

**Down But Not Out:
Depression & Pain
Assessment**

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Overview

- **Signs and symptoms of depression**
- **Signs and symptoms of pain**
- **Complications in pain and/or depression**
- **Supports for people with depression
and/or pain**

What are we looking for?

- **Changes**
 - Acute!
 - Chronic...
- **Persisting symptoms**
- **Differentiating habits from symptoms**

What Behaviors Suggest Pain?

- **Direct observation or history from caregivers**
 - **Assessment by proxy—nursing assistants or family members or regular caregivers**
- **Observe during movement (walking, morning care, transfers)**
- **Unusual behavior should trigger assessment of pain**

Pain Indicators

—at rest and with movement

Vocal complaints: Non-verbal (Expression of pain, not in words, moans, groans, grunts, cries, gasps, sighs)

Facial Grimaces/Winces: (Furrowed brow, narrowed eyes, tightened lip jaw drop, clenched teeth, distorted expressions)

Bracing: (Clutching or holding onto side rails, bed, tray table, or affected area during movement)

Feldt, K. S. (1996). *Treatment of pain in cognitively impaired versus cognitively intact post hip fractured elders*. (Doctoral dissertation, University of Minnesota, 1996). Dissertation Abstracts International, 57-09B, 5574.

Feldt, K. S. (2000). *Checklist of Nonverbal Pain Indicators*. Pain Management Nursing, 1 (1), 13-21.

Pain Indicators

—at rest and with movement

Restlessness: (Constant or intermittent shifting of position, rocking, intermittent or constant hand motions, inability to keep still)

Rubbing: (Massaging affected area)

(In addition, record Verbal complaints)

Verbal: (Words expressing discomfort or pain, "ouch" "that hurts"; cursing during movement, or exclamations of protest "stop"; "that's enough")

Less-obvious Pain Indicators

- **May be attributed to psychosis or dementia**
 - **Aggressive behavior**
 - **Fidgeting**
 - **Noisy breathing**
 - **Rapid blinking**
 - **Rigid, tense body posture**
- **Untreated pain can increase confusion**
 - **Patients on opioids at risk for dose being cut**

Assume Pain is Present

- Assume Pain is Present
- Is there a painful stimulus
 - Surgical incision
 - Fracture
 - Painful procedure
 - Any tissue damage
- If so, treat
 - Observe

Pain Indicator for Communicatively Impaired Children (PICIC)

Most common cues identified by 67 parents:

- **Screwed up or distressed looking face**
- **Crying with or without tears**
- **Screaming, yelling, groaning, moaning**
- **Stiff or tense body**
- **Difficult to comfort or console**
- **Flinches or moves away if touched**

Ref: Stallard P, et al: Pain 98(1-2):145-149, 2002.

Common Pain Behaviors in Cognitively Impaired Elderly Persons

- **Facial expressions**
- **Verbalizations, vocalizations**
- **Body movements**
- **Changes in interpersonal interactions**
- **Changes in activity patterns or routines**
- **Mental status changes**

Organizing Your Observations

- **J = judgment**
- **O = orientation**
- **M = memory**
- **A = affect**
- **C = cognition**
- **C = communication**
- **S = somatics**

Depression:

Some undisputed facts

- **About 1 in 5 adults over age 18 have significant depression**
- **Depression is one of the 10 leading causes of disability in the United States**
- **Depression is frequently undiagnosed**
- **Depression is more likely to be overlooked in those with developmental delays**

Causes of Depression

- **Biological vulnerability**
- **Psychological vulnerability**
- **Medical illnesses--stroke, heart attack, Parkinson's disease, cancer, thyroid disease, etc.**
- **Environmental factors--loss, poverty, victimization**

Remember:

- **Depression is a *treatable* condition in the general population**
 - **It is also treatable among those with developmental disabilities**

Depression According to DSM-IV TR and ICD-10

---- subject to change

- **Five or more of the following symptoms have been present during the same two week period and represent a change from previous functioning**

