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IDD Webinar Pain Management Module 3

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Good afternoon my name is Lisa Zimmermann and I am from Albany New York. Thank you for joining today's webinar on pain in people with developmental disabilities. Module three about pain management. This profession with the relevant webinars which are presented in connection with social workers, counselors, registered nurses and other healthcare professionals supported with the Medicare and Medicaid coordination office. And the centers for Medicare and Medicaid services or CAS to ensure beneficiary enrolled Medicare and Medicaid have access to treatment, high-quality healthcare and full services in both programs. Since but is a goal for more integrated delivery of Medicare with the enrollees were developing technical assistance and actionable tool based on successful innovation and care modules. Such as this webinar series. To learn more about current efforts and resources please visit the resources for integrated care at www.resourcesforintegratedcare.com for more detail. Just a little housekeeping before we get started, your microphone to be made it up the presentation however there will be a question-and-answer portion at the end of the webinar, so to if you do have a question please click the raised hand future of the control panel on the right-hand side and you will see to unmute. You can also type your question into the chat window administrator what also have the polling questions throughout the presentation. So that you can submit your answers at that time. At the conclusion of the webinar, the top of appear in the browser prompting you to complete the evaluation. It is required that in order to receive three contact hours each from the Michigan social work continuing education collaborative and Association and the national Association of social workers and the national Board of certified counselors. If you are unable to complete the survey with the webinar will receive an e-mail tomorrow with the link to complete the survey at that time. If you had not already done so.

At this time all like to introduce our instructors to you. We have Dr. Eileen Trigoboff, clinical nurse specialist and with on therapy practice in New York and are the director of program evaluation at the Buffalo psychiatric Center in Buffalo New York. Dr. Eileen Trigoboff has a doctorate in nursing science and is board certified in four areas as well as being a national and international speaker and consultant on a wide variety of clinical, research and professional topics. Dr. Eileen Trigoboff is an author or co-author and contributor to journal articles as well as it editorial for professional journals. Dr. Eileen Trigoboff is a partner and independent research group and provides expert test money and reports from around countries. She's active in community vendors including clinical settings and family support groups. She also serves with symptoms and statistical consultants and welcomes numerous professional nursing organizations. Dr. Daniel Trigoboff is a clinical psychologist who specializes in applications and treatment of chronic pain syndromes. He has also worked with other departments as expertise and capacity and behavioral treatment by development, as well as other patient populations.

Welcome to our third installment, which is the treatment and dimensions for pain problems and people with development of disabilities? And we are going to be focusing on pain management and how can we intervene to reduce pain symptoms and to reduce the severity, frequency and very importantly, how

can we intervene to reduce the latest distress. Because as we could all well imagine, pain produces lots of discuss and the stress can feedback and result in even more of a pain problem. We would like to intervene in this cycle to interrupt it. What we have outline for today's that we are going to be talking about strategies for pain management and the court areas are behavioral strategy and nonpharmacologic. And we deliberately put those two up front, because the pharmacologic strategies, we are going to go over in great detail, but behavioral the nonpharmacologic are much more important. So the pain management for people who have coexisting conditions of developmental disability and say get symptoms, whatever the psychiatric symptoms will go over the major categories. And again talk about behavioral and nonpharmacologic and pharmacologic interventions. When he added psychiatric symptoms to the mix. Then we will talk about the prevention of chronic pain syndromes. Because there's a fair amount that has come out of the research and a clinical practices about how to prevent the chronic pain syndrome that can be so difficult to manage. We're going to talk about the documentation the pain management and how we communicate all of this to the rest of the team to we provide services for and then numbers.

So there are a couple of overall themes in our discussion today of intervention or pain problems with people who are developmentally disabled. And we would say in the field of healthcare, that everybody actually, whether there is a developer to disability are not I'm a has a right to have their pain effectively treated. And this rests on three considerations. Ethically we are all bound according to the ethical standards of our own profession to provide adequate pain management treatment for people who are having problems with pain. The second one would be that the clinical effectiveness of any of the other interventions that we are doing with people who are working is going to be sabotaged if they have an unmanaged or in adequately managed pain problem. And legally, it is encoded in various places in the law, the people we work with have a right to have their pain symptoms effectively. So because of the importance of these responsibilities and put we work with people who are having problems with pain and whether there developmentally disabled or not, we have to consistently, and in an ongoing way, ensure that we are adequately addressing the pain symptoms. And this is going to involve ongoing efforts of training and learning. Staying current in the pain management field and it also involves feedback from the patient and among all of the staff who are working with any particular person. All of the staff involved with the developmentally disabled patient or any patient for that matter are going to have to remain in touch with each other about what is happening with the pain problem and whether something needs to be assessed our reassessed and how the treatment plan working and what motivation make this book modifications can we make was not working as optimally as we had hoped.

So pain is not something that we are all imbued with when we are born. It's a skill and just like any other skill, you have to learn how to do that work Especially because pain sometimes can extend on somebody and create a problem, a new problem for themselves when they have to somehow figure out how to do this. So they have to learn skills, usually from the time they are at a severe disadvantage for learning. Because as we talk about when we did the Nile pathology and also making assessments, when you're in pain it challenges your cognitive functioning. So we are asking people who have pain, there is something new for you to learn while you are having a problem. So it is a new skill set and we have to give some people some room to absorb something with those demands while there are it he challenged the

cognitive and physical way. So some individuals may have advantages in coping with pain. Maybe they have a high pain threshold or something that happened to them and they don't really feel it is acutely of course. Of course there people at the other end of the spectrum were even a very minor paint like it paper cat is a major problem. But to stick with the advantages. There are people with positive attitudes and all of the research shows and consistently for many years the regardless of the source of the pain and regardless of whatever else is going on at that individual, if you have a positive attitude, you going to do a whole lot better with whatever's tossed your way. Then some people have excellent focus and good control over the thoughts and their feelings so these people will be able to respond better to what cognitive behavioral program and they may bill be able to have an advantage in learning new skills because they have group focus. But the rest of us have to learn how to perform these skills even though there may be a disadvantage. So in learning to cope for any learning process maximizes with the advantages of the individual are capitalized upon and their workarounds for any disadvantage that the individual may happen. So for example if we know that somebody has a great deal of visual dependence, they have to say something in order to have it absorbed into the cognitive processes. Then that is an advantage because there are a lot of visual cues that could be used. But the disadvantage would be that there a processing make that is good. So we are going to do a work around and find visual cues for that individual so that we can minimize the disadvantage the person has. And of course we all know the people that have the development of disability regardless of what the diagnosis is, can and do learn how to cope with pain.

So we are going to talk more extensively now about behavioral pain management. That is a particular approach to pain and pain problems. The starts with the foundation as we have been emphasizing in other presentations do that pain is a complex process. And interaction of all of the listed factors in the patient with the cognition and emotion and behaviors. And all of these factors provide possible intervention plans to try to work effectively with people who are having pain problems and who have the bullet mental disability is. -- Developmental disabilities. So when there is a sensory or pain problem it is sometimes possible that the same should function training or retraining could have a positive impact on pain problems. What other factors are involved in pain problems, oftentimes things can debug build with medication. And other excellent check that we will provide greater detail. When there are hard whatever emotional factors involved in the pain problems and are cognitive behavioral interventions and providing people with the opportunity for healing with the pain symptoms. There's use of empathy and extra support. And address those factors. And with our behavioral factors involved, there are behavioral treatment interventions that can be useful. So in this context about what we are talking about with payroll factors is that we find that pain problems and the way that people talk about and complain about pain is affected by the kind of reinforcement that they get So if a person, some way or another and there could be different ways that this could happen by getting positive real force meant -- positive reinforcement with the symptoms they're having with the problem with pain and there may be part of the could happen but we are going to go through a number of different ways that actually that can happen and then there are opportunities to affect those behavioral processes as well. So, general principles of intervening in problem in pain management. We strongly rely on behavioral observations. And we do this because we think from the perspective of behavioral pain management

and behavioral management in general, all behavior has a function. Including behaviors of complaining of pain or demonstrating pain or crying out. All of those behaviors have a function.

Generally, the function is to get something that the person wants more of, or to have less of something that the person does not want. In the case of pain, pain behaviors have the option of seeking to get last pain and more release. We also think that all behaviors are a response to a situation or circumstance or a set of events or something going on in the present environment, just prior to the time that thank you Jen the behavior. So we say that there are antecedents to the behavior. Which means that what comes just before the behavior? And that behavior is a response to the entity. And we said that there are consequences of the behavior. And what is its function. What does this particular behavior get for the person doing the behavior and in the case of pain, what does the developmentally disabled person get in some way or another when they complain of pain or demonstrate the manifest pain. . Even for self-injurious behavior if a person is injuring themselves or cutting himself or herself or burnings themselves restricting the head against the wall or so forth. We think that there are antecedents and factors that come just before the self-injurious behavior of the self-injurious behavior is a response to the things that happened just after the self-injurious behavior which can do with a hint as to what the function of the behavior might be. Whether it is getting attention from staff or providing internal sensations were felt to be needed at that point. So all behavior is a response to what came before and all is a function and it alters what just happened afterwards in some way but the patient with the positive reinforcement.

So, in order to figure out what is the function for the behavior and what is the behavior response to his a behavioral analysis. So we are going to observe very closely the pain complaint and the pain related behavior of the bullet mentally disabled people with whom we are having problem with pain. We will ask what a response is to and what function is it serving. So there was a hypothesis of how can we intervene with this person that we are working to help them alter their behavior or acquire skills or cope more adaptively with the pain problem is that my continue to have it. I would then be designing a plan where the person might be taught the skills or taught to alter their behavior and we may want to give them a lot of the enforcement and praise and pension and positive feedback when they are able to engage in the more adaptive behavior in response to pain. Because this is a complicated process, it's frequent the percent first, design the behavior plan we did not design a plan that looks like it looks when it's fully effective or to say it another way of frequently changes are necessary and try things out with the behavior plan and we can see what is working well and what may not be working quite so well. So we have to expect we will modify the Plan B and plan C as we observe the results of what we're trying to do with the behavior plan.

