

The Dance of the Invisible Impairments: Chronic Pain Syndrome & the Disability Insurer

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The diagnosis, treatment and determination of work capacity are steps in a unique dance engaged in by professionals working with individuals with chronic pain. It is the Dance of the Invisible Impairments. From the professional's vantage point, this dance may resemble a poorly choreographed, discordant, almost arrhythmic form of wasted energy. To the consumer, it must feel like one big wrestling match.

The health and disability insurance industry's reliance on evidence based medicine requires clear, tangible and objective pieces of information to treat and determine the degree of work incapacity. Ambiguity, subjectivity and invisibility invite a disability insurance paradox. This paradox states, "Anyone who invests great amounts of time and energy having to prove they cannot work, will not work". Unfortunately, this is the essence of chronic pain management and the subsequent determination of work capacity.

This Dance of the Invisible Impairments must evolve into a true working partnership where there is timely intervention that supports and maintains reasonable work options. Without this disability prevention partnership, the management of chronic pain becomes a malignant interaction of competing self-interests. This discussion is offered as a starting point to build this partnership.

Work and Chronic Pain A review of the recent disability and rehabilitation literature on chronic pain and work suggests that employment outcomes are consistently poor (1,7,8,9,10). While there are some promising advances in treatment protocols, chronic pain has been equated to long term, permanent unemployment or under employment by the health care and disability insurance industry (2, 14,15, 19).

The critical questions are, "Do poor work outcomes result from significant physical incapacity or are there other key influences? Is the individual's work status a consequence of self-fulfilling expectations or the product of their inability to solve a complex health and employee relations predicament? Are the lost time patterns simply a result of the lack of accessibility to clearly successful treatment models? Is depression the common thread that invites and maintains poor work outcomes? Are these outcomes generated by the competing self-interests offered by the health and disability insurance carriers?"

Work and Disability Insurance Disability insurance is the business of mitigating financial loss created by injury, illness or chronic disease. It is not an entitlement program. The business principles of disability are based on applying well defined economic and risk management formulae against expected incidence, duration and return to work rates. The core feature of this very precise business is the

application of a uniquely imprecise criterion for eligibility, i.e. the capacity to work.

The disability insurer establishes an objective process to determine eligibility and the differences between impairment and disability. The ambiguity of diagnoses, as well as the inconsistency of treatments establishes the foundation by which the disability insurer makes absolute decisions.

The Invisible Impairment Pain is subjective and invisible. Work capacity is fluid. The description and measurement of chronic pain and its effect on an individual's capacity to engage in remunerative employment is dependent on a wide range of medical conditions. It is also dependent on accessible treatment options, employer and patient expectations and economic incentives.

application of key return to work principles. Several of these are:

- Is the impairment/pathology real & compensable?
- There is an explicit and elaborate focus on self-diagnoses
- High rates of co-occurrence with other Functional Somatic Syndromes
- Self-perpetuating cycle of disability
- The perception that things will get worse
- Portrayal of the condition as catastrophic, all encompassing in the person's life
- Subject to stigmatization & disability cynicism

Return to Work Principles The following principles (Figure 1) are widely accepted by the disability insurance industry as critical to promoting return to work success.

Figure 1
Principles of the Return to Work Process

Principle #1	Diagnosis does not equal disability
Principle #2	Work motivation powers the RTW process
Principle #3	Work transition is the key practice
Principle #4	The Return to Work Plan defines the process

Common characteristics reported with individuals with chronic pain include excessive fatigue, sporadic work attendance, lack of concentration, lapses in memory and ability to complete tasks (2, 4,14). Special patient groups with chronic pain have reported greater job demands with incongruent skills and perceived loss of control in jobs leading to real or perceived job insecurity. They also report less camaraderie or social isolation with co-workers (16, 17, 18, 19)

Correspondingly, there are many unique chronic pain issues that invite the disciplined

Principle 1 - Diagnosis Does Not Equal Disability: In the disability insurance industry, impairment is considered the objective loss of function and can, in most cases be accurately measured. On the other hand, the degree of disability is subjective and depends on many factors. Impairment is a medical construct while disability is contractual and socially determined. Impairment is a stated condition. Disability can be a state of mind. Chronic pain syndrome uniquely spans both impairment and disability. The diagnosis is not a sentence to lifetime unemployment.

Impairment is a product of disease, dysfunction or trauma. The definitions of disability are negotiated. The different thresholds within various benefit plans

Figure 2 illustrates this functional relationship.

