequacy of the statutory standard the Commission reviewed the history of the provision and the events summarized below leading to its enactment.

During the Congressional deliberations on Public Law (P.L.) 98–460, several Members noted the influence the Federal courts were exercising in defining various pain standards in the disability program. In addition, the decisions regarding pain varied considerably from circuit to circuit, and primarily addressed how a claimant allegation of pain was to be assessed and evaluated in deciding whether a claimant was under a disability. Some Members were concerned that the court opinions had gone beyond what the Congress had intended by giving too much weight to allegations, thereby redefining the concept of disability. They believed that the court pain standards were improper and beyond the intent of Congress. Other Members were concerned that the Social Security Administration (SSA) was too restrictive in its interpretation of how to evaluate pain, thereby wrongly denying benefits.

Further compounding the diversity of court rulings for adjudicating allegations of pain was the requirement by some courts that the Secretary reopen many hundreds of previously decided claims for the purpose of applying a court defined pain standard. This created administrative burdens for SSA, but provided the opportunity for benefits to be awarded to claimants whom the courts adjudged to have been wrongly denied at the administrative levels. A related but broader issue was the sensitive matter of whether the Secretary was required to adopt diverse court standards at the administrative level, thereby having different standards in different geographic areas in contradiction to the congressional dictates for a uniformly administered national disability program.

In enacting the statutory standard, the Congress made clear that it intended that uniform standards be applied in adjudication of disability claims involving allegations of pain during the interim period in which this Commission studied the question of the evaluation of pain and disability and assessed the adequacy of the Social Security [Administration] standard expressed in the statute in light of the Commission findings. At the same time, the Congress intended to eliminate further detailed judicial pronouncements on the issue of an appropriate pain standard. Although court opinions were generally consistent with SSA policies regarding pain, courts perceived that certain aspects of the administrative record did not clearly show adherence to those policies. In a few decisions, court opinions could be read to conflict with existing Social Security [Administration] policies. Since enactment of P.L. 98–460, however, it is significant to note that the courts have deferred to the new statutory language and, in some cases, gone so far as to find prior court rulings to be superseded by the statutory definition of pain.

Report of Discussion

The Commission does not perceive its role as that of interpreter of court opinions on pain. It recognizes that each opinion may, in fact, be subject to various interpretations. (See Appendix F [of the full report] for a compilation of significant court opinions on the issue of pain.)

However, the Commission was specifically asked to consider the appropriateness of the statutory standard enacted in 1984, and to comment on whether the standard should be allowed to "sunset" on the December 31, 1986, expiration date or be extended. This question came up for discussion several times and was the subject

of considerable debate.

In general, the Commission understands and finds no fault with the administrative need for a statutory standard to ensure a uniform policy, nor does the Commission question the statutory requirement that pain be considered in evaluating social security disability claims. However, the members differ in their stance on the adequacy of the statutory language in defining pain. In particular, there is concern that the statute does not provide for consideration of impairment due primarily to pain where there is insufficient objective medical signs and findings to establish a medically determinable physical or mental impairment which could reasonably be related to the alleged pain and its corresponding functional restrictions.

The importance of the question of the adequacy of the statutory standard cannot be overlooked. At present some 55,000 social security cases are pending before the Federal courts. Of these, more than 95 percent involve claims for disability. There are no precise statistics with respect to how many also include pain allegations, but from preliminary data (see Appendix C [in the full report]), it is reasonable to assume that it may be an issue in as many as half of them.

The Commission, therefore, appointed a subgroup to examine the existing statute and develop recommendations regarding the advisability and nature of any change to be made. As a result, several proposals for amending the existing statute were brought before the Commission. The principal thrust of the changes being recommended was to define the consideration to be given to pain in evaluating disability and, particularly, to more clearly recognize chronic pain syndrome (CPS).

The Commission believes that there is inadequate data to ensure that any change in the statute at this time would properly and clearly define pain and, in particular, pain not clearly attributable to objectively determinable physical or mental causes, and that the necessary data will not be available prior to January 1, 1987.

The expectation of the Congress was that this Commission would be able to:

(1) complete its mandated study of the issues;
(2) evaluate the appropriateness of the standard; and
(3) recommend extension, modification, or termination of the statutory language

in time for the Congress to act prior to January 1, 1987. However, in view of the complexity of the issues, the Commission observes that this expectation may have been too optimistic. Therefore, it was the considered opinion of the Commission that, provided the statutory language did not specifically bar conducting a proposed experiment, the current statutory language adequately and appropriately calls attention to the necessity of considering pain in adjudicating disability claims and that there is no need for clarification or modification of the statutory language at this time.

Although the Commission believes that it may be necessary in the future to modify the existing statutory language to clearly define impairment due primarily to pain, and particularly CPS, and to outline the consideration to be given to allegations of pain in the adjudicative process, any proposed modification would be premature in light of the need for additional data.

At the same time, the Commission is recommending an experiment or experiments (described more fully on pages 111–119 of [the full] report) to examine whether there should be a disability category for impairment due primarily to pain and to study the feasibility, efficacy, and cost effectiveness of rehabilitation where impairment is due primarily to pain. The results of this experiment(s) in conjunction with the findings of the study being conducted by the Institute of Medicine of the National Academy of Sciences (see page 55 and Appendix B [of the full report]) on pain, chronic illness behavior, and disability will permit a more informed recommendation for any needed change.

Finding

The introduction of a statutory requirement has promoted uniformity of adjudication at all levels within Social Security and has generally caused the courts to defer to the statutory language. Thus, to the extent that uniformity and national program administration are desirable objectives for the disability program, the presence of a statutory standard has been effective.

Recommendation

The current statutory standard for the evaluation of pain should be extended without modification for the duration of the experiment(s) being recommended by this Commission and for 1 year thereafter. Any modification in the statutory language should only be made after additional data are acquired as a result of the study being conducted by the Institute of Medicine of the National Academy of Sciences and through the experimental process.

Lack of Knowledge: Inadequate Tools and Techniques

The Commission observed that the general lack of knowledge and understanding of chronic pain and chronic pain behavior is reflected in the lack of adequate Social Security Administration (SSA) tools and techniques for obtaining information about pain.

In drawing this conclusion, the Commission carefully reviewed the methods and forms which are used to

obtain information from claimants, treating sources, and others about pain and pain behavior and reviewed copies of the standard application forms used by the district offices (DOs) and medical request forms used by the State disability determination services (DDSs), as well as a representative number of the special questionnaires currently used by DDSs to obtain specific information in claims where pain is alleged. (See Appendix E [of the full report].) What follows is a review of those methods and the Commission findings and recommendations for improvement.

Report of Discussion

Information about a claimant's pain may be obtained in a variety of ways and from a number of sources. One of the first indicators that pain may be involved in a disability case often comes during the DO interview. Then, either as a part of the description of why he or she is disabled, or in response to the interviewer's questions, the claimant may allege pain. Alternatively, an alert interviewer may notice the claimant's behavior during the interview and direct certain questions to the claimant which will elicit information about the pain and the effect the pain has on the claimant's capacity for certain basic functions, such as sitting, standing, walking, etc. The information obtained by the DO interviewer is part of the file forwarded to the DDS.

In the course of its development, the DDS may obtain information from a number of sources, including the claimant's treating or consulting physicians, consultative examinations, hospital records, interviews with third parties who have knowledge of the claimant, etc. Any of these sources may indicate the presence of pain and report specific information which will corroborate the claimant's allegations.

Usually, when objective medical findings are present which corroborate the allegations, the issue of evaluating the degree to which the pain affects the claimant's functional capacity is not as difficult as when objective medical findings are absent. However, when the objective evidence does not corroborate the extent of the alleged pain in terms of severity, duration, or frequency of occurrence, the reviewer must consider all of the available information regarding the claimant's alleged pain. This would include the evidence which has been received from the claimant during the initial and any followup interview, the claimant's treating or consulting sources, or other medical sources who may have examined the claimant, and also information which may be in file or readily available from family, friends, neighbors, coworkers, or others who know the claimant and would be able to provide information on the claimant's daily activities, behavior patterns, activities, prior to and since the alleged onset of the pain, etc. The final determination must take all of this information into account.

At present, much of the above information is obtained through the use of standardized forms. Thus, SSA uses a standard disability application which records information about the nature of the claimant's impairment, the onset of the illness or injury, the date the claimant last worked, the nature of the claimant's work prior to the alleged onset, etc. The claimant is also asked whether he or she has difficulty performing a range of activities, such as sitting, standing, walking, bending, seeing, hearing, etc. At the same time, the interviewer is expected to observe and note any difficulties the claimant exhibits in any of these areas during the course of the interview. All of this information is forwarded to the DDS for consideration and evaluation in conjunction with the DDS development of the medical evidence.

DDSs have developed standardized forms which they regularly use to request evidence. While the basic form is generally designed to be usable in obtaining information about a wide variety of medical conditions, many DDSs have designed modified forms to request specific details about the claimant. Thus, there are a large number of special forms which have been developed for use when requesting information from a cardiologist, orthopedist, ophthalmologist, etc. In these modified forms, the DDS questions are tailored to encourage the reporting source to provide as complete information on the claimant as possible.