So as part of the behavioral out analysis of pain or pain behavior, we would like to take a look at how the pain is expressed. Verbally, with words, bulky sounds, facial expressions. Certain kinds of movements or holding a body in a particular way. Increased activity. Under activity, physiological responses like irregular breathing or facial flushing. Differences in the interactions with the person might have with others when here she is in pain. And, we would like to observe furthermore, if there is any anticipatory behavior prior to the experience of pain. So for the example of developmentally disabled person may be scheduled for a medical procedure or the valuation procedure and they might experience some discomfort with the procedure as to do they start indicating that discomfort even prior

to the procedure? Or the person complaining of pain are expressing pain during certain types of activities? And what are those activities? Is the pain expressed after the activity? Is an expressed repeatedly are chronically? And is it associated with certain psychological or even environmental events such as a change in circumstances or fears or startles response or your quality or sadness or depression? Again, when we look at these behaviors, these behaviors to communicate pain, their time to ask a question, what are these behaviors responding to one of the antecedents to the behavior. Then from our observations, what is the function. What do they get? What the communications get for the patients that they may not be currently getting any other way? Frequently, we are going to be focusing on who the pain is experienced with and who is around the person complains of pain. And where they or what are are they doing when they are experiencing the pain. You might notice that these are factors D and I. Environment and interaction in the MESIP framework and that's because we often find that environmental and interactional factors play strong roles and how well a person is doing. Whether developmentally disabled or not and coping with pain. And we might also intervene with environmental interaction treatment plans that are less intrusive than intervening them with a medical issue or psychiatric issue.

So it is important and it becomes important to look at the environment and interactional factors. Both because they can be heavily involved in pain problems and their less intrusive in some ways to intervene with and some of the other factors. So after we do the behavioral analysis of the person's pain symptoms, we want to develop a plan based on the behavioral analysis. And there are some general but suppose about this to manage pain. First about have to be doable and workable for all of the involved people. The developmentally disabled patient. The stuff caregivers. The healthcare providers. Other people who have contacted the person. We all have to understand the behavior plan. Be at some kind of agreement with the behavior plan and how to implement it and be able and willing and ready and have the time to implement them. On an ongoing basis with the pain behavior plan if it will have any chance at all to work. We also have part of the behavior plan, ongoing monitoring. To see how well the plan might work or might not be working. To give a quick example of the behavior plan of this sort, we had a 67-year-old male patient with autism. And he had a problem with shoulder pain. And pressure. So he was being treated with an antidepressant medication that also have some impact on pain symptoms and also the pain medication on a regularly scheduled builds. And this person was in the socialization group that ran from 2 PM until 3 PM. And we noticed over called in on a consult because it's noticed that the shoulder problem seemed to get a lot worse that you could complain that your shoulder hurt or the team at them. Not infrequently that has to leave the group to get an assessment of what is going on.

So he looked at this to the MESIP the environmental sensory interactional and psychological assessment network and then we did the behavioral pain analysis, what is the behavioral response? What is the function? It seemed you did not like the socialization group. That was not a particularly good experience for him. And the function, at least in part of the complaint of pain during the socialization group pretty gets out of the socialization group. So as a part of the behavior plan, we had other groups that were running that was the music group that he liked a lot better so he began to go to the music listening group instead of the socialization group. And we also set up but daily time. Every day at 5:00 he talked to the staff member that he could depend that doing so about what his pain was like that day. So

instead of having the feeling that if he did not complain of pain when it happens and no one would be listening, and he had a daily schedule time to give a report about what was going on with his pain symptoms. We asked everybody and participated in giving him a lot of positive reinforcement but was able to stick with the plan and also made sure that he was getting enough interaction but was not complaining with pain so that this was not the case that the only time you got any significant staff interaction is when he was complaining of pain. All of these interventions were implemented with the frequency of his pain complaints. For the doing the music group or other points in the went way down again. So that the quick example of a behavior plan for somebody. The autism, the depression and the pain problem. Here are some other sample interventions that could be put together for behavior plans. Let's talk about each one. Authorization of accidental positive reinforcement of pain complaints. We listed this first because this happens very frequently. Especially in situations where the person is in a treatment facility or some kind of group home or develop mentally disabled people. Sometimes what can happen in a situation like that is that if the person develops the pain problem then that talks about pain and does that assessment.

So complaining of pain leads to increased staff contact and the receipt of empathy and support? Up the day. Breaks up the boredom and gets everything up and moving is under the control so all of those things can be positive reinforcement and can happen by accident. Because as staff members we have to evaluate and assess what subject complaints of pain. And we are not actually meeting to positively reinforce the pain complaints of focus on the pain. The packet happens. And one of the interventions that is helpful in a situation like that it involves two things. A, interacting more with the person when they're not in pain and not complex that the did not have to complain of pain and more attention to get the interpersonal stimulation. And then if the person complains of pain and we would like to do the pain assessment. And the medical assessment of what's going on with the person at the time. In a competent and effective way but also in an emotionally neutral way. On overly dramatic or hyper support of sort of way so that the accidental positive reinforcement does not come along with that assessment we're doing the pain problem.

The second one on this list as the differential pain and coping behavior. So theoretically, if we have a behavior plan in place for managing pain symptoms, we may be working on improving the person's skill to work with pain so comes in that example so that maybe relaxation training or maybe distraction techniques or it might be when he let the staff know about pain attitude in the speaking voice rather than shouting yelling or screaming. And when we see that the person is following the plan and learning to do those things, then you have to be very careful that we positively enforce develop mentally disabled people that were working with that way. To do those things. Because it can sometimes happen and the general principle of the squeaky will they get the grease so to speak. When people start coping with their pain more adaptively and more constructively, can be less attention-getting and the stuff can move on to spend more time with other people and less time at the person about the problem. That we fail to differentially positively reinforced the new acquisition of adaptive coping skills. So, paying attention to the kinds of interactions that we have with people that are learning of new or more adaptive coping behaviors and giving an adequate and positive reinforcement is very important.

Now and the last presentation we talked about the fact that sometimes even people on regular schedules of medication, that the PRM but schedules and sometimes a regular activity schedules, they can develop expectations about when they're going to have pain symptoms. And he can become in a classical conditioning format, kind of a self-fulfilling prophecy. So I expect to fill pages before I get my pain medication at the clock and lo and behold at 2:45 PM, everything starts to hurt for the hearing in question starts to hurt. In that case, it can be helpful to try to provide some additional variety of activity or stimulation during that final interval before the next scheduled pain medication is given. And arrange for some different kinds of stimulation to be going on. Distraction or talking with people and sometimes disrupts the buildup of those expectations. And skills training. What is so compelling about this is they indicated that developmentally disabled people like everybody else can learn and that the can learn things like different kinds of relaxation take weeks. And will talk about more adaptive ways to address it and distraction techniques and altered self-statements. A variety of cognitive behavioral techniques that can be useful and learn about. What other things that the think about Richard to do skills training is, how the person that we are working with learn best? Because some people learn best when they can have a chance to do a lot of interacting and learning like the conversation back and forth. And their questions and answers and other people learn better when it's more of a didactic or format where they listen to the teacher or the person join to help them with the skill answer the questions for the end then maybe they don't like to ask them any questions that the instructions but we have to think about working with what is their preferred learning style and we can figure that out in part by seeing how they have learned other things and had to learn by being on the units or involved in the treatment program. And try to apply that knowledge to learning the skills that they obtain as more adaptive. In addition to all of the behavioral pieces that the use, and as have been mentioned, we will continue on with nonpharmacological management. And using the behavioral interactions management, the opportunity to really work well while it decreases and computations.

So we started dumping another chemical into any object and it can introduce a whole another set of and interactions with other medications. Interactions with food, interactions with fluid, time of day. What our normal biological and metabolic systems in the terrible systems. So sometimes we have to. It compels sometimes to just add a medication. But just consider some of the nonpharmacologic strategies and what is needed for that. So for the behavioral plan, you have to take a look at what else the doctor had mentioned. What are the pain causes? And those definitions are essential. So for example, if a person realizes that something is going to hurt them like they're going to have a physical therapy session or they're going to have to get up and do some kind of an exercise and that hurts the floor. And so the person is going to have a potential paid reaction with a fully expect of Québec or something that has been happened it is not happening right now. But thing that might very well have a potential expectation. That's an expectation for pain to be there. I will answer the potential categories. And developmental disabilities and trauma experiences. Many people in the general population of that, experiences the people who have developmental disabilities, regardless of the extent of it, have megawatt, then people in the general population. And when you have had, the chances triggered are very real. So the potential to have a pain experience is heightened for someone who is been traumatized. That is the logical category and everyone has the logic and the function with that. So if the person says to themselves, this hurt before, it's going to hurt again. And even that pain only happens

intermittently, it reinforces and conditions individual. So that they have a logical system set in place in there going to have new pain experience. There are actual pain experiences and we go more into great deal in that and what the person has an ongoing and proven pain experience. Then there's also environmental situations for pain that have to be taken into account when you are doing pain management. Because it could be a couple of times were somebody's complaining a great deal about having pain there watching TV in the living room and the residents and their saying they have pain in a particular area. So we get up and move into an area where we can talk to them in a more quiet situation, it turns out that there is a spring busted with are sitting in it was poking right there in that part of their body. So the very complex and highly sophisticated fixes that these consultants put into place when it was just a spring on the couch. So take a look at some of the environmental factors that may be going on. Sometimes it would not necessarily know there is an environment the feature going on because you don't have the situation like let's say somebody has some cervical or even lower back disk problems like the disc is bulging or they have some twisting going on in the vertebral column. And if a cold draft pick them, they're going to go into a muscle spasm. And the cold draft might be a problem. In fact it may be very refreshing to most people. But this individual could have a great deal of pain resulting in the environment the future. So some nonpharmacological strategies for dealing with these pain situation is first of all would be the comfort card just in general and trying to establish pain halfway for the individual to reach that they can go get something that's going to be comfortable for them. So in that comfort box for example, it might be something that addresses their sensory issues. And I think we mention this from the assessment please. When we said maybe a 32-year-old woman who had down syndrome was very attractive to the microfiber scarf that one of the staff members had on and she was touching it and giving a great deal of coming out of that. So into her comfort box with the microfiber piece of material. So anything that the person can really enjoy or be distracted by or be interested in, that can help them deal with their pain, should go and that comfort box. Everybody has something that is different along those lines. Sensory experiences, some people really need to have some tactile experience. So for sample, it may be the plastic grocery store garbage bags. And a couple of the newspapers and stick stuff in there and private dock and the back in the could just talk from one hand to the next. And at the drop of because they do not have good dexterity, you may be dealing with breaking anything. And also the drop but it's not going to go rolling under a couch or a table with a person has to go lay there. So those kinds of sensory experiences can be good. To opening something that is pleasant for them feels good.

