I, Jennifer M Fisher, hereby submit this original work as part of the requirements for the degree of Master of Arts in Anthropology.

It is entitled:
You Are How You Speak: A Discursive Study of Experts and Expertise in Pediatric Pain Assessment

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You Are How You Speak: A Discursive Study of Experts and Expertise in Pediatric Pain Assessment

A thesis submitted to the
Graduate School
of the University of Cincinnati
in partial fulfillment of the
requirements for the degree of

Master of Arts

in the Department of Anthropology
of the McMicken College of Arts and Sciences
by

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June 2011

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Abstract

Studies of experts and expertise have traditionally been undertaken by cognitive psychologists as a way to discover the mechanisms by which individuals can be experts, and they have conceptualized expertise as something individuals possess. More recently, however, anthropologists and other social scientists interested in language and discourse have begun examining expertise in terms of discursive practices, wherein individuals enacts expertise by utilizing available discursive resources.

The purpose of this study is to discover the ways in which pain assessment expertise is discursively enacted in ten research interviews conducted with key informant “pain experts” as part of a broader study aimed at developing and testing pediatric pain assessment measures. An analysis of these interviews within the framework of discursive psychology reveals that pain experts enact their expertise in three ways: statements and discussion of credentials, the use of domain-specific language (jargon), and the utilization of expert knowledge (where individuals put their specialized knowledge into practice, such as critiquing traditional assessment techniques and creating new techniques) This study also addresses some of the special issues associated with pediatric pain assessment. Because of the subjective nature of pain, especially among children, it is important to address how individuals can be experts on other’s mental states. Physicians and researchers must be mindful of the effectiveness of current assessment and management techniques for their ability to understand pain as clearly as possible. There has been a recent interest in incorporating patient’s voice into the process which has produced better outcomes for all parties involved.
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Acknowledgements

First and foremost, I would like to express my sincere gratitude to my advisor Dr. C. Jeffrey Jacobson Jr. for his support. His guidance helped me throughout the entire process of research and writing of this thesis. I would also like to thank Dr. Stephanie Sadre-Orafai for her encouragement, continued guidance, and insightful ways to address this study.

Last but not least, I would like to thank my family: my parents Michael and Donna Fisher, my aunt Rebecca Lee, and Ilan Newaz for supporting me through all my endeavors.
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Chapter 1

Introduction

1.1 Background

The ethnographic record demonstrates that every society recognizes expertise and the very practice of ethnography deals with mapping and representing social distributions of knowledge. Anthropological research and practice traditionally utilizes cultural experts, or “key informants” because of their valuable knowledge of processes, people or happenings that are more extensive, detailed or privileged than ordinary people (Payne and Payne 2004: 134).

Anthropologists and other ethnographers traditionally value the “key informant” as a figure who possesses special or privileged substance, access, knowledge, ability, or expertise in a given domain of social importance whose status is marked in culturally specific ways at different levels of cultural and social organization (e.g. shamans, priests, midwives). “It was not until the 1950s and 1960s that commentary on “the expert” began to appear routinely within ethnography – the expert was a somewhat transparent social designation and one that did not need further anthropological theorization” (Boyer 2008: 38). Recent literature has focused on “the expert” but has not reached the same level of study as in other areas such as the cognitive sciences.

As anthropologists Dominic Boyer and Summerson Carr argue, having experience and specialized knowledge does not equal expertise; it is not something an individual is born with but rather something that is created. As Boyer notes, acts of expertise “and the capacity to operate productively in a culture of expertise are acquired processually” (2008: 44). Being able to take part in areas that require expertise is acquired through processes, which vary within professions where different sets of knowledge and skills are obtained. Expertise is also something that people do rather than something people hold or have. As Carr writes, “it is inherently interactional.
because it involves the participation of objects, producers, and consumers of knowledge” (2010: 17). This means that expertise is enacted in specific contexts, where individuals are in constant interaction with other individuals and objects.

1.2 Discursive Psychology

“Discursive psychology” reflects a (broad) range of social-psychological approaches to language and interaction. In discussing it here, I rely upon the resources of Jørgensen and Phillips and Potter and Wetherell. Jørgensen and Phillips are authors of a widely cited and used textbook that provides an introduction to social psychology and discourse analysis. They provide clear and concise approaches to discourse analysis, including a breadth of knowledge about discursive psychology. Potter and Wetherell’s text also provides an introduction to social psychology that is easy to understand because it simplifies theoretical concepts within discourse analysis. Their text has been influential in changing the way researchers treat discourse, shifting it from a cognitivist perspective to a social action

Jørgensen and Phillips have defined discursive psychology as a way of learning how people use available discursive resources to construct representations of the world (2002: 7). The focus is on discourses ranging from everyday talk to specialized interactions (e.g. psychiatric diagnoses) in specific contexts. Discursive psychology also focuses on the social consequences of using available discourses. This approach can be utilized to examine texts ranging from simple newspaper articles to academic texts, from everyday conversations to semi-structured interviews.

Discursive psychology does not seek to examine internal psychological conditions. It was an approach created as a means of exploring how people view themselves and others through social interactions (Jørgensen and Phillips 2002: 7). Cognitive psychology treats talk-in-turn
interactions as reflections of mental states, whereas discursive psychology views talk as a social mechanism. Studying the types of language we use is important because it allows us to gain better understanding of how others construct ideas. For example, we speak to one another daily, we read books, or watch television (Potter and Wetherell 1987: 9). It is embedded so deeply in our daily practices that it can be taken for granted. Discursive psychology brings all types of conversation into focus because it seeks to understand how people shape and view the world through discourse.