Over the past several years, increasing attention has been paid to allegations of pain from the claimant, his or her treating sources, or others. In a number of States, this has resulted in the development of a number of special "pain" questionnaires aimed at providing a clear and complete picture of the claimant's pain. In some cases, the questionnaires are designed for completion by medical sources. This type of questionnaire may be a substitute for the standard form or a supplement to the standard medical report form. Whether the request is a modified standard form or a special form designed to obtain information about pain, the intent is the same. The reporting source's attention is specifically focused on the question of the pain and the report, if complete, should provide a description of the longitudinal history, nature, extent, duration, and severity of the claimant's pain.

In other instances, the DDS has developed pain questionnaires which are designed to obtain more information from the claimant. These forms ask the claimant to provide detailed descriptions of the pain, its effects on activities of daily living, relationships with others, ability to work or perform a variety of work related activities, etc. Some of these "pain" questionnaires are completed by the claimant and mailed to the DDS, others may be completed through a telephone interview conducted by either a DO or DDS interviewer. In some cases, the DDS will also interview one or more relatives, friends, or others regarding the claimant's

condition.

Again, all of this information should be considered by the DDS in arriving at a disability decision. Once the decision is made, a decision rationale is prepared which should reflect the degree to which pain was weighed into the actual decision.

At the hearing level, the administrative law judge (ALJ) can request additional information from the claimant, his or her family, friends, former employers, coworkers, etc. In addition, the ALJ can request the DDS to obtain additional medical information from treating or consultative sources as to the claimant's impairment(s), including the nature, extent, and effect of any alleged pain.

In reviewing the existing forms and evaluating the effectiveness of the information gathering system currently used by DOs and DDSs alike, the Commission realizes that the problem that faces SSA goes back to the lack of knowledge and understanding of pain and pain behavior—by the claimant, his or her treating source, and the adjudicative teams—and precludes effective data collection at all levels.

The Commission spent considerable time in discussing the manner in which it could best aid SSA to improve its information gathering tools. Along this line, several members of the Commission explored possible formats for appropriate questionnaires for claimants, treating sources, and others. These prototype documents were brought before the whole Commission for discussion and comment during the October 1985 meeting and again during the January 1986 meeting.

In reviewing these prototypes, several members voiced concerns that were supported by the Commission as a whole. One of the principal concerns was that the limited tenure of the Commission did not allow the type of indepth work that should properly go into the design of an appropriate and reliable data gathering instrument.

Another consideration was that, although the members had considerable expertise in the area of pain and pain behavior, design of questionnaires today involves high technology and a specific type of expertise that went beyond that available within the Commission.

However, even assuming the members had the time and expertise to design appropriate instruments, the development of such instruments would require an improved profile of SSA's claimants and caseload involving pain allegations to ensure a statistically sound product. There was doubt as to whether the information currently available was adequate to develop a form or questionnaire which would meet the strict criteria the Commission set for itself.

Notwithstanding the above reservations, the Commission believes the prototype questions developed during the course of its meetings reflect the type of information which is needed by SSA to properly evaluate pain and pain behavior. (See Appendix E [of the full report] for examples of questions which should be incorporated in a questionnaire to be developed by SSA with the help of experts in the technical development of such instruments.)

In a related discussion, the Commission recommended that for uniformity of administration, when pain is alleged for the first time at the ALJ level, unless a favorable determination can be made on the basis of other information in file, the case should be automatically remanded to the DDS for development of the new allegations and reconsideration of the earlier DDS decision. In doing so, the Commission recognized that this would entail delays for some claimants. The Commission noted the inefficiency of providing for the possibility of two ALJ hearings—one to determine if a favorable decision could be made at the initial hearing without supplementing the record of pain, and a second if the case were remanded for development of pain, again denied by the DDS, and the claimant then filed for a hearing on the issue of pain.

However, a majority of the Commission held, after considerable discussion and a formal vote, that the recommendation of a mandatory remand is appropriate. In making this recommendation, the Commission has no intention to delay decisions and believes that institution of the procedure will in the long run promote more efficient information gathering and development of pain-related disability cases at the earlier stages of adjudication. Commission members have reason to believe that there is a percentage of cases in which information is intentionally withheld at the earlier levels of adjudication in order to bring the case before the ALJ for a face-to-face hearing. The Commission expects that once claimants and claimant's representatives are aware of the automatic remand provision, they will be encouraged to provide more complete information at the earliest possible date.

Finally, the Commission notes that, although SSA has a training program designed to familiarize all adjudicators with the law and regulations for the evaluation of pain, no amount of training can ensure a complete understanding and determination of the claimant's situation because neither the trainers nor the trainees fully understand the nature of the problem facing them. This can be compounded because the claimant, who is also in most cases unaware of the forces contributing to the pain experience, may be unconsciously amplifying the problems. This situation is true at all levels of adjudication and crosses all social and economic groups.

Findings

It is essential that the initial DO interview process be able to identify pain cases as early as possible. Improved interviewing techniques will enable pain cases to be placed on a separate track with routinely required early face-

to-face inteviews at the DDS level. This will provide a more complete description of the claimant's pain and the effects of such pain on his or her ability to function early in the claims process, thereby eliminating the need for repeated requests for additional development. It should also reduce, to some extent, the number of pain cases which are denied at the initial, and even the reconsideration, level because of incomplete evidence and/or understanding of the effects of the individual's symptomatology.

The Commission cannot ignore the possibility that an allegation or report of severe pain will not surface until the case is before the ALJ. In such situations, the needs of both the claimant and of SSA may best be served by remand of the case to the DDS for the necessary development and reevaluation of the evidence rather than incurring added expense and potential delay by holding the case at the hearing level. However, the Commission recognizes that there are factors other than pain which are considered in the adjudicative process, and although the Commission is interested in the pain aspects of the case, it does not recommend delaying a favorable decision for the purely academic development of the alleged pain.

Recommendations

The Commission recommends that the early stages of the disability claims procedure should be redesigned to adduce more adequate information about pain and pain behavior. Several specific steps should be pursued toward this objective. These include:

(1) Additional training focused on issues of pain to be provided to State DDS employees, to ALJs, and to others within the social security disability system, in order to instruct government personnel about issues raised by pain complaints;

(2) Redesign of SSA application forms to alert interviewers and/or adjudicators to cases where pain is a substantial element in the claim and development of questionnaires to collect more information about pain at the earliest opportunity. The initial application form should provide the claimant a clear occasion to detail the pain, when present. Questionnaires and forms sent to treating and consulting physicians and, where appropriate, to the applicant, his or her family, friends, and other potential sources, should also have additional provision for eliciting detailed descriptions of pain behaviors, when applicable. Further, the Commission recommends that SSA, wherever possible, use experts for the design and testing of such questionnaires and other data gathering instruments.

(3) Personal interviews or face-to-face examinations at the DDS level should be required earlier in the decisionmaking process in pain cases to enable first hand personal evaluation to supplement paper reviews and telephone interviews.

(4) Regulations should require decisionmakers at each stage and at all levels of adjudication of a disability case to specifically address the issue of pain whenever it is raised by the claimant or the record, and to state explicitly all findings and the basis for such findings regarding the nature, extent, and severity of pain.

In any case where disabling pain is alleged for the first time at the ALJ stage, and the ALJ is unable to otherwise dispose of the case (e.g., by awarding benefits on medical or medical-vocational grounds or denying benefits based on the claimant's failure to satisfy the nonmedical eligibility requirements), the ALJ should be required to remand the case back to the State DDS for further development of the record regarding pain.

Lack of Reliable Method For Measurement of Pain

The Commission was asked whether a valid and reliable method of measuring pain for purposes of assessing impairment due primarily to pain exists.

The disability regulations require, without exception, that disability must be established on the basis of verifiable and objective medical evidence, as demonstrated by medically acceptable clinical and laboratory diagnostic techniques, with emphasis placed on the repeatability and reliability of such techniuqes. Further, the law requires that there must be medical signs or other findings which establish that there is a medically determinable condition which could reasonably be expected to produce a claimant's pain. Therefore, the Commission considered whether a valid and reliable method of assessing impairment due primarily to pain is available.

In conjunction with this, the Commission reviewed a wide spectrum of medical and nonmedical methods of assessing pain and heard testimony from experts in the field of pain measurement, and from Commission members and others experienced in the clinical management of pain patients.

Report of Discussion

Early studies in clinical pain measurement were restricted to the development of pain measurement scales used to report clinical and experimental pain. Since 1960, numerous investigators have suggested the much more complex nature of pain and have developed a wide variety of assessment tools.

These investigators sensitized the research and rehabilitation communities to the existence of more than just the somatic or sensory components of the pain experience. The result has been the development of combination treatments for pain patients and the beginnings of more appropriate evaluative tools combined with the development of a multidisciplinary team approach to the treatment of chronic pain.

Because of the crucial nature of the question of just what is possible in the area of pain measurement, the Commission decided that although it had considerable expertise in pain treatment and the evaluation of pain for rehabilitation and insurance purposes, it would pursue any available additional knowledge of pain measurement through a literature review on the intersection of pain and disability with the help of consultant services contracted by the Institute of Medicine (IOM) of the National Academy of Sciences and by hearing testimony from experts in the area of pain measurement.