The laws of Canada sensory experiences the sometimes people are tactilely oversensitive are hypersensitive in they really cannot have something like massage, just outline be too distracting for them. But they can do some self-massage and will talk about that in a minute. Anything that is going to distract from their pain, their favorite musical or music. And somebody who very much like the rap group, but I cannot remember the name. But once she has a hard time, she knows to turn on that particular group’s music because it really helps with the rhythm that distract. That helps her to focus on managing the pain. And then the biofeedback which is the highly effective method we can teach people that very many levels of intellectual ability and disability to change their physiological variants. So a behavioral plan can could didn't complement depending on the person's with the sent to these and levels. Something is very responsive to eyes. So that is very responsive to huge. The same exact period

can be heat and ice responses at different times. We have had some options available. Acupuncture not quite as often do we use active puncture but I keep pressure can be very helpful. And I will roll this into the massage as well. There are a lot of people with developmental disabilities that have luxury front. And those luxury the ticket get a massage therapist specializing in the development of disabilities to come in and do special massage. But if somebody's hypersensitive, they certainly may not want somebody else to massage them. But it's still nice to give a full massage. We have one massage therapist we work with that teaches people how to do self-massage. Especially when people are stressed, having this web between the index finger and just very gently increasing the pressure and then decreasing while you are rubbing and a small circle. That is something somebody could do to themselves as much as they can tolerate. And so the massage therapist can sit next to them and teach them some things about it. Is also something called the fair can. It is a cane shaped like a big cracks it has knobs and it's not expensive. And the individual can do it themselves or somebody can do it for them. And it identifies the trigger point or that a special triggers of stress we call them on where the tension actually accumulates and you get a lump in the muscle and the muscle fibers are supposed to glide along each other. But when you have this spasm or codification are often those of the muscle fibers causes a little bit of a jam up in the process and the muscle fibers don't like the kind of jam up and I got it so that. And you have the their you can do to stop the massage where the points are. Conduct the muscle is less painful. Their ultrasound and usually physical therapist do this and it may not be very click or not very scary. It is an increase a very small vibrations that can increase the heat in the area and increases of the circulation of the area to promote healing but they have relaxation of the muscle fibers which tends to blow them down and each move them around a little bit. So thus I can begin internal massage using the ultrasound to create what can do that. That would be pretty helpful for people. The tens which is an electrical nerve stimulator which is you has four patents and it is attached by wire to a little pack that when you set the settings it increase it to so that the person starts to feel the pulse. And you can wear that for an hour or you can work for 10 hours. Usually an hour is a good way to get it going. So, can it actually interrupt some of the pain symptoms that are going on? It's not a medication.

The only trouble is we know this that we have had the standard care that they come with can have some pain reaction and people can be sensitive. You would know that if you put a Band-Aid on them. So that they have hypoallergenic center pads. Or a vibration usually from a massage or an pushing or putting that with have lower back pain with their speak to you can have a hello in between their knees or their pillows that have been a standard kind of thing that kind of goes all the way around it and let it up the way get into Tuesday's there. So you can roll over it and it will follow you have to go searching for it and it disrupts asleep. But that is another way to do with the current text Breathing exercises and teaching people how to please properly. Which we usually know how to breathe in and out to breathe properly for pain management to freeze into the counter for the very minimum and eight is even better. And when you breathe in your stomach goes out. And then to hold that for a count of four. So the buildup to it and then to exhale as if you are squeezing toothpaste up to. So that your stomach is going to go in as you're exhaling. And those breathing exercises can be very calming and very helpful for people who have paid couple of visualization and guided imagery, you have to give a set amount of cognitive power to do that but we have found that there are exceptions window some of examples of people who could do it in a group setting with another number of times were everybody imagines a certain the end of the

check ahead of time that if someone may be triggering then there should be a, here. Is it a both the ways of distracting from pain but also getting expression of the pain in a different mode. So somebody has a great deal of orange or great deal of red with their trying and trying to rest and especially if they're not very verbal or if there is a select group for the time being. Now we get to the events. The pharmacologic interventions are for people that have reflected disabilities but they also have pain. Let's talk about non-opioids first. Because there are options for pain management that did not include opioid medication. There are issues with opioids. There are antidepressants. Very frequently we know that people have the person reaction that amplified and consistent. So that is something you need to keep in mind. If the person has depression, that whatever pain they had is going to feel worst about. Is a antidepressants can be effective at championing down the pain reaction? So there are some antidepressants. Not all of them will do it, but you're going to be looking at things like the buildup, which is originally from about 17 years it was indicated that surely now perfect pain medication. And then about eight or nine years ago so given the indication is another which is certainly along those lines. But things that Paxil? Is that serotonin reuptake inhibitor or an SSRI and it has a calming effect. It is an antianxiety antidepressant. And sometimes the anxiety as well as the depression can heighten pain temptations. If you lower both of those features you will have less pain. Are at the consultants to select at the consultants that may decrease their logic hypersensitivity that some pain messages are composed of. So some sections are rock. The generic name for it around is about time and GABA is one trend that is that we deal with a lot for society and for pain. That has specific features. So for example a biweekly to give someone the pension that we may have 1200 or 1400 or 1500 mg a day. From going to give them the right for pain management, I might give them 2420 600 mg. So too much higher dose there are of course consequences for the person that will probably be sedated. But it can manage their pain. There are some interesting features that we have been told when people take this for pain management is that it does not make the pain go away. It makes the pain go over there. So does not quite as in the center of their awareness. It's there, but it's more manageable maybe you don't care so much about it. Antianxiety medications are of course, to me groups. Benzodiazepines and non-benzodiazepines.

So lowering somebody's anxiety can also express the pain experience and we would prefer then you have the pain and prefer that they be given on a regular basis. Not on a PRN basis, but if you have to give these because the study is so green eyes then it should be regular pain medication schedule and not a PRN schedule. And I could have an effect for lowering somebody's plan. Also relaxants can be get especially if your pain is caused by muscle spasms. So there are also relaxants. There are many anti-muscle spasm medications and what they can do. Another over-the-counter non-opioid medications such as aspirin what you have to be careful because the content towards things may not want to do. Ibuprofen is an anti-inflammatory which is good but sometimes people get a lot of uncomfortable side effects from writing in an attempt don't spot Jordan Allen it just works for them. But if you can cut down on that information and that is the source of the pain, that's a good way of handling it without going to the opioids. The Tylenol group or anything along those over-the-counter areas that can be medication for you. So let's talk about the opioids and the distance for the population even though they have these disadvantages. But as we mentioned with many of these medications, they really should be scheduled. This should not be PRN administration. So think about when you are giving the medication and if it's on a regular schedule. You want to very that schedule from time to time but the pain med is usually not a

good idea. Consider the patient controlled analgesia or that this year. And you have to put that together with the monitoring to see if there is an effectiveness and that would only be after or sometime after virtual procedure or some procedure like that The difficulty with opioids are only little bit more complex than the difficulties that would be for the general population. Substance dependence is a much bigger problem with people who have developmental disabilities and people who don't. That everybody has an issue with opioids. Everybody's the rubble to have a dependence on the substance. And the problem is that you can take a little bit of extra of your opioids and it can cause a great number of problems. Constipation. All of the opioids because a slowing down of gastrointestinal system so going to slow down first ulcers which means the person will becomes constipated as a result of the medication. If they're already constipated because they're taking 15 other medications the constipated them or they just have principle Down syndrome and attend to have much more constipation than people in the general population. The opioid is going to make it worse and have to stay right on top of that. If to make sure they're hydrated and well hydrated with water. Just water. I know I can be very vague about things. But hydrating with something that has other things in it like hydrated with crystal white or with coffee or hydrated with tea or soda. Those other component actually takes up a lot of energy. So whatever fluid or whatever water you are getting into is challenging your metabolism to try to metabolize all that extra stuff that is going on. And just in general, people web development of disabilities should not the drinking a lot of soda or anything that carbonated. Because it increases things and anyone over 50 should not be having a lot of carbonation because it causes problems. And a lot of medications that people are on the development of disabilities usually have that is a side effect. So you want to double up on that.

So watch the constipation and the water maybe a little lime juice or lemon juice. But really not a whole lot of components to it could have that gastrointestinal metabolism. Respiratory depression and side effect of all the opioids. Slows down the breathing. So you don't want to have a whole lot of slow respiratory rates in people who have developmental disabilities. Because they have a lot of respiratory vulnerability. They don't want to have their breathing go down any lower because they're more likely to get the one you. They're more likely to get upper respiratory infections. The potential for overdose is very high. Especially if the person has their opioid in hand. They're going to forget that the ticket or if they feel better after the took one, they may forget or they may take a whole lot better after the take for. So the potential for overdose is very dangerous. And the tolerant, everybody develops a tolerance to it opioid. Everybody develops a tolerance to benzodiazepine. Tolerance means you will be more over time. And more means constipation. More respiratory depression. And the risk that the person could overdose. The pain sources needs to be kept in mind when you're trying to manage any kind of pain. What is the pain come from? If it is acute or if it is procedural. Or if they just got postoperative and it just had surgical procedures of some kind. That pain is sometimes easier to treat because we know where it's coming from and when I worked there.

