Commentary: Evidence-based Assessment of Pediatric Pain

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The article by Cohen et al. examining the evidence basis for measures of pediatric pain is a state-of-the-art review of empirically supported instruments for childhood pain. Given the burgeoning interest in the field of pediatric pain and the plethora of relevant measures, the Cohen review is extremely timely and will likely have a substantial impact on the field by helping to guide clinicians and researchers in their quest for the best available assessment tool to meet their specific needs. The authors are to be commended for implementing a clear, systematic approach to evaluate the evidence base for a wide range of instruments to assess pediatric pain. Their evaluation system has its origins in the framework developed by the American Psychological Association (APA) Division 12 Task Force on Promotion and Dissemination of Psychological Procedures (Chambless & Hollon, 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1993). These original criteria, developed over a decade ago, defined the standards by which psychological therapies may be judged efficacious. As such, the Division 12 Task Force criteria were instrumental in propelling the science of clinical psychology forward. The criteria developed by Cohen and colleagues (Cohen et al., in press), also commissioned by the APA (Division 54, Society of Pediatric Psychology Assessment Task Force) represent an extension of this prior approach and as such constitute an important step in promoting the rigorous study of childhood pain.

A key feature of the Cohen article is the inclusion and review of assessment instruments that are applicable not only to clinical practice but also to research settings. As noted by Cohen and colleagues, evidence-based work in the field of pediatric psychology includes not only a consideration of relevant aspects of clinical practice and the characteristics of the patient, but may also extend to the research setting. Whereas the study of pain in clinical populations remains a critical means of advancing our knowledge regarding the etiology and maintenance of chronic/recurrent pediatric pain, there is a growing recognition that the controlled laboratory setting offers distinct advantages for the testing of hypotheses regarding pain responsivity. For example, the reproducibility of laboratory procedures allows the investigation of effects without confounding variables (e.g., variations in intensity/duration) inherent to clinical pain episodes and painful “real world” medical procedures. However, it goes without saying that the success of any experimental or clinical pain investigation rests on the inclusion of appropriate measures of pain. Thus, a crucial point emphasized in the Cohen et al. review is that a consideration of the overall quality of a measure does not speak to the question of whether a particular measure is best suited to the specific context, setting, or hypothesis to be tested. The discussion by Cohen and colleagues drives home the key point that pediatric psychologists need to be mindful of the specific questions to be addressed as well as their own level of expertise in deciding which instrument is the best for the job at hand.

What is most encouraging about the review by Cohen and colleagues is that of the 17 measures reviewed, all were found to meet criteria for either “well-established” (n = 11) or “approaching well-established” (n = 6). This finding alone is good news to clinicians and researchers working in the area of childhood pain and suggests that a certain maturation point in the assessment of pediatric pain has been reached. Nevertheless, there is still additional work that remains to be done. One crucial issue is the examination of possible variations in pain report from various sources of information on the child’s pain. Clearly, the child is not the only source of information on his or her pain. Childhood pain may be reported or observed by others including parents, peers, and teachers; the information derived from these external sources may differ from that reported by the child, particularly among younger children. In the case of external observers of the child’s pain, it is possible that the observer’s own pain experiences may influence ratings of the child’s pain, especially for very young children or for nonverbal children. Similarly, the
sex of the observer as well as the sex of the child may each separately and together influence the assessment of children’s pain. The influence of gender role expectations in relation to pain have been highlighted among adults (Robinson et al., 2001; Robinson, Wise, Gagnon, Fillingim, & Price, 2004), and children (Myers et al., 2006), suggesting that sex and gender should be carefully considered in the assessment of pain, particularly when multiple sources of information on the child’s pain are included. Further research may be directed at delineating how various sources of information regarding the child’s pain may be synthesized and which measures may be considered the best for these purposes.

As alluded to by Cohen and colleagues, additional consideration might be given to racial/ethnic differences in assessing pain in children. Although the study of variations in the pain experience among children based on race/ethnicity is still nascent, pediatric psychologists would be well-served in giving careful consideration to the impact of race/ethnicity in childhood pain. For example, we recently found in a sample of chronic pediatric pain patients that non-Caucasian children reported fewer limitations in family activities and better perceived mental health than Caucasian children (Tsao, Meldrum, Kim, & Zeltzer, 2007) as measured by the well-established child report version of Child Health Questionnaire (Landgraf, Abetz, & Ware, 1999). Future research should strive to include diverse samples to ensure that established measures of pediatric pain are valid across all race/ethnicities.

Conflicts of interest: None declared.

Received, revisions received and accepted March 3, 2008

References


