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Chronic pain in older adults

The prevalence of chronic pain in the older adult is estimated at between 50-80% (Helme and Gibson, 2001). With the population of older people expected to double in Ireland in the next 20 years (National Council on Ageing and Older People, 2004) chronic pain needs to be at the forefront of the government healthcare agenda. The International Association for the Study of Pain acknowledged this issue when they launched a campaign in 2006 against pain in the older adult, highlighting chronic pain as one of the most significant problems facing future primary healthcare providers.

Osteoarthritis has been highlighted as the most common cause of pain for the older adult (Tsai, Tak, Moore and Palencia, 2002). This is an irreversible disease and prevalence increases with age (Symmons, Mathers and Pfleger, 2006). In addition the World Health Organisation (2002) states that osteoarthritis is the fourth leading cause of years lost due to disability (YLD) at a global level. Research conducted by the Department of Health and Children (DOHC) (2002) reported that the quality of life index of Irish patients with chronic pain was lower than that of people with terminal illness. Further to this, Breen (2002) states that people living with chronic pain are more likely to suffer from depression, anxiety and reduced activity.

UNDER-REPORTING OF PAIN

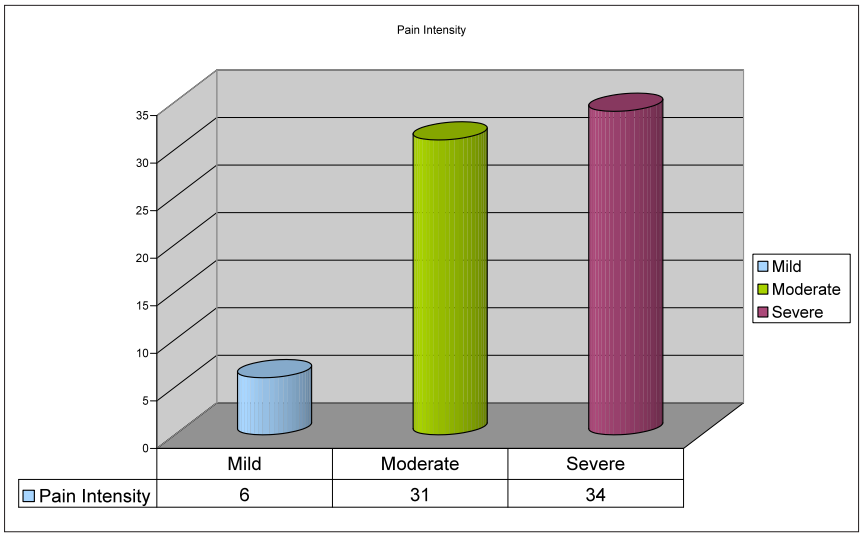
Pain remains the primary reason that a person goes to see their GP (McCaffery and Pasero, 1999; Turk and Melzack, 2001) and most pain conditions are treated in the primary care setting. However, despite global advances in services and treatment, chronic pain remains under-treated and largely under-reported in the elderly population (Helme, 2001). Veale, Woolf and Carr (2008) found that many Irish patients delay seeking treatment for up to two years for chronic pain. Various international studies also suggest that a significant proportion of patients who experience chronic pain do not seek help (Elliott, Smith, Penny, Smith and Chambers 1999; Watkins, Wollan, Melton and Yawn, 2006; Mitchell, Carr and Scott, 2006; Bedson, Mottram, Thomas and Peat, 2007; Veale et al., 2008).

Yong (2006), has suggested that older adults help seeking behaviour can be attributed to attitudes. It may be that older people are self-medicating (Woolf, Zeidler, Haglund, Carr, Chaussade, Cucinotta, Veale and Martin-Mola, 2004) and deciding not to bother the doctor, nurse or their family with aches and pains because they themselves believe that pain is 'a normal part of ageing?' (Sarkisian, Hays and Mangione, 2002). Schofield (2007) concurs with the latter explanation stating that older people are less likely to seek help for pain as they are resigned to the fact that it is part of the ageing process.

RESEARCH

This paper presents findings from research that attempts to develop a better understanding about chronic pain in the older person and explores some of the reasons why older adults do not seek help. The study was conducted through two primary care sites in the south of the country and a sample of 72 older adults completed the Pain Attitudes Questionnaire (Yong, Bell, Workman and Gibson, 2003), the Pain Beliefs Questionnaire (Edwards, Pearce, Turner-Stokes and Jones, 1992) and the Level of Expressed Need Questionnaire (Smith, Penny, Elliott, Chambers and Smith, 2001).

Figure 1 Pain intensity distribution



PAIN SEVERITY

The intensity of pain was described by participants in terms of mild, moderate and severe and participants were asked to rate their pain within these parameters. Findings presented in Figure 1 demonstrate that there was an almost equal distribution between the moderate and severe categories. For example, 47% (n=34) of participants rated their pain as severe, while 43% (n=31) rated it as moderate. Very few (n=6) indicated that their pain could be categorised as mild. These figures are somewhat similar to a pan-European study by Breivik, Collett, Ventafridda, Cohen and Gallacher (2006) where between 40-50% of respondents rated their pain as severe in Spain, Italy and Israel.