Figure 2
Elements of Work Motivation

$$\text{Motivation } f \frac{V + \text{Pos}}{C}$$

demonstrate this. Correspondingly, the respective state worker's compensation, Federal civil rights statutes (e.g. Americans With Disability Act) and disability case law create changing and often conflicting definitions of disability with similar impairment groups. Inconsistent definitions of disability create migration across benefit and insurance programs. This migration suggests that disability is also political, i.e. disability is fueled by competing self-interests.

Principle 2 - Work Motivation:

Motivation is not a singular concept. There is no motivation switch that is turned on or off. Motivation appears to be a product of key behavioral and cognitive functions.

It is important to understand the level of work motivation that can power a particular person's efforts to stay at or return to work. The observed motivation to stay at home or return to work has been described as a function of three key elements (13). They are:

- The value or utility of work (V)
- The perceived chances of (Pos) successfully going back to work
- The real and perceived cost of going back to work (C)

The value of work may vary by the success a person has achieved, as well as the degree of job satisfaction and quality of their work. The onset of impairment within various career stages and job performance levels may generate differences in work motivation.

For some, work is all encompassing, woven into the fabric of the person's self esteem. For others, work is simply a bad habit that has no intrinsic value. The type of work that the person returns to has shown to be a critical factor in the observed work motivation. The individual will take measure of the impact an injury or illness has on his or her ability to work.

Research (5, 6) has identified that one's intent or anticipation to return to work prior to entering into treatment can be predictive of the final work status independent of objective physical impairment. Preliminary conclusions are made as to the likelihood of staying at or resuming a job. In the case of chronic pain, this personal RTW assessment can be a weekly if not daily event. These ongoing, but informal RTW assessments can be dramatically affected by cognitive distortions both reducing work motivation and creating unrealistic expectations. These cognitive distortions may include over-generalization, catastrophication or

premature conclusions. The time with the clinician can be a strong reminder of positive work expectations.

Each person will also make a judgement as to the cost of going back to work. This cost may be economic. They may gain or lose financially. The perceived cost may be in increased pain or discomfort. The cost may be silently determined that if I go back to work, "The pain will kill me!"

Correspondingly, the person with chronic pain will experience differing levels of expected and observed work motivation. These can be easily misinterpreted as malingering or less than maximum effort to resume former job responsibilities. "Poor" motivation may be an artifact of depression or misinformation on future work capacity. These cognitive distortions have been shown to be quite common and are important return to work influences in cases of chronic pain and Functional Somatic Syndromes (2, 7, 14).

Principle 3 - Chronic Pain and Work Transitions:

Individuals heal incrementally, over time. Even in the shortest duration cases, work transitions improve the capacity to resume full work safely. In the case of an individual with chronic pain, these increments of increased function can be cyclic or become evident over such an extended time that they go unnoticed by the clinician, the employer and often by the individuals themselves. But they are there.

These transitions become the real return to work pathways. They can be temporary, permanent, short term or extended. The sooner the transitions begin and are reinforced the better. Work transitions need to be incorporated within the treatment plan for chronic pain syndrome. Most work transitions need to be a blended part of the

medical and behavioral health care, patient support and work site flexibility offered by the employer.

All work transitions do not need to occur at the work site and may not begin immediately following the injury or illness. In the case of chronic pain, dual track RTW transitions offer the opportunity to begin work activities in a simulated work environment that mimics the essential functions of the job. A crossover can be achieved to the employment setting with time limited accommodations or assistive technology.

Medical treatment that focuses solely on symptom elimination and management related to chronic pain has been shown to offer limited return to work success (1). To reduce lost time and prevent work disability, graded applications of increasingly more strenuous physical and stress-related functional demands need to be considered. Basic work capacities, such as strength, stamina and endurance, flexibility, cognitive problem solving and stress management, need to be enhanced. Each is a building block for a wide range of work tasks. Advances in these areas are part of any multi-modal treatment program.

The orientation to preserve and improve functional capacity may be considered more critical than attempts to seek diagnostic labels for our evidence based medicine and compensation systems. With a well-defined and accurate inventory of functional capacities, the employer, employee and the physician can have an accurate picture of what the individual is able to do. This will assist the disability insurer to make timely and accurate determinations of the degree of disability.

Principle 4 - The Return to Work/Action Plan: A return to work plan is the focused process of determining when, but more importantly how the resumption of work can occur. This is critical to reduce the RTW ambiguity. The RTW plan offers both direction and feedback to the clinician, the disability insurer, the employer and most importantly to the individual. Figure 4

effectiveness and poor long-term clinical outcomes.