Just what is possible in the area of pain measurement is a key point in the evaluation of pain for disability purposes. Although a direct measurement of the level of pain would be useful, a measure of the person's functional capacity to perform work would be a necessary and more reasonable index of disability to assure uniform treatment for all claimants.

The expert testimony confirmed the Commission's understanding that although current clinical pain measurement research being conducted by the National Institutes of Health and other research centers holds some promise, it is not in a stage that can be expected to produce useful administrative tools in the near future. Clinical pain assessment scales can produce only relative results. Although they can be used to demonstrate something like the effectiveness of a drug, they have very little validity as absolute measures of pain. For example, a visual analog scale can be used with validity to compare an individual's rating of pain before and after the administration of a drug and to measure the relative change in the rating. But any attempt to compare the findings for different individuals would have very little face validity because each individual's rating scale is subjective.

Another major issue is just how useful experimental pain studies are in assessing the magnitude of suffering caused by chronic pain. Acute stimuli not only produce a limited-duration "pure" pain entity, they also ignore the importance of psychological stresses and other nonsomatic, nonsensory, contributors to the pain experience. All of this is not to say, however, that an assessment battery cannot be developed to provide better ways to make decisions about disability and impairment.

The experts testified that pain can really best be defined as a description of an individual's experience encompassing physical, mental, social and behavioral processes, and all dimensions involved in the pain experience need to be evaluated to make a useful determination of whether or not an individual is incapacitated by the pain. Pain behavior, including verbal reports of pain, thus becomes the means to make as objective an assessment as possible of an essentially subjective area.

The following discussion presents the problems of measuring pain in terms of impact on disability evaluation for claims involving chronic pain as opposed to acute pain. (See Part Two, page 67 [of the full report] for a discussion of acute vs. chronic pain.)

An individual with a pain experience of a magnitude that approaches disability will almost always demonstrate a preoccupation with the pain as evidenced by constant reference to the condition and the fact that all activities are considered in relation to the pain. As a corollary manifestation, this preoccupation with pain leads to an overutilization of the health care system. Back pain claimants, for instance, routinely have a history of multiple operations with the result that it is difficult to determine if the surgeries are the cause or the result of the pain.

Another pain-associated behavior is the inappropriate use of analgesic and/or depressant drugs. Physicians who work with patients in centers set up specifically to deal with pain, report reduced levels of drug use when patients are treated appropriately.

Other pain behaviors include reduced levels of activity and avoidance of responsibilities. This might, for instance, be the voluntary restriction of all forms of movement or the foregoing of normally pleasurable activities or hobbies. An individual who was fond of walking or of chatting with neighbors reenforces the verbal complaint of pain by giving up these normally pleasurable activities because of the pain. The avoidance of work or other responsibilities by someone who has always responded well to normal societal demands that certain things be done, not because he or she necessarily wants to do them but because they should be done, is an indication that the individual feels that the pain is now an overriding factor.

A final, and perhaps most obvious, group of pain behaviors are those pain behaviors which involve motor activity. These include things like rubbing the painful area and facial expressions like grimacing. Controlled movement (guarding) is also prevalent as is the practice of sitting, lying, or standing in other than normal positions (bracing). Taken as a group, these pain behaviors give a picture of an individual who is exhibiting how much pain affects his or her life.

The instruments for indirect measurement of pain encompass both behavioral and verbal aspects. Both are important aspects for evaluating the problems. The distinction between behavioral and verbal is important even though both in the ultimate sense are behavioral. People vary in their ability to express in words experiences they are having, placing a constraint on reliance solely on words. Conversely, actions and words often are influenced in quite different ways by the consequences they meet; i.e., by learning and conditioning effects. The often great divergence between what people say and what they do is perhaps the most obvious illustration. The implication of this in the measurement of pain is that reliance should not be placed solely on either overt actions or verbal statements. Instead, behavioral indicators can be used to check verbal reports and any discrepancies pursued to further delineate the problem. While neither should be considered the definitive criterion, actions are generally a more reli-

able reflection of an individual's functioning than are his or her words. This issue is discussed further below.

Pain behavior testing can be broken into four categories: (1) measures of the presence or absence of suffering; (2) measures of the reported magnitude of pain; (3) measures of personality, motor or body movement performance; (4) measures of family responses to pain behavior.

Measures of the magnitude of pain entail a variety of behavioral and verbal tests, including preoccupation with pain, abuse of medication, and motor behaviors like guarding and bracing. These are perhaps the most central to pain measurement, but it is important to remember that magnitudes for both verbal and other behaviors will be strongly influenced, if not dictated, by the personality and environmental factors measured by the personality, motor and body movement tests. This category of tests attempts to measure personality and environment to filter out what psychologists call "behavioral style." The extremes of behavioral style for pain measurement purposes might be *called, in layman's terms, "pain minimizers" and "pain maximizers." But there are as many variations as there are differences in daily activities, family interactions, and* work histories.

During its evaluation of the various available measures of pain behavior, the Commission reviewed many of the principal measures used today, with specific attention to the McGill Pain Questionnaire (MPQ) and the Minnesota Multiphasic Personality Inventory (MMPI). The MPQ is widely used and provides the responder with sets of words from which to choose in describing aspects of his or her pain. It addresses sensory, cognitive, and emotional or motivational aspects. While the MPQ is a psychological test to assess the sensory and affective aspects of pain, it has not been used to assess disability due primarily to pain.

Perhaps the most widely used and studied instrument is the MMPI. This is a true/false type personality test which contains numerous scales. It can be scored objectively and computer-based interpretations have been developed (and are continuing to evolve with increasing validity). Many studies have been carried out with the MMPI in regard to pain and many other kinds of human problems. However, the MMPI also has not yet demonstrated the kind of predictive validity essential to precise measurements about pain, nor has it yet yielded precise predictors of success in treatment or rehabilitation programs. Like the MPQ, it clearly deserves more study, but has not as yet progressed to where it can serve as an acceptable measure for the assessment of clinical pain as it relates to disability.

Despite drawbacks in relying on individual tests, a number of tests are now available which, when used together, would cover the gamut of physical, mental, social, and behavioral processes. Mood and personality tests are important because they affect how an individual will respond to pain. Any pain questionnaire used by the Social Security Administration (SSA) should, far from being a straight directory of physical pain, encompass information about social contingencies, environmental pressures, rewards, and the family and social system under which the individual is functioning.

The experts believe that any assessment battery adopted by SSA should be followed by an interview with someone specifically trained in pain assessment. Further, such an assessment battery would require expert interpretation.

In conjunction with the exploration of possible techniques which could provide SSA with reliable and repeatable methods to measure the effects of pain on function, the Commission reviewed the potential use of ergonomics in claims development.

Ergonomics is the study of conditions of the workplace. It applies mathematics to calculate what a person can do, how much weight he or she can lift, move, carry, etc., and is a way of measuring the safeness of the workplace by examining the strength requirements of the job (standing, walking, sitting, pushing/pulling, lifting, carrying) and then evaluating mathematically whether the individual can meet those requirements.

Employers apply ergonomics to ensure safety in the workplace by predetermining whether an individual can meet the strength demands for required job tasks. While certain norms have been established, the measure of whether a given individual can perform a job is specific to that individual and each individual's capability must be independently calculated. In assessing pain behaviors the methods of ergonomics are necessarily limited to the extent to which the individual engages in the requisite activity. Failure of the individual to perform on the basis of alleged or reported pain does not permit one to infer the extent of nociception arising from tissue or structural defect; only that the individual engages in the specific behavior of refusing to perform or of performing less than adequately.

Given a complete description of the strength requirements of a job, a professional trained in ergonomics can predict whether or not an individual demonstrates ability to perform that job. Conversely, ergonomics can be used to mathematically predict an individual's limits of strength. This information can then be applied by a trained professional, such as a vocational counselor, to identify jobs the individual should be able to perform.

Ergonomics can, therefore, provide SSA with an objective, mathematical assessment of a given job's requirements. Thus, where information for a given job, employer, or industry, is available to the State disability determination services (DDS), it may be useful in combination with other information in file, including the medical assessment of residual functional capacity, in evaluating the claimant's ability to perform job tasks under Steps 4 and 5 of the sequential evaluation. (See Part One, pages 30–33 of [the full] report.) Similarly, where an individual has undergone an ergonomic assessment, the predictive values for the

individual may be obtained by the DDS and considered in conjunction with all other information in file. A drawback to SSA's adoption of consultative ergonomic assessments is cost, estimated at approximately $1,500, and the limited availability of trained professionals and equipment in many geographic areas.

Finally, the Commission determined from its collective knowledge, the literature review contracted by the Institute of Medicine, and expert testimony, that "state of the art" medical technology is not currently able to assess disability due primarily to pain. Any immediate serious approach to the problem of pain measurement must, therefore, begin with a recognition of the need to assess pain behavior in a multidimensional way.

The Commission agrees with the expert testimony that a set of assessment procedures is needed that is both specific to pain patients and psychometrically appropriate. To be psychometrically appropriate any set of assessment procedures must be (1) internally consistent and reliable as a group, (2) a valid measure of what they are meant to measure, (3) utilitarian, cost effective, more easily administered with instructions that can be readily understood by the test-taker, or have better face validity then current tests, and (4) sensitive to change to reflect the results of such test measures as treatment, drugs, etc.

