Pain is experienced by patients of all ages. Over 34 million Americans - aging adults, adults, adolescents and children, suffer from pain. Pain is the most common reason patients of all ages give for seeking medical care. According to Joint Commission resources, “Each and every patient has a right to the assessment and management of pain.” There is no simple definition of pain. Pain is whatever the person experiencing the pain says it is, existing whenever the patient says it does. Although pain is a subjective and personal experience, patients in various age-groups have characteristic responses to pain. This newsletter will describe the concept of pain and typical age-specific pain responses. Behavioral responses to pain, as well as population-specific pain assessment, will also be discussed.

PAIN

Because pain is an individual experience, patient self-reporting is the single most reliable indicator of the existence and intensity of pain. According to the American Pain Society “It is not the responsibility of patients to prove they are in pain; it is the nurse's responsibility to accept the patient's report of pain.” Tolerance to pain varies from person to person, and from time to time in the same person. Regardless of the cause, pain as the person perceives it, is what must be managed. The individual who is experiencing the pain is the judge of the severity of pain, and the relief of pain.

Certain types of pain are more common in certain age-groups. Chronic, continuous or regularly occurring, pain that extends over a period of 6 months or longer, is more common in middle and aging adult. Chronic pain affects more than 1 in 5 Americans. Although occurring in any age-group, chronic pain occurs more often in middle and aging adults, affecting more than 50 million people. Common chronic painful conditions in these age groups include arthritis, fibromyalgia, shingles, and neuropathy.

Acute pain, occurring from an identifiable cause, such as tissue damage caused by disease, injury, surgery or other invasive procedures, is common in all populations. It is relatively short-lived and can range in intensity from tolerable to unbearable.

Pain is often not only a physical response, but often an emotional one, as well. Sadness and anxiety often accompany chronic or severe pain. The patient also often has an internal dialogue - “I can’t take this.”; “No one knows what I’m going through”; “Someone please help me.” Emotional responses seem to aggravate pain responses.

POPULATION-SPECIFIC PAIN RESPONSES

ADOLESCENTS: Adolescents, 12-18 years old, typically show less vocal and behavioral protest to pain. “It hurts” or “You’re hurting me” are common verbal expressions. Much self-control is usually evident. However, adolescents may Withhold or exaggerate their reaction to pain according to who is present. For example, teens usually have less of a reaction to pain around peers and more when family members are present.

Adolescents commonly view an illness, injury and treatment in terms of how their body image, their appearance, will be affected, rather than the degree of the associated pain. Any change to their body, such as sutures, and the potential of scarring, which will make them look different from their peers, can be devastating to the adolescent.

ADULTS: Young and middle adults experiencing pain are usually able to interpret its origin and possible cause. However, most adults see pain as a threat to their safety and typically become anxious when they are in pain. For example, they may worry whether a persistent headache is a sign of something more serious, such as a brain tumor.

Young and middle adults may withdraw from others, including healthcare providers, when there are in pain or on the opposite extreme, they may complain about their pain and talk incessantly about their agony. They are usually quick to ask for, sometimes demand, help with getting pain relief. If pain has been anticipated, such as that post-operatively, reactions are usually less intense then when pain is unexpected.

AGING ADULTS: Statistics show that up to 65% of older adults living on their own or with family, and up to 80% of seniors in long-term care facilities, have pain. Conditions such as dementia further complicate an older adult’s ability to seek and receive adequate care for his or her pain.
There is no evidence that elderly persons perceive pain differently from younger persons. Although aging adults are not less sensitive to pain, they generally report pain less often than adults or adolescents, for a number of reasons. Many older adults, their family members, as well as healthcare providers, believe pain is a natural occurrence with aging. Although elderly patients do develop more chronic diseases as they age, pain is not an expectation of normal aging. The elderly may fear that pain indicates worsening of a disease and, therefore, may not report it. Aging adults may also fear that drug therapy, particularly opioids, will cause addiction, as well as adverse effects, such as confusion, constipation, sedation and dizziness. The elderly patient may take a mild analgesic, and then discontinue it because “it did not help”. Assuming that anything stronger may be “addicting”, the patient accepts the pain as inevitable. The patient’s beliefs about the use of pain medication should be examined, especially myths about addiction.

Elderly patients may feel that being stoic and refusing to “give in” to pain are appropriate behaviors. Many older patients will not report pain because they “don’t want to bother anyone”, or they don’t want to be seen as bothersome, a complainer, or hypochondriac. Many older adults believe that healthcare providers should know when they’re in pain and believe everything possible is already being done to help them. Some elder patients may feel their pain will not be believed or that nothing is going to help. They’ll just “have to live with it”. Healthcare providers must consider these age-specific responses, which commonly become barriers to assessing pain in the elderly. Additionally, accurate pain assessment and effective pain control may also be impeded by age-related changes, if evident, such as dementia and confusion. In patients with such impairments, special attention must be paid to nonverbal cues of pain. For example, someone with dementia, who is unable to ask for analgesia, may express pain by grimacing, moaning, crying out, or resisting a caregiver’s attempts to move his or her body. Although such objective data is not as reliable as a self-report of pain, they warrant further assessment. Regardless of the patient’s age, certain behavioral responses may indicate pain. These include:

- Facial grimaces
- Favoring one limb
- Clenching of teeth or fists
- Rubbing/holding the painful site
- Decreased activity / Mobility
- Sighing / Moaning
- Sadness / Withdraws