We know generally what can help it and how long it's going to last. Unfortunately we don't get that very often. Shorter-term treatment usually minimizes the consequences of from ecological treatment. So the person is not going to be on those opioids or any other medication for long period of time. They're going to get off of it. But the product -- of chronic pain is much less protectable and the source is difficult to

localize. You may not know the pain comes from several pain conditions in several physical conditions that cause pain has referred pain. So you might have somebody who has pain here and what is really going on is that he responded to it. But it's going to affect his teeth and his jaw and his bride. Are you may have somebody who has something behind their scapula and the shoulder blade and what is going on as they have a kidney infection or kidney stone. For an ectopic pregnancy or no variances to. And the pain is difficult refer to different parts of the body. But it is on a chronic basis and much less protectable if somebody has also spasms or if somebody has moved towards arthritis or light gauge osteoporosis. So the long-term nature of what we have to do the medication, along with the unlikely full resolution of the pain, will probably record the pain goes away. This but the consequences of what's going on with their medication much dire. I would like to throw into additional considerations about medications and the medical measures for pain management. One is a particularly when we are working with older development as a patient, many times there can be a very slight increase in bacteria and the urinary tract and if you do the lab and it is not technically classified as a urinary tract infection. But it may be running at the high-end of what is were carted to be the, range. And our experience with older patients with the developmentally disabled or not who happens to become vulnerable for a wide variety of disturbances including psychiatric, emotional and also increased pain substance symptoms. So it's part of the MESIP when there is increased pain. Particularly the person is had a prior history of urinary tract infection problems or running by counsel bacteria even within the normal range of the urinary tract layout it's worth it to look into that as a possible contributor. I will jump in with that so we need to get analysis back and it says that it is negative, for this population that does not really tell us everything that we need to know. It does not have to be colonized in terms of bacterial levels to be challenging. Because for individuals that have so many problems and their systems are not robust enough. So take a very good luck when you are doing a urine analysis and if the lab result comes back and is negative, you need a little bit more detail and you may want to pay more attention to that. And the other thing that we will throw in here I guess, going back to the use of the Ron son and gabapentin, sometimes people who are prescribed certain doses of Neurontin for pain management, and we see that perhaps it's not as effective as we were hoping it would be. And there is lab test that can give the level for Neurontin, just like you make it the level for other ant seizure medications you can get it from the lab test for the Neurontin level and that level is kind of an inexpensive tests of the facilities often don't like to order at much and they're not crazy about it.

And there is not really a wide body of literature that directly relates on the one hand the experience of pain two on the other hand, exact levels and lab levels of gabapentin. However, it seems reasonable to think that if we are working with somebody and they're taking the Neurontin for pain medication and if somehow the prescription does not seem to be doing very much, and we went and got lab level and it was pretty low, that might be an him. Argument to try and increase the dose of the medication. Is medically feasible. On the other hand, if we had a person taking Neurontin and it did not seem to do much when we did the lab and the level was closer to the normal range or in the normal range. That's probably more likely that that might not be that effective pain management medication for that particular person. So the bit of an expensive lab test, but if you're in the situation where the Neurontin is being prescribed, for pain management, it might add some information to help the prescriber make a more effective choice. Have a lot of information. Much more information than we had years ago that

some people are metabolizes and some people are slow metabolizes. And that there are genetic determinants to this and the pharmacokinetics of the pharmacodynamics. There are some fascinating publications of I must say so myself. There are fascinated. About how these medications are metabolized by individuals and it does not mean in the larger picture. So if you have for example a custom level any seat is very low but they're taking what should be a therapeutic dose. Then you know that that person is a reactive metabolites are and that probably very safely can have a much higher dose that higher than might even be indicated because we are going by typical reality and not just a standardized test for everybody in the country. Had broken down. So the take a look at some of these levels and look at the clinical situations and see if the chemical pictures matches what's going on with the laboratory picture. And you may have a little bit more leeway that way and it is the prescriber as well. And all of the information that you document about how their pain is responsive or nonresponsive to the mountain or to any other pain medication.

We talked about that and module numbers two about the assessment. But every clinician has something priceless to add to the treatment of the pain in general. I'll also throw one third consideration which is that many of the medications that we use, but are there for pain management or for treatment of psychological or psychiatric problems, have expect above side effects. And when possible, it's a good idea to try to use those that affected the therapeutic manner. So for example, if we have developmentally disabled person that is a problem and also problem with depression, and maybe they have been prescribed the antidepressant Remeron maybe they're having appetite problems and Remeron as a result of the depression they're having appetite problems and so did good one to help the person makes in their way level and gain back some of the way to have lost. Many times of the paper mom to get tired. And if you're working with some of his pain symptoms are keeping him awake at night or if the depression is making it more difficult than the sleep or both, it would be connected to schedule that dose of Remeron but right at that time. So in that case we are trying to the side effect of fatigue the Remeron as is medically feasible for example to help address the present problems with sleep. So it is worthwhile if we are working with somebody who has the pain problem and maybe other problems with the range of medications being prescribed. To think about what are the expectable side effect of these medications and how can we think about both scheduling and time again frequency and so forth. If possible to get some of the side effects in the therapeutic treatment? I would like to things that affect competently. Sometimes people have unusual side effect reactions. But when it's predictable, we want to make use of it. And is a side effect of the 14 cups of coffee that we drink this morning, we seem have got to the breaker little early in rushing through her material. So we will take a 10 min. break. We will come back after a few.

Welcome back. Okay. Welcome back from the break and let us resume. Pain management considerations for people who are developmentally disabled. And have coexisting pin pop-ups and psychiatric systems. So some of the people we work with are already development of the disabled and they will have psychiatric histories or current eccentric problems. And they will develop pain problems or the pain problems they are they had are going to get worse. So in this case we are faced with the subsidy to come up with effective management strategies for both the psychiatric difficulties and the pain problems. We will give away the conclusion the little bit by saying that the main principle of doing

this successfully this is the both problems. The pain problem and the psychiatric difficulties have to manage simultaneously. So sometimes, people take the approach that way to manage the psychiatric symptoms first. And somehow but the pain problem off and start managing it or addressing it once the psychiatric difficulties are under better management. And then other people kind of make the opposite and complementary mistake words taught that we can start by managing the pain difficulties and then when the pain problems under better control that we can move on to try to address the psychiatric symptoms as well. But the problem with this approach is that each type of symptoms is likely to worsen the other. So pain symptoms are certainly likely to intensify the psychiatric difficulties that people with psychological problems Artie have. And in the same way, psychological difficulties are very likely to worsen the pain problems that somebody may be developing. So pain problems and psychiatric difficulties reinforce each other, creating a vicious positive cycle. And the effective way to intervene at that is to work and start out working with both simultaneously. That may be a complicated process as we get into it we will see what some of the important steps are. So we need to think about the same order or cascade of interventions the people have this "stability simply take after difficulties as we thought of for people with developmental disabilities that had pain problems with no psychiatric symptoms. We would start with behavioral interventions as appropriate and we will also think about nonpharmacological interventions and comfort measures of the other Dr. who brilliantly explained. And then as a last resort, we would think about pain medication. When I say last resort, we are not talking about avoid if at all possible because remember that the overall goal is effective pain management. And effective pain management does include pain medications. But this is just the order in which these interventions should be considered.

So, when we are considering behavioral interventions, remember that we are going to do a behavioral analysis of the pain symptoms. And we are going to identify a set of behaviors or cognitive behaviors that we are going to work with the patient on changing or making more adoptive or learning skills or improving and we will work as a staff to make sure we are reinforcing the kinds of changes that we think would be helpful. For the nonpharmacological strategy will have comfort boxes and so forth, just as for developmentally disabled people who have pain symptoms but without psychiatric difficulties, even those who have psychiatric difficulties can benefit from the nonpharmacological measures as well. And we are going to look at the pain medications that we might use and think about things like regular scheduled versus PRN. On as we were discussing prior to the break type the therapeutic use of side effects of medications. When at all possible. So the kinds of observations that we need to do in this case are even more competent at the ones what they were a pain problem because now we are not only looking at all of the details of the pain complaints and behaviors and statements and behaviors and physiological evidence an interactional evidence and emotional aspects of the pain problem. But in addition, we are looking for the psychiatric symptomatology whether this anxiety, depression, irritability, psychotic symptoms, and the general principle is that we have to try to evaluate, assess and observe and monitor both turns of symptoms together.

Simultaneously. And one of the things that we are looking at in the course of doing the general approach is to see if the pain symptoms and the psychiatric symptoms seem to have some connection to each other. In other words, to the psychiatric symptoms get worse when the pain is worse? Or looking at it

the other way, does the pain get worse if the person is having an exacerbation of psychiatric symptoms? Observe those kinds of connections, then we can hypothesize that an important part of this person's pain problem can be psychiatric symptoms. And psychiatric symptoms continue to contribute to the problem of pain. In a few minutes but will go over some specific examples of that and ways that that could happen. Because of this added complexity, we could easily see that having a Plan B in mind and having a plan C and mind which Artie we had that anyway even when they were not psychiatric symptoms present, now we have to be even more ready to make adjustments in the treatment plan for pain and for the psychiatric symptoms. So we will be observing how the pain is expressed even like with develop actually disabled person to do have the psychological is to pick an expression of pain and adding the expression varied with psychiatric symptoms. And receive the psychiatric symptoms, like for example paranoid delusions or auditory hallucinations. Or rapid fluctuations in mood or move just service like any depression or for that matter clinically significant anxiety and if we see any of those things or if those things appear to have any relationship with the episodes of pain. Again, if the answer is yes, if the person comes more paranoid prolong symptoms of pain at the same to be responding to internal stimuli and assumed to have more pain or if the mood is more repressed or irritable that may have more symptoms of pain that strong evidence that there may be a connection from the psychiatric symptoms and the pain. If we don't see a relationship like that or connection between let's say, paranoia or pain or auditory and visual hallucinations and paint for food disturbance and depression and a. -- Pain. Then we may be in that situation, working with two separate problems that don't happen to relate to each other. In either case, it points out the importance of working with both simultaneously. Because of both the psychiatric symptoms and pain symptoms are related, we might address the psychiatric symptoms in order to get as good of a management of pain symptoms as possible. If they're unrelated, then in addition to working effectively with the pain problem you also have to work effectively with all of the other problems that the patient has.