Symptoms

- **Depressed mood (feeling sad or empty) most of the day, nearly every day, by client report or by observation.(Patient is tearful)**
- **Irritable mood is commonly seen in children, adolescents, and people with developmental disabilities**
- **Markedly diminished interest or pleasure in most activities**

Symptoms

- **Significant weight loss when not dieting or weight gain; significant change in appetite nearly every day**
- **Insomnia or hypersomnia nearly daily**
- **Changes in motor behavior: agitation or slowing—observable by others**
- **Fatigue or loss of energy**

Symptoms

- **Daily feelings of worthlessness or extreme guilt—may be delusional or have hallucinations**
- **Diminished ability to think or concentrate; indecisiveness**
- **Recurrent thoughts of death or suicide; recurrent thoughts of suicide plan**
- **Suicide attempt**

Vegetative Symptoms

- **Sleep**
- **Appetite**
- **Weight**
- **Energy**
- **Bowel functioning**
- **Sexual appetite**

Symptom Summary

- **Symptoms cause clinically significant distress or impairment in usual areas of functioning**
- **Symptoms are not due to effects of substance or general medical condition**
- **Not better accounted for by Bereavement**

Types of Pain

- **Nociceptive vs Neuropathic**
- **Physiologic vs pathophysiologic**
- **Acute vs chronic**
- **Malignant vs nonmalignant**
- **Pain syndromes**

Nociceptive Pain (Acute Pain/ Physiologic Pain)

**Pain resulting from activation of
primary afferent nociceptors by
mechanical, thermal or chemical
stimuli**

Neuropathic pain Pathophysiologic Pain

- **Pain resulting from damage to peripheral nervous or central nervous system tissue or from altered processing of pain in the central nervous system**

Neuropathic —Pathophysiologic Pain

- **Results in cellular changes that occur in peripheral and central nervous systems**
 - **Results in sensitization to the transmission of pain signals**
- **Neuroplasticity—ability of neurons to change their structure and function**
- **Peripheral and central sensitization—response to stimuli is increased**

Result of Central and Peripheral Changes

- **Hyperalgesia**
 - **Primary hyperalgesia**
 - **Secondary hyperalgesia**
- **Allodynia**
- **'wind-up' of C fibers** (a phenomenon of progressively increased neural response to repeated noxious stimuli)

The ABCs of PainS

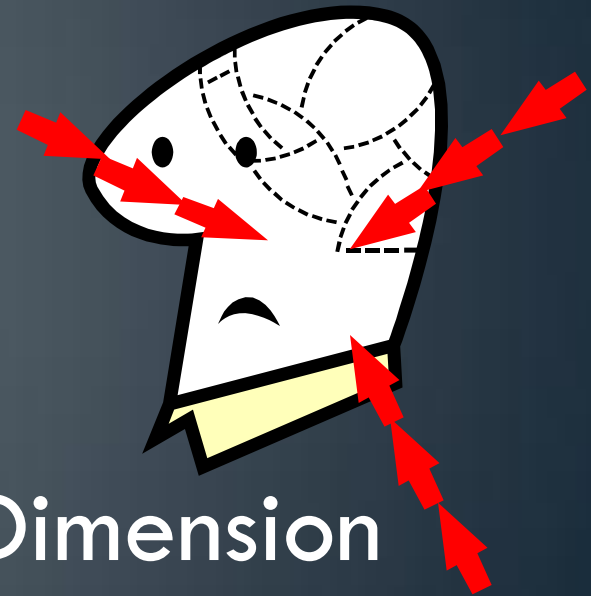
Affective Dimension

Behavioral Dimension

Cognitive Dimension

Physiological-Sensory Dimension

Spiritual Dimension





Treatment Approaches

- **Strategies for assessment of depression**
 - **Support**
 - **Motivation**
 - **Change in interests**

Emotional Release

- **Music, art**
 - **Creative expression; mood expression**
- **Social expressiveness**
 - **Is there a chance to share?**
- **Friendships**
 - **People who listen & care**
 - **Reciprocity**