Likewise, the use of duration guidelines as the primary driver of return to work with chronic pain syndrome is problematic. Both, MMI and duration guidelines are useful tools serving as critical decision points. All too often, each is applied as

Figure 4

Elements of a Return to Work Plan

- Determine the current and/or projected functional impairments
- Define the extent of duration of the functional impairments
- Define work site accommodations that are required and possible
- Identify any employee relation issues that may be a RTW barrier
- Outline transitional work options and key benefit dates
- Communicate plan to the respective supervisor and physician
- Review RTW Plan bi-weekly or as appropriate in long duration cases
- RTW Plan is revised as appropriate in 30 day increments with vocational rehabilitation services initiated at 90 days of lost time

presents the traditional elements of a formal return to work plan.

Return to work planning is different than case management. Medical and vocational case management are necessary, but not sufficient. This is especially true in complex cases with extended work disruptions.

A common error in case management related to chronic pain is the singular pursuit of Maximum Medical Improvement (MMI). That is, once MMI is achieved the person is expected to go back to work. If they don't, the employer can cut or reduce benefits. While we know benefit deadlines influence return to work dates, this is a bureaucratic practice that leads to a false sense of RTW

starting points rather than end points. They can be useful RTW milestones to be incorporated into the plan.

The Employer's Role In the RTW Plan

In spite of the variations and permutations of the definitions of disability, it means basically one thing to an employer....Lost time and lost productivity. As a critical member of the disability prevention team, the employer has a distinct role in supporting a RTW program. The healthcare team and insurance carrier often exclude the employer. At the same time, the company may readily accept this exclusion. They become a reluctant partner in the dance. This sets the stage for potential

miscommunication of intent, expectations and accountability.

Every employer needs to be involved. The size and distribution of the work force, as well as the type of industry and insurance program are not relevant. This becomes critical, in that many long-term disability programs have a 26-week elimination period prior to the claim being filed. If this is the case, the disability carrier may not see the case until six months of lost time have occurred. This puts significant pressure on the clinician and employer to create a program that protects the employability of the individual.

The following points highlight critical roles the employer is invited to embrace:

- Identify competing management return to work self-interests
- Define clear RTW roles and incentives for supervisors/managers, co-workers and labor officials
- Identify Return to Work pathways and work site accommodations on an employee neutral basis
- Do not use the disability system to remove poor performing employees
- Expect all employees to return to work through a clear and formal program

Many employers become overwhelmed with various State and Federal lost time compliance programs. They may be happy just to comply with the law, as opposed to becoming intimately involved with specific RTW planning. The functional ambiguity surrounding the chronic pain patient may invite the employer to simply keep the person “disabled” to prevent potential liability.

On the other hand, a number of large employers and disability insurers are creating sophisticated disability management programs. They feature timely reporting and tracking of lost time. They offer effective communication of the benefits and apply timely RTW planning. They couple this with aggressive work site accommodations and work hardening programs. The majority of these companies provide the RTW initiatives within their worker’s compensation programs. There needs to be balance of services among all employees off work.

The Clinician’s Role In RTW Planning

The clinician can play a critical role by understanding how various non medical barriers reduce treatment effectiveness. The barriers are based on working with a broad band of medical providers who describe the non-medical impediments that impact their medical management practices:

- Job Performance, Employee Relations & Corporate Human Resource Practices
- Depression and Work
- Work Site Inflexibility
- Disability Cynicism
- Iatrogenic Disability

While each barrier is important, the most significant barrier for the clinician is Iatrogenic Disability or treatment induced disability.

There are two primary types. Iatrogenic Disability is encountered in the form of impairment and the resulting work disruption due to treatment effects. Reduced alertness, excessive fatigue, cognitive distortions, visual loss, nausea created by the medication can be disabling. These are typically transient, predictable and can be accommodated.

The most insidious form of Iatrogenic Disability is when the physician asks the individual “when do you want to go back to work?”. This question asked in isolation from a formal return to work plan and without any consideration of job demands and work capacity may invite the wrong answer. Iatrogenesis is effectively managed by applying the basic RTW Principles.

Summary: The Dance of the Invisible Impairments illustrates the intimate nature of the treatment of chronic pain and the process that determines work capacity. With the coordination and timing of a well-

trained dance team illustrating what is possible, such a partnership offers opportunities to protect both the productivity and economic well being of the individual with chronic pain. By establishing appropriate return to work incentives within disability insurance benefits coupled with less ambiguous treatment programs, we are able to encourage the individual impaired by chronic pain to work within his or her functional capacities. With that, The Dance of the Invisible Impairments becomes an art form rather than a tortuous exercise that it seems to have become.