Discursive psychology draws explicitly on post-structuralist theory, which stresses that individuals are not only producers of discourse but also the target for discourse, according to Jørgensen and Phillips (2002: 110). There are two strands within discursive psychology, along with a third strand that combines the two. The first strand is “a poststructuralist perspective that builds upon Foucauldian theory of discourse, power and the subject” (Jørgensen and Phillips 2002: 104). The second strand is “an interactionist perspective that builds on conversation analysis and ethnomethodology,” or the study of ordinary people’s methods: “the methods in question being those used for producing and making sense of everyday social life” (Potter and Wetherell 1987: 18). The third strand places equal stress on what people do with their talk and text and on the discursive resources that are deployed. Within this third strand, “the concept of interpretive repertoires is often used in place of discourse in order to emphasize that discourses are drawn on in social interaction as flexible resources” (Jørgensen and Phillips 2002: 105). Types of discourse can vary from context to context. Likewise, the discursive resources utilized by individuals are subject to change and are also dependent upon context.
1.3 Discourse Analysis

There is no clear consensus on what discourses are, how they work, or how they should be analyzed and different perspectives offer their own suggestions (Jørgensen and Phillips 2002). Discourse is a vague term but it generally refers to the idea that “language is structured according to different patterns that people’s utterances follow when they take part in different domains of social life” (Jørgensen and Phillips 2002: 1). We take place in various discourses, depending upon the context of our situation. Who are we with and what are we speaking about are taken into consideration and we change our discursive resources where appropriate. Another definition of discourse is that it can be seen as an entity or object, but discourses themselves are complex sets of relations including relations of communication between people who talk, write and communicate in other ways with each other (Fairclough 2013).

Discourse analysis begins with the premise of structuralist and post-structuralist linguistic philosophy and that our access to reality is always through language. Meanings and representations are real but they only gain meaning through discourse (Jørgensen and Phillips 2002: 9). The purpose of discourse analysis is not to understand what people really mean when they say something, but to observe patterns within what has been said and to understand the social consequences of various “discursive representations of reality” (Jørgensen and Phillips 2002: 21). What we say, how we say it, and to whom we say it to is the foci of discourse analysis. It is interested in how language allows us to construct our own realities and what we believe to be true by examining how we speak of objects, places, and people.

1.4 Purpose of Study

A discursive psychology perspective holds that “language is not simply an expression of experiences but rather language in practice constitutes experiences and subjective, psychological
reality” (Jørgensen and Phillips 2002: 102). Language is a key tool for understanding experiences and realities of others. For this study, I am interested in exploring experts and expertise through the lens of discursive psychology. Discursive psychology asks “What are people doing with their talk and text?” Therefore I am interested in the ways experts utilize their discursive resources to enact expertise. Pain assessment experts were interviewed as part of a study aimed at developing valid pain assessment measures for children.

I begin my study with a background of the literature on expertise. Most studies approach expertise from a cognitive psychology lens which suggests that expertise is something people by acquiring a specific skill set. However, here I focus primarily on the anthropological literature of expertise and, because this study focuses on pain assessment experts, I also turn my attention to literature on the anthropology of pain. After reviewing some of the relevant literature, I focus on the subject matter at hand: analyzing ten transcribed interviews. Utilizing methodology set forth by Potter and Wetherell, I analyze these interviews for elements of expertise and will examine them based upon ideas learned from the literature. After completing a thorough analysis, I discuss the results of my examination. It is there I detail specific enactments of expertise that I discover. At the end of the examination, I will provide insight on this study’s significance and the need for further research, alongside the conclusion for this study.
2.1 Traditional Studies of Experts and Expertise

The study of expertise began with the development of formal models and laboratory studies of the cognitive basis of performance (Ericsson and Smith 1991: 12). An early perspective investigated the study of thinking using “protocol analysis” or cognitive interviewing, where the participants were instructed to “think aloud” while solving everyday life problems. Experts were asked in other studies to think aloud while selecting moves for chess positions (Ericsson and Charness 1994).

Early research on the differences between experts and novices led directly to the creation of new methods of instruction, particularly in medical education where early expert-novice studies led to the creation of “problem-based learning” (Barrows and Tamblyn 1980). An interest in medical cognition led to the development of the “expert-novice” framework, which held that “regardless of domain, expert reasoning involves the use of knowledge organized into schemata” (Evans and Patel 2013: 195). Arthur Elstein (Professor Emeritus of medical education) and colleagues discovered that experts could recognize patterns and links between clinical findings and could make connections or inferences from said data (Higgs et al. 2008).

According to Jørgensen and Phillips “the field of social psychology has traditionally been dominated by the cognitivist paradigm which explains social psychological phenomena in terms of cognitive processes such as thinking, perception, and reasoning” (2002: 96). Cognitivist studies have been interested in the mental mechanisms that individuals, particularly those in specialized areas, utilize in order to complete tasks. A key premise in the field that the world is filled with copious amounts of information that individuals must use categories in order to create
meaning (Jørgensen and Phillips 2002: 98) For example, we create mnemonic devices to remember difficult concepts. This condenses the information and allows us to remember key points.

These cognitivist studies of expertise provide researchers a psychological perspective on this area of study but they only deal with expertise as it relates to how they solve problems and learn or retain concepts. In the next section, I discuss the anthropology of expertise and how utilizing cultural experts for the sake of understanding the everyday has led to the study of these individuals, not just in what they do, but how they speak of what they do.

2.2 Anthropology of Expertise

Anthropologist E. Summerson Carr focuses on enactments of expertise through four constitutive processes. The first process involves apprenticeship, training, and socialization and examines the development of expertise during periods of training (2010: 19). The second process focuses on authentication and evaluation, where individuals “make it their business to become intimate with classes of culturally valuable things that are relatively inaccessible or illegible to laypeople” (2010: 21). It is during this process that experts learn how to relay the specialized knowledge they have learned during periods of training. The third process focuses on institutions and authorization. Institutions give out items such as diplomas once individuals have met the standards they have set forth. They determine when an individual has made the transition from novice to expert. The fourth process focuses on naturalization. Carr writes, “Expertise is widely established as the simple speaking of what one knows…One must master the performance of what is remembered in uncluttered and context-relevant ways” (2010: 26). Individuals have learned specific knowledge (where they also gain a specific lexicon) and have been credentialed
by an authority. Experts must be able to utilize these key elements and be able to do so naturally, so as to master the full performance of expertise.

Anthropologist Dominic Boyer argues that while anthropological commentary on different kinds of experts appeared routinely in ethnographies during the 1950s and 1960s, this category did not require further anthropological theorization, as “expert” was seen as a relatively transparent social designation. He suggests that anthropologists define and theorize the expert in an open manner “as an actor who has developed skills in, semiotic-epistemic competence for, and attentional concern with, some sphere of practical activity” (2008: 39). While the process of acquiring expertise has been studied in the cognitive sciences, Boyer suggests that researchers focus not on expertise itself, but rather on the actor and how they act out this expertise. He writes that by theorizing both experts and expertise, anthropologists can provide a framework to further study expertise from perspectives other than the cognitive sciences and within anthropology itself.