Emotional Release

- **Being valued as a productive member of society**
 - **Greeted in public**
 - **Team (social) fun/joy**
- **Work – paid or volunteer**
- **Community membership**

Interpersonal connection

➤ Individual Therapy

- Supportive

- Psychodynamic

- Rate matches individual's capacity for intensity

➤ Group Therapy

- Gender; Specific problem

- Size, frequency, safety

Interpersonal connection

➤ Behavior Therapy

- DBT: structured assignments; stepwise; relearning the personal meaning of symptoms
- CBT: particularly helpful for anxiety disorders

➤ Art Therapy

- Expression within context; use of different media; therapist present!



Physiologic Factors

➤ Diet

- Sugar; caffeine; sedatives...

- High-low see-sawing creates depression, amplifies pain

➤ Food intake

- Frequency; balanced; interesting

Physiologic Factors

- **Medical conditions**
 - **Chronic pain conditions**
 - **Skeletal, muscular**
 - **Oxygenation**
 - **Secondary depression**
 - **Thyroid functioning**
 - **Energy metabolism**
 - **Obesity**
 - **Mobility; gravitational effects**
 - **Cancer**

Fitness effects

- **Regular aerobic exercise**
 - **Oxygen utilization, circulation**
 - **Strength, balance**
 - **Outlook**
- **Relaxation techniques**
 - **Visualization, desensitization**
 - **Meditation**
 - **Yoga, stretching**

Sleep issues

- **Sleep hygiene**
 - **Decrease stimulation before bed**
 - **Avoid awake activities in same location**
 - **Lighting: dim – dark; enough for orientation when day/night cycles easily confused**
- **Regular, sufficient sleep**
 - **Individual variability**
 - **Broken periods as increase in age**
- **Assure no sleep apnea**

Therapeutics

- Medications
 - Effects overlap
- Procedures
 - Depression
 - Pain: TENS
- Alternative therapies

Medications & Treatment

➤ Antidepressants

➤ SSRI, SNRI, TCA, MAOI

➤ ECT, DBS, TMS

➤ Anxiolytics

➤ BZD, SSRI, a-blocker, b-blocker

➤ Alcohol, opiates

Medications

- **Augmenting strategies**
 - **Combinations of medications**
 - **Adding lithium, antipsychotic, anxiolytic medications**
 - **Use of CAM**
(complementary and alternative medicine)

Alternative therapies

- Acupuncture
- Massage therapy
- Aroma therapy
- Herbal therapy
- Ayurvedic therapy



How do we approach treatment?...

- **Context**
- **Functionality**
- **Integrating preferences and “what’s good for you”**

Definition of Pain

“Unpleasant sensory and emotional experience arising from actual or potential tissue damage or described in terms of such damage”

Medication Management-- Analgesics

Analgesics
Three Types

```
graph TD; A[Analgesics Three Types] --- B[Nonopioids (acetaminophen, NSAIDS)]; A --- C[Opioids (mu agonist, agonist-antagonist)]; A --- D[Adjuvants (multiple examples) & Anesthetics];
```

Nonopioids
(acetaminophen,
NSAIDS)

Opioids
(mu agonist,
agonist-antagonist)

Adjuvants
(multiple examples)
& Anesthetics

Acetaminophen

- Mechanism of action is not certain
- Probably centrally acting—?cox-3 inhibitor
- Acetaminophen toxicity
 - Hepatotoxicity
 - Toxic metabolite (NAPQI)
 - Several other mechanisms lead to hepatotoxicity
 - Mechanism not completely understood
 - Nephrotoxicity >4g/day for long periods
 - Uncertain cause
 - May be caused by activity of NAPQI in renal microsomes
 - Increase frequency to 6-8 hrs in renal failure

