

David P. Schwartz, Ph.D.
Clinical Psychology and Behavioral Medicine
Hamilton Health Associates
6531 Winford Avenue
Hamilton, OH 45011
Ph. 513-863-2273
Fax 513-863-6022

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Testimony on Ohio Senate Bill 291

Thank you for the opportunity to give testimony on this important bill. I am speaking on behalf of the Ohio Psychological Association (OPA), and would like to give some background information on the crucial importance of psychological factors in the assessment and treatment of pain.

By background, I am a licensed clinical psychologist who has worked in both research and treatment of pain disorders since 1982. I am currently in private practice in Hamilton, Ohio specializing in evaluation, consultation, and treatment of pain, disability, and complex medically involved patients. I also chair the OPA task force on worker's compensation issues, and serve as the OPA representative on the Bureau of Workers' Compensation's healthcare quality assurance committee (HB222). Unfortunately, the quarterly meeting of the committee is from nine till noon on May 11, necessitating my submitting this testimony in written form.

As a starting point, it needs to be made clear that the experience of pain in human beings is massively impacted by their emotional and psychological state. Multiple studies have shown that if one simply looks at the amount of physical damage from an injury, the level of pain and disability experienced by the individual cannot be predicted. Two people can have an injury which appears identical to the limits of our imaging technologies such as MRIs, yet will have greatly differing reports pain and observable levels of disability and medication use. In fact, a classic study showed that when radiologists were given MRIs of individuals with severe pain or who were pain-free, the radiologists were able to correctly pick the patient's group at 50%- no better than flipping a coin! On the other hand, knowing a patient's level of understanding of their pain, and their levels of, anxiety, fear, and depression will predict both their level of pain and the amount of disability and medication use with her injury far better than information about their physical diagnosis. As an example, it has been shown that individuals who are candidates for lumbar fusion surgery cannot have their outcome predicted based on physical factors, but with the addition of an appropriate psychological evaluation an individual's risk for failure can be identified with a high degree of accuracy. This fact (plus some modest efforts on my part) has led to the Bureau of Workers' Compensation adopting the standard of requiring a mandatory psychological evaluation prior to such surgery. Other states which have required this evaluation have shown improved outcomes and decreased costs.

The impact of psychological factors on pain is best illustrated by a simple experiment. First, we generate a standard pain stimulus such as heat or pressure to your finger, and then adjust the intensity of the stimulus until you state your pain is at a 5 on a 10-point scale. We hold the stimulus steady, but cause you to have an increase in your level stress or anxiety, such as remembering a traumatic incident in your life or administering a stimulant such as adrenaline. This will reliably cause you to state your pain is now at a higher level, say 8/10. In other words, the physical sensation generating the pain has not changed, but level of activity in your sympathetic nervous system has increased, with the result that your perceived level of pain will increase as well. On the other hand, if we help you learn a relaxation exercise or administer a mild sedative, your reported level of pain will decrease, again due not to a change in the actual physical stimulus, but to a decrease in your level of emotional activation.

Simply put, stress and anxiety increase the level of pain you feel. At the same time, being in pain tends to cause us to feel stressed and anxious. This sets up a feedback loop where stress and pain mutually increase each other.

The simple finding has profound impact on the assessment and treatment of pain, yet despite over 40 years of research and clinical work, it is still not widely recognized or assessed by many physicians. In over 30 years of working with pain, I have seen massive shifts in the recognition of the need to treat pain, such as the recognition of “pain as the fifth vital sign “in medical and nursing training. Unfortunately, this has led to a focus on assessment of the level of self-reported pain, while ignoring these crucial emotional and psychological factors which in fact are at least as important as the pain level to the overall functioning of the individual. In the vast majority of treatment, when a patient is seen by a “pain specialist” the only question asked is “on a scale of 1 to 10, what is your level of pain?”. Obviously, failing to address the emotional and psychological side of the patient's pain experience leads to inadequate treatment. In fact, a major factor in the overuse of opiate pain medication is physicians failing to assess these psychological factors, then when the patient states that their pain control is inadequate, escalating the opiate dose! In other words, the physicians attempted to treat anxiety with morphine, which is a poor fit and generates multiple difficulties. I should add that some physicians attempt to treat these factors with the addition of benzodiazepine such as Valium, which are also habit-forming and in combination with opiates greatly increase the risk of respiratory depression and death. A recent op-ed in the NY Times by Dr. David Kessler, former FDA commissioner, traces the growth of the “treat pain with opiates” movement, highlighting the fact that in fact that in most cases, these drugs do not improve the actual functioning of individuals with chronic pain and has led to massive overuse, addiction, and deaths.

It is the consensus position of all professional and scientific societies for the study of pain (American Pain Society, American Academy of Pain management, International Association for the Study of Pain, etc.) that comprehensive treatment of pain includes assessment and treatment of psychological factors. More important, treatment that includes these factors is far more effective. A trained pain psychologist can identify individuals who are at risk of medication overuse, and decrease this risk through a combination of education and pain/stress coping skills. Pain sufferers given access to appropriate psychological services consistently show improved life functioning, improved mood, and decreased medical usage and costs.

It is important to comment on the need for better integration of psychological treatment in those unfortunate individuals with pain who have become opiate dependent. These individuals have failed surgery, interventional treatment, and medication treatment, and have become physically and psychologically dependent on opiates. In the majority of cases, these were not individuals with a history of substance-abuse or who were drug seeking, but have become dependent because physicians failed to recognize their lack of improvement was due to non-physical factors such as I have described, and continued to escalate opiate dosages until the person became addicted. Far too many of these individuals, when dropped from medical treatment due to physician's concerns of escalating dosages, end up addicted to heroin or other street opiates. These individuals are especially difficult to treat and do not do well in traditional substance-abuse programs, as they do not see themselves as "drug addicts," and such programs do not include any treatment for their actual pain. The good news is that interdisciplinary programs, such as the pain rehabilitation program at the Cleveland Clinic, which focus on a combination of psychological intervention and physical reactivation along with medication withdrawal have consistently been shown to be the most effective treatment for these difficult patients. If you are dealing with an individual who has had pain for years and is dependent on opioids, the single most effective treatment is not surgery, injections, or interventional pain management. It is an interdisciplinary treatment program, which has been well documented over 40 years of study. The bad news is that these programs have greatly been reduced over the past 20 to 30 years, as insurance companies preferred to pay for opiates and surgery rather than these programs and such documented effectiveness. In order to help individuals who have become so dysfunctional as a result of their mistreatment of their pain, it will be crucial to support and grow such programs again in Ohio.

In summary, in order to adequately treat and manage pain conditions, it is crucial to address the psychological factors by including a well-trained health psychologist in the evaluation and management of these patients. I would be happy to provide further information, references from relevant research, etc. should the Committee so desire. Thank you for this opportunity.

David P. Schwartz, Ph.D.
Ohio Licensed Psychologist #4154
Chair, OPA Task Force on Workers Compensation Reform