mindbody wellness

Assessment & Treatment of Pain in Older Persons with Dementia

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Gerontological Society of America Meeting
Dallas, TX 2006

Distinguished Discussant:

Victor Molinari, PhD

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Background:

Medical and Psychiatric Comorbidity

- **General Population** **15-20%**
- **Acute psychophysiological** **15-20%**
- **Chronic psychophysiological** **50-75%**
- **General Medical** **25-30%**
- **Chronic Medical** **25-40%**
- **Chronic Medical with chronic pain** **50-75%**

Background:

Prevalence Rates of Medical and Psychiatric Comorbidity in LTC

Anxiety Disorder	25-50%
GAD	17-21%
MDD	12-50%
Dysthymia	17-30%
Bipolar	2-12%
Psychotic Disorders	10-16%
Severe Dementia	50-90%

Provider, June 2003

Background:

Prevalence Rates of Medical and Psychiatric Comorbidity in LTC

Psychiatric SX associated with Dementia

Paranoia	35%
Delusions (Hallucinations)	30%
Depression	46%
Anxious Agitation	31%
Aggressive Acts	25%
Behavioral Problems	64-83%
All psychiatric disorder	80-90%

American Association of Geriatric Psychiatry

Medical Conditions Associated with Chronic Pain in LTC

Osteoporosis, Arthritis, DJD, Sights of old fractures,
Peripheral Vascular Disease, CVAs, Diabetes,
Neuropathies, Sympathetic-RSD, MS, Parkinson's ,
G.I.: Ileus, gastritis, peptic ulcers, diverticulosis,
Renal conditions: ESRD, stones, bladder distention,
Connective Tissue Diseases,
End stage Cancer,
Myofascial injuries or D/O, Fibromyalgia

American Medical Directors Association

Prevalence Rates of Chronic Pain in LTC

25% Report chronic pain,

50% Report intermittent pain that decreases QOL

40%	Low back pain
15%	Site of previous fractures (hip, osteoporosis)
10%	Neuropathies
10%	Leg cramps
10%	Claudication
10-30%	Cancer

35% Report pain at multiple sites

IASP DEFINITION OF PAIN

- An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.
- Pain ***is always*** biopsychosocial & subjective. Each individual learns (socially, classically, and operationally) the application of the word through social experiences related to injury (actual or potential tissue damage) in early life (and through out the life span).

Pain in Persons with Dementia: Background Issues & Problems

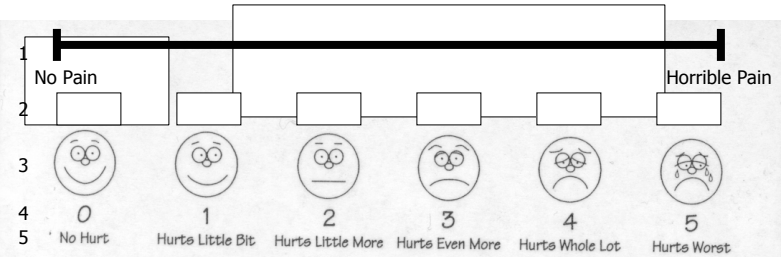
- Pain is associated with adverse outcomes
- Pain is a significant problem in nursing
- Persons with Dementia are at a high risk for under-diagnosis
- Persons with Dementia are at a high risk for under-treatment

Verbal Pain Assessment is Problematic in Persons with Dementia

- Poor Completion Rates: In a study of NH residents, even after the exclusion of patients so severely demented that they couldn't answer yes/no questions
  - 17% of the demented participants were unable to answer any of 5 simple verbal pain rating scales
  - Only 32% meaningfully responded to all 5 scales (Ferrell, Ferrell, & Rivera, 1995)

Simplistic Pain Assessing

- Assessing Pain
  1. Visual Analogue Scales (100mm long, Scale 1-100)
  2. Color
  3. FACES
  4. Numeric Rating Scale
  5. Verbal Rating Scale



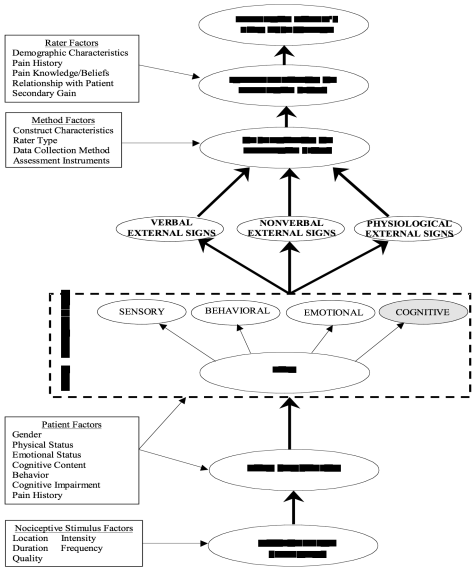
Verbal Pain Assessment is Problematic in Persons with Dementia

- <u>Dementia Severity is Negatively Correlated with Pain Prevalence</u>: In adult day care patients,
  - self-reported pain prevalence was 48 - 71% in cognitively intact patients
  - self-reported pain prevalence was 30 - 57% in mild to moderately demented patients

WHY ASSESSING PAIN IS SO DIFFICULT in PERSONS with DEMENTIA

- Resident must be able to understand the rater's request for a pain rating
- Resident must be able to accurately recall pain events in a given time
- Resident must be able to interpret the experience of harmful stimuli as painful events

Assessing Pain in Non-communicative older adults with dementia



Snow AL, O'Malley K, Kunik M, Cody M, Beck C, Ashton CM, Bruera E, Novy D. A conceptual model of pain assessment for non-communicative persons with dementia. *Gerontologist*, 44:807-817, Winter 2004.

Web links:
Nursing Assessment Of Pain
Mind Body Wellness GRRAS

www.cityofhope.org/prc/elderly.asp

www.mindbodywellnesspc.com

Psychological Assessment: Toward Non-pharmacological Rx

- Psychological Evaluation of Pain is a part of a Multidisciplinary Evaluation
- Psych. Evals consider the affects of historical learning and experiences on current pain expression and behaviors.
- With this knowledge, the efficacy of both pharm. & non-pharm. interventions increases

LTC Interdisciplinary Team

- Nursing
- Primary Care Physician
- Social Worker
- Rehab and Restorative Therapists
- Geriatric Psychologist (NeuroPsych & GMCBT)
- Geriatric Psychiatric/Neurologist Consultation
- Nutritionist
- Clinical or Consulting Pharmacist
- Wound Care
- Hospice/Palliative

Psychological Evaluations

- Medical Conditions Associated with Pain—Med Hx
- Recent & Historical Stresses/Trauma
- Personality and Psychophysiological Styles affecting pain reporting, emotional suffering and the development of dysfunctional pain and illness behaviors.
- Cognitive status or impairment that affects pain presentation
- Pain & other noxious Sx perceptions—level of suffering; its affect on activities, and emotional response to pain.
- Depression (negative thoughts about self, situation, & future)
- Dysfunctional Behaviors
- Cooperation with ADLs and Level of Assistance Needed

Dementia, pain, depression, behavioral disturbances, and ADLs: toward a comprehensive conceptualization of quality of life in long-term care

Daisha J. Cipher [1] and P. Andrew Clifford [2]

SUMMARY
Objectives Quality of life in long-term care settings is a multidimensional construct that includes functional, cognitive, behavioral, and psychological variables. Quality of life variables have been found to be related to one another, but directional influences have not been tested.
Methods The purpose of this study was to develop and compare two competing path models composed of quality of life variables, including dementia, pain, behavioral disturbances, and ADLs.
Results Path analytic results revealed that cognitive, emotional, and behavioral variables interact with one another to predict patients' activities of daily living. Pain levels did not influence activities of daily living directly, but rather influenced behavioral disturbances and depression, which in turn influenced activities of daily living.
Conclusions These preliminary findings suggest that in order to assist long-term care residents in improving their activities of daily living, decreasing pain is likely to yield the greatest overall improvements. Future research on the relationships between quality of life variables is recommended to further develop multidimensional treatment models for healthcare providers in long-term care.

key words—quality of life; long-term care; pain; elderly

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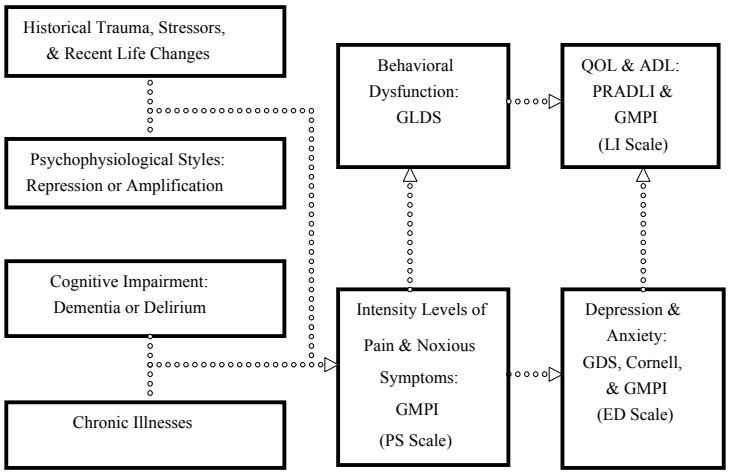
Int J Geriatr Psychiatry 2004; 19: 741–748.

Quality of Life in Long-term Care:

MBW: Assessment & Treatment Effectiveness Model



Model for Quality of Life in LTC

Recent and Historical Stressors in LTC

- **Residential** Last 3 months or as stated

- Change in residence 1-3 months
- Change in residence this year
- Change in social activities
- Change in roommate
- Roommate Difficulties
- Change of room
- Change in caregiver(s)
- Difficulties with caregiver(s)
- Difficulties with another resident(s)
- Recipient of verbal abuse
- Recipient of physical abuse
- Loss of social status or role
- Loss of productivity

- **Medical** Last 6-12 months or as stated

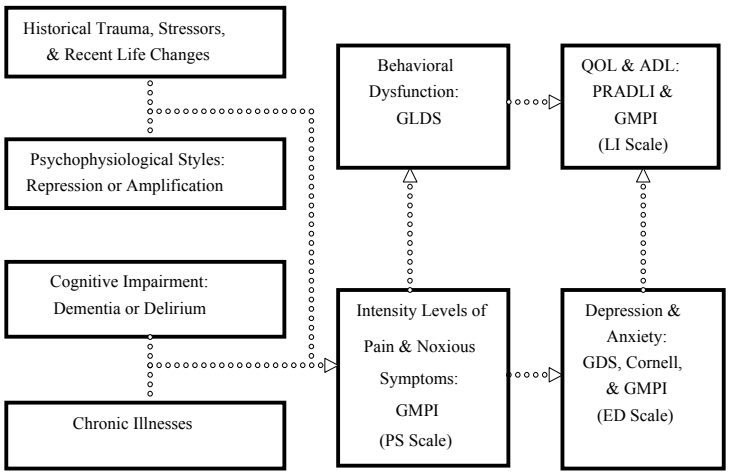
- Recent Infection last month
- Recent hospitalization
- Change in medical status
- Disfigurement
- Terminal diagnosis
- New disability
- Failed Rehab
- Decline in functional capacity
- Loss/decline of sight
- Loss/decline of hearing
- Decline in oral intake status
- Chronic Noxious Symptom(s)

