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I've been staring at faces lately. Of course, as a grad student in the throes of dissertation writing, that must mean these are not live faces—no one has time for that anymore. No, these are drawn and photographed faces.

From top to bottom: The Wong-Baker FACES Scale, The Faces Pain Scale, a portion of The Oucher Scale

These faces were all illustrated or captured in an effort to create a graphic pain scale for pediatric patients. What's fascinating is that, despite the fact that most of these scales were designed in isolation from one another—that is, the literature surrounding their introduction rarely, if ever, cites the development of the others—the similarities between them all does not end at the time-period in which they emerged. Each scale was developed in the context of pediatric nursing by, almost exclusively, women. And the originator of each scale points to one piece of research as a

strong influence: an unpublished thesis, completed by a nursing student at the University of Iowa in 1974.

Jo Eland's masters thesis, "Children's Communication of Pain," documents the researcher's efforts to help children express the amount of hurt they feel before, during, and after medical procedures. In it, Eland pulls heavily from mid-century child psychology (the field in which she would eventually get her PhD), directly referencing the Rorschach and Children's Apperception Test. The latter, a version of the Thematic Apperception Test adapted for younger audiences, uses ten cards, each with a drawing of one or more animals performing an action. It is up to the test's young subject to explain to the researcher what the animals on the cards are doing, thus providing said researcher with clues to the inner-workings of the child's psyche.

From the Gale Encyclopedia of Mental Disorders:

> *Consider, for example, the card in which a ferocious tiger leaps toward a monkey who is trying to climb a tree. A child may talk about his or her fears of aggression or punishment. The monkey may be described as a hero escaping punishment from the evil tiger. This story line may represent the child's perceived need to escape punishment from an angry parent or a bully. Conversely, a child may perceive the picture in a relatively harmless way, perhaps seeing the monkey and tiger playing an innocent game.*

Eland, then, sought to incorporate the same sorts of projective techniques used in the Rorschach and C.A.T. in her child-appropriate pain scale. She drew five cartoons, each with a dog in a different painful situation; she chose the animal because "it is well liked and not apt to be sex stereotyped" (18). "The sketches are an attempt," she writes, "to duplicate familiar painful events that could happen to a child with the intent of excluding as much as possible, magical thinking from the child's description of pain" (18). Children were asked to put the pictures in order of what hurt the dog the most to what hurt him the least. A new picture, wherein the dog was portrayed in a manner relating to the child's condition, was shown. The subject was then asked to place it in the sequence, rating their pain along the dog-delimited scale.

Eland's primary goal during this study "was to develop a method for children in the 4 to 8 year old range to communicate the intensity of pain they were experiencing" (13). By pulling from projective psychological testing methods, she was nodding to the belief that researchers or caretakers might be able to extract a "true" evaluation of the child's pain. After all, the C.A.T.'s predecessor, the T.A.T., was developed by Harvard researchers Henry A. Murray and Christina Morgan in the 1930s. It was used by the OSS (the precursor to the CIA) because of its "reputation for revealing the deepest aspects of an individual's unconscious" (Miller 9). The OSS's subjects, of course, were quite different from Eland's. She was dealing with individuals who "cannot distinguish what is real from what is not real" (10), per the work of child psychologist Jean Piaget, upon whom Eland (and others developing scales in the decade following) leaned heavily.

The face-based scale is the preferred method of researchers (see Tomlinson, et al. 2010) and, at least in my experience as a chronic-pain patient, it is rare to find a doctor's office without the Wong-Baker FACES or FPS tools on the wall. The authors of the T.A.T. and C.A.T. are sure to point out that the tools are *subjective*: they must be interpreted by trained professionals. And yes, the distributors of most of these scales include some instructions regarding their use. But my point is that we need to be thinking about the origins of these scales, especially because so many decisions are made based on their use. Projective techniques were based on delving into one's unconscious. Certainly practitioners today don't think that's what they're doing when they ask a patient to rate their pain using the smiley faces. But the ideas behind the scales point to the desire to find out someone's *real* pain—not what their own face is conveying, or how they might describe it verbally. What does it mean when we rely so heavily today on these purportedly valid tools of one's apperception to measure what they are feeling?

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Works Cited

Eland, Joann Marie. *Children's Communication of Pain*. University of Iowa, 1974.
Tomlinson, Deborah, et al. "A Systematic Review of Faces Scales for the Self-Report of Pain Intensity in Children." *Pediatrics*, vol. 126, no. 5, Nov. 2010, pp. e1168–98. *pediatrics.aappublications.org*, doi:10.1542/peds.2010-1609.