General Hospital Psychiatry 37 (2015) 434–440

Contents lists available at ScienceDirect

General Hospital Psychiatry

journal homepage: http://www.ghpjournal.com

Associations of borderline personality with pain, problems with medications and suicidality in a community sample of chronic non-cancer pain patients prescribed opioids for pain

Gabrielle Campbell, M.Crim. [a,*], Raimondo Bruno, Ph.D. [a,b], Shane Darke [a], Louisa Degenhardt, Ph.D. [a,c,d,e]

[a] National Drug and Alcohol Research Centre, University of New South Wales, Sydney NSW 2052, Australia
[b] School of Medicine, University of Tasmania, Hobart TAS 7000, Australia
[c] School of Population and Global Health, University of Melbourne, Parkville VIC 3010, Australia
[d] Murdoch Children's Research Institute, Parkville VIC 3052, Australia
[e] Department of Global Health, School of Public Health, University of Washington, Seattle, WA 98195, USA

ARTICLE INFO

Article history:
Received 3 February 2015
Revised 13 April 2015
Accepted 13 May 2015

Keywords:
Borderline personality disorder
Chronic pain
Opioids
Dependence
Suicidality

ABSTRACT

Objective: Borderline personality disorder (BPD) is common in patients with chronic non-cancer pain (CNCP). BPD patients often report worse pain and are more likely to abuse opioid medication. Although the prevalence of suicidality is high in both CNCP patients and those with BPD, no studies have examined the interrelationship of BPD, CNCP and suicidality. This article aims to examine the prevalence and associations of BPD in a large community sample of CNCP patients and the association with medication problems and suicidality.

Methods: Data from a national sample of 978 CNCP patients prescribed pharmaceutical opioids for CNCP. The screener from the *International Classification of Diseases*, *version 10*, International Personality Disorder Examination was used to identify patients with symptoms of BPD.

Results: One in five CNCP patients (19.1%) screened positive for BPD. BPD was associated with a number of demographic and clinical features, such as daily benzodiazepine use, and was independently associated with lifetime pharmaceutical opioid dependence [odds ratio (OR) 2.49, 95% confidence interval (95% CI) 1.42–4.38], past 12-month suicidal thoughts (OR 2.9, 95% CI 1.90–4.39) and lifetime suicide attempts (OR 3.19, 95% CI 2.16–4.72).

Conclusions: BPD symptoms were prevalent among people prescribed opioids for CNCP and are associated with a number of adverse consequences. Further, those screening positive were at elevated risk of suicidal behaviors. Careful opioid prescription monitoring and appropriate referrals by clinicians are warranted in BPD with CNCP.

© 2015 Elsevier Inc. All rights reserved.

1. Introduction

Borderline personality disorder (BPD) is characterized by a longstanding, pervasive pattern of affective dysregulation, identity disturbances and interpersonal dysfunction and is associated with high levels of distress and suffering in the individual, as well as difficulties in functioning [1]. The prevalence of BPD in patients with chronic pain has been estimated at 30% [2], notably higher than 2% in the general population [3].

While self-injurious behavior is common among people with BPD, 50–80% report no pain associated with this behavior [4]. On the other hand, they have been found to be over-represented in patients with chronic pain. BPD has also been found to be associated with past-year chronic back pain, frequent/severe headaches and other chronic pain conditions [5]. Sansone refers to this as the 'pain paradox' [6] and suggests that chronic pain, as opposed to self-injurious behaviors, is not under the individuals control and, thus, poorly tolerated in people with BPD.

People with BPD are often high users of health services and access general practitioners and specialists more frequently than those without BPD. They also present more frequently to pain clinics or present with more pain problems in primary care [7,8]. Further, emerging research suggests that BPD patients may over-utilize their opioid medication in an effort to cope with chronic pain [6]. Due to the inflexible, pervasive and maladaptive behaviors of the patient with BPD and the high health service utilization, the BPD patient is often described as a 'difficult patient' [9]. To date, research has been limited: specifically, a recent review found only eight studies on the association between BPD and chronic pain from 1994 to 2011 [2] and only a few have examined medication non-adherence and dependence [2].

Another concern is the high rates of suicidal behaviors in both chronic pain and BPD. It has been estimated that chronic pain patients are 2–3 times more likely to engage in suicidal behaviors compared with those without chronic pain [10]. Further, at least three quarters of BPD patients attempt suicide, and approximately 10% eventually

* Corresponding author. National Drug and Alcohol Research Centre, University of New South Wales, 22-32 King Street, Randwick, NSW 2031, Australia. Tel.: +61-2-9385-0286; fax: +61-2-9385-0222.
E-mail address: g.campbell@unsw.edu.au (G. Campbell).

http://dx.doi.org/10.1016/j.genhosppsych.2015.05.004
0163-8343/© 2015 Elsevier Inc. All rights reserved.

complete suicide [11]. This rate is approximately 400 times greater than the general population [12]. With such high rates of suicidality in patients with chronic pain and patients with BPD, and limited research to date, the association between BPD, chronic pain and suicidality warrants investigation.

The Pain and Opioids IN Treatment (POINT) study is a cohort of people in the community who have been prescribed strong opioids for chronic pain. POINT provides an opportunity to examine BPD, chronic pain and suicidality in a large community-based cohort. The aims of the current paper are to:

(1) Determine the proportion of community based chronic pain patients who are taking opioids, who screen positively for BPD;
(2) Examine the relationship between BPD and pain and medication related factors, such as pain severity and interference, oral morphine equivalents (OME), medication non-adherence and dependence in chronic pain patients; and
(3) Examine the relationship between BPD and suicidality in chronic pain patients.