Recent and Historical Stressors in LTC

- **Social/Family** Last five-ten years
- Perceived abandonment
- Perceived neglect
- Perceived financial abuse/loss/stress
- Separation from spouse
- Separation from child
- Loss of spouse (death)
- Loss of child (death)
- Loss of family (death)
- Death of close friend(s)
- Death of roommate
- Difficulties with Family
- Loss of Home/Car
- Loss of Social Support

- **Historical** Trauma/Themes
- Death of Parent
- Abandonment/Neglect
- Parental/Spouse Sub. Abuse
- Emotional Neglect/Abuse
- Death of Sibling(s)
- Perceived Physical abuse
- Perceived Sexual abuse
- Marital Physical Abuse
- Marital Emotion Abuse
- Natural Disaster/Traumatic stress
- Chronic Illness <65 <70 <75 yrs
- Death of child/spouse
- Interpersonal difficulties

Quality of Life in Long-term Care

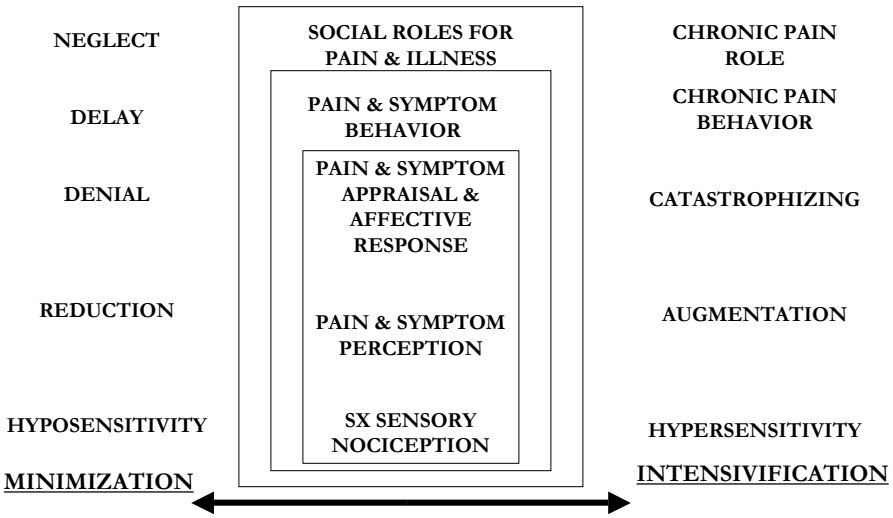


Model for Quality of Life in LTC

Subjective vs. Objective Pain Assessment

DYSFUNCTION **FUNCTIONAL** **DYSFUNCTION**

Dworkin & Whitney (1992), Handbook of Pain Assessment, ed Turk & Melzack



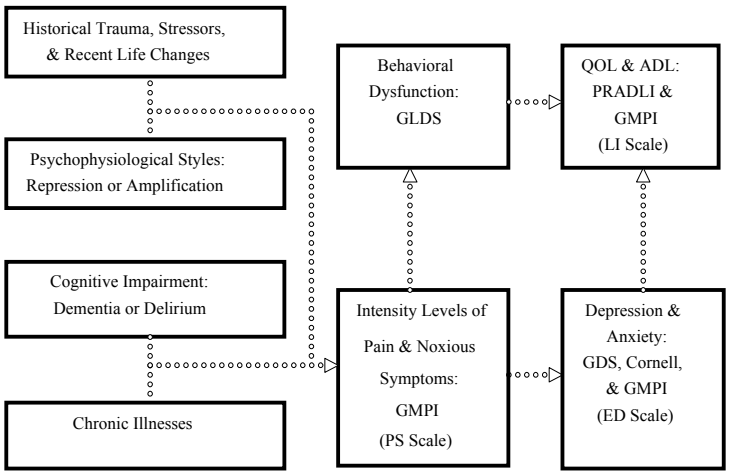
Personality & Interpersonal Styles: Affects on the Person's Reporting of Physical and Emotional Symptoms

Interpersonal Styles	Personality Styles	Personality D/Os
Socially Skilled: **Under report**	Confident, Socially outgoing, Active Independent	Narcissistic Histrionic Charismatic Exploitive
Emo. Repressed Socially Passive **Under report**	Cooperative Rule Oriented Loner Introversive	Dependent Obsessive Compulsive Schizoid Schizotypal
Socially Volatile **Over report**	Inhibited-cautious Civilly disobedient Actively cautious Forceful	Avoidant-anxious Passive aggressive Negative-Anx/Depressed Antisocial Exploitive

Psychophysiological Styles: Affects on presentation, somatization, report of illness experience, and report of emotional distress.

Psychophysio. Style	Personality Traits	Pathologicial Conditions
Repressor I: **Under report**	Positive Unemotional Socially Desirable	Pollyannaish-Denial Alexithymic Psychologically Naive
Repressor II: **Under report**	Cog. Absorption Trance Ability Dissociative Ability	Somatic Stress D/Os Conversion D/Os Somatization D/Os
Amplifiers: **Over report**	Emotional Threat Cautious Hypersensitive	Neurotic-Labile Pessimistic Dysthymic Catastrophic Hypochondrical Anxiety D/Os

Quality of Life in Long-term Care



Model for Quality of Life in LTC

Medical Conditions Associated with Chronic Pain in LTC

Osteoporosis, Arthritis, DJD, Sights of old fractures,
Peripheral Vascular Disease, CVAs, Diabetes,
Neuropathies, Sympathetic-RSD, MS, Parkinson's ,
G.I.: Ileus, gastritis, peptic ulcers, diverticulosis,
Renal conditions: ESRD, stones, bladder distention,
Connective Tissue Diseases,
End stage Cancer,
Myofascial injuries or D/O, Fibromyalgia

American Medical Directors Association

Prevalence Rates of Chronic Pain in LTC

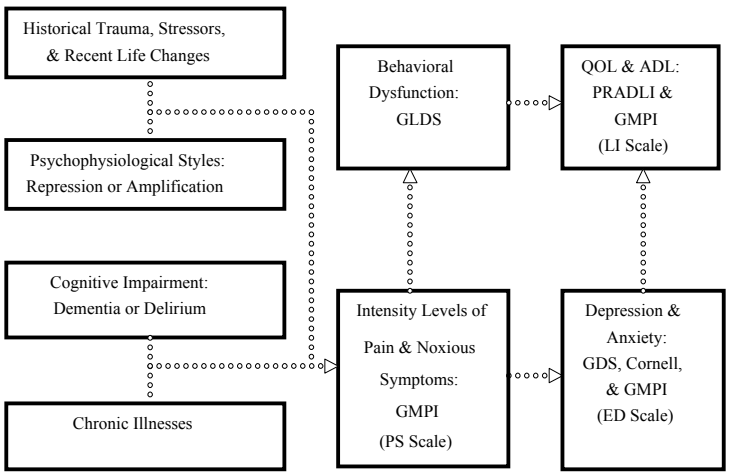
25% Report chronic pain,

50% Report intermittent pain that decreases QOL

40%	Arthritis or DJD (Low back pain, knees, etc.)
15%	Site of previous fractures (hip, osteoporosis)
10%	Neuropathies
10%	Leg cramps
10%	Claudication
10-30%	Cancer

35% Report pain at multiple sites

Quality of Life in Long-term Care



Model for Quality of Life in LTC

Reisberg's Stages/Levels of Dementia

Stage of Dementia & Cognitive Impairment	Functional Abilities: FAST	Mental Age: Retrogenesis
Stage 1--Normal No complaints	1: Holds a job	Adult--ability for formal thought processes
Stage 2--Very mild deficits. Forgetfulness	2: Holds a job	Adult--ability for formal thought processes
Stage 3--Early Confusion Mild Cognitive Impairment (MCI)	3: Holds non-demanding job	12+ years
Stage 4--Late Confusion Dementia Mod. Cog. Impair.	4: Needs daily to 24 hour supervision	8-12 years, behavioral problems start.
Stage 5--Early Dementia Severe Cog. Impair	5: Needs 24 hour supervision, some help	5-7 years, modified independent in ADL
Stage 6--Middle Dementia Mod Sev Cog. Impair.	6: Needs mod to Max assistance in ADL	2-5 years of age
Stage 7--Late Dementia	7: Loss of verbal and sensory motor abilities.	18 months and below

Behavioral Manifestations of Pain in the Demented Elderly

Daisha J. Cipher, PhD,
P. Andrew Clifford, PhD,
and Kristi D. Roper, PhD

In long-term care settings, behavioral disturbances are exhibited more often by those residents with some level of cognitive impairment. The extent to which pain influences dysfunctional behaviors, and the extent to which pain manifests itself as dysfunctional behaviors, has not been empirically studied. The purpose of our study was to investigate the relationship between pain and behavioral disturbances among long-term care residents suffering from varying levels of dementia. A cross-sectional study of 277 long-term care residents aged 60 and older was conducted to (1) determine the influence of pain on the number, intensity, frequency, and duration of dysfunctional behaviors; (2) investigate the differences between residents with varying levels of dementia who were suffering from acute pain in the intensity, frequency, and duration of 19 behavioral categories; and (3) investigate the differences between residents with varying levels of dementia who were suffering from chronic pain in the intensity, frequency, and duration of 19 behavioral categories. Results suggest that pain influenced behavioral disturbances among those with severe dementia more often than those with moderate or mild dementia, and residents with chronic pain who have severe dementia exhibit significantly more dysfunctional behaviors than those with earlier-stage dementia. These findings support the utility of comprehensive behavioral analysis involving clinical ratings of intensity, frequency, and duration of dysfunctional behaviors, with the assessment of the resident's level of dementia. Moreover, our results imply that pain and other forms of physical suffering must be adequately treated in order to reduce behavioral disturbances and improve quality of life.

Keywords: Behavioral disturbances; pain; long-term care; elderly

J Am Med Dir Assoc 2006; 7: 355–365)

"Behavioral Indicators of Chronic Pain in the Demented Elderly"

Cipher, Clifford, & Roper (2006)

Across all dementia levels:

- Depression
- Withdrawal
- Loss of wt. or appetite
- Inactivity

Lower levels of dementia :

- Increased unrealistic demands

Higher levels of dementia:

- More aggressive behav.
- More Agitation
- More Wandering
- More Soc. disruptive behav.
- More distressing repetitive behav.