Findings

Numerous attempts have been made to try to develop methodologies for measuring pain objectively. This is, as yet, not possible because pain is inherently a subjective personal experience and we are necessarily limited to observations of pain behavior, including the person's reports. With acute pain, attempts at measurement have been somewhat more successful, at least in experimental settings and in a limited number of clinical settings where patients have been taught to describe the quality and intensity of pain and their degree of relief, using measurement tools that have established validity. Chronic pain, however, is a more complex entity, with additional social and psychological factors requiring a multidimensional approach to evaluate the person's report of pain.

Recommendations

The Commission recommends that a multidimensional assessment battery be developed for use in the proposed experiment described on pages 111–119 of [the full] report, and its value as predictive of the rehabilitation potential of disability claimants tested as part of the experiment. The Commission further recommends that if this battery proves successful, SSA give consideration to its eventual adaptation for inclusion as a regular step in the disability evaluation process.

Because of the importance of this area to the development of a valid and reliable method of evaluating pain for social security disability program purposes, the area of pain measurement has been referred to the Institute of Medicine (IOM) of the National Academy of Sciences for further study. (See Appendix B [of the full report] for more detail on the IOM study.)

Facilities to Evaluate Pain

In conjunction with discussions about the availability of methods to evaluate impairment due primarily to pain, the Commission investigated the availability and reliability of facilities devoted specifically to the evaluation, treatment, and/or rehabilitation of pain patients. While these facilities are in a state of growth and evolution, the following is a summary of what the Commission found to be the current status of such facilities and the specifications that would be required for a pain center to be able to provide the Social Security Administration (SSA) with a comprehensive assessment of a claimant alleging impairment due primarily to pain. For purposes of this report the term "pain center" is used as a generic for the type of facilities described below.

Historically, pain centers evolved in the United States and in Europe within the biomedical model, as multidisciplinary groups of physicians to review difficult diagnostic and therapeutic pain problems, or both. Most early pain centers were actually equated with "nerve block clinics" when nerve blocks represented the only nonsurgical treatment modality besides drugs for pain control.

In the last 20 years, advances in research in the behavioral sciences added new dimensions to the study of pain which promoted new promising treatment strategies of behavioral medicine.

The evolutionary process is still in full progress and can easily be traced in the variety of pain control facilities around the world, ranging from unimodal pain clinics to highly sophisticated multimodal pain control centers. In 1977, an initial **Directory of Pain Clinics** was published by the American Society of Anesthesiologists (ASA). While the directory, as published, was faulted by the fact that it included only unverified data submitted by the respondents to the questionnaire and many clinics were not identified, it was an initial attempt to identify resources available to chronic pain sufferers.

A further revision of the directory was published in 1979 and listed by the ASA as an **International Directory of Pain Centers/Clinics.** The survey listed 273 United States clinics, of which 42 percent were of the multiple discipline type, 35 percent modality oriented (primarily nerve block clinics), and the remaining 23 percent were syndrome oriented (back pain, orofacial pain, headache, etc.). Of the 273 pain clinics listed in the United States, 41 percent were directed by anesthesiologists, 10 percent by orthopedists and psychiatrists, 9 percent by psychologists, 9 percent by neurosurgeons, 8 percent

by dentists, 7 percent by neurologists, and 6 percent by nonmedical personnel. Of the United States clinics listed, 40 percent were of the outpatient variety, 21 percent inpatient, and 13 percent both in- and out-patient. The remainder failed to list the location of the service rendered.

In the 1979 directory, the Committee on Pain Therapy of the ASA proposed several definitions which will be useful for any discussion of the value of pain centers as a tool to be considered by SSA. Those definitions are as follows:

Major comprehensive pain centers—A major comprehensive pain center is an organized facility with both space and personnel committed to the evaluation of the interaction of the physical, emotional, and sociological aspects of chronic pain problems, possessing the capability of developing a multidisciplinary approach to pain management, conducting research, and training of pain specialists among varied health care personnel.

Comprehensive pain centers—A comprehensive pain center is an organized facility with individuals or groups managing a great variety of chronic pain problems but unable to fulfill the academic prerequisites for a major comprehensive pain center. The center should have the personnel and facilities for evaluation of the psychosocial as well as the physical aspects of chronic pain behavior and for administration of therapy appropriate to the problem found.

Syndrome-oriented pain center—A syndrome-oriented pain center is an organized facility which provides an indepth study of all aspects of a particular pain problem and offers an acceptable treatment program for that problem. Examples of syndrome-oriented pain centers may be: low back pain centers, headache or facial pain centers, cancer pain centers, spinal cord injury centers, etc.

Modality-oriented pain centers—The modality-oriented pain center is a facility which offers the chronic pain patient the appropriate therapy as defined by the specialty of the center. Other therapies may be used as adjuncts on a referral basis. Such a center may or may not provide extensive evaluative processes or interdisciplinary treatment. Examples of modality-oriented pain centers include nerve block clinics, transcutaneous electrical nerve stimulation (TENS) clinics, acupuncture clinics, biofeedback clinics, mental health centers, etc.

All reports from the various pain control centers emphasize the important role played by the pain team for successful outcome of treatment. To form an effective team, all members should share a common language and a common philosophy, agree on the same therapeutic goals for each patient, and have easy interdisciplinary communication and access to patients' records. This team consists of physicians, psychologists, physiotherapists, occupational therapists, nurses, social workers, and experts in vocational counseling.

There have been no new directories of pain centers since 1979, nor is there any other registry by which such facilities can be identified. It is variously estimated that in the United States there are presently some 1,000–1,500 clinics, but there is as yet no certification program for training the pain therapy personnel except as part of training programs in other disciplines, of which most are anesthesiology fellowships. There are also few accepted protocols for treatment of any chronic pain problem other than cancer pain.

There are a number of organizations with an interest in the evaluation and treatment of pain and impairment due primarily to pain which were mentioned in the course of the Commission's discussion of this topic. While the Commission believes it is necessary for the reader to understand the role that these organizations have played in conjunction with the growth of pain centers and, therefore, provides a brief description of three such groups, at this point the Commission in no way endorses these organizations or recommends them or any particular pain center to SSA.

The **American Academy of Algology** was formed in 1983 as a nonprofit association of licensed physicians and surgeons with an M.D. degree within the 50 United States. Membership is limited to those in the field who are presently spending a majority of their time in clinical practice in the treatment of patients with chronic pain or patients with pain due to terminal cancer. Also accepted for membership are physicians who have, over the years, demonstrated through past clinical work or pain research, an outstanding knowledge of and contribution to the field of pain treatment. At present there are 156 members.

The Academy aims to (1) support the formation of a specialty of algology with the long-range aim of applying for recognition as an American Board of Algology through the appropriate channels, and (2) strive to ascertain and educate its membership concerning the various aspects in the social economic field related to the delivery of health care to patients with chronic pain or pain due to cancer.

The **American Pain Society** (APS) was founded in 1977 to (1) promote the control, management, and understanding of pain through scientific meetings, research activities, and clinical services, (2) inform the public of advancement in the area of pain, and (3) develop standards for training and ethical management of pain patients. The membership includes physicians, dentists, psychologists, nurses, and other health professionals interested in pain. In 1985 there were 1,000 members.

The APS conducts postgraduate continuing education programs and professional training scientific conferences, and compiles statistics. The Society meets annually and publishes an annual **Membership Directory.**

The **Commission on Accreditation of Rehabilitation Facilities** (CARF) was founded in 1966 and in 1985

listed 350 Survey Consultants. CARF aims to encourage development and improvement of uniformly high standards of performance for all facilities serving individuals with physical and developmental disabilities.

CARF surveys and accredits rehabilitation facilities, including those involved in chronic pain management, and conducts research and educational activities related to standards for facilities offering programs in hospital-based rehabilitation, spinal cord injury, chronic pain management, outpatient medical rehabilitation, infant and early childhood development, vocational evaluation, work adjustment, occupational skill training, job placement, work services, residential services, independent living, and psychosocial areas. The Accreditation Program is administered by a 16-member appointed board of trustees.

Report of Discussion

The American Pain Society (APS), in its concern over the rapid proliferation of self-styled pain specialists and pain clinics, appointed a committee to recommend standards for both inpatient and outpatient facilities. The standards accepted by the Society were essentially those contained in the ASA Directory of 1979 for major comprehensive clinics and later adopted by a national Advisory Committee of the Commission on the Accreditation of Rehabilitation Facilities (CARF). Subsequently, CARF assumed the responsibility for accreditation of pain facilities. While CARF has now accredited some 45 facilities, it neither evaluates the quality of, nor endorses the agendum of, these facilities.

Thus, there are currently no criteria by which the programmatic competency of pain facilities may be identified, although many excellent programs provide both comprehensive physical and psychological evaluation and utilize multimodal rehabilitative therapy.

Comprehensive evaluation utilizes prescreening, record review, medical and psychological examinations and testing, and other diagnostic procedures. Treatment programs are developed individually for each patient and include medical, psychological, and functional (musculoskeletal) interventions. Although outpatient programs may be less expensive, the cost of inpatient programs may be justified in the context of a substitute for reimbursement for disability. However, the results of followup studies would not favor one program over the other.

