BORDERLINE PERSONALITY DISORDER FEATURES AND PAIN: THE MEDIATING ROLE OF NEGATIVE AFFECT IN A PAIN PATIENT SAMPLE

Sarah L. Tragesser, PhD,1 Daniel Bruns, PsyD2 and John M. Disorbio, EdD3
1Psychology, Washington State University, Richland, WA; 2Health Psychology Associates, Greeley, CO and 3Integrated Therapies, Lakewood, CO.

There is considerable evidence that personality disorders, including Borderline Personality Disorder (BPD), tend to co-occur with chronic pain. Mood disorders also co-occur with chronic pain conditions. Given the central role of affective instability and negative mood in BPD, we proposed that affective features of depression, anxiety, and hostility may account for the association between BPD features and pain complaints in a patient sample. 777 patients completed the Battery for Health Improvement. This included measures of DSM-IV BPD features, affect scales (depression, anxiety, hostility), and pain items. First, a series of multiple regression analyses were used to test the hypothesis that BPD features were associated with pain complaints, somatic complaints, and highest and lowest pain in the past month, controlling for gender and payment type. BPD features were associated with pain complaints, somatic complaints, and highest and lowest pain in the past month, controlling for gender and payment type. BPD features were associated with pain complaints, somatic complaints, and highest and lowest pain in the past month, controlling for gender and payment type.

CORRESPONDING AUTHOR: Elizabeth K. Seng, MS, Psychology, Ohio University, Athens, OH.

PSYCHIATRIC COMORBIDITY IS NOT ASSOCIATED WITH POOR TREATMENT RESPONSE IN SEVERE MIGRAINE

Elizabeth K. Seng, MS and Kenneth A. Holroyd, PhD
Psychology, Ohio University, Athens, OH.

Mood and anxiety disorders are comorbid with migraine and increases in migraine-related disability. Psychiatric comorbidity is thought to predict poorer migraine treatment outcome, but empirical evidence supporting this assumption is lacking.

Severe migraine sufferers completed 5 weeks of optimal acute therapy, and if migraineurs remained uncontrolled, were randomized (N = 232) to one of four additive treatments: Preventive (beta-blocker) Medication (PM), Preventive Medication Placebo (PL), Behavioral Migraine Management (BMM)+PL, and BMM+PM. A 4-month BMM dose adjustment phase was followed by a 12-month evaluation phase. Psychiatric disorders were identified by the PRIME-MD (Spitzer, 1994) structured diagnostic interview. Migraine-related impairment was assessed with the Migraine Specific Quality of Life Questionnaire (MSQOL; Jhingran, et al., 1998). Migraine episodes/days were obtained from a daily headache diary completed throughout the study. Mixed models for repeated measures analyses evaluated whether changes in migraine-related impairment were influenced by psychiatric comorbidity (mood and/or anxiety disorder).

Contrary to conventional wisdom, participants with psychiatric comorbidity showed larger improvements than participants with no psychiatric comorbidity: migraine-related impairment, F(1, 296.432)=15.902, p<.001; mental component scores decreased over time, t=3.04, p<.001, while physical component scores increased, t=-2.13, p<.05. This suggests that distress would improve from pre-treatment to 90 days as uncertainty regarding acute treatment decreased, but that physical function would worsen with the increased demands on caregivers to manage patient needs. Measures included the SF-36 (SF-36), the Center for Epidemiological Studies-Depression (CES-D), and the caregiver version of Cancer and Treatment Distress (CTXD). The 176 caregivers were on average 48 years old (SD=11.3), 65% female, 88% Caucasian and 92% spouses or partners of the patients. Scores on the CES-D decreased from pre-treatment to 90 days, t=2.43, p<.01, but remained more depressed than population norms, P<.001; 42 percent of caregivers at pre and 34% at 90 days had CES-D scores ≥16, the cutoff for depression, vs. population norms of 19% with score ≥16. Mean CTXD score also decreased, t=4.54, P<.001. Mental component scores of the SF-36 increased, t=-2.13, P<.04, while physical component scores decreased over time, t=3.04, P<.001. Caregiver outcomes during the acute phase of HCT were consistent with our hypotheses. Physical functioning worsened over time while emotional function improved. Nonetheless, caregivers reported substantially higher rates of depression relative to population norms at both times. Although most caregivers appear to manage well, they are at risk for depression and need screening and referral to appropriate treatment options.

CORRESPONDING AUTHOR: Jean C. Yi, PhD, Fred Hutchinson Cancer Research Center, Seattle, WA, 98109; jyi@fhcrc.org

SYMPTOM PROFILES IN SURVIVORS OF ALLOGENEIC HEMATOPOIETIC STEM CELL TRANSPLANTATION (AHSC)

S. Mitchell, PhD, CRNP,1 M. Beyans, PhD, RN,1 L. Wehrlen, RN, BSN,2 M. Cole, PhD,3 L. Silverman, BA,1 O. Prachenco, MA,2 E. Koklanaris, BSN1 and G. Wallen, RN, PhD3
1National Institutes of Health, Bethesda, MD and 2Lawrence Technological University, Southfield, MI.