While Boyer admits the openness of the definition of expert may appear to weaken its analytical capacity, he finds that “the way in which it highlights the tension between the experiential-performative and social-institutional poles of skilled knowing and doing gives researchers analytical traction in just the right place” (2008: 39). If we look at the study of expertise as being on a spectrum, cognitive sciences would be on one end, while social sciences would be on the other. There is a tension between what these fields think about expertise, but this allows for further study of expertise with methodologies that meet in the middle. For example, drawing upon his fieldwork among German professional intellectuals, Boyer offers an argument for a richer representational and analytical practice in the form of a manifesto of five points. He argues that 1) researchers should conduct participant observation to understand the differences
between experts and non-experts; 2) pay attention to the process of how one becomes an expert; 3) understand that within anthropology there are varying views of experts and there is need for a better understanding of the relationship between cultures of expertise and anthropological expertise; 4) anthropologists should seek to understand that behind the expert are desires and aspirations that should not be discounted; and 5) understand that experts are ultimately human and we should learn about them outside of the social role they are fulfilling (2008: 44-45). Similar to Carr, Boyer gives readers yet another set of processes by which to study expertise.

2.3 Anthropology of Pain

Pain is a universal feature of the human condition but cultural elaborations of pain are quite diverse (DelVecchio Good et al. 1994: 1). For example, the Sakhalin Ainu of Japan talk about “bear headaches” that represent the heavy steps of a bear while Latinos in North America distinguish dolor de cabeza (headache) and dolor del cerebro (brainache) as two distinctive experiences and disorders (DelVecchio Good et al. 1994: 1). Medical anthropologist and comparative sociologist Mary-Jo DelVecchio Good et al. have developed a set of studies containing experiences of chronic pain in the context of American culture and society. These studies highlight the daily effects of pain, how it becomes a unique experience, how it affects family and the workplace, how it is treated, and the effects of culture and society on the pain experience. (1994: 14).

Utilizing ethnographic methods, DelVecchio Good explores how pain creates a strong yet unseen force on people’s everyday lives including what is at stake for sick people and their family, what is learned during the pain experience by those who encounter it and those who provide care. (1994: 15). What links the series of studies together is the anthropology of
experience (1994: 16). A vitally important aspect to this work is that it examines chronic pain from an anthropological perspective and utilizes traditional methods such as participant observation, which allows anthropologists to uncover ideas about pain that are embedded in everyday discourse and clinical communications (1994: 18-19).

Anthropologist Mara Buchbinder focuses on the role language plays in medicine. She writes of “illness narratives,” which consist of personal experiences as therapeutic resources and meaning-making agents. These are often filtered through complex household dynamics that mediate their production (2010: 109). However, limited research has examined the ways in which illness stories are lived and told in relationally constructed social worlds (2010: 109). In this particular study, Buchbinder focuses on what illness narratives are really about by analyzing the illness stories narrated by a mother and her thirteen-year-old son (who suffers from chronic migraines).

Buchbinder is interested in what is left out of some accounts of illness and suffering and to explore why they are omitted. She draws on the work of Judith Butler (2005) to investigate how storytelling shapes narrative production (2010: 109). Illness narratives are found to be necessarily fragmented, partial and rhetorical in nature within interviews. Giving an account of one’s pain is a strategic and selective process which creates moments of clarity as well as interruptions and silences. There are pieces of information that individuals willingly disclose, but there are other pieces that either get lost or are not spoken. She finds that medical anthropologists ought to attend more closely to the institutional structures and relations in the process of eliciting illness narratives as well as the interactional framework of interviews, as they provide many interpretive clues (2010: 126).
Anthropologist Linda Hogle focuses on changes in the roles and relationships of those given the authority to make decisions about medical therapies within the context of the regulation of and information provided about pharmaceutical drugs. Hogle argues that the relationships among expertise, authority, credibility, and control are negotiated and contingent. Expertise and authority may entail conflict, compromise, novel alliances, or tacit agreements (2002: 276). Her view is a departure from the one held by anthropologists that have studied knowledge in medicine. Traditional models of power focus on the dominance of the professional, where there is little to no working with the patient, or the interests of the state before the individual. (2002: 276).

Drawing upon fieldwork that focuses on the control of information about Tamoxifen (a drug used for cancer treatment), Hogle discusses the growing trend towards promoting drug sales using direct-to-consumer advertising, attempts to regulate this type of activity, reactions from women who are targets of the information, in addition to health activists who have their own interpretations (2002: 277). As a result of this study, the activities of governmental and non-governmental authorities, private commercial interests, patients, activists, and others are neither bounded nor in opposition to one another. There are constant alliances and alignments being made but there are also times when interests are in contest with one another. It is here that expertise is negotiated, challenged, and validated (2002: 298). Anthropologists should concern themselves with sorting out the complex relations between authority, credibility, and expertise because various political and economic forces would benefit from further study (2002: 300).

Social scientists have turned away from expertise as something individuals possess by utilizing various mental mechanisms that allow for the instant retrieval of information to viewing expertise as something enacted in real time that is always subject to outside forces. Only recently
have anthropologists taken an interest in studying the person(s) they so heavily rely on for information. There is literature available about experts, expertise, discursive psychology, and the anthropology of pain, but none provide a synthesis of these elements. The goal of this study is to describe types of enacted expertise in interactions. These methods allow researchers to discover the embedded discourses that take place not only in institutional settings but also interactions that take place outside of those walls. Next, I describe the methodology used in this study to uncover the taken-for-granted discourses and bring them into focus.
Chapter 3
Methodology

3.1 Introduction to Methods

A common methodology in discursive psychology (and one of the methods used heavily in anthropology) is semi-structured and unstructured interviewing (Jørgensen and Phillips 2002: 121). Semi-structured interviews allow researchers to ensure needed information is elicited without forcing the respondent to adhere to a schedule or particular order of questions. Discourse Analysis does not have a set methodology, so it is useful to conduct DA within a specific framework and anthropology (as well as discursive psychology) utilizes this method. Small sample sizes are useful and generally recommended because discourse analysis takes a considerable amount of time. In this study I focus my analysis on ten interviews with individuals in a similar field, allowing me to more clearly see the particular discursive practices of pain assessment experts.