The general principle and clinical work and in this case that would apply to psychiatric symptoms. So far person who has the psychiatric history it may be similar in a number of ways for the April analysis that we were looking at with the person did not have psychiatric symptom. So, we want to look at how pain is expressed before or I should say how the patient experiences pain at various circumstances. So for example, if they usually experience it during a particular activity then what comes first? The onset of the activity of the onset of the pain complaints? Do they experience it during a particular activity? What of the various parts of the body that may be involved? Did the experience pain following activity? What of the residuals of that activity that made the symptoms? Verbal, vocal, enter actual, behavioral. One additional thing to look at is whether or not paying complaint seemed to be related to the schedule of psychiatric medications they may be taking. For example, if a person has trouble with psychosis, developmental disabled patient and history of paranoid schizophrenia and treated with antipsychotic medication to differ primary psychotic symptoms. Suppose they are getting that medication twice a day, for arguments sake. Does the person observe just prior to the medication does administration to be been coming more paranoid and simultaneously complaining of more playing -- pain. Strong hint in this case. Paranoia are contributing to that persons paying complaint and managing paranoia war effectively may need different schedule medication, does, differed antipsychotic medication. May also have impacts on pay problem. Similarly. If the person is being treated for and anxiety problem as well as

patent issues, and when they have more anxiety seem to be complaining of pain. When they take anti-anxiety medications, pain seems to decline as well and might argue for a close look at Hal we are managing this persons anxiety problems. Are we doing everything we can with medication, behavioral treatment for anxiety. That may have benefit for pain symptoms as well. If we see pain is experienced by somebody who has developmental disability and depression and the worst their depression gets, the worse there paying gets, you would expect this to be the case because as discussed in prior workshops, seems to be a close election between depression and pain. Some of the same neural pathways seem to be involved in expression of pain and expression of depression. When treating somebody developmentally disabled and treating for pain and depression as well, we see from our psychiatric observations that they seem to have some symptoms of depression. They are sad. They are having periods of crying. Not enjoying much, not much appetite and losing weight, not sleeping well. Heaven for good, maybe ideas of suicidality, of hurting self or others. We see depressive symptoms in somebody treating were depression. In trading for pain, might be able to make prediction the pain problem is not going to respond as well to the pain medicine in intervention as we were seeing a continuation of depression. In that case, argument for reevaluating treatment of depression and making changes or treatment plan for depression whether medication related or therapy related or act committee related. That would address depression more effectively. In this particular case particular developmentally disabled person, if addressed depression more effectively, may address pain symptoms more effectively. Frequently, woman look at the behavioral analysis of pain in people who have coexisting psychiatric systems and developmental disability, we would look to see if the pain is experienced with certain staff members. More complaints depending on evening shift or day shift, certain family or better start -- family members or visitors. Our their certain types of people with home the patient seems to be experiencing or complaining of pain? If we see these things, if we see there are certain staff members with whom the patient experiences higher levels of pain complaints, we may want to evaluate which staff members the patient is complaining more on. When they are on, for example, one hand getting positive reinforcement for pain complaints and positive reinforcement by those staff members, or do those staff members have particular characteristics that, to this particular patient, interact with that person's psychiatric disturbance to make the psychiatric disturbance worse and then lead to increased paying complaint.

For example, developmentally disabled person with psychic trick history am paying complaint in past has been, unfortunately, traumatized by somebody and the evening shift comes along and people working on the evening shift who look like the person who inflicted the trauma or some way interact, maybe with voice tone, accidentally, like the person who inflicted the trauma, that might be a clue when the paying complaint get worse with certain types of people, staff members that there is and unaddressed or under addressed problem of a psychiatric nature that needs to be looked at. In this case, maybe a component of PTSD. When certain family members come in and patient complains of pain then at other times, one explanation for this can be if family members may in some cases accidentally be reinforcing pain complaints. In some cases, for example, when there is litigation about accident and patient is plaintiff and family members are involved, family members may overtly encourage patients to complaint for pain and better appearance in court room and bigger settlement. We have to notice if pain or family invoke a complaints. Versus if somebody has long-term cyclist -- psychological issues in their family and

expressed those psychological issues. What we see that pattern, family members or visitors invoking more paying complaint, one thing we should think about in terms of assessment is whether are not issues present invoked by those people. Certainly certain types of people such as tall people, particular gender, deep voices, characteristic. If you can identify a certain characteristic with whom the patient into RxN seems to invoke more paying complaints, that is strong hint there is underlying psychological issues either we haven't addressed or not addressing adequately. Those, in turn, are more likely to invoke increase in pain complaints. Similar comments could be made about observing where the patient experiences pain or is it experienced during certain activities, certain physical activities? Sometimes those locations, or those activities if we think about them may be close to kinds of psychological issues the patient might be wrestling with but expressing through pain symptoms. These are psychological issues that can frequently be associated with increased paying complaints a developmentally disabled patients. -- developmentally disabled patient. Anxiety symptoms. When patient is anxious they present anxiety symptoms and hyper and experienced pain. Depression symptoms, we talked about it now about how depression and pain, to some extent, seem to operate same neural pathways and processes and therefore, person more likely to experience pain. Pain on the other hand predisposes a person to an additional risk of depression. If a person is agitated, they have the same type of hyperactivity and internal focus someone who is anxious may have an maybe more disposed to experiencing pain.

A person, developmentally disabled person with pain psychosis, particularly with -- component focuses on pain of paranoid delusions. They may have a delusion somebody acting at a distance is doing something bad, well, evil causing them problems. They have actual pain and incorporate that into the paranoid delusions and regard pain as confirmation of their delusional idea of being persecuted at a distance. These four psychological issues and syndromes can be associated with increased ankle-length -- paying complaints. And corollary way we do treatment of problems. Adequate as possible might be able to reduce patient's vulnerability to ongoing pain symptoms or to get the payment problem to its best possible place. When we develop behavior plans for this patient population, we are developing behavior plans for me -- both the pain problem and the psychiatric issue. The plan should address both the pain and the psychiatric Rob loves. Just as said earlier, paver waiver plants have to be workable for everybody involved. All of the disciplines involved with the person, psychiatrists, psychologists, nurses, social workers, therapy eight, physical therapists, rehabilitation therapists and everybody else with whom the patient interacts has to understand the plan, behavior plan, has to have opportunity to apply employee into it. Everybody has to be on same page that this is a good idea to do. Everybody has to have the motivation, skill and time to carry it out. This is really a team activity that causes disciplines. -- that crosses disciplines. All staff have to implement behavior plan for managing pain psychiatric symptoms. If we have a treatment unit that has 10 staff members on it and one of those staff mentors -- staff members are implementing plan and at one doing something else, absolute their DB behavior plan will fail. This is -- absolute the behavior plan will fail.

This is one of the weakness of behavior plans. If we are treating somebody with formal logical agent, it just takes one person to administer medication. If treating your plan, it takes everybody on the treat -- if we're treating with behavior plan it takes everybody on the treatment team for it to work. Behavior plans are easily disrupted, therefore, we have to proceed with frequent evaluation of how the behavior

plan is working to see if there are any disruptions and do any of those disruptions relate to anyone on the staff not onboard or two other complicated factors we will discuss. In addition to psychiatric symptoms, pain problems, Avella mentally disabled person is another complex a fine factor. Plan for pain and psychiatric problems should not go on autopilot. Always more monitoring is better than last monitoring in these cases. We will talk about a couple of sample behavior plans. Two examples coexisting psychiatric symptoms and pain problem of developmentally disabled patient. A sample behavior plan for pain and psychosis. For the pain part of the problem, we've done our MESIP evaluation and behavioral analysis, pain behavior. We see we have developmentally disabled patient has a pain problem and is having ongoing problem with psychotic symptoms. We find the person is shouting out frequently all day long. When in pain. The behavioral part of the plan for the pain related behavior would be to try to help the patient learn to express aim complaint at a normal or better, more adaptive voice volume, rather than shouting out, have positive reinforcement, p raise, and with the support when person is complaining of pain in a more adaptive communicative style. As treatment goes along, work on skill acquisition. When the pain is adequately addressed to the extent possible, whatever amount is left, can patient learn relaxation technique that is appropriate. Can they learn self distracting skills? Can they learn to make cell positive statements like, I can get through this to help manage stress related to the pain? Were the psychosis heart of the behavioral manage land, we would have -- manage plan, antipsychotic medication will be given. If feasible, would have reality orientation. People who have psychotic symptoms need more frequent help support reminders of what is going on versus what may not be. People who are psychotic need more directive guidance from staff then the non- psychotic person.

Over time, the patient may be able to learn some skills, even if the maximum benefit of treatment they have some ongoing residual internal stimuli like delusional hallucinations, we might teach some skills to distract from those perceptions and lines of thinking when they do occur. In this plan, we have elements that address both important components of the pain and important components of the patient's psychiatric difficulty. Now, let's say were working with developmentally disabled person who has pain and depression. The component of the behavior plan, for example, for the pain would be arrived after we do MESIP analysis and we do a behavioral pain analysis. We see we have developmentally disabled person having ongoing problem with depression. They seem to be increasing their pain complaints. We observe what happens is a staff never comes over and does assessment of the symptoms, talks to too the person in a solicited and passive manner about what's going on work we know about depression what a person is depressed. They need more empathy and support. Our behavioral analysis seems to indicate part of the function here is to get more empathy and support. Remember all behavior is a response. All behavior has a function. In this patient, the responses to not only the pain but perhaps also a sense of loneliness and need for support. Function complaint is having is to get that support. In this case, we would like to change the way staff interact with the person so they are interacting at a higher frequency, giving that empathy and support, even when the person is not complaining of pain so that when connection of pain and receiving empathy and support is not so strong. As mentioned in another example, evaluation needs to be done a pain complaints, they are done in an effective way but not overly dramatic or overly supported, as compared to all the other interactions. We would, perhaps, in this case also think about scheduling a time every day, a meeting that the patient gets to meet with the