Co-occurring symptoms have a deleterious impact on health outcomes exceeding that produced by individual symptoms, however research examining symptom profiles in AHSC survivors is sparse. We used latent class analysis (LCA) to classify survivors based on their patterns of endorsing 30 physical and psychological symptoms, and explored the association of symptom profiles with self-assessed health. Data were drawn from an ongoing longitudinal study of AHSC survivors (n=150) who were a median age of 45.5 years, male (63%), and a median of 47 months post-transplant. Measures included the Rotterdam Symptom Checklist and the SF-36 v.2 Health Survey. Item analyses revealed marked variability in symptoms. A median of 11 symptoms (range 0–26) were prevalent, with a median of 1 symptom (range 0–20) experienced as moderately to extremely bothersome. LCA supported a three-class model representing a group without physical or psychological symptoms (LC1); a group with few physical symptoms but prominent anxiety, nervousness, worry, and irritability (LC2); and a third with prominent physical symptoms (muscle aches, reflux, dry mouth, sore eyes, headaches, and shortness of breath), together with depression, anxiety, diminished libido, and insomnia (LC3). Fatigue and difficulty concentrating were most prevalent in both LC2 and LC3. The group with prominent physical symptoms was distinguished statistically (p<.01) and clinically significant impairments in physical (PCS normed mean 41.9±9.3) and mental (MCS normed mean 41.6±9.2) health on the SF-36, while in LC1 and LC2, physical and mental health were preserved and comparable to the US general population (LC1 PCS=53.7±6.5; MCS=56.4±6.5; LC2 PCS=48.5±9.1; MCS=49.9±8.7). Identifying homogeneous symptom classes in survivors of AHSC may yield insights about the mechanisms that underlie symptom profiles. Research to explore the differential impact of covariates and to evaluate interventions tailored to specific symptom profiles is warranted.

CORRESPONDING AUTHOR: Sandra A. Mitchell, PhD, CRNP, Clinical Center, National Institutes of Health, Bethesda, MD, 20892; mitchls@mail.nih.gov

MULTI-SITE STUDY OF CAREGIVER OUTCOMES DURING HEMATOPOIETIC CELL TRANSPLANTATION (HCT)

Jean C. Yi, PhD,1 Karen L. Sviyala, PhD,1 Janet R. Abrams, PsyD,1 Samuel Silver, MD, PhD,2 Debra K. Tiemen, RN, PhD,3 Jeffrey Matous, MD,2 John R. Wingard, MD,2 Roger Dansey, MD,4 Richard McQuellon, PhD5 and Shelby L. Langer, PhD1
1Fred Hutchinson Cancer Research Center, Seattle, WA; 2University of Michigan, Ann Arbor, MI; 3Stanford Medicine, Palo Alto, CA; 4Rocky Mountain Cancer Centers, Denver, CO; 5University of Florida, Gainesville, FL; 6Karmanos Cancer Institute, Detroit, MI and 7Wake Forest University, Winston-Salem, NC.

HCT places high demands on patients and their family caregivers. We assessed caregivers at the 7 transplant centers listed above at 2 time points during the acute phase of HCT: pre-transplant and 90 days post-transplant. We hypothesized that distress would improve from pre-treatment to 90 days as uncertainty regarding acute treatment decreased, but that physical function would worsen with the increased demands on caregivers to manage patient needs. Measures included the SF-36 (SF-36), the Center for Epidemiological Studies-Depression (CES-D), and the caregiver version of Cancer and Treatment Distress (CTXD). The 176 enrolled caregivers were on average 48 years old (SD=11.3), 65% female, 88% Caucasian and 92% spouses or partners of the patients. Scores on the CES-D decreased from pre-treatment to 90 days, t=2.43, P<.01, but remained more depressed than population norms, P<.001; 42 percent of caregivers at pre and 34% at 90 days had CES-D scores ≥16, the cutoff for depression, vs. population norms of 19% with score ≥16. Mean CTXD score also decreased, t=4.54, P<.001. Mental component scores of the SF-36 increased, t=-2.13, P<.04, while physical component scores decreased over time, t=3.04, P<.001. Caregiver outcomes during the acute phase of HCT were consistent with our hypotheses. Physical functioning worsened over time while emotional function improved. Nonetheless, caregivers reported substantially higher rates of depression relative to population norms at both times. Although most caregivers appear to manage well, they are at risk for depression and need screening and referral to appropriate treatment options.

CORRESPONDING AUTHOR: Jean C. Yi, PhD, Fred Hutchinson Cancer Research Center, Seattle, WA, 98109; jyi@fhcrc.org

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