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<tr>
<th>Facial grimaces</th>
<th>Bracing / Guarding</th>
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<tr>
<td>Favoring one limb</td>
<td>Decreased appetite</td>
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<td>Clenching of teeth or fists</td>
<td>Restlessness / Anxiety</td>
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<td>Sweating</td>
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<td>Decreased activity / Mobility</td>
<td>Irritability</td>
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<td>Sighing / Moaning</td>
<td>Crying / Screaming</td>
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<td>Sadness / Withdraws</td>
<td>Insomnia</td>
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### Population-Specific Pain Assessment:

On-going assessment of patients’ pain, often referred to as the fifth vital sign, is essential. Numerous pain assessment tools are available to meet the needs of all patients, such as young children who are not able to quantify their pain, or patients, for whatever reason, who are unable to verbally communicate their pain. Many elderly, especially those with dementia or confusion, relate best to pain-measuring scales which include word scales like “mild, moderate, or severe” and the happy-to-sad FACES scale, traditionally used for children.

When assessing pain, speak slowly and clearly, facing the patient. If a patient is unable to communicate, assume that known painful procedures, such as surgery, will result in pain, and should be treated accordingly. In such cases, evaluation of the patient’s response may need to be based on behavioral indicators.

### Numeric Pain Scale:

When using this pain scale, consistency throughout the healthcare facility is important, such as whether pain is assessed on a scale of 0-5 or 0-10.

#### 10 Point Numeric Scale

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<th>7</th>
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<tbody>
<tr>
<td>No Pain</td>
<td>Little Pain</td>
<td>Medium Pain</td>
<td>Large Pain</td>
<td>Worst Pain</td>
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### The Faces Scale:

The Wong-Baker FACES rating scale, traditionally used in children, consists of 6 faces ranging from a happy, smiling face depicting "no pain" to a tearful, sad face depicting "worst pain". It also has a numeric scale, 0-5, corresponding to the faces and word descriptions. The healthcare professional or family member should point to each face using the words to describe the pain intensity. The patient should be asked to choose the face that best describes his or her own pain. The corresponding number should be recorded on the pain record.

#### Which face shows how much hurt you have right now?

- **0** No hurt
- **1** Hurts little bit
- **2** Hurts little more
- **3** Hurts even more
- **4** Hurts whole lot
- **5** Hurts worst

### Verbal-Descriptor Scale

This pain rating scale uses descriptive words to denote varying intensities of pain. It should be explained to the patient that at one end of the line is no pain, and at the other end is the worst pain. In between are little, medium and large amounts of pain. Ask the patient to choose a point on the line which represents his or her pain now. Or, ask the patient the word descriptors - "Is your pain medium or is it less or worse than that?" Once the pain intensity is determined, assign a number to it, such as “little pain” is a pain intensity of 2.5; “medium pain” is 5, when based on a 10 point scale.

### On-going assessment of pain is essential and should be considered the fifth vital sign. Regular assessment of pain and documentation allows all care providers to see the pain measurement, and pain can be managed according to the patient’s on-going responses.
1. Pain is whatever the person experiencing the pain says it is, existing whenever the patient says it does.
   a. True
   b. False

2. Brooke, 13 years old, has a broken femur and multiple lacerations on her face. She is talking on the phone to her friend, smiling and joking. When she hangs up, you ask her to rate her pain on a scale of 0 to 10. Brooke rates it as an 8. Based on your assessment, you document:
   a. In no acute distress, talking on the phone.
   b. Minimal pain evident, smiling and joking.
   c. No guarding or facial grimacing noted.
   d. Patient rates pain level as an 8.

3. Brooke’s parents enter her room and she starts crying, telling her mother how badly she is hurting. This change in behavior is likely because adolescents commonly:
   a. have little self-control when it comes to responding to pain.
   b. fear pain indicates the worsening of their condition and possible death.
   c. accept pain as inevitable and that nothing can be done to control it.
   d. often withhold or exaggerate their pain response, depending upon who is present.

4. Since Brooke has lacerations on her face, she is most likely to view her accident and pain in terms of how her body image will be affected.
   a. True
   b. False

5. Adults who are in sudden acute pain are likely to:
   a. see it as a natural occurrence with aging.
   b. keep their pain to themselves, not wanting to be seen as a complainer.
   c. be afraid that it indicates something more serious.
   d. refuse to take an opioid for fear of becoming addicted.
6. A 50 year old man is to undergo a bone marrow aspiration. Local analgesia has been injected at the site. Once the procedure begins the patient screams loudly and curses. The healthcare professional should:

   a. tell the patient the procedure will be over soon.
   b. ask a family member to hold his hand.
   c. explain to the patient that he shouldn’t be in that much pain.
   d. request the procedure be stopped and additional analgesia be given.

7. A 75 year old woman with a fractured wrist denies pain, stating, “I can live with it.” The patient is displaying a common barrier to pain assessment and management in this age-group.

   a. True
   b. False

8. Elderly patients often refuse pain relief, particularly opioids, for all of the following reasons EXCEPT the fear of becoming:

   a. addicted.
   b. constipated.
   c. short of breath.
   d. confused.

9. A patient is disoriented and unable to communicate. Which behavioral responses least likely indicates he is in pain?

   a. Sleeping
   b. Restlessness
   c. Sweating
   d. Facial grimaces

10. Elderly patients, who are confused, often relate best to word pain scales, rather than numeric pain scales.

   a. True
   b. False