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1. Ashburn, MA, Staats PS. Management of Chronic Pain. Lancet. 1999 May 29; Volume 353(9167): pp. 1865-9
2. Barsky, Arthur J., M.D., and Jonathon F. Borus, M.D. Functional Somatic Syndromes. Annals of Internal Medicine. June 1999. Volume 130. Pp.910-921.
3. Fishbain, DA, R. Cutler, HL Rosomoff, RS Rosomoff. Chronic Pain Disability Exaggeration/Malingering and Submax Effort Research. Clin J. Pain. December, 1999. Volume 15 (4): pp. 244-74
4. Fishbain, DA, R.B. Cutler, H.L Rosomoff, T. Khalil, R. Steele-Rosomoff. Impact of Chronic Pain Patients’ Job Perception Variables on a Return to Work. Clin J Pain. September 1997. Volume 13 (3): pp. 197-206.
5. Fishbain, DA. RB Cutler, HL Rosomoff, T. Khalil, R. Steele-Rosomoff. Prediction of “Intent”, “Discrepancy with Intent”, and “Discrepancy with Non-intent” for the Patient with Chronic Pain to Return to Work After Treatment at a Pain Facility. Clin J Pain. June 1999; Volume 15(2): pp. 141-50.
6. Fishbain, DA, HL Rosomoff, RB Cutler, R. Steele-Rosomoff. II. Do Chronic Pain Patients’ Perceptions about their Pre-injury differ as a Function of Worker Compensation and Non-worker Compensation Status? Clin J Pain. December 1995; Volume 11(4): pp.279-86.

7. Hadler, Nortin M. Fibromyalgia, Chronic Fatigue, and other Iatrogenic Diagnostic Algorithms. Postgraduate Medicine. Volume 102. August 1997. Pp.161-177.
8. Hellstrom, C., B. Jansson, SG Carlsson. Subjective Future as a Mediating Factor in the Relation between Pain-related Distress and Depression. Eur J Pain. June 1999. Volume 3(3): pp.221-233.
9. Holzberg, Ad, ME Robinson, ME Geisser, HA Gremillion. The Effects of Depression and Chronic Pain on Psychosocial and Physical Functioning. Clin J Pain. June 1996; Volume 12(2): pp. 118-25.
10. Hubbard, JE, J. Tracy, SF Morgan, RE McKinney. Outcome Measures of a Chronic Pain Program: A Perspective Statistical Study. Clin J Pain. December 1996; Volume 12(4): pp. 330-7.
11. Keel, P. Pain Management Strategies and Team Approach. Baillieres Best Pract Res Clin Rheumatol. September 1999; Volume 13(3): pp.493-506.
12. LeFort, SM, K. Gray-Donald, KM Rowat, ME Jeans. Randomized Controlled Trial of a Community-Based Psychoedu Program for the Self-Management of Chronic Pain. Pain. February 1998; Volume 74(2-3): pp. 297-306.
13. Mitchell, K. "Vocational Rehabilitation of the Myocardial Infarction Patient". Psychological Aspects of Myocardial Infarction and Coronary Care, 2nd ed. Mosby, 1979. Eds. Doyle Gentry, Ph.D. and Redford Williams, M.D.
14. Righter, Elisabeth L. and Randy A. Sansone, M.D., Managing Somatic Preoccupation. American Family Physician. June 1999. Volume 59. Number 11. Pp3113-3120.
15. Rucker, KS. HM Metzler. Predicting Subsequent Employment Status of SSA Disability Applicants with Chronic Pain. Clin J. Pain. March 1995; Volume 11(1): pp. 22-35.
16. Stratton, KV., R. Maisiak, JM Wrigley, MB White, P. Johnson, PR Fine. Barriers to Return to Work among Persons Unemployed Due to Arthritis and Musculoskeletal Disorders. Arthritis Rheum. January 1996; Volume 39(1): pp. 101-9.
17. Stroud, MW., BE Thorn, MP Jensen, JL Boothby. The Relation between Pain Beliefs, Negative Thoughts, and Psychosocial Functioning in Chronic Pain Patients. Pain. February, 2000. Volume 84(2-3): pp.347-52.
18. Tan, V., MD. Cheatle, S. Mackin, PJ Moberg, JL Esterhai, Jr. Goal setting as a Predictor of Return to Work in a Population of Chronic Musculoskeletal Pain Patients. Int. J Neurosci. December 1997; Volume 92(3-4): pp. 161-70.
19. Williams, AC., P.H. Richardson, MK Nicholas, CE Pther, VE Harding, JA Ralphs, IH Ricardson, DM Justings, JH Chamberlain. Inpatient vs. Outpatient Pain Management: Results of a Random Controlled Trial. Pain. July 1996; Volume 66(1): pp. 13-22.