2. Materials and methods

The study was approved by the Human Research Ethics Committee of the University of New South Wales (HREC reference: #HC12149). The study also received A1 Australian National Pharmacy Guild Approval to approach pharmacists to assist with recruitment of participants (Approval No. 815). Full details of the study design have been published elsewhere [13] and characteristics [14] of this cohort have been described in detail elsewhere.

2.1. Recruitment

POINT participants were recruited through community pharmacies across Australia. Of the 5745 pharmacies with available contact information, 5332 were contacted by researchers (93%) and 1868 agreed to assist with recruitment (33%). Participants were eligible if they were 18 years or older, competent in English, mentally and physically able to partake in telephone and self-complete interviews, without serious cognitive impairments, living with chronic non-cancer pain (CNCP) and taking prescribed Schedule 8 opioids for CNCP for more than 6 weeks. Schedule 8 is an Australian classification of drugs of dependence that are subject to additional regulatory controls regarding their manufacture, supply, distribution, possession and use [15]. Schedule 8 opioids include morphine, oxycodone, buprenorphine, methadone and hydromorphone. A history of injecting drug use (IDU) was not an exclusion criterion, but people currently prescribed pharmaceutical opioids for opioid substitution therapy for heroin dependence or for cancer were not eligible. Of the 2725 participants referred into the study, 2091 were assessed for eligibility (78%). A total of 1873 participants were deemed eligible (90%) and 1514 completed the baseline interview (81%). Full details of the recruitment methods are published elsewhere [13].

Phone interviews were conducted by assistants who had a minimum 3-year health or psychology degree. Interviewers had received training in the survey instrument and were provided glossaries of chronic pain medications and conditions. Participants also completed self-complete surveys and a 7-day medication diary. In the current study, $n=747$ returned their self-complete survey and 724 returned their medication diary.

2.2. Measures

The measures, tools and domains collected were based on recommendations made under the auspices of the Initiative on Methods, Measurement, and Pain Assessment in Clinical Trials [16,17]. Full details of the measures used in the study have been reported elsewhere [13].

2.2.1. BPD

Of the 1514 participants enrolled in the POINT study, 978 completed the BPD module. The BPD screener was adapted from the International Personality Disorder Examination (IPDE) and was used in the Australian National Survey of Mental Health and Wellbeing (NSMHWB) [18]. The performance of the BPD screener within the NSMHWB has been studied at length [19]. The screener uses the *International Classification of Diseases*, *version 10* (*ICD-10*) criteria to assess whether a set of 10 borderline traits were 'true' or 'false' about the participants typical personality. Participants were classified as screening positively for BPD if they endorsed three or more of the symptom criteria, and they indicated that the symptoms interfered with their life [18]. Due to the association between BPD and suicide, the symptom 'I've never threatened suicide or injured myself on purpose' was removed from the classification. This only slightly reduced the sample that screened positive for BPD from $n=195$ to $n=187$.

It must be noted that there are two common methods of scoring the IPDE for BPD: firstly the simple categorical scoring method in which a score of three or more indicates that the person has 'failed the screen for that disorder' and should be followed up with an interview. A second scoring method is the criterion-based scoring that mirrors the *ICD-10* diagnostic criterion. To screen positive for BPD using this method, the person must score three or more on the five impulsive items and score two or more on the borderline-unstable five items. They must also indicate positive to questions on the 'pervasiveness' and 'associated disability' items. These two methods have a tendency to over- and under-identify positive (simple scoring and criterion scoring, respectively) cases. A suggested scoring system is to use the simple criterion of three or more and the additional question of pervasiveness [19]. Since the categorical scoring system has been used in other studies using the IPDE for BPD in chronic pain [5,20], in the current study, we have used the categorical scoring with the addition of the pervasiveness item so that our study is comparable. In the current study, not including the suicide item for the BPD screener, 33.5% [95% confidence interval (95% CI) 30.6–36.6] would screen positive using the simple categorical scoring (a score of three or more), and 4.5% (95% CI 3.4–6.0) would screen positive using the criterion scoring. The use of the suggested method by Lewin et al. (score of three more and a positive on the pervasiveness item) resulted in 19.1% (95% CI 16.8–21.7) screening positive for BPD.

2.2.2. Pain and pain-related measures

Participants were asked about chronic pain conditions they suffered from in the past 12 months. They were also asked the age of onset of the pain condition and how long they had been in pain. Current pain severity and pain interference were measured by the Brief Pain Inventory [21], as a continuous score out of 10. A higher score indicates more pain severity or interference. The Pain Self-Efficacy Questionnaire [22,23] produced a continuous score out of 60, with a higher score indicating more confidence in managing life despite pain.

2.2.3. Physical health

The Short Form 12 (SF12) is based on population norms and measures physical and mental health functioning over the previous 4 weeks, with a mean score of 50 and an SD of 10 [24]. One item from the World Health Organization Quality of Life WHOQOL-BREF questionnaire [25] used measures of self-rated health: "How would you rate your quality of life" dichotomized to very poor/poor and neither good nor poor/good/very good.

2.2.4. Medications

OME daily doses were estimated [26] using available references [27–29]. Self-reported opioid use was obtained from a medication diary completed over a 1-week period as part of the self-complete questionnaire mailed to participants. Of the 978 participants in the

Download English Version:

https://daneshyari.com/en/article/6081658

Download Persian Version:

https://daneshyari.com/article/6081658

Daneshyari.com