NSAIDS

- **NSAIDS—Antiinflammatory, antipyretic, analgesic**
- **Mechanism of action—prostaglandin inhibition by way of COX-1**
 - **Prostaglandins**
 - important in maintaining integrity of GI and duodenal mucosa
 - Important in modulating renal plasma flow
- **NSAIDs inhibit formation of thromboxane—effecting platelet aggregation**
- **Use with caution in pts. with history of asthma**
 - Inhibits prostaglandin E—responsible for bronchodilation

Pain Mechanisms: The “Pain Process”

- The neural mechanisms by which pain is perceived involve a process that involves four major steps:

1. Transduction

2. Transmission

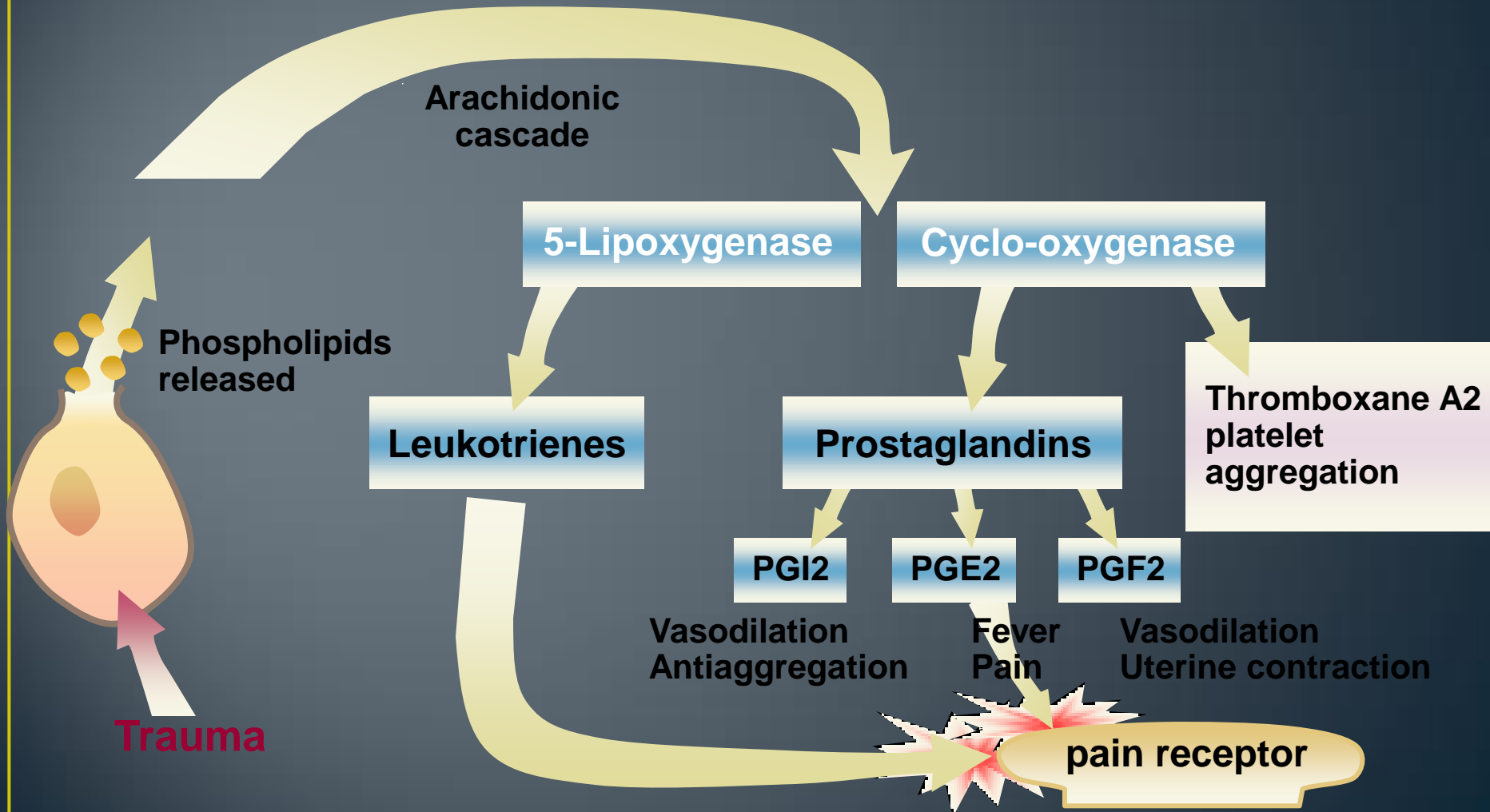
3. Modulation

4. Perception

4

major steps

Transduction: Nociceptive Chemical Stimuli



Class	Generic name	UAD	Brand name
Propionic acids	Naproxen	500 mg initially- followed by 250mg q6-8h	Naprosyn, Anaprox, Alleve
	Flurbiprofen		Ansaid
	Oxaprozin		Daypro
	Ibuprofen	400-800mgQ6-8h	Motrin
	Ketoprofen	25-75 mg Q6-8h Max 120mg/d	Orudis, Oruvail
	Ketorolac	(parenteral)	Toradol
Indoleacetic acids	Sulindac	200mg Q12h	Clinoril
	Indomethacin	25-50mg q8h	Indocin
	Etodolac	200-40mg q6- 8h	Lodine

Class	Generic name	UAD	Brand name
Phenylacetic acids	Diclofenac	50 mg/q8h	Cataflam, Voltaren
Salicylic acids (nanacetylated)	Salsalate Choline magnesium trisalicylate	1000-1500 mg/q12h 1000-1500 mg/q12h	Disalcid Trilisate
Naphthylalkanone	Nabumetone	1000-2000 mg/day	Relafen
oxicam	Piroxicam		Feldene

COX-2 Inhibitors

- **May have fewer GI effects than COX-1 inhibitors**
- **Should be avoided in patients with creatinine clearance <30ml/min**
 - **Carry same risk as traditional NSAIDs**
- **Celecoxib—Celebrex**
 - **UAD=100-200 mg q12h max=400 mg/d**

Characteristics of Opioids

- **No ceiling effect**
- **Usually no end organ damage with chronic use**
- **Metabolized by the liver**
 - **Metabolite toxicity**
 - **Avoid using meperidine and propoxyphene**
- **Excreted by the kidney**
- **Cause tolerance and physical dependence**
- **Reversible with an antagonist**