staff member and review what has happened with pain that day so the patient has the feeling, every day, some with going to listen and not knowing and having to cry out in pain and depend on [Indiscernible]. As I mentioned, you would need increased apathy and support. -- empathy and support. People depressed developmentally disability and depressed need a certain level of activity and interaction when medically feasible. It is important to support persons mood. Unfortunately, when people get depressed, they tend to withdraw and that worsens the depression. By helping patient maintain adaptive schedule on daily basis, which can help with the persons the press in mood and increase empathetic support can help with depression. Those are examples, to problems, psychosis and depression with pain in developmentally disabled person. You can see behavioral treatment plan would include elements to address both pain problem and the depression. Sometimes we work with developmentally disabled people who have problems with pain and also anxiety. These two frequently go together because, frankly, who doesn't get anxious when they are paying. It person has pre-existing psychiatric problem with anxiety that will be worsened by pain. Again, internal focus of hypervigilance and hyper activity can't to go along with anxiety tends to worsen pain perceptions -- can go along with anxiety intends to worsen pain perceptions. Relaxation procedure could be a form of progressive muscle relaxation. It could be [Indiscernible] imagery. It could be a relaxed reason. It could be a distracting activity such as listening to music. The particular form of relaxing Sager needs to be tailored to individual person you are working -- the particular form of relaxation -- relaxing needs to be tailored to individual person you are working with. Forms of relaxation can be helpful. Distraction or developing skills distracting one in pain, particularly one anxious, could be useful information. That could involve activity or could involve making certain kinds of self statements are using positive behavioral techniques like [Indiscernible]. Imagine you are seeing stop sign, eight sides, [Indiscernible]. Think about something else. And anxiety, particularly, we find when medically feasible, exercise is very helpful because some of the same internal physiological mechanisms that are involved in increased anxiety symptoms such as fatigue would be improved by exercise and less likely to contribute to anxiety problems. Many times, people with developmentally disability problems, when they do express pain will be sad and crying form of pain expression. In this particular case, as feasible working on skills to express pain in more adaptive way. Again, scheduling daily pain monitoring session and positive reinforcement when pain expressed appropriately would be helpful. Before instituting the behavior plan, we should examine the environmental contributions or causes of both pain and psychiatric symptoms. Why are we emphasizing the co-existing now? What is special about that? If you think about it, the medical factor, sensory factor, interactional factor and psychiatric factor all involve the patient. The E factor, environmental factor is where that patient is. If you find environmental factors country beating to pain with psychological difficulties and alter them, we are doing relatively less intrusive interaction that if we start mucking about with patient medical treatment, center processes, interactions are psychiatric status. Some problems are solvable with relatively simple environmental interactions, interventions I should say. For example, we had a 60-year-old male patient post stroke with associated white sided pain [Indiscernible] and mild [Indiscernible] disability. He was in a facility. When it came time for lunch, patient [Indiscernible]. He was right in the traffic pattern. When staff coming back-and-forth the kitchen had to walk right past this person with the tray carrying food. When he was in pain, the traffic was frequently because it is a common after effect of stroke. He would reach out and grab at the staff and appropriately. This was, obviously, very distraught them behavior -- disruptive behavior to staff. Turned

out, in addition to reviewing pain management, treatment which needed medication change, it was possible to have him sit on the other side of the table where he was not in the traffic pattern and could not grab staff inappropriately. Here, a simple environmental intervention probably save a lot of work and a lot more intrusive interventions with the person and basically solved the problem at that time and place for that person grabbing at staff inappropriately. We include the same basic components that are included for pain management approaches. We would also use those for pain management in people who also have psychiatric symptoms in the context of developmental disabilities. We have the same set of tech weeks from which we are going to draw. The difference, though, is some of these techniques may not be appropriate for people with certain sets of psychiatric difficulties. For example, we were talking about relaxation procedures. Some people who are paranoid, some developmentally disabled patients patient who are paranoid, matter of fact, even driven on developmentally disabled patients who are paranoid do extremely poorly with relaxation techniques. Because they are paranoid, puts them in position where they feel helpless work we have to factor in, what is the psychiatric if a cultic the person is having and modify the payment problem with intervention so we don't accidentally make the psychiatric symptoms worse. Relaxation, training sometimes needs to be delayed for person paranoid until person has that better controlled. There is a kind of relaxation were you focus on internal physiological sensations and slowing the breathing down. For some people, that is uncomfortable. For somebody highly anxious, that can be uncomfortable. Restrictions on breathing rate for anxious person sometimes makes them more anxious. We think about the standard set of a management, interventions with behavioral sort that we do, we have to put them through the filter are -- filter of what are psychiatric difficult -- the cult these that which might work other for psychiatric difficulties and which ones might we not want to pick because of the nature of the psychiatric difficulties.

Nonpharmacological strategy that we are going to spend time talking about individually takes into account person has pain. They have a coexisting development or disability of some kind and they have psychiatric symptoms. Comfort boxes, which we're mentioned before, is just an accumulation of items that that individual with his or her special features is going to be able to drive some comfort from the. People get comfort from different experiences. Some people like to listen to music. Some people would prefer a nice cup of tea. Some people like to take a shower, though that probably happens a little less often than we would prefer with these individuals. There are a lot of experiences that can be pretty helpful. Smells, factory experiences are part of the most primitive part of our brain. That part of the brain develops with the most basic aspect of who we are as human beings. Something that deals with a smell is going to be associated with a memory, more easily than anything else. It could be something you hear, see cost -- here, see, taste or something you have sensations a bout. Sometimes people can be comforted by a certain smell, aroma. That is why aromatherapy and be highly effective. There is a number of ways to do that. Everybody has something they really like to smell. Some people are happy about smelling bananas or cinnamon. Something soothing like vanilla, lilac. Everybody has something that can help them to concentrate on their wonderful experiences to distract them from psychiatric symptomatology and paying. That can go along with sensory experiences. Comfort boxes can have items in it but your sensory experiences will deal with, where is that person strength? Do they like to look at things? We recently had a young woman who just turned 30. She just had to touch things. It is not she gets a particular joy out of what she is touching work she gets joy out of touching. She does not touch

people work she touches things. She walked me plant and touch the leaf. She will walk by a stand and touch a cup. That helps her. She is very tactile oriented person. She gets a great deal of satisfaction and joy out of touching things. It works out she is not into touching people because that could be a problem. Especially, in her work site. She works in a sheltered workshop. If she liked to touch everybody, that could be a problem. It works out. Bending to her strengths of touching things, addresses sensory experiences. When she had pain, she can and her psychiatric symptom happens to be trauma and self abuse, injurious behavior. She needs to be able to focus on experience so she can't -- sensory experience so she can get past the pain surge or self injurious behavior urge. Distraction is always good. There is a number of different ways to distract as doctor Dr. Daniel Trigoboff mentioned. There's different ways of doing [Indiscernible]. People are focused on visual images. You can't imagine a stop sign. Color is good, it is shining. The word across it breeding is good. It is big, short. Contrast high between background and foreground work that distraction can be helpful. Sometimes it will take a rubber band, loose rubber band and put it around their West. Sometimes they will -- the rest. They will give it a snap. Not a painful experience but just something to say, pay attention to that instead of something else. It gives them control and gives a sense of mastery. It is very easy work you don't have to learn a lot to have a rubber band tightening around you giving you a snap. Biofeedback, as mentioned before, very helpful for wide range of people. Ice and heat, depending on the type of pain and how it responds and at what time it is responsive. Some people need first thing in the morning for muscle spasms. Date need heat on same areas around four clock or 5:00 in the afternoon to ease some of the knots that have developed in the muscles. Acupuncture and acupressure, as said before, not white as likely. Acupressure can be very useful as can massage, self massage, massage therapist who specialized in people with developmental disabilities or self massage with [Indiscernible] using something. We saw at the mall, not at the mall but at the airport. They had a small at the airport and they sold these small -- you stick your fingers in them and there were plastic areas. You could get it out to your hand and give yourself a massage just as a general sensation but also to get into the trigger point. Alters sound, I mentioned. These can be helpful for people who have psychiatric symptoms because they can put themselves in the situation where they are feeling the heat and concentrating on the heat. They have some control over the situation. A lot of people with psychiatric symptoms do not feel like they are in control. They feel burdened or these things just happen to demand don't know what to do with them. A lot of the formal -- a lot of the nonfarm a logical strategies we are talking about have capability where somebody has pain and developmental disability and psychiatric symptom to really give them a sense of control. That helps them in all three of those areas.

The TENS is pretty helpful for people with psychiatric symptoms as well as the pain and developmental disability because it can get past some of the tactile sensitivities people frequently have. It is very good for pain management. The person has complete control over how much of the tapping experience they are going to have and how long they are going to keep the electrodes on. We have found -- many have found that not to be useful strategy for person with multiples spasms. Not from cerebral palsy but from symptoms where people had delusional experience. Delusion was more mechanical in nature. We found this, of course, a challenge to somebody who has that point of view. Same thing with vibration if using a vibrator. Cushioning and splinting is very comforting. Holding themselves in a particular position, splinting so something is tighter and almost swaddled can be very helpful. Especially if the

developmental disability and the psychiatric symptom there with the [Indiscernible] nervous system. Those are calming strategy. Visualization and guided imagery we found helpful with people with psychosis as well, except as Dr. Daniel Trigoboff mentioned, if suspicion of persecute or a paranoid delusion. That can be very difficult. When you are trying to relax, you are making yourself more vulnerable. If you are trying to visualize something that is going to be soothing, if you are a suspicious person, you are not going to go there. It makes you feel vulnerable to the world. Art journaling is a good thing for people with psychiatric symptoms, especially if they are on the side of personality disorders or disruptions, strong trait personality features that are problematic work it can help. One of the people we were consulting with a couple of weeks ago, she has a lot of difficulty hearing certain words. It is very disturbing to her. Everybody has some that believe, things that bother you. You don't like to hear things. She cannot stand the word moist and bowels. Those two words were some reason release -- blouse. Those set her all. You don't have control over what words people are going to use. Some people use words moist and blouse which are normal words to use in conversation. Our journaling around that has been helpful. When she hears those words -- there are a number of them. She is supposed to sit down. She does Journal fairly well. She is supposed to sit down and write how she feels about that. It is not encouraged for her to write I do not know. It is bad. She has to be more descriptive in her Journal. She is doing quite well with it. It helps her to do that.