Findings

It is possible to establish protocols of evaluation of individuals complaining of chronic pain to establish an acceptable diagnosis. Treatment and rehabilitation programs must be multimodal and time-restricted to be cost effective. Minimal standards for pain centers should include: (1) interdisciplinary (team) evaluation to include medical, psychological, musculoskeletal (functional), sociological and vocational assessment; (2) quantitative measurements of dysfunction and therapy-related improvement; (3) rehabilitation goals, including detoxification from addictive medication, improvement of function, endurance, range of motion, lifting capacity and tolerance, patient training in self-control of autonomic function, muscle tension, self-care, stress management, assertiveness training, and psychological counseling; (4) specification of treatment objectives in a format ensuring informed consent; (5) measures of compliance with the rehabilitation program by periodic re-evaluation of medical, psychological, and functional progress; and (6) vocational and avocational counseling with a view to placement in productive activity on completion of the period of rehabilitation.

Recommendation

Whenever necessary, prior to allowing or denying social security disability benefits, SSA should use pain specialists and pain centers as consultative sources for evaluation and treatment in accordance with the specifications set forth above. For this purpose, the Commission defines a pain specialist as any health professional who has taken special training in the study of pain in their discipline.

Consequences of Granting or Denying Benefits

The Commission weighed the consequences of granting disability benefits versus denying disability benefits in the context of the Social Security Administration's (SSA's) dual and competing responsibilities to protect the interests of claimants and the integrity of the Disability [Insurance] Trust Fund and Federal general revenues.

The economic and social importance of the title II (social security) disability program is reflected by the fact that in December 1985 alone 2.7 million disabled workers and 1.2 million of their dependents were paid $1.5 billion for a projected annual program cost to the Disability [Insurance] Trust Fund of nearly $19.8 billion.

The title XVI (supplemental security income) disability program is of equal social importance and also significant economic importance to the population it serves. In December 1985, the latest month for which figures are available, $0.7 billion of general revenue funds were distributed in payments to 2.6 million blind and disabled persons under this program with an annual cost in Federal expenditures of $7.9 billion.

In reviewing the economic importance of these two programs, it is easy to see that any change which would lead to an increase or decrease in the number of benefici-

aries on the rolls would have a significant effect on claimants, the Disability [Insurance] Trust Fund, and Federal general revenues.

For example, SSA presently awards benefits to 48 percent of all those who apply each year. This includes awards at the initial level and those made at the various administrative appeal levels. A change in the definition of disability could significantly change the rate of disability awards. Social security actuaries project that a decrease in the allowance rate by 1 percent would **reduce** the benefit rolls by roughly 8,000 individuals annually at a savings of about $60 million in the first year and a cumulative savings of $900 million for the first 5 years.

On the other hand, any change which would result in an increase in the allowance rate by 1 percent would result in roughly 8,000 **more** individuals added to the rolls each year at a cost of about $60 million in the first year and a cumulative cost of $900 million for the first 5 years. Put in perspective, the potential benefit liability to the system in the case of a 30-year-old applicant is approximately $200,000, assuming an $800 monthly benefit for 35 years, discounted at 7 percent, and adjusted for a 4 percent cost of living each year. Thus, from a strictly benefit point of view, the cost of change is considerable and was noted by the Commission.

Appendix D [of the full report] contains a table prepared by SSA, Office of the Actuary, showing the present value of various benefits paid for various periods discounted at different rates and an explanation of the basis for the calculations.

In reviewing this issue, the Commission also took note of the experience of the insurance industry. Both group and individual disability underwriters are very conscious of the fact that the ratio of the disability benefit level to the claimant's earnings is a major factor in both the frequency of disability and the length of disability. Industry statistics indicate that the higher the ratio of benefits to previous earnings, the greater the chance of disability and the longer that disability.[1] Consequently, private disability programs rarely insure more than two-thirds of an individual's gross earnings or more than 80 percent of an individual's post tax earnings.

Report of Discussion

Early in its deliberations, the Commission addressed the question of whether claimants who allege disability primarily due to pain should be entitled to disability benefits. Such claimants are typically those with some physical findings which are not in and of themselves disabling, yet these claimants allege that their restrictions because of pain render them disabled. Growing out of that discussion was a point of view, held by several of the medical experts on the Commission, that paying disability benefits to such claimants may foster certain behaviors that actually exacerbate impairment and prevent rehabilitation. This concern was present throughout the deliberations as the members sought information on this phenomenon. This report of the Commission's discussion of this subject must be prefaced by three caveats: (1) there is a lack of information in this area, (2) the behavioral consequences of granting benefits is legally irrelevant, and (3) the consequences of granting benefits vary by individual.

Although several Commission members held the view that the granting of disability benefits was not in the long-term interests of the claimant because of the reinforcement of chronic pain behavior, others wanted evidence of this as demonstrated by research. As reported in Part Two [of the full report], at the request of the Commission, the Institute of Medicine (IOM) of the National Academy of Sciences contracted with an independent consultant who conducted a survey of the literature on pain and disability and presented her findings during the September 1985 meeting. This review highlighted the lack of reliable scientific studies on the subject. While some studies have attempted to compare certain rehabilitation indicators (e.g., recovery rates, duration of disability, return to work) of those who receive benefits with those who do not, all have been flawed in some fundamental way. Basic scientific methodologies, such as the establishment of control groups and precautions against observer biases, have not been rigorously observed. Compounding the problem is that different definitions of disability exist in the several studies that have been conducted, thereby resulting in different definitions of success measures. Not surprisingly, the findings from these studies make it difficult to draw valid conclusions. The consultant found that the studies, on the whole, were unreliable and unpersuasive. The Commission accepts that judgment and cautions against substituting intuition and anecdote for hard data on a subject of major consequence.

It should also be noted that the Commission made another attempt to get more information on the consequences question by asking the IOM to assemble a panel of experts to address the Commission. The IOM asked the panel members to discuss the consequences of granting versus denying benefits. It is interesting to observe that the panel members were unable to address this question and discussed other disability-related issues. This is perhaps further evidence of the lack of a common body of knowledge on the subject.

The Commission recognizes that the issue in granting disability benefits is simply whether or not the claimant meets the definition of disability. There is no requirement that benefits be granted only in those cases where it is in the long run "best" interests of the claimant. The Commission noted that such an inher-

[1]Disability Income Insurance: The Unique Risk.

ently paternalistic judgment is not a requirement of other major disability programs, including private insurance, and that it is the insured event, i.e., disability, that requires the insurer to award benefits. This principle is as appropriate to the social security disability system as it is to any other disability system.

As the Social Security Act requires personalized adjudication of claims, the consequences of the disability decision vary by individual. Thus, the Commission cautions that any future empirical studies documenting aggregate behavior should not be used to warrant a denial of benefits at the individual level. Generalized findings from research and studies do serve a useful purpose for policy planners in designing a fair and efficient disability system, but such findings should not substitute for personalized medical assessment and adjudication of the legal entitlement of a given individual.

Notwithstanding the above caveats, some Commission members believe that the granting of disability benefits may have unintended consequences resulting in reinforcement of chronic illness behavior. More specifically, some of the medical professionals who treat patients with significant pain complaints observed that the problems of individuals with chronic pain (see Part Two, pages 63–68 [of the full report] for a description of chronic pain and chronic pain behavior) may be exacerbated by the compensation system, thereby impeding chances of successful rehabilitation and return to full function.

As noted in Part One of [the full] report, the disability program, by law, requires that an individual's impairment must be substantiated by medical signs, findings, and symptoms. Further, symptoms alone can never be the basis of a finding of disability without the requisite medical signs and findings. The claimant must, therefore, "prove" his disability in order to get benefits. The act of "proving" disability serves as a safeguard to the trust fund in that entitlements are based on quantifiable evidence, not mere allegations. But, at the same time, this requirement may serve as an incentive for the claimant to emphasize allegations and ultimately, through the subtleties of self-perception, to view him or herself as more seriously disabled than is the case. This perception of serious disability may, of itself, serve as a bar to rehabilitation efforts.

Similarly, section 221(i) of the Social Security Act requires that continuing entitlement to benefits be reviewed periodically (every 3 to 7 years depending on the nature of the impairment) to insure that only those who continue to meet the eligibility requirements receive benefits. Section 2 of Public Law 98–460 further provides that individuals whose impairments improve to the point where substantial gainful activity is again possible be removed from the rolls.

The Congress has viewed the continuing disability review process as an important safeguard for the disability program. Yet, from the beneficiary's perspective, this periodic review of eligibility may be seen as fostering a continuing need to "reprove" disability and demonstrate convincingly that no medical improvement has occurred. The threatened loss of disability benefits, upon which the beneficiary and his or her family have come to depend, with the attendant loss of Medicare/Medicaid protection, may be a disincentive against medical improvement. It may well be that the work incentive provisions which are designed to encourage disabled beneficiaries to return to work (see Part One, pages 34–36 of [the full] report) cannot override the powerful messages in having to "prove" and "reprove" disability. The receipt of disability benefits can be seen as legitimizing the individual's role in a society where people are generally expected to work unless they are physically or mentally unable to do so. All of these factors—the need to "prove" and "reprove" eligibility; the need to have an acceptable reason for not working; the financial dependence on benefits and corollary health care protection—may interact in such a way as to continually reenforce chronic illness behavior and defeat efforts at rehabilitation.