- **Bind to opiate receptors— μ , κ , δ**
- **Tolerance to side effects except constipation**

Pharmacokinetics

- **Absorption**
 - **Drug solubility—lipophilic vs hydrophilic**
- **Bioavailability**
- **First pass Effect**
- **Solubility**
- **Metabolism** → **metabolites, active or inactive**
 - **Prodrugs, e.g. codeine metabolized by CYP450 enzyme CYP2D6**
- **Half-life, clearance, steady state and accumulation**

Pharmacodynamics

- **Opioid responsiveness**
 - **Efficacy—extent to which a drug “works” (as compared to others)**
 - **Potency—the dose of a drug required to produce a specified effect, e.g. hydromorphone > potency than morphine**
 - **Opioid responsiveness—affected by age, organ dysfunction**
- **Tolerance—rule out disease progression; compliance to tx**
- **Physical dependence**



Less than perfect

- **Multiple causes simultaneously**
- **Medication interactions**
- **Progressive decline or degeneration**
- **Identify what can be changed or improved**

Mores, Morals, and Morale

- **Social expectations**
 - I/DD does not predict experience
 - Appropriate standards (+/-)
- **Values and ethics**
 - Respect, boundaries, supports
 - Maintain safe practices
- **Keeping engaged**
 - Abiding with a person in pain
 - Self-care & self-awareness

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.**

Assessment clues

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

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%**

Alteration in attention, energy

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

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**
- **“Splint” to prevent change/possible increase in pain**
- **Prevent access**

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**

Irritability = masquerader

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

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**

Feed-forward loops

- **Depression**

Pain



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!!!

*Thank you for your
attention ~*

