Assessing Pain in Older Adults
What to Do When the Gold Standard Isn’t Applicable

The gold standard for assessing pain in older adults is their verbal report. However, many older adults are unable to report their pain accurately, and some may be unwilling to report pain. Approximately 4.5% to 16.8% of community-dwelling older adults have cognitive impairment (CI) (Pressley, Trott, Tang, Durkin, & Stern, 2003), which causes word-finding difficulty and thus limits ability to abstract the sensation of pain into a number or a word on a pain report tool (Rohrer et al., 2008). Further, some older adults with severe CI are mute. Unfortunately, nearly all randomized controlled trials evaluating the treatment of pain (e.g., knee/hip pain due to osteoarthritis) published recently required that participants be able to verbally report pain. Clearly, older adults with severe CI are excluded from these studies, thus no data are available to evaluate interventions tailored to their needs for pain alleviation. Without treatment of their pain, older adults with severe CI may use other means to express pain, such as wandering (Kiely, Morris, & Algase, 2000) and aggressive behaviors (Kunik et al., 2010), which are major reasons for institutionalization.

So, what is the alternative to verbal report? Over the past 20 years, more than 17 tools have been developed to assess pain in nonverbal older adults with CI (Herr, Bursch, Ersek, Miller, & Swafford, 2010), national pain experts reviewed 14 nonverbal pain tools and recommended two: Pain Assessment in Advanced Dementia (PAINAD, Warden, Hurley, & Volicer, 2003) and Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC, Fuchs-Lacelle & Hadjistavropoulos, 2004). Since observed behaviors measured by these tools may be due to circumstances other than pain, the authors recommended using an analgesic trial to verify the etiology of the behaviors after older adults are identified as having pain. This may be necessary since responsiveness to analgesic trials or interventions has been evaluated for only a few of the tools, and the results were not consistent across studies (Cohen-Mansfield & Lipson, 2008; Lane et al., 2003). Yet without verbal report of pain, responsiveness to an analgesic trial or intervention is the most important way to validate pain cues.

In addition to the lack of evaluations of responsiveness, very little information is available on the sensitivity and specificity of these tools. Sensitivity is determined by a tool’s ability to identify individuals with pain when they really are in pain, while specificity is the tool’s ability to identify individuals without pain when they are not in pain. The major obstacle to determining the sensitivity/specificity of a nonverbal tool for pain is the lack of a gold standard, such as verbal report of pain. Establishing a tool’s sensitivity/specificity in older adults with no or mild CI may be an alternative approach, based on the assumption that with the same level of pain, individuals with no/mild CI will demonstrate the same behaviors as those with moderate/severe CI.

Our knowledge of the use of pain behaviors as an alternative or adjunct to pain report is increasing. However, in addition to the
problems mentioned above, there are limitations to the ways these tools can be used. For example, the tools’ ability to detect the intensity of pain has not been established. Further, whether these tools can be used to identify specific pain conditions, including the most common chronic pain conditions (i.e., osteoarthritis and low back pain), is also unknown. Further study is needed to address these limitations.

REFERENCES


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