Different types of Dementia effect pain perception and affective presentation

- AD: decreased affective components, thus increased pain tolerance; no change in pain threshold however; therefore blunt reaction to mild pain and normal reaction to high levels of pain.
- Frontotemporal dementia: decreased cognitive-evaluative and sensory-discriminative components, can't anticipate or make timely withdraws from painful stimuli

Scherder etal 2003, 2005 ref: 79a, 79b

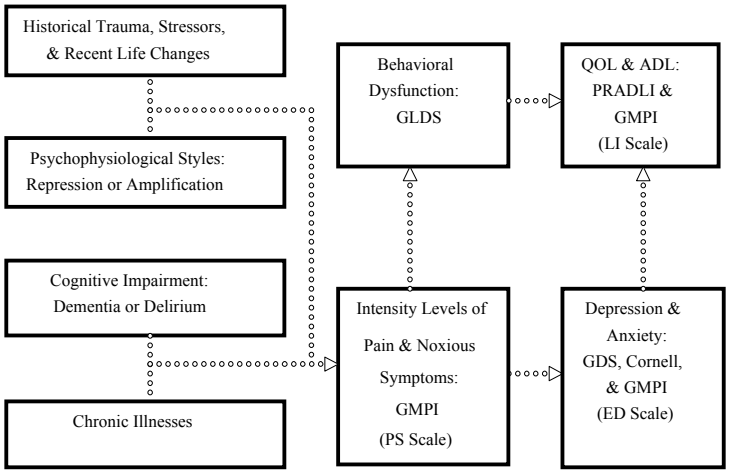
Different types of Dementia effect pain perception and affective presentation

- Vascular dementia: these patients may present with increases the affective component of pain. These patients may be less pain tolerant.
- MS and Parkinson's patients without cognitive impairment present with increased affective suffering secondary to pain. Thus these patients may be less pain tolerant.

Scherder etal 2003, 2005 ref: 79a, 79b

Quality of Life in Long-term Care: GRRAS--

Geriatric Rehabilitation and Restorative Assessment System



Model for Quality of Life in LTC

The Geriatric Multidimensional Pain and Illness Inventory: A New Instrument Assessing Pain and Illness in Long-Term Care

P. Andrew Clifford, PhD, Daisha J. Cipher, PhD & Kristi D. Roper, PhD

Clinical Gerontologist (2005), Vol. 28(3), pp 45-61

ABSTRACT. The Geriatric Multidimensional Pain and Illness Inventory (GMPI) was developed in order to assess the perceptual, functional, and emotional concomitants of pain and illness in long-term care. The GMPI was administered to 401 adults aged 60 and older residing in one of 16 long-term care facilities. The GMPI items were analyzed for reliability, content validity, and convergent and discriminant validity. Factor analysis of the GMPI items revealed three subscales, level of pain severity, level of functional limitations associated with pain, and level of emotional distress associated with pain. The GMPI items were significantly correlated with items from the Geriatric Depression scale, the Neurobehavioral Cognitive Status Exam, and the Activities of Daily Living. The GMPI is evidenced to be a reliable and valid assessment tool for assessing pain of residents in long term care facilities. Its brevity and clearly defined assessment criteria are assets to the administering clinician. Research on the utility of the GMPI as a treatment outcome instrument in long-term care is warranted. The potential for social workers and registered nurses to administer the GMPI in long-term care settings is discussed. *[Article copies available for a fee from The*

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KEYWORDS. Long-term care, pain, elderly, assessment

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Digital Object Identifier: 10.1300/J018v28n03_04

Geriatric Multidimensional Pain and Illness Inventory

Item Composition of the GMPI Subscales

FACTOR LOADING	GMPI ITEM
[redacted]	
.[redacted]	[redacted]
.[redacted]	[redacted]
.[redacted]	[redacted]
	[redacted]
[redacted]	
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Behavioral Health Questionnaire & the GMPI:

Acute & Chronic Noxious Medical Conditions which are associated with dysfunctional behaviors

Symptom Severity:	**None**		**Mild**			**Moderate**			**Debilitating**	
Pain	1	2	3	4	5	6	7	8	9	10
Concentration/Memory problems	1	2	3	4	5	6	7	8	9	10
Disfigurement/Appearance	1	2	3	4	5	6	7	8	9	10
Dizziness	1	2	3	4	5	6	7	8	9	10
Incontinence	1	2	3	4	5	6	7	8	9	10
Loss of appetite	1	2	3	4	5	6	7	8	9	10
Loss of vision or hearing	1	2	3	4	5	6	7	8	9	10
Shortness of breath	1	2	3	4	5	6	7	8	9	10
Sleep disturbance	1	2	3	4	5	6	7	8	9	10
Stomach/GI discomfort	1	2	3	4	5	6	7	8	9	10
Tremors-Parkinson's	1	2	3	4	5	6	7	8	9	10
Weakness	1	2	3	4	5	6	7	8	9	10
	No noticeable Illness behaviors		Occasional illness behaviors			Illness behaviors are interfering or distracting …			intensely disabling	dramatically disabling
	< 10%		<25 %	<40 %	≥40%	≥50%	≥75%	<50%	≥50%	≥75%

GMPI: Item 3

COMMON PAIN BEHAVIORS:

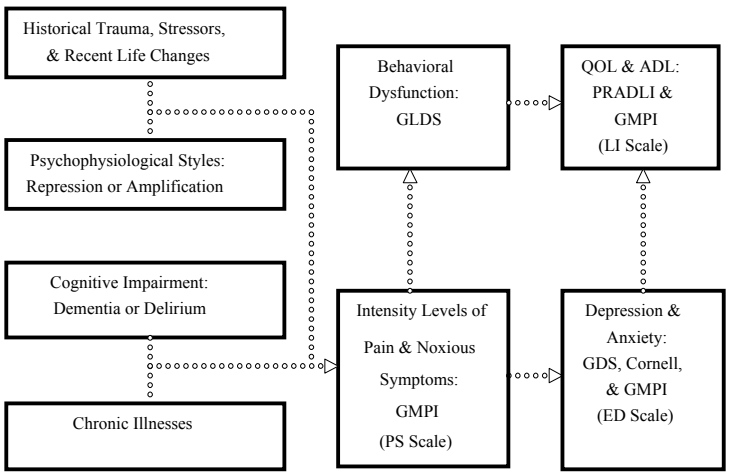
- **Facial Expressions:** frown, sadness, frightened face, grimace, furrowed brow, tightened lips, clenching jaw, distorted expressions, rapid blinking, tightly closed eyes
- **Verbalizations:** moans, groans, grunts, crying spells, gasps, sighing, verbal hostility, noisy breathing, repetitive asking for help, anxious repetitive babbling, calling out
- **Body movements:** bracing, clutching bed side rails, tense posturing, fidgeting, rocking, restlessness, shifting positions in bed or wheelchair**,** antalgic gait, pacing, agitation
- **Changes in activities:** refusing to get out of bed, refusing to stay seated, increase rest periods, refusing to eat, disturbed sleep, cessation of enjoyable activities, increased wandering
- **Changes in social interactions:** resisting or refusing care, refusing social activities, increased neediness, withdrawn, verbal or physical aggression, unreasonable demands, repetitive demands to see the doctor or nurse,
- **Mental status changes:** low frustration tolerance, learned helplessness, depression, crying, tears, increased confusion, anhedonia, irritability, dissociation-staring into space, self-neglect, loss or appetite, loss of motivation

Adapted & expanded from AGS Panel on Persistent Pain in Older Persons, JAGS 50:S205-S224. 2002

COMMON ILLNESS BEHAVIORS:

- **Facial Expressions:** frown, sadness, frightened face, irritable face, tightened lips, clenching jaw, distorted expressions, distressed face, glaring, whimpering
- **Verbalizations**: decreased verbalizations, grunts, gasps, sighing, verbal hostility, noisy breathing, repetitive asking for help, anxious repetitive chanting, calling out
- **Body movements:** bracing, listless, clutching bed side rails, lethargic, fidgeting, restlessness, touching self, fetal position-draws up legs, pacing, agitation
- **Changes in activities:** refusing to get out of bed or leave the room, refuses to eat, increased rest periods, disturbed sleep, cessation of enjoyable activities, increased wandering
- **Changes in social interactions:** resisting or refusing care, refusing social activities, increased neediness, withdrawn, verbal or physical aggression, unreasonable demands, repetitive demands to see the doctor or nurse, demanding one-on-one attention
- **Mental status changes:** low frustration tolerance, learned helplessness, depression, crying, tears, lethargy, increased confusion, anhedonia, irritability, dissociation-staring into space, increased distractibility, decreased concentration, increased self-neglect, loss or appetite, loss of motivation, loss or interest in activities, flat affect.

Quality of Life in Long-term Care



Model for Quality of Life in LTC

Assessing Dysfunctional Behaviors in Long-term Care: The Geriatric Level of Dysfunction Scale (GLDS)

P. Andrew Clifford, PhD,
Daisha J. Cipher, PhD,
and Kristi D. Roper, PhD

Objective: The Geriatric Level of Dysfunction Scale (GLDS) was developed to assess the intensity, frequency, and duration of 19 behavioral disturbance categories that can potentially interfere with longterm care.
Design: Secondary analysis of data collected from residents in long-term care facilities.
Participants: Participants were 399 adults aged 60 and older residing in one of 16 long-term care facilities.
Results: The GLDS items were analyzed for reliability, content validity, and convergent and discriminant validity. The GLDS items were significantly correlated with items from the Geriatric Multidimensional Pain and Illness Inventory, Geriatric Depression Scale, Neurobehavioral Cognitive Status Examination, and the Psychosocial Resistance to Activities of Daily Living Index.
Conclusions: The GLDS is evidenced to be a reliable and valid assessment tool for assessing dysfunctional behaviors of residents in long-term care facilities. Its brevity and clearly defined assessment criteria are assets to the administering clinician. Research on the utility of the GLDS as a treatment outcome instrument in longterm care is warranted. The potential for psychologists, physicians, social workers, and registered nurses to administer theGLDS in long-term care settings is discussed.

Keywords: Long-term care; behavioral disturbances; elderly; assessment

(J Am Med Dir Assoc 2005; 6: 300–309)

Behavioral Problems

Geriatric Level of Dysfunction Scale (GLDS) rates each dysfunctional behavior for intensity, frequency, and *duration per day* as indicated below

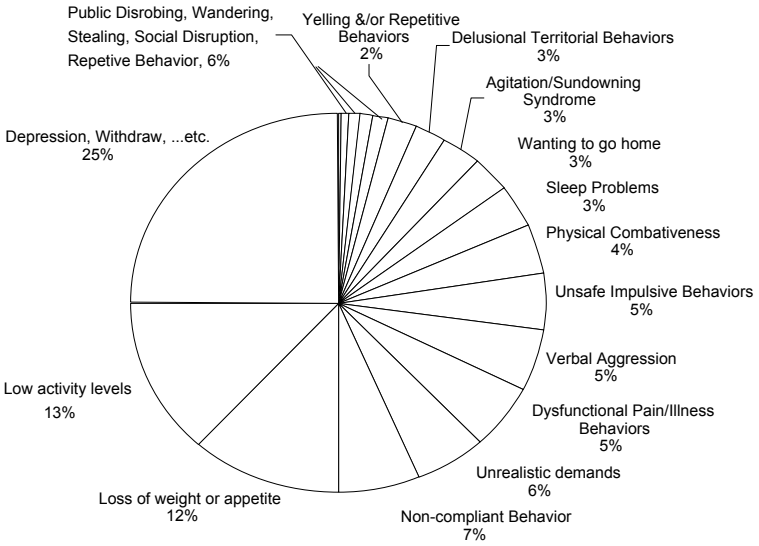
Immediate Danger to self or others	Possible Danger to self or others	Interfering medical status/care	Disruptive Self/Others/Staff	Distressing Self/Others/Staff	Distressing to staff or family	Tolerable
7	6	5	4	3	2	1
Continuous	**Several times/day**	**Few times/day**	**Once a day**	**2-6 times/week**	**Once/week**	**< twice/month**
> 6 hours/day	***≤ 6 hours/day.***	***≤ 4 hours/day***	***≤ 2 hours/day***	***≤ one hour/day***	***≤ 30 mins***	***1-2 mins***