The development of chronic illness behavior can also be looked at as a demonstration of operant conditioning which would suggest that the rewards for pain behavior tend to reenforce the continuance and persistence of that behavior. In the case of the disability claimant with pain complaints, although the primary reward may appear to be financial, there are clearly other important benefits. The legitimacy conferred by the official designation of **disabled** may be of inestimable worth if it carries with it physical and emotional support from family, friends, and the society at large. Although one would not choose to be disabled, the legitimacy conferred by that designation may be the only socially acceptable way for some individuals to work within the system to adapt to the competition of daily living.

The other side of the question, the consequences of denying benefits, is of equal importance to this Commission. Some of the consequences are readily apparent: financial instability for the claimant and his or her family; ineligibility for Medicare and/or Medicaid protection which are tied to disability entitlement; and emotional and social distress associated with loss of status as a productive member of society. The lack of financial support and health benefits can compound the individual's impairment if he or she has to exist on an inadequate diet, has no access to health care, or lives in substandard housing. Further, if the claimant has contributed to the support of the family unit, the inability to work and the resulting loss of income may cause a loss of self-esteem and, sometimes, dissolution of the family unit.

Just as the granting of benefits conveys a certain legitimacy and social acceptance to not working, the denying of benefits may jeopardize an individual's place in society. For example, the individual who has

had a long attachment to the workforce and who is later incapacitated by illness or accident has his or her role as a contributing member of the workplace and as a provider of financial support to the family suddenly disrupted. As that individual confronts the disability system, he or she must "prove" disability through an often lengthy entitlement process. If, at the end of this process, the individual is denied disability benefits, his or her whole identity is called into question.

Although there are several provisions in the social security law (see Part One, pages 34–36 [of the full report]) which are intended to encourage rehabilitation of beneficiaries, the Commission was generally critical of the rehabilitation aspects of the disability programs and viewed these provisions as inadequate to overcome the inherent financial and social advantages to continued entitlement to benefits.

Some Commission members stressed that, although consideration for referral to a State vocational rehabilitation agency is a normal part of the claims process, the truth is the State agencies have not succeeded in getting significant numbers of social security claimants into rehabilitation programs. In this regard, some Commission members questioned whether the provision restricting reimbursement of vocational rehabilitation agencies to only those cases where the individual successfully returns to work has the effect of limiting rehabilitation efforts to only the most promising candidates.

However, in considering the degree to which the existing program acts as a disincentive to rehabilitation efforts, the Commission is unable, on the basis of available information, to predict how well the social security disability population, with its profile of advanced age (47 percent of those allowed in 1983 were 55 or over), severe disability, and blue collar work histories, would respond to rehabilitation intervention. The fact that people usually enter the social security system some months after the onset of disability (and under the title II program must wait 5 months after onset before benefits are paid) may frustrate rehabilitation efforts which are generally thought to be more successful when they are offered close to the time of the disabling event. Thus, the Commission believes the issue of rehabilitation for the social security population should be explored in a more ordered way so that the important questions that have been raised during its deliberations may be answered.

The Commission recognizes that there may be some systemic features of the disability program that affect both sides of the issue of whether to grant or deny benefits. Thus, some basic assumptions that the Commission has accepted are: (1) whenever possible, rehabilitation is better than long-term receipt of disability benefits; (2) both the economy and the social security trust fund are advantaged when successful rehabilitation restores beneficiaries to employment; (3) there are impediments to rehabilitation in the present disability system.

The Commission must conclude that there is simply too little data upon which to make recommendations for changes in the basic program structure. At this point, the Commission is uncertain as to whether claimants with significant complaints of disability due primarily to pain are being denied benefits.

Findings

In some instances, the availability of public or private disability and medical benefits are disincentives to rehabilitation and may influence the persistence and continuation of pain behavior. In other instances, however, income from these sources is the major factor insulating the recipient (and his or her family) from economic deprivation and attendant potential health jeopardizing stresses.

Further, the granting of disability benefits often is used as a substitute compensation for unemployment resulting from occupational disability. As such it creates a "sick" person out of one who could be at least partially productive. As medical disability is far more expensive than occupational disability, requiring continued health care overutilization to continue to prove disability, alternative programs for support of the occupationally disabled should be explored.

The present evaluation process risks promoting iatrogenically induced complications or even disability through overdependence on objective medical evidence of impairment. Thus, under the current system, claimants with chronic pain who fail to produce sufficient objective medical evidence risk denial. The number of these claimants is unknown.

Recommendations

The Commission recommends that there be an experiment or experiments to assess the magnitude of the problem and to evaluate whether there should be a Listing category for "impairment due primarily to pain."

The Commission recommends that the experiment(s) include a study of the feasibility, efficacy, and cost effectiveness of reactivation and rehabilitation where the alleged impairment is due primarily to pain.

Reactivation/Rehabilitation Experiment

The Commission discussed the value of a reactivation and rehabilitation program as a necessary step in assessing impairment due primarily to pain.

Report of Discussion

It is in the interests of the claimant and society as a whole to make every effort to rehabilitate social security disability claimants to their full potential. Successful return to the workplace not only improves the quality of

life for the worker, but also can significantly decrease the disability costs of the social security system.

The Commission believes, with some support from expert testimony and the experience of members, that the closer to the disabling event the rehabilitation effort begins, the more likely it is to be effective. It realizes that one of the problems in the existing system is that the social security disability applicant often may not apply for benefits until considerable time has elapsed after the date of injury or illness.

On the basis of their own experience, the literature, and expert statements on the subject, the Commission members know that rehabilitation specialists emphasize that early intervention with a disabled person, in order to lay the proper ground work for a rehabilitation program, is essential to optimize results.

At the same time, the members realize that one very basic difficulty with the social security disability insurance program is that entitlement to benefits does not begin until after the individual has been disabled for 5 full calendar months, and then only if the disabling impairment(s) is expected to last at least 12 months. Thus, although many, in fact most, claims are filed in the first 5 months after the initial injury or illness, many potential claimants put off filing an application for a longer period of time. This built-in delay in filing effectively precludes immediate or early intervention for rehabilitation. In comparison, under private insurance programs, as testified to by expert members on the Commission, rehabilitation efforts begin in the very early weeks of disability, even though it may take many months for the rehabilitation program to be successfully completed.

The contrasts between the existing social security program provisions for rehabilitation and those that prevail in the private sector did not go unnoticed by the Commission members. The members realized that any proposal for early intervention would require the development of some method which would alert social security adjudicators to potential claimants who were also candidates for rehabilitation. But the Commission did not want to recommend any system which would create unmanageable workloads for the Social Security Administration (SSA) or would disadvantage potential disability claimants. Nonetheless, the Commission believes that early identification of potential rehabilitation candidates should be an integral part of a demonstration project or projects. With these restrictions in mind, the Commission concluded that a way to identify the potential disability claimant population should be developed, but determined that development of the methodology was beyond the scope of the Commission's responsibility.

Proposal For Reactivation/ Rehabilitation Experiment

The Commission realized quite early in its deliberations that there was insufficient data to determine (1) the number of claims in which pain plays a critical role in the decisionmaking process, (2) the ratio of allowances to denials where pain is the turning point for the decision, and (3) the long-term consequences of allowing or denying benefits to claimants who allege disability due primarily to pain.

Despite these drawbacks, the Commission clearly recognized that SSA does have a problem in evaluating disability claims where disability is alleged due primarily to pain, that this problem is related to the lack of any objective tool to measure an individual's pain, and that, although this problem was the reason for the Commission's existence, it was highly unlikely the Commission would be able to satisfactorily resolve all of these questions. Therefore, the Commission determined that the issues in question could best be answered through an experiment or experiments as described in more detail in the following pages.

The Commission does not intend that the proposed experiment(s) be limited to an assessment of the caseload for "pain" cases or a determination of whether the current social security procedures for evaluating disability, and specifically the medical evaluation criteria (the Listings), are adequate to properly evaluate impairment due primarily to pain. Rather, the Commission is seriously concerned with the potential adverse consequences of awarding disability benefits to claimants whose impairment is primarily due to pain and strongly advocates that any experiment(s) include a reactivation/rehabilitation program for these claimants to test the results of such a program in terms of its effectiveness in assisting individuals to return to work.

The members agree that the evidence indicates the possibility that there is a group of social security disability claimants who are disabled due primarily to pain, but who do not meet or equal the medical evaluation criteria and, under current policies, cannot be found disabled on the basis of medical-vocational considerations. Further, the Commission realizes that the social security medical evaluation criteria require that an individual have a "medically determinable physical or mental impairment" but that, under the existing policies, pain cannot be considered an impairment in and of itself.

Thus, the Commission recognized that in considering establishing criteria for determining impairment due primarily to pain, they were exploring new territory in which a symptom—pain—would be elevated to consideration as an impairment. This was a core issue underlying many of the Commission's deliberations leading up to this final report and was weighed against the financial and institutional burdens that would be imposed upon the social security disability programs if a recommendation to elevate pain to impairment level was made prematurely.