We mentioned breathing exercises. It only ethical thing we have seen with breathing exercises is people who have high spasm level with cerebral palsy. They are not able to deep breathe as deeply as we would like them too. -- we would like them too. They can't hold it as long. Any depth to the breathing is helpful. That is the nonpharmacologic. The pharmacologic intervention, again, talking about the triple whammy. We have developmental disability. We have pain and have psychiatric symptom. Let's talk about using antidepressants. Since depressive reactions do amplify pain sensations, if neurological as well is psychological fact, antidepressants can be extremely helpful. If you are treating the depression while you are addressing the pain symptoms, and when you treat the depression, your sensitivity, circular receptors, resilience in general and inability to cope because of your depressive symptoms all our familiar rated by antidepressants. You might be able to get a lot of bang for your buck out of that. The only caution we need to put into place is there are a few antidepressants that April can get abuzz off -- that people can get a buzz off of. They can get a sensation that is addictive. It is not common but something to keep in mind. We are trying to improve the situation, not and another whole layer of complexity too it. As mentioned before, there are a few that can be used. The most strategic one is gabapentin, Neurotonin. It increases hypersensitivity that some are composed of. It normalizes their mood stage. Sometimes people who are in pain are disrupted. Even if they have no diagnoses of bipolar disorder or schizoaffective bipolar, they can be destabilized to a point they are having a lot of difficulty with their mood because of their pain.

I'm sure you have all seen people in pain. If you've ever had a headache, you knock him -- you will be the most glorious, lovable person you would normally be because you are in pain. You will be more irritable, withdrawn. You won't have such a wonderful jolly time. Anticonvulsants that our mood stabilizers also will take care of that. It will help the persons mood be buoyed up a bit. The dine side of that -- the downside of changing anticonvulsant to the other or coming off anticonvulsant and titrating down, that

also can be destabilizing to the mood work most anticonvulsants have different neural pathways. That is why you switch from one to the other when not working or not working completely enough. You have to address pathway. That mood might become unstable as a result of that. Something to keep in mind when somebody is trying to get their mood and pain addressed. Along the lines of more non- opioids to deal with pain are anti- anxiety medications. This is not entirely different from when you are dealing with people who have pain and developmental disability but adding psychiatric symptom of anxiety is important to keep in mind. Some people who have schizophrenia, schizoaffective disorder, certainly obsessive compulsive disorder and posttraumatic stress disorder because they are anxiety disorders as well as generalized anxiety disorders probably need ongoing benzodiazepines to manage anxiety episodes or if they have panic. The benzodiazepine would more than likely be used on that. The rules have changed a lot across the country for what do you do with benzodiazepines? A lot of insurance companies will insist that the clinician ask about those reduction or just start the reduction of benzodiazepine. That is very difficult. You have somebody who is anxious and they are in pain and they have developmental disability and on benzodiazepine and is managing their anxiety. By law, insurance, money, clinician preference, does is reduced. Even though it must be done slowly and carefully to titration process, it cannot be rushed.

If taking somebody from the most recent one I can think of this one we had for 17 years Xanax. He cause benzodiazepine have tolerance feature to them, she had gotten all the way up to -- she is a little woman. She got all the way up for milligrams of Xanax there, says -- this is tremendous amount of Xanax. She started out with one half milligrams a day but over time up. It was determined she needed to come down. They took her from for milligrams to 3.75 milligrams, very low dose reduction. When somebody is being reduced on those of benzodiazepine, everybody needs to be aware, everybody, individual and everybody involved in their care needs to be aware this can be several days pretty brutal. Persons anxiety will be bound -- rebound. Rebound anxiety. Either being treated for -- been so I has a been go up. If you are prepared for that and everybody knows it is temporary and will sell down -- settle down and nervous and come will get better. If not be. , everybody will be thinking, including client, I can't come off of this stuff. I have to stay on it. There is no way I will be able to live without it. There is a preparatory feature Bloom reducing somebody on been so diazepam. You leave them at lower does for -- preparatory feature. The issue with benzodiazepine, physiologically but there is psychological dependence on nine benzodiazepine such as Ambien, non- benzodiazepine for sleep work the individual by become conditioned. Classical conditioning. In order to get good nights sleep they need this pill. If they don't get the pill, they will not have good nights sleep. There needs to be education and training about that. Many people who have developmental disability and psychiatric symptom may already be on anti- anxiety medication. That is because it is extremely common that the psychiatric symptom is going to have some component of anxiety too it. Being an anti- things -- anti- anxiety medication is common. Medication -- it's or -- edge time IB change to address pain symptoms. -- might be changed to address pain symptoms. It brings down, increases resiliency person has. We like to teach people how to deal with their pain an pharmacologically. Sometimes you need to have multi system in place to make it work these options for people who have developmental disability and pain is not different when they also have say -- psychiatric experience. Relaxation helps fibers to glide along each other instead of snagging and spasming. That can be made -- pain management routine. There can be significant side

effects. One is sedation. You would like to give muscle relaxant at time of day when it would be okay for them to be sleepy. You give it to them at 8:00 in the morning before work, before program, tours should duet resident, they are exhausted and want to -- chores at resident. They are exhausted. Muscle problems typically happen later in day. If you get up in morning and do stretches, you can manage muscle pain. Muscle relaxes are better done in the day. Later would probably help with sleep. You can remove one medicine from regimen. Another side effect of muscle relaxant is visual hallucinations. That has happened on more than one person we have had to consult on. They think they are having psychiatric symptom of hallucinations. They really are having hallucinations but is side effect from different source than a psychiatric disability.

Over-the-counter meds, aspirin, ibuprofen, actual Medicaid, same as someone without psychiatric disorder. Opioids, mentioned before, not to be dismissed for people with developmental disability and co- occurring psychiatric disorder trying to deal with pain. The risk of dependents is elevated when you put a psychiatric symptom into place. Just to greatly abbreviate the explanation for that is anybody who has a major mental illness schizophrenia, [Indiscernible], major depression does not matter what it is, you have major psychiatric problem, your neurological systems going to respond to substance differently. There's a temporary pathway that is developed with people in general population when a substance is adjusted. You know if you have never smoked cigarettes how very difficult it is to remove nicotine from your body along that temporary pathway. The neural pathway that goes from the pleasure centers of your brain work it can be very tough to remove. When you have a major mental illness, you put a substance -- substance of abuse in your body and forms permanent neural pathway to the pleasure centers of your brain, dopamine reactors, very quick Lee within three or four doses. There have been a couple of very competent resources with robust results that have said it is after two doses. You are giving them an opioid and risk of addiction dependents is very elevated, which is not the same for people that only have developmental disability and pain. You had the psychiatric symptom and it changes the picture and has to be kept in line. Kept in mind. That is why we do not like to go there unless we have too. If it was for surgical procedure, then the patient controlled analgesia, PC weight is not recommended -- PCA not recommended for same reason, risk of dependents dependence is high. Scheduled administration remains high in lieu of DRN. Something you can keep in mind -- PRN.

Difficulties are the same, substance dependence but much elevated. Probably six times more likely with people with psychiatric symptom on top of pain with developmental disability. All of the other side effects are the same, constipation, respiratory depression, potential for overdose that requires -- tolerance today. There is nothing we can do to guarantee a person will not go on to develop a chronic pain syndrome if you have a developmentally disabled person working with. However, there are things we can do to minimize the risk that a chronic pain syndrome will develop. Let's say we have somebody we are working with acute pain issue. Maybe, heaven forbid, broken a bone or had a contusion back problem and here are some things we can do to minimize the risk of that turning into a chronic pain issue. If pain medications are going to be used, if medically feasible, we would like to schedule them regularly as opposed to PRN. The other workshops in this one mention that PRN meds can be very problematic. PRN pain meds positively reinforce experience and complaints of pain. Regular schedule of analgesic meds are better because they can be managed medically. Training on coping adaptively with

the pain should begin sooner rather than later. Unfortunately, sometimes we see that these kinds of interventions, cognitive behavioral skills appropriate, relaxation training, distraction tech geeks are not thought of during acute pain episode because we think the person has a court legitimate unquote reason for the pain and underlying physical problem hills, automatically pain complaints will go away. -- problem hills. As we have been saying in workshops, that is not always the case. Sometimes acute pain can turn into chronic bank, unfortunately. If we start person sooner on how to cope with that pain, lower the risk that will go on to develop chronic pain syndrome. Not risk in -- not eliminate it entirely but we will lower it. It is important for all of us who work with people in general and developmentally disabled people with chronic brain problems or pain problems, we have to check are own approach and check are own attitudes. Very important to maintain a positive attitude, a visibly positive attitude with persons ability, to learn, to cope with pain adaptively. People are responsive to staff expectations. If your approach or my approach with developmentally disabled person in pain is, well, I'm going to have pain same way or say, what can they do, only have limited skills or coping techniques for pain, people are going to live down to those expectations. It is very important to monitor are own approach and attitudes. At the same time, maintain a current knowledge of what is thought to be effective in terms of pain management interventions so that we are practicing in as high-quality and effective manner as possible. Finally, as we mentioned before, it is important so we will mention it again.

If you have somebody having an acute brain problem, we want to lower their risk of development of chronic pain syndrome, we like to positively reinforce all competent coping they may be currently doing for the acute brain robbed him. -- acute pain problem. Make sure appropriately interacting with person. When not focusing on pain, provide input for socialization, stimulation, interaction. When they are coping competently with their pain -- acute pain will help with chronic pain syndrome. The documentation of your pain management program is taking credit for what you have done, what you are doing and what your alternate plans are. We talked about having a land. And then Plan B and Plan C and sometimes more than that. You have to be fairly flexible. You cannot be rigid. You have to be conscientious and think about all of the components which can get complex. You will be talking to colleagues and coming up with good aim management program. You want to make sure it is well documented so everybody gets where we are going with this. The effectiveness of the pain intervention and reassessment. You gave them something for the pain such as activity, experience, medication, distraction; something happened when they had pain that you were aware of or the complaint of pain to you. What did you do about that? How did they feel later? Usually, one hour is the standard. That is standard by accrediting agencies that you have a reassessment within one hour but you don't have to wait one hour. If you are seeing something happen within 15 minutes, 30 minutes, 35 minutes, that's when we need to reassess. That tell us everyone on the team, this person response within that time frame. You do not have to wait until one hour has passed and find out what is going on. Sometimes you see immediate relief. If they are distracted, that is immediate eventuality. That is something you need to document. What our your observations quick -- what our your observations? How is the person talking about their pain? How are they expressing themselves verbally, nonverbal you only -- nonverbally? What are you observing about them in general. These arcs ordinarily useful points of view. What does it mean? We talked about your interpretations of pain and behavior and interpretation can really set the stage for what is going to happen. What our your interpretations of what the person is doing? You give

them something to distract him their pain. They roll it off to the side, are very irritated about it. This does not mean it is never okay to try to distract them from their pain. It just means not the moment for it. That behavior is not behavior you don't want from them again or pain management useless to them. At that particular time it did not work. Try it again. If it happens again, your interpretation can take on more meaning that, this is twice and it has not worked for this individual to take that off of the list of options. Examples of an effect effective documentation of your pain management regimen is to write-down how you assessed.