Targeted Behavioral Analysis (circle all that apply and indicate level of dysfunction using the LDS):

	I F D		I F D		I F D
Physical Combativeness	___ ___ ___	Depression, Withdraw, Helplessness		Loss of weight	
Verbal Aggression,	___ ___ ___	Low Motivation, suicidality	_5_ 7__7__	Or appetite	_5__7 _7__
Agitation/Hypomania,					
Hyperactivity	_4__ 3__5_	Unrealistic demands	___ ___ ___	Pillaging, Hoarding,	
Non-compliant Behaviors	___ ___ ___	Dysfunctional Pain/Illness behaviors	5__7_ 7 __	Stealing	___ ___ ___
				Unsafe Impulsive	
Distressing repetitive behaviors	___ ___ ___	Public disrobing, Sexual Behaviors	___ ___ ___	Behaviors	___ ___ ___
Distressing delusional Behaviors	___ ___ ___	Wanting to go home	___ ___ ___	Low Activities	
Yelling/Repetitive verbalizations	___ ___ ___	Wandering	___ ___ ___	Levels	_5_ _7__7_
Socially Disruptive Behaviors	___ ___ ___	Distressing anxious behaviors	___ ___ ___	Sleep Problems	___ ___ ___

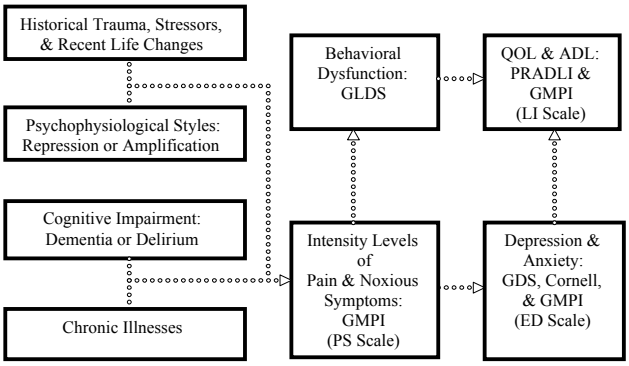
Frequencies of Dysfunctional Behaviors

Cipher, Clifford & Roper 2004, 2005



Interdisciplinary Treatment Outcome Assessment

GMCBT Assessment & Treatment Effectiveness Model



Current Studies: GRRAS Concurrent Validity & Reliability

- MMSE, DRS-2 and ILS for determining levels of dementia affects on GRRAS ratings.
- Psychophysiological Styles--Geriatric Admission of Common Faults Scale (GACFS), Geriatric Cognitive Absorption Scale (GCAS) & Geriatric Emotional Disclosure Scales (GEDS).
- Recent & Historical Stressful Events Scale in LTC
- GRRAS in LTC and Inpatient Rehab Settings comparing asymptomatic and distressed populations.
- Comparing CMAI & NPI Scales with GRRAS
- Comparing NOPPAIN, PADE, NBPS with GMPI
- Inter-rate reliability studies and training systems for GRRAS.

Psychological Assessment Determines GMCBT Treatment in LTC

Therapeutic Conceptualization & Process:
A real life model/paradigm

- Personality and Somatization Style
- Cognitive Status-Level of Dementia (accommodation)
- Risk Factors-Historical and Current Stressors/Themes
- Therapeutic Domains (Treatment Goals)
- Multidisciplinary Care Plans & CBT Interventions
- Stage of Change for each Therapeutic Domain

  Precontemplative
  Contemplative/Relapse
  Action with Support
  Self Directed Action-Maintenance

Multimodal Cognitive-Behavior Treatment

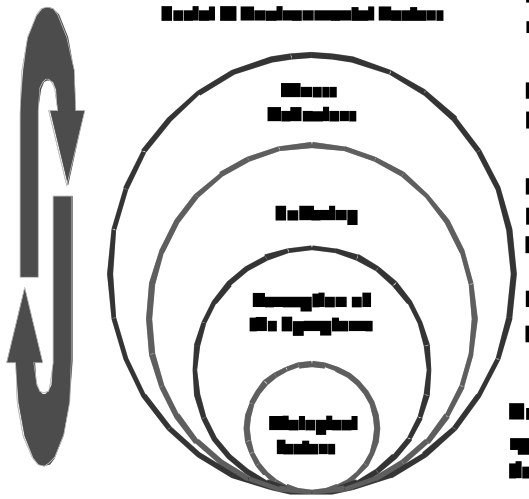
Real Life Efficacy/Effectiveness Studies

Adapted from M.E.P. Seligman (1995) Am Psychologist, 50, 965-974

- Assessment is standardized and comprehensive, & number of treatment sessions is dependent on medical necessity, and Tx focuses on multiple, parallel & interacting problems.
- Patients are their own controls—Monthly f/u evals.
- Treatments are manualized—but multimodal, transtheoretical, interdisciplinary, collaborative, individualized, creative, & self-correcting.
- Target outcomes are well operationalized, & Treatment seeks to improve general functioning, and ameliorate Symptoms.
- Clinicians & Raters utilized multiple sources and therapeutic agents (patient, family, friends & health care providers).
- Following termination of care, comprehensive f/u assessments are conducted.

Pain Management: Socialization of Patient, Family & Caregivers

Five Dimensions of Chronic Pain



Pain Management: Socialization of Patient, Family & Caregivers

The Pain Gate

Intense Pain

Factors that Increase Pain:

- Muscle Tension
- Anxiety, Anger, Depression
- Inactivity
- Catastrophizing
- Overexertion
- Increased attention to pain
- Nervous Arousal

Open Gate

Pain Trigger

Less Pain

Factors that Decrease Pain:

- Muscle Relaxation
- Counter-Stimulation
- Heat & Ice
- Happiness, Pleasure
- Distraction/Hypnosis
- Coping Statements
- Confidence/Sense of Control

Closed Gate

Pain Trigger

Treatment Goals: Focusing multiple, parallel & interacting problems.

Stabilization of depressed mood
Stabilization of anxious/irritable mood.
Pain/Med. symptom management
Improved ADL compliance
Improved cognitive functioning
Increase compliance with PT/OT/Med
Adjustment to terminal illness
Decreased dysfunction or inappropriate behaviors
Adjustment to physical disabilities or limitations
Adjustment to need for NH placement
Decrease family conflict, dysfunction or distress
Recreational/ Social/Spiritual functional restorations.
Weight management, increase or decrease.
Adjustment to difficult roommate

Behavioral Interventions: Patients are their own controls—ABAB design

Social reinforcement/facilitation Beh Rehearsal/Exposure/Habituation	Exercise (PT/OT/Restore) Motiv. Eating Motivation
Over Learning Behavioral Practice	Social Skills Training
Communication/ Empathy Skills	Assertiveness/ "Go Tell" Skills
Relaxation Training	Breathing Training
Relaxation Scheduling & Motivation	Rec/Soc Act Scheduling & Motiv.
Substance or sweets abstinence	Diet Compliance and Motivation
Up & Down time Monitoring	Self Monitoring of activities

Cognitive Interventions: Accommodates to patient's values and cognitive capacity

Orientation Exercises/Situational Analysis	Re-appraisal of situation/Theme Suggestion/Over practice
Emotional/Cognitive Empathy & Validation	Pleasure/Mastery List
ID Auto. Negative Thoughts and redirection	Rational/Realistic Thinking/Theme Dev.
Goal directed behavioral planning	Problem Solving/Theme Motivation
Validation/Attitude Clarification/Affirmation	Advantages-Disadvantages
Motivational interviewing and redirection	EMS identification & countering
Self-Hypnosis/Meditation/Visualization	Stage of change facilitation
Logotherapy/Life Theme/Meaning Work	Socialization to CBT

Stage of Change: Timing of Cognitive-Behavioral Interventions

Precontemplative	Contemplative/Relapse	Action with Support	Self-Directed
Psychoeducation: Socialization to CBT* Orientation to and demonstration of Biofeedback Orientation to Hypnotherapy and Cognitive Analgesia Orientation to basic CPT Principles Exploration of CPT conceptual Models Behavioral Monitoring* Behavioral Experiments* Thought-Feeling Worksheet Mastery-Pleasure Worksheet* Advantages and Disadvantages* Up & Down time monitoring*	**Psychoeducation** **Social Facilitation** **Exploring, Refuting, and Disarming Preoperational Barriers to Change:** Exploring Automatic Negative Thinking (ANT) Exploring Dysfunctional Assumptions (DA) Exploring Early Maladaptive Schema (EMS) Identifying Positive Life Themes as Counters* Downward Arrow Technique Learning Rational and Realistic Alternatives to ANT Exploring the Advantages and Disadvantage of Early Maladaptive Schema, Beliefs and Assumptions Validation Interventions* Indirect Suggestion/Redirection*	**Psychoeducation** **Social Facilitation** **Behavioral Interventions:** Behavioral Rehearsal/Exposure/Habituation* Exercise (PT/OT/Restore) Motivation* Eating Motivation* Over Learning Behavioral Practice* Social Skills Training* Communication/ Empathy Skills* Assertiveness/ "Go Tell" Skills* Relaxation Training * Breathing Training * Relaxation Scheduling & Motivation* Rec/Soc Act Scheduling & Motivation* Substance or sweets abstinence* Diet Compliance and Motivation* Stage of change facilitation*	Transtheoretical Approach
Social Facilitation: CPT Treatment Contract Analgesic Contract Specific Behavioral Contracts, which set limits to dysfunctional behaviors* Family Contracts, which set limits to dysfunctional behaviors* Validation Interventions* Habituation* Redirection* Indirect Suggestion/Redirection* Social reinforcement/facilitation*	**Restructuring Metacognitive Style:** Rational Emotive Techniques Learning the Empirical Method Learning Post Conventional Thinking Developing Value Based Reasoning* Developing Paradigmatic Thought Developing a Personal Spiritual Integration Logotherapy/Life Theme/Meaning Work* EMS identification & countering	**Cognitive Interventions:** Orientation Exercises/Situational Analysis* Re-appraisal of situation* Emotional & Cognitive Empathy & Validation* Motivational interviewing * Rational/Realistic Thinking/Theme Dev.* Goal directed behavioral planning* Problem Solving/Theme Motivation* Advantages-Disadvantages* Validation & Attitude clarification/affirmation* Pleasure/Mastery List* Meditation training/ Guided Visualization*	* **Appropriate for Mild to Moderate Dementia Patients**

Initial Geropsychological Therapy Care Plan

Problem:

Psychological Disorder affecting Quality of Life (QOL)
Diagnosis:

Seriousness of problem: 1) Possible Danger to self or others; 2) Interfering with medical care, 3) disruptive to self or others, and/or 4) very distressing to self or others.