The members agreed that while the collective expertise of the Commission could and did (see Part Two, pages

67–68 [of the full report]) readily identify and describe chronic pain patients and differentiate chronic pain from chronic pain syndrome (CPS) and malingering, the Commission could not determine at this time whether an individual with chronic pain or CPS is disabled within the meaning of the Social Security Act. Further, as members with clinical experience in multidisciplinary pain centers indicated that a proportion of individuals with chronic pain can be reactivated and vocationally rehabilitated through appropriate treatment programs, the Commission was reluctant to determine an individual disabled if chronic pain, in a given instance, however much its severity, is a condition potentially reversible in something less than 12 months. Finally, because of the issue of potential reversibility, the Commission could not decide whether an individual with chronic pain or CPS should be determined disabled in the sense of having a condition which would not be subject to reversal within a period of a few weeks or months given appropriate treatment. Nonetheless, the Commission believed that the first step in determining whether an impairment category for individuals with chronic pain was appropriate would be the development and evaluation of a set of criteria to identify the chronic pain individual.

With this in mind, a subgroup was formed to study the proposal and to consider the possibility of identifying those criteria which could be applied to evaluate impairment due primarily to pain. This subgroup met several times over the life of the Commission and presented a proposal for criteria for evaluation of impairment due primarily to pain before the full Commission during the October 1985 meeting.

During that meeting the Commission agreed that the proposed criteria were likely to identify individuals with chronic pain. However, several members seriously questioned whether the criteria would be able to accurately or best identify whether the individual with chronic pain was or was not disabled within the intent of the Social Security Act and in the sense of having an irreversible condition. These members, therefore, suggested that the criteria be tested before the Commission made any recommendation to SSA that the criteria be incorporated into the Listings of Impairment. Other members took an even more cautious approach and felt that a necessary first step was to test the criteria to see if, in fact, there was a group of individuals who would be able to meet the proposed criteria and were disabled, and still other members held that no valid assessment of impairment due primarily to pain could be made without first determining whether an individual could be reactivated and vocationally rehabilitated. Thus, the majority of the members felt that the lack of past experience and proven methodology for the evaluation of impairment due primarily to pain mandated that the criteria be tested and that a related reactivation/vocational rehabilitation experiment be conducted.

It is important to note that considerable debate took place with respect to the proposal that the criteria for evaluation of impairment due primarily to pain (which appear later in this section as the selection criteria for the proposed experiment(s)) be adopted on an experimental basis only. Some members felt that the agreement that the criteria could identify individuals with chronic pain and, more specifically, CPS, mandated a Commission recommendation that the criteria be nationally implemented by SSA as soon as possible. These members argued that failure to implement the criteria nationally would be a disservice to those individuals who would meet the criteria but were currently being denied disability under the existing social security policies and procedures.

Despite the persistence of this argument, the majority of Commission members felt that, although the criteria represented the full Commission's best effort at the development of a guide to evaluation of impairment due primarily to pain, no more could be reliably said about the criteria without testing and held firm in their recommendation that implementation of the criteria be limited to an experimental population.

In commenting on the criteria, the Commission cautions that these criteria have not been tested by the Commission, nor anywhere else to its knowledge. The Commission recognizes that the criteria do parallel existing evaluation criteria for certain mental impairments, but would point out that while similarities exist, this in no way is meant to imply that impairment due primarily to pain should be considered a mental impairment and would caution the reader against drawing that conclusion.

The Commission realizes that the criteria do describe an individual who would meet the definition of CPS as described in Part Two of [the full] report. However, the Commission again cautions the reader against drawing the conclusion that a diagnosis of CPS defines disability for social security purposes. At this time, the Commission is unable to draw any definite conclusions about the juncture of CPS and disability.

Perhaps one further point should be made here. As a corollary to the discussions on extension of the statutory pain standard, some Commission members expressed concern that the proposed criteria for determining impairment due primarily to pain included behavioral evidence which could be interpreted as not meeting the statutory requirement that there must be an underlying medically determinable impairment to which the alleged pain could reasonably be related and that this would preclude the inclusion of the criteria in the experiment.

During this discussion, some members argued that even though behavioral evidence was more subjective in nature than most other kinds of evidence accepted by Social Security as medically determinable, a broad reading of the term "medically determinable" would encompass behavioral evidence. This group argued if "medically determinable" was construed to include

behavioral evidence, no change in statute would be needed to ensure the feasibility of the experiment. On the other side of the issue were those Commission members who held that it was doubtful the Congress intended or even considered behavioral evidence to be accepted as medically determinable. These members felt that the Congress would wish to enact specific enabling legislation to authorize the recommended experiment(s).

Following is a description of the Commission's purpose in proposing the experiment(s) and the broad outline of the experimental design. The Commission does not feel that it is necessary or even appropriate that they include details and expects that the final design will be completed by SSA working in cooperation with experts in the field of experimental design and validity testing.

Outline of Proposed Experiment(s)

I. Purpose

(a) To assess the true size and composition of the social security claimant population where the primary impairment is pain not reasonably consistent with objective medical findings;

(b) To determine if individuals whose impairment is primarily due to pain (as defined in the selection criteria on pages 113–117 of [the full] report) and not presently entitled to title II (social security) benefits should be determined to be disabled within the meaning of the social security law;

(c) To determine what proportion of individuals determined to meet the selection criteria for impairment due primarily to pain can be reactivated and vocationally rehabilitated through intensive treatment in appropriate treatment centers and/or vocational rehabilitation centers and the treatment modalities which achieve maximum success with these individuals;

(d) To analyze the results of the reactivation/vocational rehabilitation experiment to obtain a profile of the social security claimant population identified in (c) in terms of education, work history, age, and sex, and to determine the cost effectiveness of reactivation/vocational rehabilitation in this population;

(e) To evaluate the cost effectiveness of incorporating a reactivation/vocational rehabilitation program as an integral part of case evaluation in disability claims where impairment is due primarily to pain;

(f) On completion of the experiment, to review the selection criteria for impairment due primarily to pain and evaluate the desirability of incorporating the criteria into the Listing of Impairments.

II. Design

The Commission suggests that the proposed experiment(s) be conducted in two phases. Phase I is a preliminary paper study to determine the size and demographics of the claimant population whose impairment is due primarily to pain. The Commission believes that this phase can be accomplished by SSA and will provide sufficient data on the claimant population to assure the necessity and accurate design of Phase II, which is intended as a "hands on" study of the reactivation/vocational rehabilitation treatment program as measured by the rate of successful return to the workplace. To ensure the validity and reliability of the experimental design, the Commission recommends that SSA contract with outside experts in the field of experimental design and statistics.

A. Phase I—preliminary paper study. In Phase I, SSA would institute a postadjudicative review of current disability claims. The review would be designed to determine for test purposes only what proportion of claimants meet the proposed selection criteria for impairment due primarily to pain but, under current policy guidelines, are denied disability benefits because medical evidence fails to substantiate a medically determinable impairment which could reasonably cause the alleged pain. To obtain this information, SSA would conduct a paper review of a stratified random sample of title II (social security) worker claims or concurrent title II-title XVI (claims involving both social security and supplemental security income applications) allowances and denials as determined under existing policy guidelines. Under Phase I, complete demographic information would be obtained on this group.

The Commission expects that Phase I will allow a determination as to whether there is an identifiable claimant population whose impairment is due primarily to pain but who are denied disability benefits under existing policy guidelines (see I.(b) above). The Commission views this as important because of suggestions that, despite the absence of specific listing level medical evaluation criteria for impairment due primarily to pain, existing policy guidelines allow favorable determinations under a variety of medical and medical-vocational alternatives, sometimes described as "getting in the back door." Phase I should, therefore, produce statistical data for two potential groups of claimants who meet the selection criteria: (1) those **allowed** disability benefits under existing policy guidelines, and (2) those **denied** disability benefits under existing policy guidelines.

B. Phase II—reactivation/rehabilitation experiment. Phase II of the study assumes that there is a substantial number of claimants that meet the selection criteria for impairment due primarily to pain. As indicated above, the data obtained in Phase I should identify this population and provide demographics for development of the Phase II study which is intended to predict whether the identified claimant population would benefit from a program of reactivation and rehabilitation (see I.(c) above).

III. Selection Criteria

Essentially, the Phase II study population will concentrate on disability claimants who (1) meet the selection criteria below and (2) have been denied disability under existing SSA policy guidelines. The Commission expects that the final design of the experiment will provide the appropriate control groups to ensure that any conclusions drawn from the reactivation/rehabilitation phase will be applicable to the needs of SSA in determining the accuracy of the criteria and the appropriateness of developing a Listing level category for impairment due primarily to pain.

A finding that an individual meets the selection criteria means that for purposes of the experiment that individual states that he/she could not reasonably be expected to engage in gainful work activity because of an impairment or impairments due primarily to pain. The selection criteria will be applied only when there is a prior finding that the individual is not disabled under either the existing medical evaluation criteria, i.e., does not meet or equal the Listings, or after a medical-vocational evaluation of the individual's residual functional capacity in conjunction with the vocational factors of age, education, and work experience.

The criterion which appears in Part A of the selection criteria requires that signs and findings be present which support the claimant's allegations of severe pain. This can be established by applying the criteria in either Part A.1. or Part A.2. Part A.1. applies to cases where the evidence for the existence of pain corresponds to the identification of physical tissue damage. Part A.2. deals with cases where the existence of pain is established through a variety of behavioral modifications. Part A.2.b. lists a number of behavioral manifestations and requires that the evidence in file confirm the presence of at least three of the five categories in this subsection.

