Behavioral Changes

In Pain & Depression

How fair is our assessment?

- **Further complication of an already complicated situation…**
  - **To tease out accurate feelings/sensations while in an intense affective state**
  - **Challenge: we don't have agreed upon benchmarks for "sadness"…**

A Conundrum

- **Pain and Depression can look so much alike!**
- **We may not be any good at making a definitive finding of depression or pain.**

Complication of I/DD

- **Examples of additional complications…**
- **What are the language skills?**
- **Are there cognitive/perceptual difficulties?**
- **What is the individual's proprioceptive awareness of pain?**

Assessment challenges

- **Even when a person has verbal language skills, observers have to be keyed into behavioral indicators.**
- **People with I/DD have learned that their ways of reporting their experience(s) may be disregarded.**

Assessment challenges

- **Case example:**
  - **Female, 40's; deteriorating over months → lots of medical evaluations = no etiology!**
  - **Learned she had specific physical findings**
    - **Embarrassed to reveal, "too personal" {uterine}**
    - **Didn't think anyone would listen**
  - **Pain ever-present; Disregard ever-present; Anxiety and old ways of feeling.**

- **Pain and depression (in combination) move people toward regression**

Assessment clues

Assessment clues

- **Everyone has observations & has a voice**
- **Need to learn to articulate their observations about pain, depression, anxiety…**
- **Direct care staff – often have greatest opportunities for direct observations, and have the least confidence**

Frequency of symptoms

- **Typical "behaviorist"**
  - **Teaching residents of institution; some expressive language abilities, some receptive language capabilities.**
  - **Taught emotional states: happy-sad-afraid-angry.**
  - **What feel most of time? Sad = 80%.**
- **Other behavioral consultant**
  - **Same emotional state training, more contextual**
  - **What feel most of time? "mad" = 75%**

- **Pain interrupts concentration; attention**
- **Pseudo-dementia**
- **Decreased cognitive activity**
- **Decreased social interactions**
- **Withdrawal**

Alteration in attention, energy

Activities change…..

Changes in sleep

- **May attempt to sleep more**
  - **Taking naps to deal with fatigue**
  - **Avoid situations that are painful, induce sadness**
- **Interrupted sleep patterns**
  - **Accompanied by increased irritability when awake**
- **Change in sleep position**
  - **Sitting more upright**

Guarding

- **Areas vulnerable or hurting**
- **Prevent access**
- **“Splint” to prevent change/possible increase in pain**

Pattern Changes

- **A change from typical patterns is reason to start looking further**
- **Possible associations:**
  - **Hitting head ~ headache, earache**
  - **Avoiding lights/noise ~ migraine**
  - **Biting fist ~ GERD, stomach discomfort**
  - **Avoiding foods ~ throat problems, GI pain**
  - **Increase carbohydrates ~ depression, fatigue**

- **Can mask many symptoms/conditions**
  - **Increased anxiety**
  - **Despair**
  - **Chronic pain**
  - **“a good offense is your best defense”**

Irritability = masquerader

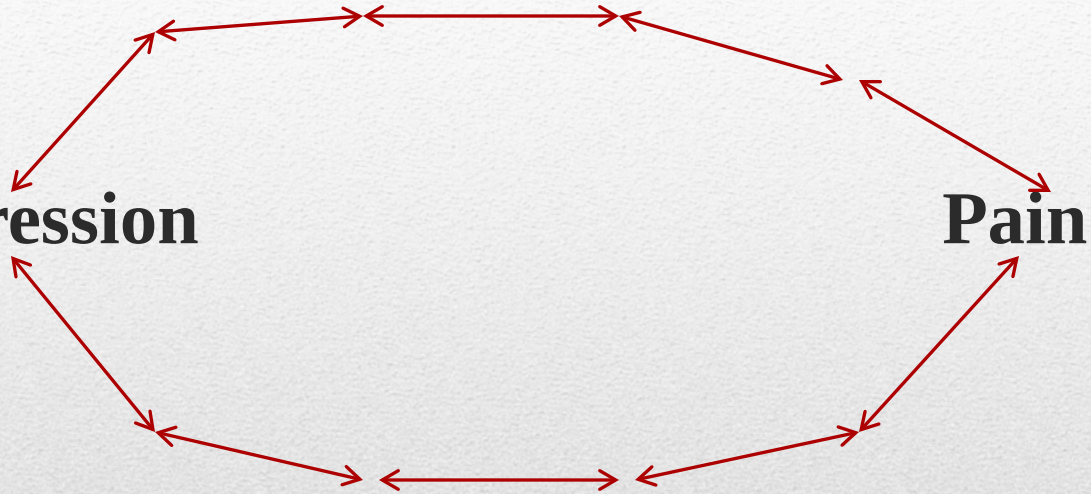
Pain Disappears

- **When have chronic, severe pain – perception of pain is altered and may be ignored**
  - **Once no longer acute, chronic pain can become the “new norm”**
- **If chronic pain is removed, what is this new state?...May not be recognized as pleasant.**

Sadness may be ok

- **Withdrawal is a form of rejuvenation of energy and spirit**
- **Closeness to people who have died**
- **Honest awareness of losses**
  - **Hope for future engagement in living**

- **Depression**



Pain

Feed-forward loops

Adapt your skills

- **Importance of asking questions**
- **Everyone has experience**
- **Develop a way to learn what the patient/client means by their actions**
  - **“that’s how they’ve always been”**

--- DOESN’T CUT IT!!!