Barriers to Change and/or Complications to treatment & QOL:
Medical Delirium;
Dementia;
Chronic noxious medical symptoms or conditions that are exacerbated when resident is active:

Disfigurement/Appearance	Dizziness/Balance px	Incontinence
Loss of appetite	Loss of vision or hearing	Nausea/GI discomfort
Paralysis	Shortness of breath	Sedation/Sleep Px
Tremors-Parkinson's	Weakness/Fatigue	Concentration/Memory Px

Others:

Acute/Chronic Pain: Site(s):

Targeted Behavioral Symptoms of the Disorder(s):
1. Physical Combativeness
2. Verbal Aggression
3. Agitation/Hypomanic/Hyperactive Beh.
4. Non-compliance
5. Distressing repetitive behaviors
6. Distressing delusional behaviors
7. Screaming/Yelling
8. Socially Disruptive/Inappropriate Behaviors
9. Helplessness/Low Motivation Withdrawal,
10. Depression, and Social isolation (Suicidal Ideation)
11. Demanding w/ unrealistic expectations
12. Dysfunctional Illness/Pain Behaviors
13. Public Disrobing, Sexual Behavior
14. Wanting to go home
15. Wandering
16. Distressing Anxious Behaviors
17. Low Appetite/Wt loss
18. Rummaging, Pillaging, and Hoarding
19. Impulsive/Disinhibited Unsafe behaviors
20. Low activity levels
21. Sleep Problems

OTHERS:

Measurable Goals

Immediate/Short-term: (_____weeks)

Lower the Seriousness/Intensity of the problem(s), measured by the Geriatric Level of Dysfunction Scale (GLDS)
Interdisciplinary consultation and intervention in order to managed both psychological and medical symptom barriers to resident's activity levels and QOL—measured by the Geriatric Multidimensional Pain/Illness Inventory (GMPI).
Interdisciplinary consultation and intervention in order to managed targeted behaviors that interfere with Activities of Living (ADL). These interventions will lower the intensity, frequency and duration of targeted behaviors measured by the GLDS and improve QOL measured by the Psychosocial Resistance to ADL Inventory (PRADLI)
Decrease negative statements measured by lower scores on the Geriatric Depression Scale (GDS), and the GMPI—Emotional Distress Scale.
OTHERS:

Long-term Goals: (_____weeks)
Maximize QOL by eliminating irrational resistance to ADLs and maximizing residents independence measured by PRADLI.
Manage or eliminating dysfunctional behaviors associated with dementia, chronic illnesses, and noxious medical symptoms measured by the GMPI and GLDS.
Facilitate a general sense of wellbeing, indicated by low scores and GDS, and GMPI—Emotional Distress scale.
OTHERS:

Approaches:

_____Estimated Weeks of Multimodal Geropsychological Therapy:
Individual (face-to-face) Therapy (with or without family members present):
40 min twice/week; 20min twice/seek; 40min once/week; 20min once/week

Individual Therapy: _____sessions.
Family Therapy: _____sessions.
Group Therapy: _____sessions.

Likely Techniques and Modalities to be provided by Licensed Psychotherapist:

BEHAVIORAL INTERVENTIONS	COGNITIVE INTERVENTIONS
1. Social reinforcement/facilitation	1. Orientation Exercises/Situational Analysis
2. Behavioral Rehearsal/Exposure/Habituation	2. Re-appraisal of situation
3. Exercise (PT/OT/Restorative) Motivation	3. Emotional/Cognitive Empathy & Validation
4. Eating Motivation	4. Motivational interviewing and redirection
5. Over Learning Behavioral Practice	5. ID Auto Negative thoughts and redirection
6. Social Skills Training	6. Rational/Realistic Thinking/Theme Dev.
7. Communication/ Empathy Skills	7. Goal directed behavioral planning
8. Assertiveness/ "Go Tell" Skills	8. Problem Solving/Theme Motivation
9. Relaxation Training	9. Advantages-Disadvantages
10. Breathing Training	10. Attitude clarification/affirmation
11. Relaxation Scheduling & Motivation	11. Pleasure/Mastery List
12. Rec/Soc Act Scheduling & Motivation	12. EMS identification & countering
13. Substance or sweets abstinence	13 Meditation training/Visualization
14. Diet Compliance and Motivation	14. Stage of change facilitation
15. Up & Down time monitoring Training	15. Logotherapy/Life Theme/Meaning Work
16. Self Monitoring Training	16. Socialization to CBT

OTHER PROSSIONAL TECHNIQUES OR INTERVENTIONS:

AN INTERDISCIPLINARY APPROACH:
Initially psychotherapy will establish a warm supportive emotional relationship with the resident as a basis for facilitating behavioral change and improved mood. While treating the psychological disorder therapists will consult weekly or monthly (as needed) with involved caregivers and family members, in order to generate a variety of individualized approaches that assist caregivers in improving the resident's daily quality of life. As psychotherapy progresses the psychotherapist will develop with nursing, family and involved CNAs an individualized care plan for each targeted symptoms and/or behaviors in order generalized therapeutic gains and measurably improve QOL.

Specific Care Plan: Dysfunctional Pain/Illness Behaviors

Problem

Dysfunctional Pain & Illness Behaviors

Pain Sites:

Diagnosis:

Level of Dysfunction (GLDS)
Intensity:
Freq:
Duration:

Antecedents:

SOCIAL 1 on 1 Too much stimulation Spefic ADLs:

ACTIVITY: Too little stimulation High need for attention

OTHER Antecedents to Behaviors Problems:

Possible Biopsychosocial Triggers:

Recent Changes	Medical Changes	Acute/Chronic SX
1.Change in residence 1-3 months 2.Change in residence this year 3.Change in social activities 4.Change in roommate 5.Roommate Diff. 6.Change of room 7.Change in caregiver(s) 8.Difficulties with caregiver(s) 9.Difficulties with another resident(s) 10.Recipient of verbal abuse 11.Recipient of physical abuse 12.Loss of social status or role 13.Loss of productivity	1.Recent Infection last month 2.Recent hospitalization 3.Change in medical status 4.Disfigurement (last year) 5.Terminal diagnosis 6.New disability 7.Failed Rehab 8.Decline in functional capacity 9.Loss/decline of sight 10.Loss/decline of hearing 11.Decline in oral intake status 12.Chronic Noxious Symptom(s)	1.Pain 2.Delirium, 3. Dementia, 4.Concentration/Memory problems 5.Disfigurement/Appearance 6.Dizziness/Balance px 7.Incontinence 8.Loss of appetite 9.Loss of vision or hearing 10.Nausea/GI discomfort 11.Paralysis 12.Shortness of breath 13.Sleep disturbance 14.Tremors-Parkinson's 15.Weakness/Fatigue OTHERS

Goals

Short-term: (____ weeks)

GDS:

GMPI:
Depression:

Anger/Irritability/Frustration:

Anxiety/Worry/Tension:

GLDS:

Intensity:
Freq:
Duration:

Long-term Goals:(____weeks)

GDS:

GMPI:

Depression:

Anger/Irritability/Frustration:

Anxiety/Worry/Tension:

GLDS:

Intensity:
Freq:
Duration:

Approaches

GENERAL:

1. Validate resident's feelings of discomfort, anxiety, helplessness: (e.g., "I know it feels impossible to anything right now.") Most noxious symptoms cause anxiety, so encourage relaxation practice using techniques outlined below.
2. Get patient to agree to small activity goals, i.e. being out of bed for 5-20mins then reconsider the situation and his/her feelings. Often getting out of bed feels good after 20 minutes or resident recognizes why they resist out of bed time—pain, dizziness, nausea, anxiety etc, then TX the SX. Based on these findings, consider routine medications prior to up time.
3. Identify desired behavior (form LTC Pleasant Event Schedule) and in very small steps, and one at a time use calm encouragement to facilitate and motivate effort.
4. Repeat desired behavior PRN.Provide encouragement and positive reinforcement for even the smallest successes and for acceptance of your help. Use sincere, concerned, and supportive tone of voice.
5. Never challenge, confront or try to "reason with" the resident with an authoritarian tone of voice. Always validating and encouraging with suggestions listed below.
6. Do not provide more assistance than is truly needed.
7.Realize that a resident's protest may be justified. Always consider that pain or a noxious medical symptom may be the reason for poor motivation. Attempt to assess and treat these symptoms. Also validate the mild to moderate symptoms that are refractory, and encourage the pursuit of quality of life despite the symptom.
8. Whenever possible involve family members and volunteers to help facilitate out or bed and room time.

SPECIFIC MOTIVATIONAL OR REDIRECTION THEMES:

SPECIFIC BEHAVIORAL

Specific Care Plan: Weight Loss, Refusing to eat, or drink

Problem

Refusing to Eat or Drink
(low appetite and serious weight loss)

Diagnosis:

Level of Dysfunction (GLDS)
Intensity:
Freq:
Duration:

Antecedents:
Noise CLUTTER: LIGHTING: ADLs
SOCIAL 1 on 1 Too much stimulation
ACTIVITY: Too little stimulation High need for attention
OTHER Antecedents to Behaviors Problems:

Possible Biopsychosocial Triggers:

Recent Changes	Medical Changes	Acute/Chronic SX
1.Change in residence 1-3 months 2.Change in residence this year 3.Change in social activities 4.Change in roommate 5.Roommate Diff. 6.Change of room 7.Change in caregiver(s) 8.Difficulties with caregiver(s) 9.Difficulties with another resident(s) 10.Recipient of verbal abuse 11.Recipient of physical abuse 12.Loss of social status or role 13.Loss of productivity	1.Recent Infection last month 2.Recent hospitalization 3.Change in medical status 4.Disfigurement (last year) 5.Terminal diagnosis 6.New disability 7.Failed Rehab 8.Decline in functional capacity 9.Loss/decline of sight 10.Loss/decline of hearing 11.Decline in oral intake status 12.Chronic Noxious Symptom(s)	1.Pain 2.Delirium, Dementia, Concentration/Memory problems 3.Disfigurement/Appearance 4.Dizziness/Balance px 5.Incontinence 6.Loss of appetite 7.Loss of vision or hearing 8.Nausea/GI discomfort 9.Paralysis 10.Shortness of breath 11.Sleep disturbance 12.Tremors-Parkinson's 13.Weakness/Fatigue OTHERS

Goals

Immediate/Short-term: (____ weeks)

GMPI:

GLDS:
Intensity:
Freq:
Duration:

PRADLI:

Long-term Goals:(____weeks)

GMPI:

GLDS:
Intensity:
Freq:
Duration:

PRADLI:

Approaches

GENERAL:
1.State required behaviors simply and in the affirmative: (i.e., one bite or one sip please)
2.Validate resident's feelings of discomfort, anxiety, helplessness, and even nausea: (e.g., "I know you don't feel like eating right now.") Anxiety can exacerbate any medical SX including nausea or SOB, so encourage relaxation practice using techniques outlined below. Many residents will deny being anxious and only report physical SX, and then refuse to eat or drink.
3.Simply state consequences of failing to comply and the benefits of complying.
4.Get patient to agree to small goals, i.e. taking one bite every minute for ten total bites. Often getting a little food in the stomach helps reduce anxiety and nausea.
5.Provide encouragement and positive reinforcement for even the smallest effort and behavioral successes. Use relaxation techniques and motivational themes every step of the way towards behavioral goals.
6.Never challenge, confront or try to "reason with" the resident with an authoritarian tone of voice. Repeat desired behaviors and motivational themes constantly, repeatedly, or PRN.
7.Use sincere, concerned, and supportive tone of voice.
8.Suggest reasonable reappraisals of negative food statements, ie—for "this food is terrible, "%?@#" , or uneatable" suggests that the food is "not desirable, mediocre, or blah, but is a means to the resident's goal—see motivational themes below.
9.Whenever possible involve family members, friends and volunteers to help facilitate appropriate eating and drinking outlined in this care plan. Family and friends can bring in food and eat together and then eat the facilities food together.