3.2 Procedures

I examined ten semi-structured interviews conducted by two PhD-level social scientists with participants identified as “pain assessment experts.” The aim of the interviews was to elicit thoughts about all areas that pain assessment experts would consider as being important in pediatric pain assessment.

3.3 Participants

Respondents were chosen based on their national and international reputations for clinical care or research in pediatric pain, impactful publications in the field or having participated in
national pediatric pain networks. The interviews were originally conducted as part of a study aiming to develop pain item candidates and to evaluate the overall conceptual scope and content validity of the PROMIS pain domain framework among children with chronic/recurrent pain conditions.

Respondents were first contacted via telephone and were informed about the purpose of the study and were then contacted via email to schedule interviews which all took place by telephone. The semi-structured interviews were audio recorded, lasted anywhere from thirty to forty minutes and afterwards transcribed. Prior to this secondary analysis, identities of all the respondents were deleted from the transcripts. The procedures were reviewed and approved by the Cincinnati Children’s Hospital Medical Center institutional review board.

Both interviewers used an interview guide and piloted the questions with each other. The questions asked during the interviews were the following: A) What is pain and how do you define pain? B) How do you assess the different dimensions or aspects of the pain experience in children? C) For patients who have difficulty communicating, how do you assess pain and are there particular behaviors or nonverbal signs that help you understand their pain? D) How do you assess the impact of pain on the daily lives of children? E) What do you find helpful for addressing different kinds of pain besides medication?
Chapter 4

Results

4.1 Discursive Enactments of Expertise

After an examination of the transcribed interviews, I developed the following codes to group data into the following categories: CR (credentials); LA (language – jargon); AP (applications of knowledge); LI (limitations to knowledge); and C (critiques involving the study of pain). Credentials included education and experience. Language included uses of jargon. Applications of knowledge included participation in national projects/publications (this category and credentials overlapped). Limitations of knowledge included specific cues from the respondents such as “I don’t know,” “I’m not sure,” or... “I haven’t done [something].” Critiques of the field were included in my analysis because part of being an expert is having the ability to critically analyze what works and what does not work.

The codes I have developed were influenced by E. Summerson Carr and her study on the discursive enactments of expertise (2010). Her study turns away from the traditional cognitivist approach to expertise and provides researchers with an anthropological framework where there is a focus on how linguistic and cultural resources are being utilized. She argues that how individuals acquire ways of representing things is the proper methodological loci for studying enactments of expertise. I utilized her study because there should be a focus on the verbal signs enacted by individuals as they portray knowledge.

I will discuss the results of the interviews in the following order: A) educational background; B) descriptions of pain; C) characterizations of various aspects of the pain experience; D) assessing pain in children with difficulty communicating; and E) assessing the affects of pain on the daily lives of children. I have provided excerpts from the interviews in
order to show the embedded discourses of pain assessment experts. In sections 4.2 and onward, I discuss in detail three enactments and their importance in understanding the discursive elements of expertise which are A) credentials; B) language use; and C) ways in which individuals portray their utilization of expert knowledge. After discussing these elements, I will turn my attention to how individuals can state their expertise in a subjective area such as pain and how someone can claim to be an expert of another’s mental states.

The respondents were first asked to describe their education and experience. They have all trained in a specific domain and have applied their knowledge in ways that are beneficial to the field of pain research and ultimately the alleviation of pain. They have all been part of the PROMIS national project, have published new assessment techniques, or have continued research via clinics or laboratories.

The respondents were then asked to describe pain. Most could explain it in their own words but respondents two and ten referred to commonly used or well-known definitions, for example, the IASP definition states that “pain in an unpleasant sensory and emotional experience associated with actual or potential tissues damage.” This definition also states that pain is a subjective experience (IASP 1994: 209). Margo McCaffery’s definition states that “pain is whatever the person says is occurring, wherever and whenever the person says it does,” and is another definition stated by respondent two (Ferrell 2005: 83). However, there was a consensus on the subjectivity of pain and its effects on emotional, sensory, and physical well-being. Pain was also described as being context-dependent and based on the patient’s history.

Respondents were asked how they characterized the different dimensions or aspects of the pain experience in children. All of the respondents reported using various pain scales ranging from the standard 0-10 scale to adjective descriptor scales. For example:
I1: And how do you go about assessing pain severity? What tools or instruments?

R9: We use a whole series of instruments; um…we have VAS pain intensity measure. We measure; we have several items that measure inference due to pain. We administer the multi-dimensional pain inventory which has a number of subscales and also yields cluster. Are you familiar with the MPI?

Additionally, some of the respondents focused on observable traits, such as gait and changes in their body as they talk about pain, as well as vocalizations from the patients (who used metaphors and visual imagery to describe their pain):

I1: So what would be some specific examples of pain behaviors?

R1: I walk bent over because of my pain, I cry out because of my pain, ah…you know I avoid shifting my body because of my pain. Things that could be potentially observable, um…[national project] we developed an item bank for pain behavior and it’s pretty unique that there’s not really, most pain behavior studies involve observation of a person, rather than their own self-report, and so this is kind of a new area getting at self-reported pain behavior, which sort of is evolving and we’ve developed a few additional items and discarded some of the original items, and from the original [national project] behavior item bank and are studying them in several chronic pain conditions.

The respondents have changed their assessment techniques over time and have utilized other ways of reporting such as self-reports and parent proxy. When asked if things have changed they responded:

R2: Well, of course my thinking has changed. I mean each, each, I , I think I’ve published eighteen articles on pain assessment and each one represents a, a change of some sort in my knowledge, thinking, or whatever. What, what’s the…key? I think my conversations with [individual] have been an important highlight. He has a very sophisticated understanding of pain as a social communication, and I think the social communication model is absolutely crucial in, in making sense of this. And, unfortunately, it’s not, you know, it doesn’t follow the simple fever-thermometer model that nurses would like to follow in measuring pain. But, but it’s, it’s the, it’s the reality. That’s, you know, that complexity is true of pain assessment.
Both self-report and observational aspects. So that, that’s the single-most important.