We talked about that in module number two. Write-down what you think is going to work for this individual. What had you seen work for the individual? How do they act when they were pulling themselves together around a pain management situation? How vigorous has everyone been in directing the issue? Did it start fairly early, which would be ideal if pain management trigger happens as soon as possible. All reason why they had pain to begin with. Might have had surgery, injury, dealing with that kind of documentation. When you document what you have assessed, what it means, what you did and how it worked, those main features covers your basis. It allows you to take credit for everything you are doing and gives a map for everybody working with that individual now and in the future for how this can really begin to work to increase polity of that persons life. You are increasing the staff understanding of this individual and how they work. You can find out a great deal just by those four steps work you write those down. You keep them updated. That's going to be your effective documentation. Many pain management interventions are not medical in nature. Many of them are interactional or rehabilitation component. In another way, many times in trying to intervene in pain symptoms with people with development disability will involve us communicating with person interacting with the person. It is always helpful to think how we can adapt our communications to fit the person we are working with. Patience do best when communication practices are taken into account.

Previously mentioned, working on skill building or skill acquisition, some people like to have a lot of Akin forth question-and-answer and discussion format. Other people might like just to get the fax to tell them what they are supposed to do. That kind of approach. We need to try to understand -- understand that about the person we are working with in fit that to their reference. Some preference about communications about pain management treatment in general we're going to be result of values they may have learned long-term, maybe long ago as part of their family of origin when growing up. It is helpful working within pain management to understand what those are as well. For example, person may have grown up in environment where the approach to health was if something is wrong, take a pill. Now, they have run into a [Indiscernible]. They don't feel well and something hurts. Give me medicine and I will feel better. Or staff member will approach person trying to talk to them about skill building or other behavioral plans or comfort boxes in response -- and response might be [Indiscernible]. Example of effective things in that circumstance is you can't always take a pill. It's not time for your pill. You -- we recommend you don't say things like that. In part because if it crossed persons values, likely to produce trouble work you might think of saying instead, what might go wrong with person value systems say something like, this technique we will learn they help your appeal look better so you are not argue with their preference to take a pill, your same -- you are saying something and organs with their value system. We also have examples when a opposite happens. A person may grow up in family environment

where they are taught all medications are bad. Never take a medication. It is chemical. I am not taking it. I don't want chemicals in my body. Putting aside consideration for entire universe, including everybody and everything and it is made up of chemicals whether you take pills or not. This is a value system that has -- that you have to be aware of and respect if your interventions are going to be as effective as they possibly could be. In that case, you have to support the idea that the non- pharmacological intervention is the primary focus of what we are trying to do and the pain medication prescribed is just for short term and may help all of the other non- pharmacological behavioral skill approaches a little better. Important to know who is the person with whom you are working. Where are they coming from in terms of their values about pain, pain expression, pain treatment and medical treatment.

One time, the other extraordinarily excellent Dr. Eileen Trigoboff and I were out American psychological association many years ago. We wrote in the elevator with BF Skinner, one of the founders of behavior. He was [Indiscernible] at the time. We asked him, being the probing people that we are -- It was a long elevator ride. How are you feeling now that you're in the 80s? What is it like for you? He said the best thing I can tell you if you want to experience what it is like to be in your 80s is put on eyeglasses with something smeared on eyeglasses and hard to see. Maybe cotton ball them out when hard to talk. Hard to get through your day [Indiscernible]. We thought that was a very witty response to our question. In the same vein, we meet with each other, we have treatment meetings where we discussed a management for developmentally disabled persons. Sometimes it can be useful, out there as it sounds, take a few minutes communicating pain to each other without using facial expressions or words or not using body language. Yet some idea of what it feels like to try to communicate pain, problems with pain, some of the communicative disadvantages people with disability diffs -- developmental disability has. That can sensitize us and make us, perhaps, more effective in understanding these kinds of communications. It is also very useful to have case discussions. Pain management with development h e -- developmentally disabled person, whether or not they have coexistence psychiatric Robbins, very complex and difficult thing. It is not every 29 East effort -- a routine effort, like if someone has bacterial infection, take antibiotic and standard treatment. In pain management, not any effective standard treatments.

There are combination of interventions that come after complex assessments. In formulating those assessment and treatment plans, you Lord the odd you will miss something. If you talked it over with other team members, other people on team, particularly with expertise and experience in working with developmentally disabled people with pain problems. You have a wider selection of options you can pick from. Sometimes it can help articulate problems that may be floating around in the back of your mind and not quite gotten into words. It may be something about your approach or something you are thinking about in the discussion that can come out. Often that can be helpful. If the discussions are constructive and productive, I can help serve to energize the treatment team and keep us all working on pain management interventions, even in stubborn situations where treatment refractory, treatment resistant chronic pain or getting a lot of resistance. It is always good to get the support of one's coworkers, particularly, those who no something about pain management. We encourage a lot of communications, face discussion. Role-playing is appropriate, as well as greedy -- leading in the field of pain management and taking workshops like this to stay current and motivated in working with chronic

pain patients. Involving others in the process is useful. This is too complex and difficult to do alone. You need to talk to other people. You need to hear what other people have to say such as family members, friends, workshop, colleagues, peers, other professionals. You need to hear what other people have to say. The treatments, as the wonderful Dr. Daniel Trigoboff said, it is different for almost every individual. Every single time we have come up with a comprehensive plan for somebody, it has been because we have role-played. We have had case discussions. We've had 2000 cases we have consulted on. We have had thousands of options. We did not come up with all of that on our own. We have brought in other people. We respect information other people have to give us, even if information is shared in an ungracious way. Some people become very irritated because pain is so complex and management so hard copy for become demoralized, irritable. They say things like, that is not going to work. I can hear where that is coming from, but it is still giving me a lot of information. We both have incorporated that into what we have been taking away from the situation is other people are frustrated and not and easy go to them. They have tried several things. None of them have worked. We need to look at number seven through 15 and look at combining them a different way. Another option that isn't used quite as often as we think would be best to do is take advantage of ethics community -- ethics committee and community involvement. [Indiscernible] and national alliance for mentally ill, advocacy groups, all of these clusters of people have particular point of view. Not going to be 100% of what you need because everybody will have their niche of information they are good at. That is where their expertise lies. It contributes something to what is going on. It will help you deal with much more complicated situation you might be prepared to deal with the information you have in your head right now. Listen to other people, even if they are communicating things ungracious or in a frustrated way. They still have something to offer you. Of course, relevant publication and peers can offer a great deal of information as well. The ultimate goal of the entire program we have been talking through these three modules is ongoing Pain Assessment, which never stops. You have someone that has been in pain, you have assessed and keep assessing it. You keep assessing the management program you have come up with. Ultimately, what we are trying to do is improve the quality of life for those individuals who have any kind of developmental disability and any kind of pain work that is what we are going with. We have some time.

We have some questions. We have questions you have for us but these are questions we have for them. There are five of them. I can start. Question one, which of the following our pain management interventions that can be useful with developmentally disabled recipients? Number one, taxation training, over two, prescription analgesics, number three, social interaction opportunities, number four, positive reinforcement of pain complaints. The correct answer is, C, 12 and three. Relaxation training, analgesics, social them traction. We don't want to enforce but that -- [Indiscernible].

Question number two, with developmentally disabled recipient is in pain, which following can be effective pain management technique? Talking calmly referring intervention, ignoring to avoid positive reinforcement, referring to subscriber for analgesic for other Analogic intervention or talking calmly, relax, avoid anxiety which can increase in pain. The correct answer is D, talking calmly, referring to -- referring for evaluation. And helping them maintain relaxed breathing to avoid anxiety. Keep in mind, these symptoms can make pain worse.

Question number three, throughout their lifespan, down syndrome symbionts are: Likely to benefit from pain management at all points when having pain symptoms. Number two, they need pain management interventions less verbally oriented at age due to Alzheimer's dementia in this group of recipients. Number three, are unlikely to need pain management for gastric discomfort. Number four, likely to need analgesic for pain management at any point. Correct answer is C, may need pain management, less verbally oriented as they age through prevalence of early onset Alzheimer's, dementia, and this group of recipients.

Question number four, working with autistic recipient, H 35, appears increasingly sad and begins to complain of nonspecific back pain. You should number one, refer her for evaluation of pain symptoms only because likely her sadness is a result of the pain. Number two, referred for psychiatric evaluation. Likely pain complaints our consequence of her depression. Number three, reassured soon she will be better -- the better as research shows pain are transitory. Number four, refer for evaluation of her pain symptoms and of the depressive symptoms as they can't interactively worsen over time. The answer is A, number four. We talked about how depressive symptoms, been symptoms may become interactive.

Question number five, most able and appropriate strategy for documenting pain management with interventions includes: Number one, don't put to many notes into record about interventions they tend to be repainted it. Number two, remembering it is not necessary to document no change in symptoms because that would be obvious to the treatment team anyway. Number three, using ratings from pain symptom checklist is as only reliable and valid indicator in progress of treatment. Number four, use all source of information about effective -- effectiveness of pain management strategies and document frequently and extensively so that anyone reading the record will understand how recipient is responding to the pain management if inventions. Correct answer is, D, use information document competently.

There's going to be a survey that should pop up on Internet browser. If you do not see it, tomorrow you will be sent e-mail with link in i t. Just follow the e-mail. If you have questions or comments, that is one Lisa does her stuff. That is how you get ahold of her. Lisa will check and see if anybody has any questions. We have a raised hand from [Indiscernible]. Leslie, you are unmuted. Go ahead and ask your question now. . We have no other questions today. Okay. This completes the three modules that focused on pain through neuropathology how you would assessed, treat and manage somebody would developmental disability and they have pain. We hope it has been helpful. Thanks for your attention. We echo that sentiment. We hope it has been helpful. Thank you. Thank you. [Event Concluded].