SPECIFIC MOTIVATIONAL OR REDIRECTION THEMES:

SPECIFIC BEHAVIORAL TECHNIQUES:

Relaxation technique:

Specific Care Plan: Depression—Negative Statements

Problem

Negative Statements & Depression

1) Dissatisfaction with life 2) Disinterest with activities 3) Emptiness 4) Boredom
5) Negative mood 6) Worry regarding the future 7) Unhappiness 8) Helplessness
9) Social disinterest 10) Cognitive decline 11) Unable to enjoy life 12) Worthlessness
13) Low energy 14) Hopelessness 15) Low social status 16) Personal suffering
17) Feeling disliked 18) Feeling lonely 19) Depressed about SX 20) Anxious about SX
21) Frustrated w/ SX 22) Unable to cope with SX 23) Wishing for Death 24) Suicidal Ideation
25) Other(s):

Diagnosis:
Level of Dysfunction (GLDS)
Intensity:
Freq:
Duration:
Current Geriatric Depression Score (GDS):_____
Antecedents:
SOCIAL 1 on 1 Too much stimulation Spefic ADLs:
ACTIVITY: Too little stimulation High need for attention
OTHER Antecedents to Behaviors Problems:

Possible Biopsychosocial Triggers:

Recent Changes	Medical Changes	Acute/Chronic SX
1.Change in residence 1-3 months 2.Change in residence this year 3.Change in social activities 4.Change in roommate 5.Roommate Diff. 6.Change of room 7.Change in caregiver(s) 8.Difficulties with caregiver(s) 9.Difficulties with another resident(s) 10.Recipient of verbal abuse 11.Recipient of physical abuse 12.Loss of social status or role 13.Loss of productivity	1.Recent Infection last month 2.Recent hospitalization 3.Change in medical status 4.Disfigurement (last year) 5.Terminal diagnosis 6.New disability 7.Failed Rehab 8.Decline in functional capacity 9.Loss/decline of sight 10.Loss/decline of hearing 11.Decline in oral intake status 12.Chronic Noxious Symptom(s)	1.Pain 2.Delirium, 3. Dementia, 4.Concentration/Memory problems 5.Disfigurement/Appearance 6.Dizziness/Balance px 7.Incontinence 8.Loss of appetite 9.Loss of vision or hearing 10.Nausea/GI discomfort 11.Paralysis 12.Shortness of breath 13.Sleep disturbance 14.Tremors-Parkinson's 15.Weakness/Fatigue OTHERS

Goals

Immediate/Short-term: (____ weeks)

GDS:

GMPI:
Depression:

Anger/Irritability/Frustration:

Anxiety/Worry/Tension:

GLDS:

Intensity:
Freq:
Duration:

Long-term Goals:(____weeks)

GDS:

GMPI:

Depression:

Anger/Irritability/Frustration:

Anxiety/Worry/Tension:

GLDS:

Intensity:
Freq:
Duration:

Approaches

GENERAL:
1.Validate resident's thoughts and feelings. Let them vent for short periods, validate, but do not reinforce with prolonged attention or agree with their statements.
2.Never challenge, confront or try to "reason with" the resident with an authoritarian tone of voice, but always attempting to be validating and encouraging to the resident uses suggestions as listed below.
3.Identify desired enjoyable behavior (from LTC Pleasant Event Schedule) and in very small steps, and one at a time use calm encouragement to facilitate and motivate effort and progress towards desired goals, using relaxation techniques and motivation themes outlined below. Repeat desired behaviors and motivational themes constantly, repeatedly, or PRN.
4.Get patient to agree to small activity goals, i.e. being out of bed or room for 5-20mins then reconsider the situation and his/her feelings. Often getting out of bed or room triggers anxiety and exacerbates medical conditions—pain, dizziness, nausea, anxiety etc, then TX the SX. Based on these findings, consider routine medications prior to up time. Use validation, reapprais als, motivational themes, and relaxation techniques every step of the way toward behavioral goals that objectively counter negative statements and poor quality of life.
5.Provide encouragement and positive reinforcement for even the smallest effort and successes and for acceptance of your appropriate level of help.
6.Use sincere, concerned, and supportive tone of voice. Suggest reasonable reapprais als of negative statements, as outlined below.
7.Whenever possible involve family members and volunteers to help facilitate motivational, reapprais als, and redirection themes outlined below.

SPECIFIC MOTIVATIONAL, REAPPRAISALS, OR REDIRECTION THEMES:

Relaxation Techniques:

Specific Care Plan: Agitation

Problem

AGITATION AND/OR CONFUSION

Diagnosis:

Level of Dysfunction (GLDS)
Intensity:
Freq:
Duration:

Antecedents:
NOISE: CLUTTER: LIGHTING: ADLs
SOCIAL 1 on 1 Too much stimulation
ACTIVITY: Too little stimulation High need for attention
OTHER Antecedents to Behaviors Problems:

Possible Biopsychosocial Triggers:

Recent Changes	Medical Changes	Acute/Chronic SX
1.Change in residence 1-3 months 2.Change in residence this year 3.Change in social activities 4.Change in roommate 5.Roommate Diff. 6.Change of room 7.Change in caregiver(s) 8.Difficulties with caregiver(s) 9.Difficulties with another resident(s) 10.Recipient of verbal abuse 11.Recipient of physical abuse 12.Loss of social status or role 13.Loss of productivity	1.Recent Infection last month 2.Recent hospitalization 3.Change in medical status 4.Disfigurement (last year) 5.Terminal diagnosis 6.New disability 7.Failed Rehab 8.Decline in functional capacity 9.Loss/decline of sight 10.Loss/decline of hearing 11.Decline in oral intake status 12.Chronic Noxious Symptom(s)	1.Pain 2.Delirium, 3.Dementia, 4.Concentration/Memory problems 5.Disfigurement/Appearance 6.Dizziness/Balance px 7.Incontinence 8.Loss of appetite 9.Loss of vision or hearing 10. Nausea/GI discomfort 11.Paralysis 12.Shortness of breath 13.Sleep disturbance 14.Tremors-Parkinson's 15.Weakness/Fatigue OTHERS

Goals

Immediate/Short-term:(___weeks)

GMPI:

GLDS:

Intensity:
Freq:
Duration:

PRADLI:

Long-term Goals:(____weeks)

GMPI:

GLDS:
Intensity:
Freq:
Duration:

PRADLI:

Approaches

GENERAL:
1.Approach calmly and identify self. Maintain a calm tone of voice.
2.Simply state reason for interaction
3.Do not make fast movements and show a pleasant or gentle concern in your body language; take an attitude of being a servant.
4.Redirect resident PRN: (e.g., "Let's take a walk," "Can we talk over here?" "let's enjoy a snack together.")
5.Limit the resident's activities to the morning hours, when possible.
6.Allow resident to nap in the afternoon and late mornings for 45 minutes.
7.Allow resident to sleep in clothing (e.g., a sweat suit) and change clothing for the day in the mornings.
8.Remove the resident from a stressful situation with redirection (see below)
9.Use exercise in the morning and early afternoon to reduce energy build-up and stress.
10.Avoid frequent changes, crowds, loud noise or anything that can be overwhelming to the resident. See antecedents and psychosocial triggers in the problem column to the left.
11.If the resident is not a danger to themselves or others, consider giving the resident "their space." Leave the resident alone and come back later.

SPECIFIC MOTIVATIONAL OR REDIRECTION THEMES:

SPECIFIC BEHAVIORAL TECHNIQUES:

Specific Care Plan for Non-Compliance

Problem
NON-COMPLIANT BEHAVIORS
Diagnosis:
Level of Dysfunction (GLDS)
Intensity:
Freq:
Duration:

Antecedents:
NOISE: CLUTTER: LIGHTING: ADLs
SOCIAL 1 on 1 Too much stimulation
ACTIVITY: Too little stimulation High need for attention
OTHER Antecedents to Behaviors Problems:

Possible Biopsychosocial Triggers:

Recent Changes	Medical Changes	Acute/Chronic SX
1. Change in residence 1-3 months	1. Recent Infection last month	1. Pain
2. Change in residence this year	2. Recent hospitalization	2. Delirium, Dementia, Concentration/Memory problems
3. Change in social activities	3. Change in medical status	3. Disfigurement/Appearance
4. Change in roommate	4. Disfigurement (last year)	4. Dizziness/ Balance px
5. Roommate Diff.	5. Terminal diagnosis	5. Incontinence
6. Change of room	6. New disability	6. Loss of appetite
7. Change in caregiver(s)	7. Failed Rehab	7. Loss of vision or hearing
8. Difficulties with caregiver(s)	8. Decline in functional capacity	8. Nausea/GI discomfort
9. Difficulties with another resident(s)	9. Loss/decline of sight	9. Paralysis
10. Recipient of verbal abuse	10. Loss/decline of hearing	10. Shortness of breath
11. Recipient of physical abuse	11. Decline in oral intake status	11. Sleep disturbance
12. Loss of social status or role	12. Chronic Noxious Symptom(s)	12. Tremors-Parkinson's
13. Loss of productivity		13. Weakness/ Fatigue
		14. OTHERS:

Goals
Immediate/Short-term:
(____ weeks)

GMPI:

GLDS:
Intensity:
Freq:
Duration:

PRADLI:

Long-term Goals:(____weeks)

GMPI:

LDS:
Intensity:
Freq:
Duration:

PRADLI:

Approaches
GENERAL:
1. State required behaviors simply and in the affirmative: (i.e., tell the resident what he/she can do, not focusing on what they cannot do).
2. Simply state consequences of failing to comply and the benefits of complying.
3. Redirect as stated below, if resident becomes resistant or abusive.
4. Give resident space.
5. Do not reward attention-seeking behaviors with any emotional response.
6. Avoid arguing and questioning.
7. Encourage the resident to participate in social and recreational activities that are purposeful, meaningful and positive. Do not force participation, but facilitate action using techniques below .
8. Provide encouragement and positive reinforcement for even the smallest successes and for acceptance of your help.