Part B of the selection criteria relates to the degree of impairment caused by the pain. It requires that the file clearly document the existence of **all** of the listed items. As it is possible for an individual's functioning to vary over time, the level of functioning at any point in time may not give an adequate picture of the actual overall level of function. Therefore, to establish the severity of the individual's impairment, it is important that evidence from all relevant sources over a sufficiently long period of time prior to the date of review be obtained. To properly evaluate the degree to which reported pain affects an individual's functional abilities, consideration must be given to all of the available evidence, and any variations in the level of functioning must be taken into account before arriving at a determination of impairment severity over time.

Part B of the selection criteria requires consideration of whether the individual has any functional loss due to pain in four areas considered essential to work. The four areas are (1) activities of daily living (B.1.), (2) social functioning (B.2.), (3) ability to complete tasks (B.3.), and (4) functional capacity to perform basic work activities (B.4.). The degree of functional loss for each of these areas will then be rated in accord with the methods which will be proscribed in the final experiment protocol.

For purposes of these selection criteria, "activities of daily living" includes activities such as cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring appropriately for one's grooming and hygiene, using telephones and directories, using a post office, etc. To properly evaluate the extent to which reported pain affects the individual's ability to engage in activities of daily living, it is necessary to define the extent to which the individual is capable of performing and participating in these activities. In the context of the criteria, "marked" does not refer to the number of activities which are restricted, but to the overall degree of restriction or combination of restrictions which is present.

For example, a person who is able to dress and feed him or herself, eat at the dinner table, read the evening paper, etc., might still have marked restrictions of daily activities if he or she is unable to sit at the table for extended periods of time, cannot easily move from one position to another or from one room of the house to another, regularly carry items from one area of the home to another, or frequently sit comfortably when using private or public transportation, without some pain.

"Social functioning" refers to an individual's capacity to interact appropriately and communicate effectively with other individuals. This includes the ability to get along with others, e.g., family members, friends, neighbors, store clerks, landlords, bus drivers, etc. Impaired social functioning may be demonstrated by a history of altercations, evictions, firings, fear of strangers, avoidance, social isolation, etc. Strength in social functioning may be documented by the individual's ability to initiate social contacts with others, communicate clearly with others, interact and actively participate in group activities, etc. "Marked" difficulties in social functioning is not measured by the number of areas in which the individual's social functioning is impaired, but the overall degree of interference in a particular area or combination of areas of functioning. For example, an individual who refrains from initiating social contacts with others, ceases to participate in sustained group activities, or often declines social invitations, because of pain, may have marked limits on his or her social functioning.

Subsection B.3., "failure to complete tasks in a timely manner," refers to the work-related functions of concentration, persistence, or pace. Some individuals may report that pain interferes with their ability to concentrate or sustain attention sufficiently long to permit

the timely completion of tasks such as those commonly required in work settings. In activities of daily living, concentration may be reflected in terms of ability to complete tasks in everyday household routines. Strengths and weaknesses in concentration may be evidenced through observations of the frequency with which errors are made, the time it takes to complete tasks, and the extent to which assistance may be required to complete tasks.

While assessment of an individual's ability to complete tasks may best be observed in work and work-like settings, information which is obtained through direct interview and/or psychological testing by a psychiatrist or psychologist experienced in working with pain, and reports from relatives, friends, coworkers, and others, must also be considered important in evaluating the degree to which the individual is able to function in this area.

In terms of the selection criteria, "marked difficulty in performing basic work activities" refers to the individual's ability to deal with the normal activities of work, i.e., sitting, standing, walking, pushing, pulling, carrying, lifting, repeated on a daily and continuing basis, as well as to nonexertional aspects of work such as difficulty in concentration, or remembering and following simple instructions, getting along with supervisors and/or coworkers, etc., on a sustained and regular basis.

The distinction between what the individual says and what he or she does is often critical in assessing clinical pain. Therefore, where the individual reports that he or she is unable, with some frequency, to perform some or all of the normal demands of work due to pain, every effort must be made to obtain documentation from all available sources as to the extent and the duration of the reported restriction(s). Where objective medical evidence to support the reported limitation(s) is available, this type of evidence should always be obtained. However, information from family, friends, neighbors, coworkers, etc., may also be important in evaluating the reported limitation(s) and should also be obtained whenever available.

To meet the selection criteria the individual must meet BOTH A and B:

(A) Pain, as evidenced by:
(1) Measurable impairment of function with physical tissue damage in body parts specifically related to the complaints of pain; OR
(2) a. Pain complaints apparently disproportionate and/or inappropriate in location, in intensity or duration to the physical damage and/or its normally expected healing time;
AND
b. Behavioral manifestations of pain which must include THREE of the following:
1) Preoccupation with pain as evidenced by persistent and repeated complaints, or willingness to undergo repeated painful diagnostic or therapeutic procedures in search of a cure;
2) Overutilization of health care system as evidenced by frequency of physician visits, or surgical procedures, or frequent changes of health care professionals;
3) Persistent excessive use of analgesic and/or sedative drugs;
4) Consistent audible and body language displays such as grimacing, bracing, guarding movements, or disturbances of station or gait as observed by physicians, interviewers, associates, family, and other observers;
5) Other accepted, objectifiable pain-related behaviors such as sleep disturbances, eating disorders, or sexual dysfunction.
(B) Frequent and/or persistent episodes of ALL of the following due to pain:
(1) Marked restriction of activities of daily living; AND
(2) Marked difficulties in maintaining social functioning; AND
(3) Failure to complete tasks in a timely manner; AND
(4) Marked restriction in objectifiable functional capacity to perform basic work activities.

The Commission recommends that, in addition to the above selection criteria, the experiment (1) be limited to individuals age 50 or under (Statistics and studies indicate that individuals who are under age 50 have the greatest opportunity for rehabilitation and also represent the greatest potential expense to the Disability [Insurance] Trust Fund if they remain in benefit status.); (2) be structured to focus on individuals with pain complaints related to the back and neck (This group represents the largest percentage of disability claims in the targeted age group.); (3) last for a sufficient period of time to ensure proper statistical results and followup; (4) be designed to include use of appropriate data-gathering instruments to ensure a reliable geographic and demographic profile of the Phase II population to allow valid subsequent determinations as to demographic or geographic differences; (5) require design and utilization of an appropriate multidimensional instrument for assessment of the rehabilitation potential of the study population; and (6) use the criteria for acceptable rehabilitation centers and facilities as outlined on page 99 of [the full] report as one element to qualify such centers and facilities for purposes of design and implementation of Phase II.

IV. Conditions of Participation

On the basis of the testimony it has heard and the experience of those members who are associated with multidisciplinary pain treatment facilities, the Commission believes that reactivation/rehabilitation programs need not be very long. Some programs may be as short as 3 months or less, although others are longer. The Commission recognizes that claimant participation in Phase II must be voluntary, but believes that claimants can be encouraged to enter the experiment through an incentive

program. Thus, the Commission recommends that claimants selected for the study be granted a time-limited monthly stipend, to begin with the month in which the individual agrees to enter a reactivation/rehabilitation program and to continue during the time the individual takes part in the program and for a limited time thereafter so long as the individual fully participates in the program. The stipend will be calculated to equal the monthly title II benefit the individual would have received had disability been awarded.

Further, the Commission recommends that as a condition of participation, all individuals entered in the Phase II experiment agree to a suspension of their appeal rights during the period in which they are enrolled in the experiment. At the conclusion of the experiment (or the termination of the individual's participation) all appeal rights will be restored.

During the course of Phase II, the progress of all participants should be monitored and appropriate data collection instruments utilized to record information on rehabilitation activities to include, but not necessarily be limited to, information about self-rehabilitation and both successful and unsuccessful work attempts.

At the conclusion of the individual's specified period of participation in Phase II, or at such time as the individual ceases to fully participate:

The monthly stipend will cease;
The individual's appeal rights will be restored;
The data compiled during the course of the experiment will be reviewed, analyzed and become a permanent part of the disability claims file.

V. Followup

The Commission anticipates that it will take no less than 1 year after the conclusion of the experiment to analyse the data collected during Phase II and prepare a final report.

Recommendation

The Commission recommends that Congress and the Department of Health and Human Services appoint a new Commission as soon as feasible after the conclusion of the experiment(s) to assess the validity of the criteria for determining impairment due primarily to pain and of the effectiveness of the rehabilitation program. This new Commission should also be charged with responsibility to review the findings of the study being conducted by the Institute of Medicine (IOM) of the National Academy of Sciences, to survey the interim progress in evaluating pain, and to reaffirm the national focus upon the issue of pain. It should include one or more members with expertise in the deliberations, findings, and recommendations of this Commission and with the findings and results of the study being conducted by the IOM on the intersection of pain and disability.

The new Commission would be expected to provide answers to the questions which this Commission is unable to respond to at this time to include recommendations as to:

(1) the appropriateness of the current statutory standard for the evaluation of pain in the disability decisionmaking process;
(2) whether there should be a specific set of listing level criteria for the evaluation of impairment due primarily to pain; and
(3) whether a special rehabilitation program for selected claimants should be instituted as part of the disability evaluation process for individuals determined to have a high potential for successful return to the workplace.