In this instance there was a focus on keeping up-to-date with contemporary assessment tools, in addition to consumer feedback (which shows an interest in how effective they are among patients). As more research becomes available about the extreme subjectivity of the pain experience, the continued sole reliance on traditional methods of assessment will no longer work in the long-term, where the goal is to ultimately alleviate pain.

For patients that had difficulty communicating, the respondents focused on observable features such as facial expressions or watching the patient move parts or their entire body into a particular position (similar to when they assessed pain in patients without difficulty communicating). The respondents were asked how they assessed pain in the daily lives of children and what dimensions they felt should be measured. They inquired about daily activities and found that several patients avoided social activities, peer groups, and discussing their pain with friends or family for fear of misunderstanding or not being believed:

**I2:** Yah. Okay. And okay so let’s just come back to pain impact for a minute. So how do you assess the impact of pain on the daily lives of children?

**R6:** I probably have a pretty broad conceptualization about impact which is you know virtually any aspect of daily life can be affect and if you think about for kids and what their daily life is situation around, it’s a combination of their physical functioning, their social functioning, their school functioning, as well as family relationship kind of functioning. Um…and then within that you can go even, you know spin off of these each a bit more. I think what’s hard is really characterizing as pain related, impact versus what their functioning is in those areas that may or may not have anything to do with pain.

I have described the general layout of the interviews and have provided examples to illustrate some of the respondents had discussed in their interviews. In the following sections, I discuss in further detail the discursive resources being used by the respondents to enact their
expertise. The enactment of expertise I examined were the statement of credentials, the use of jargon, and the utilization of expert knowledge. After examining these discursive resources, I discuss an important subject matter which is how some can be an expert of such a subjective and private experience such as pain.

4.2 Expertise as Credentials

Carr states that “if expertise is enactment, it is also fundamentally a process of becoming rather than a crystallized state of being or knowing” (2010: 19). The process of becoming an expert involves often lengthy periods of training and becoming intimate with specific sets of knowledge. Often times, interviews with experts involve inquiry into their credentials as they are one signifier used in projecting themselves as experts.

Respondents were asked to provide their background where they described the kinds of work they do, whether that involved working in a clinic or conducting research. They also spoke to any project participation. Finally, the respondents generally included any current research such as creating new assessments techniques. For example, one respondent had been working in private practice for eighteen years and one third of his patient population consisted of children. Another respondent has focused on quality of life for over twenty five years (which resulted in the creation of an inventory that has seen over 525 peer-reviewed journal publications).

Carr states that “would-be experts must continuously work to authenticate themselves as experts as well as to authenticate the objects of their expertise” (2010: 21). It is a continuous process, but one that must be undertaken in order to maintain expert status. People make decisions about who we consider to be expert and do so based upon credentials set forth by individuals and those with “higher credentials” (such as a degree from a prestigious university) are often seen as having higher quality education. It is one thing for an individual to be able to
simply state how many years they have practicing or where they obtained a special degree, but language (which I will discuss in the next section) also lends itself to the enactment of expertise.

4.3 Expert Language

Language is a primary mechanism people use to share ideas and communicate with one another. Carr discussed the use of expert registers as “ways of speaking that is recognized as a special kind of knowledge and manifests in interaction as such” (2010: 20). In the following example, the interviewer and respondent are using jargon to discuss different ways of measuring pain. Both interviewers have knowledge of pain scales; therefore they can use them almost, if not just as flexibly as the respondents. This is a way for the respondents and the interviewers to signify to one another that they understand medical jargon and therefore have special types of knowledge:

I2: Yes I do remember the intentional focus, so okay, um…

R4: We are also measuring pain wind up now using a thermal pain task, which is something we haven’t done before, and we’re also, we don’t have the results yet, but we’re looking at autonomic responses to stress.

I2: So looking at more of the physiological indicators.

R4: Yes.

There is a need for an expert register when portraying expertise “because being socialized as an expert involves establishing a deliberate stance in relation to a set of culturally valued or valuable objects” (Carr 2010: 20). Experts talking with other experts must utilize jargon in their conversations so as to maintain their social role and to show they have mastered a particular lexicon, therefore further naturalizing (and enacting) their expertise.
There is much to be said about “talking the talk” because it can have positive and negative effects. With regards to enacting expertise, “jargons are not attempts to guard or obfuscate expert knowledge, but rather a way to signify it” (Carr 2010: 20). One must be able to incorporate jargon into practice in order to enact expertise in situations where it is needed (such as interacting with other professionals in the same field). The drawback of using jargon can be best viewed within the context of doctor-patient relations where the relationship is one of expert-layperson. Too much jargon can be confusing to patients and may lead to adverse consequences such as misinformation or the resistance of patients to follow “doctor’s orders.” However, not using “enough” jargon may create the idea that professionals do not have a specialized knowledge. This is a scenario where individuals do not have access to the same discourses, therefore it is important to find “a happy medium,” wherever that may lie.

4.4 Expert Knowledge

There is a colloquial saying that goes “you can talk the talk, but can you walk the walk?” which holds quite a bit of weight in this study. Descriptions of credentials and use of jargon can only construct (or enact) expertise to a certain extent. Utilizing knowledge learned through institutions is also an enactment of expertise. During the interviews, several respondents discussed the creation of new assessment techniques in order to provide more effective treatment. The following example showcases the culmination of what I consider to be a well-rounded example of an enactment of expertise:

**I1:** So to begin with, can you just give me a brief sketch of your areas of clinical and research expertise?

**R3:** Well, specifically, it’s, I an inventory, which is got over 525 peer-reviewed journal publications. So quality of life is something that I’ve been spending a lot of time on between the past 25 years. More specific to
pediatric pain, I started doing pediatric pain research when I was doing my postdoc at [university], a lot, in the last 1970s. So I developed a [pediatric questionnaire] in the early 1980s and particularly in pedi-, in kids with junior rheumatoid arthritis, and really spent a lot of time developing conceptual models for pain, pediatric pain, in the 1980s.

These new scales and techniques were developed out of the performance of uncertainty - a challenge to expertise. For example, one respondent states that:

R9: The patient’s life gets bundled into their response, that’s problematic, and that makes for a very messy measurement…so how do we use what looks like an identical metric across different situations, and I don’t think it lines up well, and I think that’s part of the challenge of this whole field.

