

## *Guest Editorial*

# Assessing Pain in Older Adults

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In recent years, pain control has become a topic of increased interest in the United States. Although the interest originated in professional societies (the American Pain Society has called for pain to be treated as a "fifth vital sign"), regulatory agencies have now picked up on the issue. For example, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), probably the most important of the regulatory agencies, has established standards for pain assessment to be implemented by the upcoming year (JCAHO, 2000).

Clinical research on pain has also grown. Although long a topic that was virtually ignored, research on pain in older adults is an area of particular growth. There has been progress in the understanding of relations between nociception and dementia (Benedetti et al., 1999; Farrell et al., 1996), and in the understanding of pain coping and adjustment (Keefe & Williams, 1990), and an enhanced appreciation of the importance of disability management in older adults (Zeiss et al., 1996). An area where progress has lagged, however, involves the clinical assessment of pain in geriatric patients, both with and without cognitive impairment. Recognizing deficiencies in this area, the American Geriatrics Society has promulgated guidelines for assessing geriatric pain, guidelines reflected in the JCAHO regulations referenced above.

Improved assessment of pain is important for several reasons. First, epidemiologic studies have shown pain to be widespread in older adults (Mobily et al., 1994), so that it is commonly encountered in clinical settings. Second, demographic trends presage growing numbers of persons in older age groups, suggesting that pain will constitute an increasing public health problem. Probably the biggest reason that improved assessment techniques are needed, however, is related to treatment. When adequate strategies for pain assessment are absent, treatment is often compromised (Feldt et al., 1998; Ferrell, 1991; Sengstaken & King, 1993). Moreover, poorly treated pain has been linked with increased disability (Williamson & Schulz, 1992) and depression (Parmelee et al., 1991). Several assessment issues require attention if clinical care is to improve.

One such issue affects both clinical care and research: the need for improved instrumentation. There is a decided lack of reliable, validated measures for assessing pain in older adults. Although a number of instruments have been identified for the general adult population, only recently has research examined the measurement properties of pain assessment instruments in older adults. Several instruments have been identified with

acceptable measurement properties for use in older adults, including those with mild to moderate cognitive impairment (Grossberg et al., 2000; Herr et al., 1998). To date, however, the measures are not widely used. Further work directed at instrument development for this patient group is needed, as is work designed to speed the integration of these and other instruments into practice.

Although beginning progress in instrumentation is evident for patients with mild to moderate cognitive impairment, assessment of pain in patients with severe cognitive impairment remains highly problematic. The latter patients typically exhibit severe deficits that interfere with communicating subjective states such as pain (Gagliese & Melzack, 1997; Sengstaken & King, 1993). Hence, among these patients, pain can only be imputed (e.g., when they exhibit increased levels of agitation). Several behavioral observation systems designed to assess agitation have been used with these patients, although neither is specific to pain (Cohen-Mansfield Agitation Inventory, Cohen-Mansfield et al., 1989; Discomfort Scale for Diseases of the Alzheimer's Type, Hurley et al., 1992). A recent study demonstrates a more pain-specific approach, embedding the observation system developed by Hurley and colleagues (1992) within a pain treatment protocol (Kovach et al., 1999). This study showed that agitation decreased in a significant percentage of patients who received analgesics. Other preliminary work has shown that routine administration of low-potency analgesics (i.e., acetaminophen) decreases the need for psychotropics in agitated patients with severe dementia (Douzjian et al., 1998). Although preliminary, these stud-

ies suggest that observational systems can be integrated into treatment to manage pain and pain-mediated agitation. Further development and elaboration of such systems and treatment protocols deserve investigation.

Aside from issues related to instrumentation, pain assessment in older adults is complicated by a complex set of communication problems that involve both patients and health care providers. Some of the communication difficulties are associated with cognitive limitations that interfere with communicating internal states (Sengstaken & King, 1993). Nondemented patients, however, may also communicate pain poorly. For example, sensory loss, including decreased sensitivity to visceral pain associated with aging (Harkins, 1996), can complicate assessment (e.g., in "silent" ischemic attacks that present to the emergency room; Barsky et al., 1990). Further, older patients appear to use different decision rules in regard to pain, especially chronic, daily pain. There is evidence that such pain is often considered to be an inevitable part of aging that must be tolerated rather than treated (Leventhal & Prohaska, 1986; Prohaska et al., 1985). This decision rule leaves the patient vulnerable to pain exacerbations by limiting the amount of information that patients convey to providers, greatly complicating treatment.

Communication problems, however, are not restricted to patients. There is evidence that providers, prone to underestimate severe pain across most age groups (Grossman et al., 1991; Tait & Chibnall, 1997), tend to underestimate pain more generally in older adults (Weiner et al., 1999). Moreover, inaccurate pain estimates persist despite educational initiatives and/or changes in

hospital protocol that make patient pain ratings more obvious (Desbiens et al., 1996). As noted earlier, misjudgments regarding pain severity also affect treatment decisions. Older adults are undertreated for pain following orthopedic injury (Feldt et al., 1998) and are underrepresented in referrals to specialty pain clinics despite the prevalence of the problem and evidence that they can benefit significantly from such treatment (Kee et al., 1998).

Although it has long been recommended that pain in older adults be treated similarly to that in younger adults (Ferrell, 1991), it is clear that current clinical care does not meet that standard. As has been widely recognized, assessment and treatment paradigms for older adults must improve. Hopefully, the presence of new guidelines and regulatory standards will impel clinical research and care in these much needed directions.

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