SPECIFIC MOTIVATIONAL OR REDIRECTION THEMES:

SPECIFIC BEHAVIORAL TECHNIQUES:

Current Research on Pain Management in Long-Term Care

"Dementia, Pain, Depression, Behavioral Disturbances, and ADLs:
A Comprehensive Conceptualization of Quality of Life in LTC"

Purpose: Develop and compare two competing path models composed of quality of life variables

Sample: 234 LTC residents suffering from chronic pain

Method: Path analysis of two models; comparisons of goodness of fit

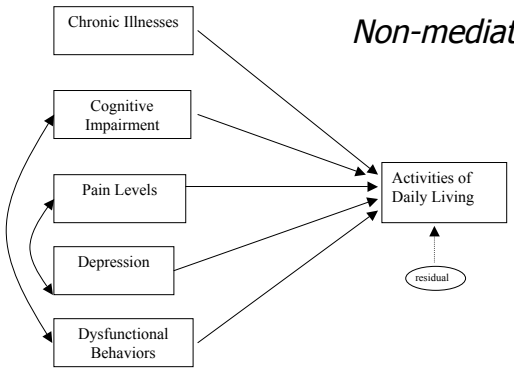
Results: Mediational model significantly better fit

Conclusion: Assessing and treating pain is likely to yield the most improvements in quality of life

Cipher, Clifford & Roper, 2004 International Journal of Geriatric Psychiatry

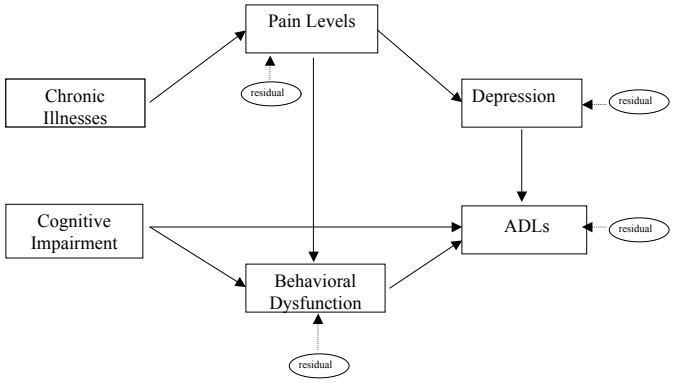
"Dementia, Pain, Depression, Behavioral Disturbances, and ADLs:
A Comprehensive Conceptualization of Quality of Life in LTC"

Non-mediational model



“Dementia, Pain, Depression, Behavioral Disturbances, and ADLs:
A Comprehensive Conceptualization of Quality of Life in LTC”

Mediational model



“Dementia, Pain, Depression, Behavioral Disturbances, and ADLs:
A Comprehensive Conceptualization of Quality of Life in LTC”

Goodness of Fit Indices for the QOL Path Model

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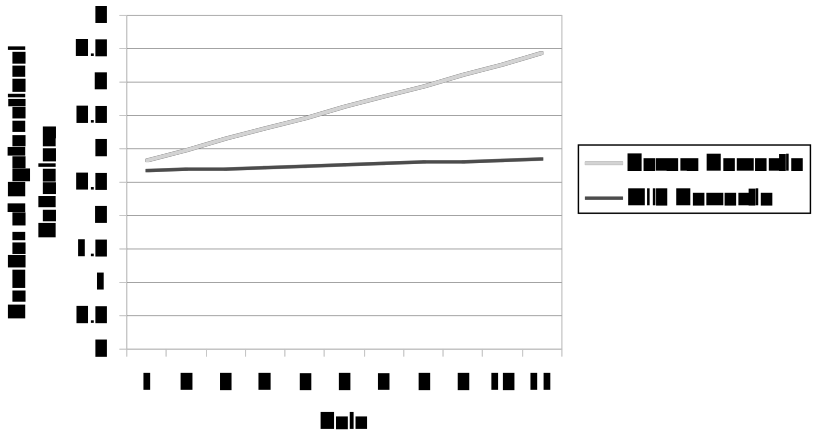
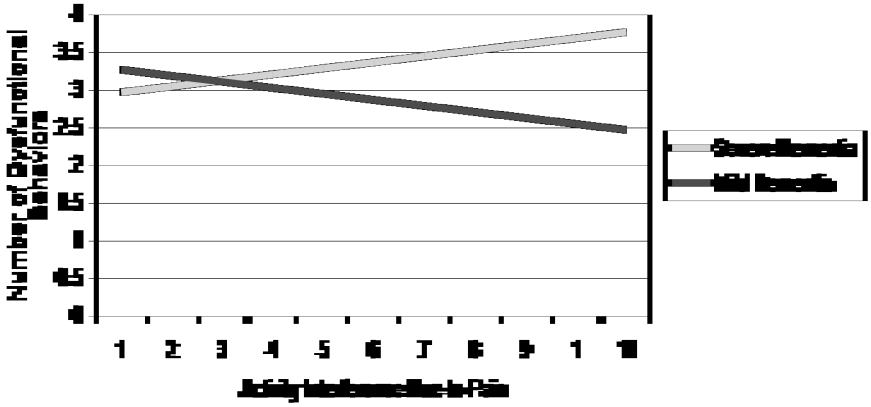
"Behavioral Manifestations of Pain in the Demented Elderly"

- Purpose: Investigate mediating role of dementia in the relationship between pain and behavioral disturbances
- Sample: 237 LTC residents suffering from chronic pain
- Method: Comparisons of pain & behavior relationship between groups of LTC residents (Severe dementia versus mild dementia; NCSE μ= 2.97 & 6.67, respectively)
- Results: Pain and behaviors were significantly related in those with severe dementia
- Conclusion: Residents unable to communicate due to dementia are likely to manifest their pain via behavioral disturbances

"Behavioral Manifestations of Pain in the Demented Elderly"



“Behavioral Manifestations of Pain in the Demented Elderly”



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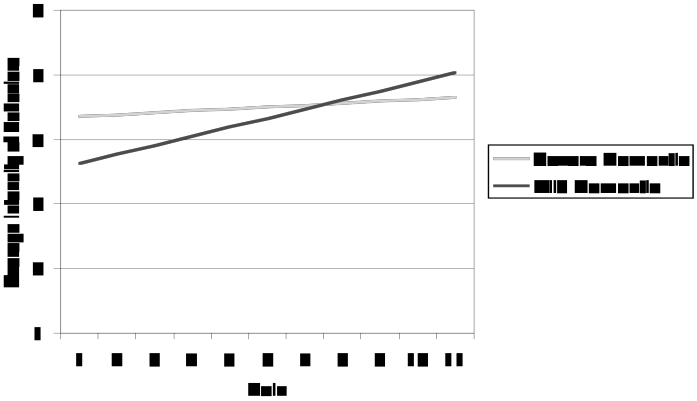

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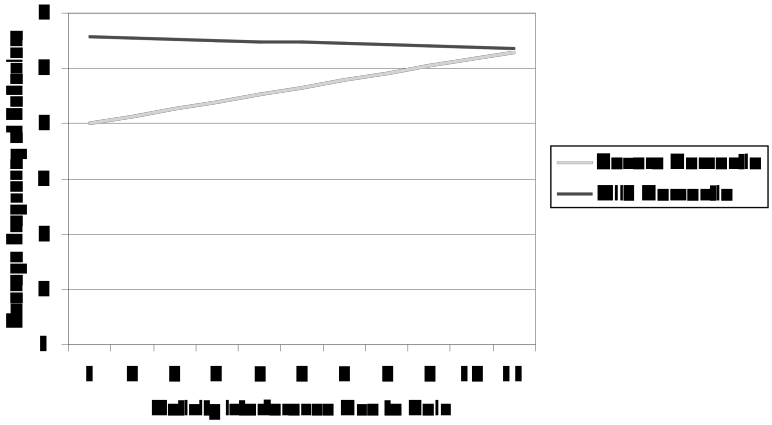

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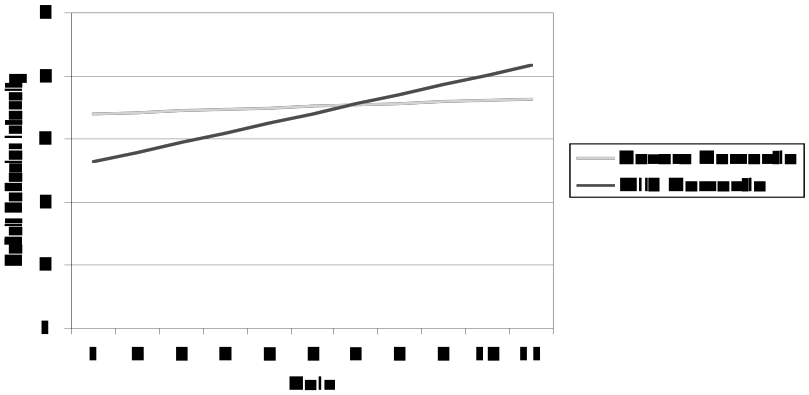


Efficacy of Psychotherapy in LTC: Current State of the Literature

- Geropsychological treatment is generally effective in treating depression in both ambulatory and nursing home populations
- There have been no studies conducted on the efficacy of geropsychological treatment in improving overall quality of life, including pain, ADLs, and behavioral disturbances
- Studies primarily focus on convenience samples, especially in LTC settings

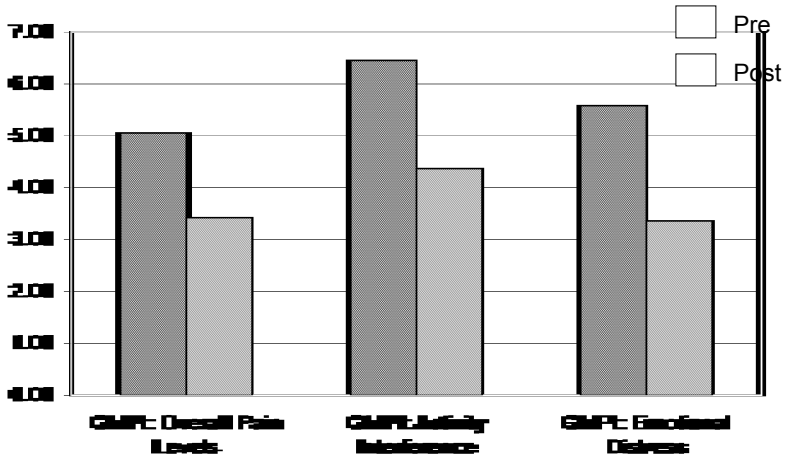
Thompson & Gallagher, 1984; Thompson, Gallagher, & Breckenridge, 1987; Gatz, Fiske, Fox, Kaskle, Kasl-Godley, McCallum, & Wetherell, 1998; Thompson, Coon, Gallagher-Thompson, Sommer, & Koin, 2001

"Efficacy of Geropsychological Treatment in Improving Quality of Life in LTC"

- Purpose: Investigate the efficacy of geropsychological treatment in LTC residents' quality of life
- Sample: 42 LTC residents suffering from chronic pain
- Method: Six week treatment period consisting of an average of eight to 10 sessions
- Results: Significant decreases in most QOL variables from pre to post-treatment
- Conclusion: Tx is likely to yield improvements in QOL