By having uncertain experiences and moments when traditional methods leave them at a loss for answers, the respondents had been forced to use their specialized knowledge to create new methods of assessment. Fortunately for patients, researchers and clinicians alike, this should not be taken in vain, considering that new ways of thinking (and ultimately acting) are derived from these uncertain experiences.

The above examples show the respondent utilizing jargon, discussing their credentials, and utilizing expert knowledge, thereby enacting expertise. The following figure I created shows the relationship between the various discursive resources I have brought to light and how they can be connected to create enactments of expertise. What it comes down to is what kinds of discursive resources are utilized in specific contexts and how they enmesh together. They are often mundane taken for granted but that’s the point of anthropology – to study the everyday human experiences and how they shape our lives.
Thus far I have established evidence of enactments of expertise and will now focus on how discursive psychology allows for the understanding (so to speak) of a subjective experience such as pain and another’s mental state. Edwards and Potter focus on “mind and reality,” which is “how people deploy common sense notions of an ‘external’ reality as a kind of setting for, and evidential domain for inferences about, a range of mental states and personal characteristics” (2005: 243). The respondents in these interviews are pain assessment experts. Expertise can justifiably be enacted through discursive resources but how can someone be an expert on
another’s subjective states of mind? Individuals, especially pain assessment experts may think they are expressing others’ inner thoughts when they are describing the pain experience but how can this be so, when it is something so subjective and private.

Mara Buchbinder’s study considers what can be gained by thinking about chronic pain not only as a private experience, but also as a public one that is managed, explained, and understood in deeply rational ways and often in relation to expert knowledge. Scholars have argued that “chronic pain is inexpressible, imperceptible, and alienating, thus unknowable by others” (2015: 2). There are obvious epistemological constraints on comprehending what is happening in the internal states of others. However language is the mechanism that takes pain from a deeply private and unknown experience to a richly described phenomenon (2015: 2).

During an analysis of the interviews, I observed that the respondents attempted to describe their patient’s pain to the interviewers. Buchbinder observed that explaining pain comes with two interrelated problems: pain’s status as an inner experience and the inadequacies of language to fully capture the experience. During the interviews, the respondents tried to give the best representation of pain by citing a textbook definition, pulling from their personal experiences or describing their patient’s pain. For example, one of the respondents described pain as the “achy-wakeys” which means that whatever pain they are experiencing is keeping them up at night. For children who have a limited vocabulary, this was possibly the best representation of their pain. Fortunately there has been a proliferation of adjective-descriptor scales that allow patients (especially younger children) to allow for better assessment and treatment. For example, respondent four was asked if they used a pain scales to give some sort of estimate. They responded: “I sometimes do, it’s not always…I think it doesn’t quite capture it.”
In the interviews the respondents have described their patient’s pain as well as possible, but also have taken those utterances of what kind of pain, where it hurts, how badly it hurts, et cetera, and condensed them into a generalized definition. What happens here is that a private and personal experience becomes public and generalized, therefore losing its significance to patients. One caveat that Sullivan (psychiatrist and behavioral scientist) would make is “how do we know if we are being sincere” and “how can we verify that we are being completely transparent about the nature and extent of our pain?” (2004: 433). This is a genuine concern that appeared in one of the interviews. For example:

**I1:** Okay, alright, so then I, I guess the question “Are there particular behaviors or non-verbal signs that help you understand the quality and severity of pain?” is kind of a loaded one right?

**R3:** Yeah, the kid cries. Does that mean they really have physical pain, or is, has it been reinforced by their family of origin that any little sensation results in them being comforted. And that’s so culturally derived, and so cultural, and, and family-derived, that’s not really a measure of pain, it’s a measure of something else.

Here, the respondent’s concern was a cultural one. They understood that behavioral manifestations are functions of different ethnic groups. Some groups either reinforce or do not reinforce overt manifestations of pain, which is why it is still important to continue utilizing non-verbal aspects and parent proxy but also re-innovating the ways in which pain is assessed. Likewise, a multidisciplinary approach would beneficial for all because researchers from various circles could combine their specialized skills to create better assessment tools through various methods, but not limited to participant observation and interviews.
Chapter 5

Discussion

5.1 Strands of Discursive Psychology

In the introduction, I wrote of three strands within discursive psychology: Foucauldian, ethnomethodological, and a blend of the first two. (Jørgensen and Phillips 2002: 104). The first perspective focuses on “how people’s understandings of the world and identities are created and changed in specific discourses and on the social consequences of these discursive constructions” (Jørgensen and Phillips 2002: 105).

Foucault addresses issues of knowledge such as what it consists of, the evolution of valid knowledge, how it is passed on, what function it has for the constitution of subjects and shaping of society, and what impact specific knowledge has on the overall development of society. Foucault described knowledge as “kinds of contents which make up consciousness and/or all kinds of meanings used by respective historical persons to interpret and shape the surrounding reality” (Wodak and Meyer 2009: 34). In Foucault’s later work, he became concerned with how knowledge was working through discursive practices to regulate the conduct of others; he “focused on the relationship of knowledge and power and how power operates with institutional apparatus and its technologies (techniques)” (Wetherell et al. 2001: 75). Power has the ability to be “constrained and prevented” but can also “produce new discourses – new kinds of knowledge, new objects of knowledge, new practices, and new institutions” (Wetherell et al. 2001: 75).

There is a constant push and pull with regards to how power works in society; it is constantly being established but being taken away at the same time. Power is not an institution, a structure, or possession (no one “has” power) and power is everywhere.
During the interviews, credentials, jargon, and utilization of expert knowledge constructed power. Credentials were stated at the beginning of the interviews in order to establish credibility but also power in the form of prestige. For example, respondent three stated: “I started doing pediatric pain research when I was doing my postdoc at Johns Hopkins, a lot, in the late 1970s.” Jargon was used throughout the interviews as a way to explain respondents’ work but also to establish that they are part of a group of individuals with specialized knowledge and know what they are talking about. For example, when asked about the scales utilized in practice, respondent seven stated “…You know, the McGill, is one, the Brief Pain Inventory is another.” Utilization of expert knowledge came into play whenever the respondents discuss criticisms of traditionally used methods and use what they have learned throughout years of practice and study to create new methods and ideas. For example respondent one stated “That’s mainly where I operate is developing new system assessments or function assessment. You know I do a little work oncology, but not too much, and a fair bit in ocular diseases which is kind of interesting.”