PAINFUL AREAS OF THE BODY

Participants were asked to indicate the area(s) of their body that were affected by pain. The lower back was the most frequently cited painful area of the body by 45 people, with almost equal distribution between the older adult (>65 year) and the older old (75-85 years). This was closely followed by knee pain (n=35). Shoulder and upper arm pain was reported by 32 participants, 63% were aged between 60-74 years and the remainder were aged over 75 years. Two hundred and fifty six responses were summed across all areas, indicating that a substantial number of participants, indeed if not all, had pain in multiple areas of their body. Table 1 lists the six most common sites of pain indicated by the older adult in this study.

Table 1

Areas of the body most commonly affected by pain in the older adult
• Lower back • Knees • Shoulder and upper arm • Hips • Neck • Wrist and hand

PAIN MEDICATION

Preliminary analysis of the data revealed that 83% of respondents had taken pain killers recently and 69% indicating that pain medications were taken often. However, it is unclear from the questionnaire whether these were over the counter or prescribed medication. In some cases there may have been a combination of both. Despite the apparent large percentage of older adults who are taking pain medications, according to this study, almost half were still experiencing severe pain on a daily basis. There are major issues to consider here as many patients may be taking pain medications that are ineffective. Also there are safety issues to consider, especially in terms of over the counter treatments which are not regulated together with the prescribed medications from the GP.

CONCEALING PAIN

The data suggested that people who were not willing to disclose their pain to others (stoic-concealment) were less likely to seek help from healthcare professionals. In this study, 78% of respondents agreed that there was 'no good in complaining about their pain' — indicating that participants may have complained in the past and either treatment was ineffective or nobody listened. Also, 68% of older adults agreed that 'they hide their pain from other people'. Various reasons were given by participants for this and some included not wanting to worry family members and not wanting to be seen as a complainer by health professionals. Similar findings were noted by Cairncross, Magee and Askham (2007) in a long term care setting where residence were reluctant to express their pain to others for fear of being labeled a nuisance. It is evident from this study that a large percentage of older adults were not willing to disclose their pain to others which is an essential step in seeking appropriate help.

PAIN AND AGEING

Over half (51%) of the respondents believed that 'pain was part of the ageing process'. This is of particular concern as "patients beliefs are likely to influence the way patients present their problem to healthcare professionals" (Edward et al., 1992 p. 271). In other words, if older people believe their pain is a normal part of ageing they may in affect play down the pain they are experiencing, rather than actively seeking a cure (Calnan, Wainwright, O'Neill, Winterbottom and Watkins, 2007). These beliefs may also influence the patient's ability to adjust to living with chronic pain or affect adherence with treatment regimes.

DISCUSSION

The importance of detecting attitudes that may affect the reporting of pain is an essential part of pain assessment and management as it is unambiguous that the presence of stoic

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[1] Soriano et al. The effectiveness of nutritional supplementation in the healing of pressure ulcers. Journal of Wound Care. 2004 Vol 13(8)pp.319-23
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attitudes can lead the patient to underreport their pain. Inaccurate pain assessment and subsequent under treatment of pain by nurses and doctors can have serious implications for the older adult in terms of quality of life, sleep disturbance, mood, deconditioning of muscles due to poor mobility, increased risk of falls, social isolation and even depression (Jones, Fink, Clark, Hutt, Vojir, and Melis, 2005).

Efforts in the past have focused largely on pain assessment tools, such as, the visual analogue scale where a patient rates their pain on a scale of 1-10. However, attitudes need to be assessed first to determine if the patient is 'at risk' of underreporting their pain. If these attitudes are present patients need to be educated on the importance of precise expression of pain so that correct analgesia can be prescribed, resulting in better clinical and psychological outcomes. It is acknowledged that other confounding variables may lead to under-reporting such as, fear of medication (Davis, Hiemenz, and White, 2002) and lack of knowledge regarding the negative consequences of under-treated pain by older adults and the exploration of these areas are recommended for future research.

CONCLUSION

Healthcare professionals need to be more aware of people that are 'at risk' of not seeking help and target these people at opportunistic visits by asking the patient if they are experiencing pain. Patients also need to be reassured that even if they don't have an organic cause for their pain they will be believed and treated. A comprehensive assessment of older adult's pain needs to include attitudes and beliefs, because if present these attitudes may affect the reporting of pain and subsequent help seeking behaviour. Nurses and doctors also need to demonstrate to older adults' that asking for help is not a sign of weakness. They need to educated them on the importance of reporting pain, thereby reducing the negative outcomes of under-treated chronic pain.

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