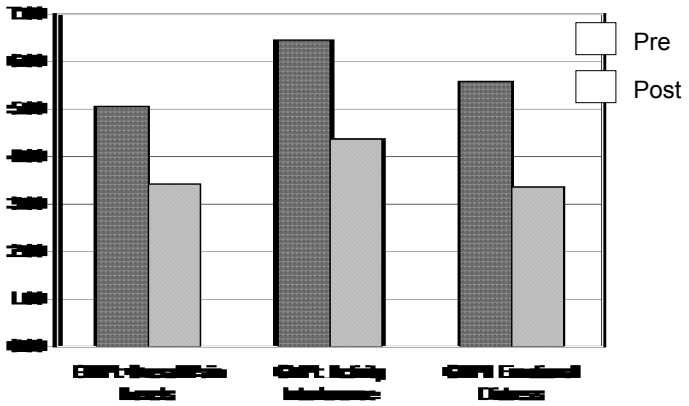
Improvements in GMPI Scales

"Efficacy of Geropsychological Treatment in Improving Quality of Life in LTC"



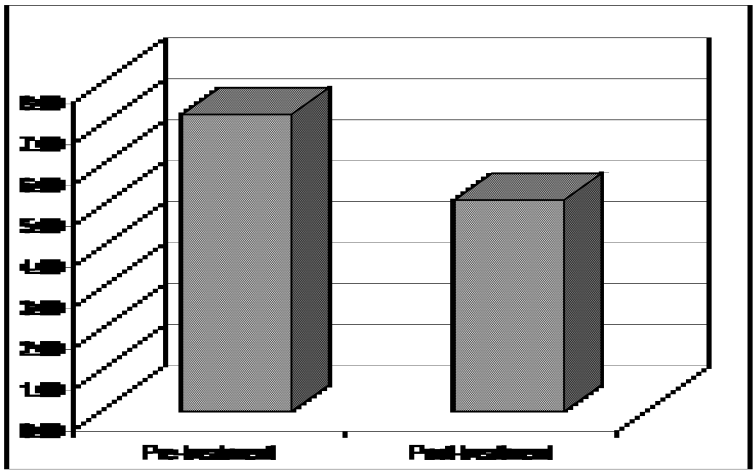
Improvements in Geriatric Multidimensional Pain and Illness Inventory (GMPI)

"Efficacy of Geropsychological Treatment in Improving Quality of Life in LTC"



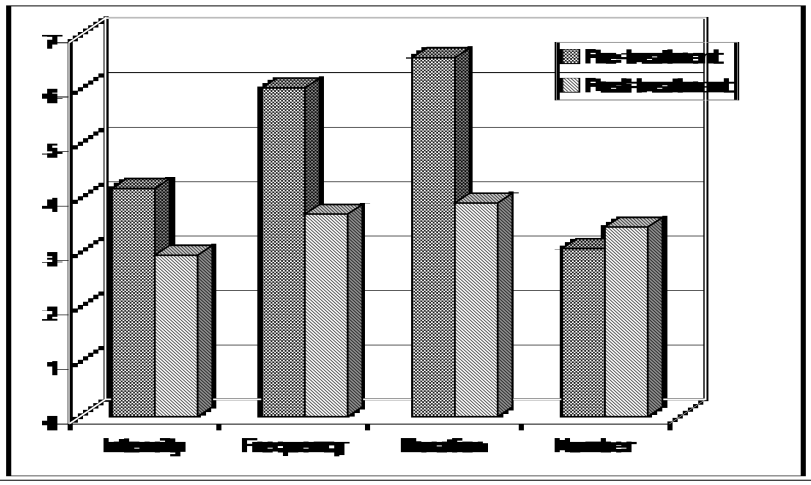
Depression Scale Improvements

"Efficacy of Geropsychological Treatment in Improving Quality of Life in LTC"



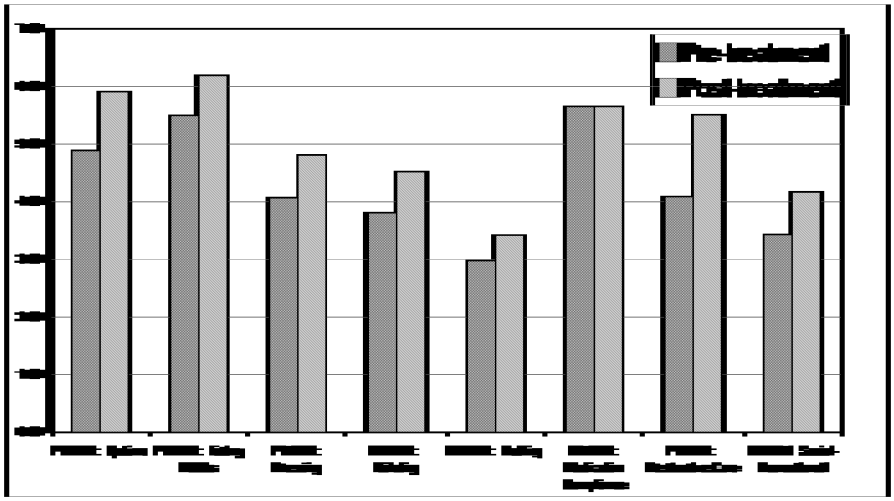
Improvements in Dysfunctional Behaviors

"Efficacy of Geropsychological Treatment in Improving Quality of Life in LTC"

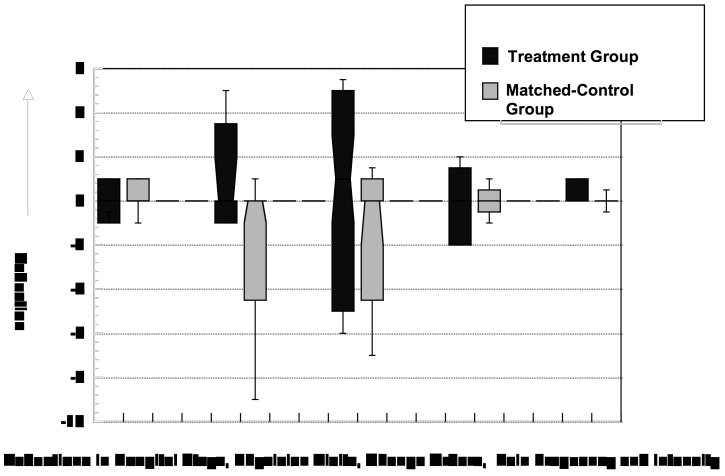


Improvements in PRADLI

"Efficacy of Geropsychological Treatment in Improving Quality of Life in LTC"



"Efficacy of Geropsychological Treatment in Improving Quality of Life in LTC"



Research Conclusions

- Geropsychological assessment and treatment models need to emphasize the need for the alleviation of pain, as it appears that decreasing pain results in fewer behavioral disturbances, lower depression, and improved ADLs.
- Geropsychological treatment is likely to be effective in improving residents' quality of life, including pain, ADLs, and behavioral disturbances.
- Pain and limitations due to pain have varying effects on behavioral disturbances depending upon residents' level of dementia.

Directions for Future Pain Assessment Research in LTC

- Conducting a thorough medical history to understand co-morbid medical and psychiatric issues
- Understanding the resident's personality and psychophysiological styles
- Assessing and recognizing behavioral disturbances as a sign of pain (severe dementia ~ acting out behaviors; mild dementia ~ complaining)

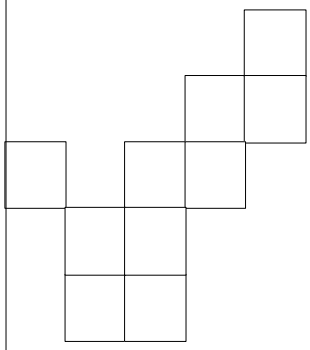
Directions for Future Pain Assessment Research in LTC

Scherder et al, 2003 and 2005

- Delineating between the different subtypes of dementia: Patients with Alzheimer's exhibit fewer affective aspects of pain but have higher pain tolerance; Patients with Parkinson's have higher pain affectation
- Delineating between the patients' stage of dementia
- Assessing sensitivity to tactile stimuli, temperature, and pain may be indicative of post-stroke pain or neuropathy
- Using adequate assessment instrumentation for the particular type of stage of dementia

Directions for Future Pain Management Outcome Research

- Delineating between the efficacy study and the effectiveness study
- Moving beyond convenience samples
- Realistic definitions of successful outcomes
- Research designs that use adequate controls
- Instruments with improved measurement and scaling properties
- Blind evaluations



Research Directions – Victor Molinari Discussant

Mental Health Practice & Aging
Geropsychological Approaches to Pain management in Long Term Care
(Chairs, Clifford, Cipher & Roper)
Gerontological Society of America Meeting, Dallas, 2006

MH Problems of LTC Residents

- NHs- 60% have a mental disorder
- NHs -40% suffer from depression; 3.5% - 20% suffer from anxiety
- ALFs - 31-56% have mental disorders
- Appears to be a bi-directional relationship between pain & mental health problems

Clifford/Roper/Cipher studies – Pain Assessment

- Assessment guides intervention
- Comprehensive Assessment - physical, social, current/past stressors, cognitive, psychological (Axis I) personality (AxisII)
- Assessment - non-verbal measures
- Assessment not only of pathology but of cognitive/personality strengths & QOL

Clifford/Roper/Cipher studies – Pain Treatment

- GMCBT addresses the problem of pain which is so common in LTC
- GMCBT requires coordination to treat pain in LTC settings where co-morbid medical, depressed, +/or demented conditions are so often encountered
- GMCBT attempts to translate improvement in pain into better day-to-day functioning

Clifford/Roper/Cipher Studies – Process of Change

- Employs bio-psycho-social model & emphasizes multidisciplinary care
- Refer to OT, PT, RD, social worker, psychiatrist
- Staff & family used as adjuncts – social context
- Multi-modal form of psychological treatment – we don't know enough to stick with just one paradigm
- Flexible approach - cognitive & interpersonal
- Promote attributions of control over pain & skills to reduce catastrophizing of pain

Recent Pain/LTC Research Studies

- Do not view all LTC settings as the same
- Suggest CBT interventions may be a first-line treatment for agitation due to pain
- Pain may increase depression & vice-versa
- Simplify approaches to address pain in those with dementia
- Use hospice & palliative care services to reduce suffering in dying patients & family

Research Challenges

- Recruitment – fraught with difficulties in LTC settings – consent problems
- Randomization – NH residents who choose to participate may be in less intense pain
- Adherence – need simple instructions & plans – do not interfere with other scheduled activities – Those with PD or severe pain less compliant
- Drop-outs – sickness & death common for those in pain – pain may preclude continued participation

LTC Research Directions

- LTC is finally getting a literature of its own
- We should not let difficulties doing RCTs deter us from evaluating interventions to determine 'real world' effectiveness
- Mixed qualitative/quantitative methods
- We need to adapt our methodologies to fit the LTC setting – view it as a challenge

Future Pain/LTC Research

- Find ways to improveQOL for LTC pain pts
- Carve out new roles for family members to identify pain & help with its management
- Document that multidisciplinary MH treatment decreases pain, enhances QOL & perhaps reduces other health care utilization
- Use this knowledge for advocacy& to direct training of MH professionals & NH staff