One area of interest was when respondents stated that they introduced and utilized self-reports and parent proxy in order to elicit more information. Self-reports and parent proxy allow the patient and their family to become involved in the management process. The ideal “medical interview” integrates the patient-centered and physician-centered approaches where the patient leads in areas where he/she is the expert (symptoms, preferences, concerns), and the doctor leads in their domain of expertise (details of diseases and treatment) (Ong et al. 1995: 903-904). By incorporating the patient’s voice, they are no longer “powerless” and maintain some control over their treatment plans during the interactions with their doctor. In Hogle’s (2002) study, she argues that there are constant alliances being made at the same time contestations are also being
made (p.277). It is here that expertise is negotiated, challenged, and validated (2002: 298). Because of the need to integrate the patient’s voice into the management process, the pain expert’s expertise is being challenged because their knowledge is no longer the sole opinion being relied upon. However, their expertise is also being validated because they understand the need to incorporate the patient’s voice, which means they are utilizing their expert knowledge. For example, respondent four worked with his patients to help them change the language they used to describe their pain in order to help others have a better understanding of what they are experiencing:

I2: Right, so that’s part of that social, peer, and how they explain things.

R4: Oh and we sometimes rehearse what they are going to say, this is probably more younger kids, but what they going to say when someone asks them why they’ve been gone from school for so long, or ah… and they’re afraid that person is meaning that they shouldn’t have been gone or whatever, so we’ll rehearse some statements about how to explain their pain.

By incorporating the patient’s voice with their own, the pain assessment experts understand that there are social hardships that come with the pain experience. There is a constant push and pull between the desires of the pain assessment experts and the patients. Nevertheless, they find common ground on which to approach the pain experience, one where expertise can remain enacted but can be a shared experience.

The second strand in discursive psychology draws upon conversation analysis and ethnomethodology. The study I have conducted is one in discourse analysis, only similar to conversation analysis in that they both allow for researchers to analyze functional and sense-making properties of language. The purpose of this strand is to analyze everyday conversations not set up by a researcher, to allow for a more naturalistic study. However, semi-structured interviews, like the ones used for this study, work almost as well; semi-structured interviews
allow for a somewhat natural conversation to take place, but the researcher’s goal is simply to
make sure everything has been covered (which is why the interviewers asked additional
questions not found in the original list). This perspective theorizes and empirically explores
identities as “resources that people enlist to accomplish the business of talk” and the focus is on
the ways in “which particular identities are used on talk in a specific context to perform social
actions such as legitimizing a particular attitude” (Jørgensen and Phillips 2002: 49; 109).

The identities on display in the interviewers are those of physicians and researchers.
Having this type of identity comes with certain responsibilities, such as acting the role of an
expert within their field. Deploying the term “expert” to describe individuals within the medical
profession is an effective way of drawing boundaries around who does and does not count as
legitimate members of that category (Antaki and Widdicombe 1998). Boundaries are what
separate the expert from the lay-person and one of the most pervasive boundaries comes in the
form of language (for example, how one speaks about a certain topic).

The third strand is a synthesis of the two strands that “treats identity as a product of
specific discourses and as a resource for accomplishing social actions in talk-in-interaction”
(Jørgensen and Phillips 2002: 110). Wetherell and Potter’s approach has been central for the
development of discursive psychology. They view discourses as “‘interpretive repertoires’
(broadly discernible clusters of terms, descriptions and figures of speech often assembled around
metaphors or vivid images) [Wetherell and Potter 1992: 90] that are used as flexible resources in
social interaction” (Jørgensen and Phillips 2002: 107). This perspective does not wish to
categorize people but rather to identify the discursive practices through which the categories are
The aim of this study was not to categorize the individuals I have analyzed, but to examine the discursive practices researchers and physicians use to construct their expertise. We have assigned the label of expert to physicians and researchers based solely on the fact that they fill a social role of someone who should be an expert but rarely do we think about what makes them an expert. We should study the language they use because it is helpful in understanding their available discursive resources learned through training and how they are utilizing them in specific contexts. More so, individuals give meaning to experiences by virtue of the words available and discourses create a world that looks true/real for the speaker. The way the researchers and physicians construct pain and the pain experiences of their patients is what they know to be true through experiences.
Chapter 6
Limitations, Conclusions, and Implications for Further Research

6.1 Significance of Study

An examination of the literature showed that a specific study such as this had not been undertaken. Several studies had been conducted on the construction or enactment of expertise mostly from a cognitive psychology standpoint. Some literature from an anthropological perspective was available, but none with this specific focus in mind. Nevertheless, the anthropological literature provides a basis for understanding expertise from a discursive standpoint and provides some methodological basis for how new studies can be conducted.

Incorporating Wetherell and Potter’s focus on the third strand of discursive psychology was useful in this study because it allowed me to see how individuals categorize themselves and others as a discursive practice. Not only did discursive psychology provide a methodological basis for the study of expertise but Wetherell and Potter’s synthesis of the two strands helps researchers understand how people construct their understandings of the world through social interactions and how these understandings work to understand social organizations created through speech and interaction (Jørgensen and Phillips 2002).

6.2 Implications for Further Research

In future studies, it is advisable to conduct discourse analysis of expertise through interviews performed by the researcher because I neither conducted nor transcribed the interviews. The interviews were conducted by two PhD-level individuals and transcribed by research assistant. It is important for investigators to conduct as well as transcribe the interviews because they will have the ability to gauge body language and tone, but also make sure that
during the transcription process nothing is left out. Additionally, it is suggested that all interviews are conducted by the same individual in order to maintain consistency. Interviews that focus on a particular population (such as children with chronic pain) should be conducted with experts whose experience is with that group.

While a discourse analysis allows readers to see common themes as was the case with this study, this is not to say that enactments of expertise cannot be studied in other ways. I suggest the inclusion of scholars from various disciplines to develop a more concrete methodology of studying expertise. I also suggest that scholars continue this study and examine how expertise is enacted in various scenarios. A good example of a discourse-centered ethnographic study of expertise would be similar to that of Stephanie Sadre-Orafai’s work in the fashion industry. A crucial element that makes her work ethnographically sound and is one of the hallmarks of anthropology is participant-observation. Participant observation entails “embedding oneself in the everyday lives and practices of a group of people while observing what they do, talking to them about it, and doing it alongside them over an extended period of time” (Sadre-Orafai 2016: 104) The goal of participant observation is to “capture the meanings and textures of their everyday experiences” (Sadre-Orafai 2016: 104). Conducting interviews to discover the ways in which experts enact their expertise uncover quite a bit about the discursive resources put into play, but a long participant observation period would uncover more – like how experts speak to other experts in the same field, how they speak to patients and parents but also how they act and speak when they are not in situations that call for them to enact expertise. One of the key points made by Dominic Boyer was to humanize the expert. While experts are performing a social role, they are also enmeshed in all the complexities anthropology recognizes human life to entail (2008: 45). Participant observation would allow anthropologists to discover the richness of
lives that occur outside of institutions where performing expertise would be required and find that there is more to individuals than we can see through solely interviews and questionnaires.

6.3 Conclusion

Expertise has been examined from a cognitive psychology perspective and has been the dominant view of the subject. It argues that expertise is something that people possess. From an anthropological standpoint, the “key informant” always been utilized to gain inside knowledge of a particular topic, but literature about them has not come to fruition until recently. Anthropologically, expertise is something that is enacted and how it is performed is through language. In order to study the discursive nature of expertise, researchers utilize discourse analysis to examine texts for themes and patterns (as well as specific language used, as would be the case with jargon). For this study, I have conducted a discourse analysis of ten interviews with experts in pediatric pain. Credentials, language, and expert knowledge have shown how expertise was enacted and these factors contribute to the larger “issue” of the deconstruction and reconstruction of an expert’s power. A discourse analysis makes it possible for readers to weigh the practical consequences of different discourses and to show the problems and possibilities created by their existence (Talja 1999: 474). Discourse analysis is commonly used in discursive psychology and views language as something that constitutes experiences (Jørgensen and Phillips 2002: 102). By performing a discourse analysis on these texts, I found that expertise was enacted through the use of jargon, the statement of credentials, and the utilization of expert knowledge. I also found the third strand of discursive psychology, utilized by Potter and Wetherell, was most helpful for placing this studying within a suitable framework. Physicians and researchers in this study enact expertise with their talk and deploy several discursive resources (which I have listed above). I implore researchers of the social sciences to continue to
undertake the task of discovering more of the discursive practices of experts. If we are utilizing experts for our ethnographic research, why not write about what makes them our experts and help expand the discursive literature of said individuals.


These interviews were conducted by interviewer 1 and are noted in the text as I1.

<table>
<thead>
<tr>
<th>Respondent 1 (R1)</th>
<th>Credentials</th>
<th>Jargon</th>
<th>Application of Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>National projects</td>
<td>Psychometric; proxy; physiologic</td>
<td>Critique of current pain scales; development of new scales</td>
</tr>
<tr>
<td></td>
<td>PhD and postdoc work</td>
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<tr>
<td></td>
<td>Research on behavioral medicine</td>
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<td></td>
<td>Focus on quality of life</td>
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<tr>
<th>Respondent 3 (R3)</th>
<th>Credentials</th>
<th>Jargon</th>
<th>Application of Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Psychometric; nocicpetive; longitudinal</td>
<td></td>
<td>Critiques of pain scales; development of conceptual models</td>
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<th>Respondent 5 (R5)</th>
<th>Credentials</th>
<th>Jargon</th>
<th>Application of Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>National projects</td>
<td>ISP; gold standard of pain assessment; proxy; visual analog scale</td>
<td>Development of online diary and self-management techniques; working with other experts to develop core domains</td>
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</tr>
<tr>
<td>PhD and postdoc work</td>
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<tr>
<td>Research on behavioral medicine</td>
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<tr>
<td>Focus on quality of life</td>
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<th>Respondent 7 (R7)</th>
<th>Credentials</th>
<th>Jargon</th>
<th>Application of Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recall time; psychoimmunology; psychoendocrinology; physiological; McGill Pain Questionnaire</td>
<td>Development of new methods for self-report and techniques used in surveys</td>
<td></td>
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<tr>
<td>Respondent 9 (R9)</td>
<td>Credentials</td>
<td>Jargon</td>
<td>Application of Knowledge</td>
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<tr>
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<tr>
<td>VAS pain intensity measure; EMA readings; Keith’s behavior rating system; PROMIS; AIMS</td>
<td>Development of new techniques (daily readings); focus on functioning and behavior</td>
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I have combined the credentials of all respondents in order to disguise their identities.
APPENDIX B

These interviews were conducted by interviewer 2 and are noted in the text as I2.

<table>
<thead>
<tr>
<th></th>
<th>Credentials</th>
<th>Jargon</th>
<th>Applications of Knowledge</th>
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<tbody>
<tr>
<td>Respondent 2 (R2)</td>
<td></td>
<td>IASP; gold standard; FACES scale; visual analog scale; social communication model; pediatric pain profile; functional disability scale; social communication model</td>
<td>Publications of changing views in knowledge of pain; clinical trials</td>
</tr>
<tr>
<td>Respondent 4 (R4)</td>
<td>Backgrounds in assessment and management</td>
<td>Children’s depression inventory; MASK; pain beliefs questionnaire; pain response inventory; Dot probe; biofeedback; PROMIS</td>
<td>Utilization of scales in research; understanding pain triggers based on up-to-date information</td>
</tr>
<tr>
<td>Respondent 6 (R6)</td>
<td>Work in pain clinic (with children and adults with different pain diagnoses)</td>
<td>Idiopathic; visual analog scale; numerical radian scales; proxy; BAPQ</td>
<td>Helping children change their language about pain and helping to generate personal goals</td>
</tr>
<tr>
<td>Respondent 8 (R8)</td>
<td>Part of focus groups Published</td>
<td>PROMIS; VAS; equal interval scales; proxy; TMD trial</td>
<td>Development of techniques for self-efficacy (i.e. distraction)</td>
</tr>
<tr>
<td>Respondent 10 (R10)</td>
<td></td>
<td>IASP; psychosocial; CDI; patellofemoral syndrome; VAS scale; MFIQ/FIQ (scale); self-efficacy</td>
<td>Physical observations (gait or preferential usage); focus on impact (avoidance of activities); helping increase self-efficacy</td>
</tr>
</tbody>
</table>

I have combined the credentials of all respondents in order to disguise their identities.