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Borderline Personality Symptoms & Chronic Pain Patients: An Understated Consequence of the COVID-19 Crisis

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Disclosures

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Learning Objectives

1) Identify the symptoms of Borderline Personality Disorders required for formal diagnosis
2) Summarize the specific behaviors associated with Borderline Personality Disorder that can make patients disruptive to pain practices
3) Explain how evidence-based screening for Borderline Personality Disorder serves as an initial step in the management of these patients within pain management practices

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EDITORIAL

Manifestation of Borderline Personality Symptomatology in Chronic Pain Patients Under Stress: An Understated and Exacerbated Consequence of the COVID-19 Crisis

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Introduction

To the best of our knowledge, no one has ever suggested that it is "easy" to suffer from intractable chronic pain, with some subgroups impacted more than others. This burden has had a particularly strong impact in the United States, where the chronic pain treatment system has demonstrated failings with respect to access to care[1–8] Because chronic pain is so poorly treated in the United States, patients have

Chronic Pain and Stress

- Stress is present in ALL of our lives, and manifests itself uniquely in each individual
- Chronic pain is stressful, and stress causes chronic pain to be exacerbated
- Reciprocal interactions involve the hypothalamus, pituitary gland, adrenal cortex, adrenal medulla, and multiple immune cells

Chapman CR, et al. J Pain. 2008;9(2):122-145.

Chronic Pain and Stress

- Yet, we can't ignore the emotional reciprocity that occurs as well

Mills SEE, et al. Br J Anaesth. 2019;123(2): e273–e283 (narrative review).

- For many years, pain practitioners have focused on patients' depression and anxiety
  - These are the conditions most frequently and closely linked with poor physical outcomes

De Heer EW, et al. PLoS One. 2014; 9(10): e106907.

- How do pain clinicians approach these comorbidities?

Chronic Pain and Stress

- Brief screening is a good start!
  - Common tools for brief screening for depression include the Beck Depression Inventory-2 (BDI-2) and the Patient Health Questionnaire-9 (PHQ-9)
  - Others seem to be developed every year…
  - Common tools for brief screening for anxiety include the Beck Anxiety Inventory (BAI) and the Generalized Anxiety Inventory-7 (GAD-7)
- What is done with screening results that are positive?

Response to Positive Screens

- Three options:
  1) Initiation of pharmacotherapy
  2) Referral for mental health counseling
  3) Both (depending on provider and patient preferences)
- Ignoring the psychological sequelae is an option, but generally doesn't end well

Schatman ME, Thoman JL. Psychological Injury and Law, 2015;8:311-322.

- Screening and treating/referring is now the standard of care in pain medicine

Turner ME, Fireman M. Evaluating the biopsychosocial milieu of chronic pain. In: Matthew AM, Fellers JC (eds.). Treating Comorbid Opioid Use Disorder in Chronic Pain. Springer International Publishing Switzerland, 2016:35-45.

Other Psychological Responses to Stress

- Personality disorders
- Defined as “An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture”

&

“The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood”

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 5th ed. APA Press, 2013.

- But are they really….?

Classification of Personality Disorders

- PDs are classified into 4 “clusters”
- Cluster A
  - Paranoid
  - Schizoid
  - Schizotypal
    - Generally described as “odd” or “eccentric”
- Cluster B
  - Antisocial
  - Borderline
  - Histrionic
  - Narcissistic
    - Generally described as “dramatic,” “emotional,” or “erratic”

Classification of Personality Disorders

- Cluster C
  - Avoidant
  - Dependent
  - Obsessive-compulsive
    - Generally described as “anxious” and “fearful”
- All personality disordered patients can be annoying
- Yet it’s the Cluster B patients about whom we really have to worry…

Bad Segue Slide

Borderline Personality Disorder (BPD)

- 9 specific symptoms – 5 of the 9 must be present for a dx
  1) Affective (emotional) instability including intense, episodic emotional anguish, irritability, and anxiety/panic attacks
  2) Anger that is inappropriate, intense, and difficult to control
  3) Chronic feelings of emptiness
  4) Self-damaging acts such as excessive spending, unsafe and inappropriate sexual conduct, substance abuse, reckless driving, and binge eating
  5) Recurrent suicidal behavior, gestures, threats, or self-injurious behavior such as cutting or hitting oneself
  6) A markedly and persistently unstable self-image or sense of oneself
  7) Suspiciousness of others' thoughts about oneself, and even paranoid ideation, or transient and stress related dissociative episodes during which one feels that his/her or their surroundings appear unreal
  8) One may engage in frantic efforts to avoid real or imagined abandonment
  9) One's relationships may be very intense, unstable, and alternate between the extremes of over idealizing and undervaluing people who are important

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 5th ed. APA Press, 2013.

Prevalence of BPD

- General population – Estimated at 1.6%

Lenzenweger MF, et al. Biol Psychiatry. 2007;62(6):553–564.

- Chronic pain patient population?
- Prevalence as high as 62.5% has been empirically determined

Frankenburg FR, Zanarini MC. Clin Psychiatry. 2004;65(12):1660–1665.

- Averaging studies from 1994 to 2012, Sansone & Sansone found a prevalence rate of 30%

Sansone RA, Sansone LA. Innov Clin Neurosci. 2012;9(1):10-14.

BPD and Chronic Pain

- Why is the prevalence in chronic pain patients so high?
- A number of theories have been postulated regarding etiology…

1) "Excessive Aggression"

Kernberg O. J Am Psychoanal Assoc. 1967;15(3):641-685.

- ❖ Maintains that aggression is a basic human instinct
- ❖ Excessive aggression can either be a genetic predisposition or due to excessive frustration in childhood
- ❖ Patients thought to vascillate between inappropriate expression of aggression and defensive internalization or projection onto others

Theories of Borderline Personality

2) "Emotional Dysregulation"

Linehan M. Cognitive-Behavioral Treatment of Borderline Personality Disorder. New York, NY: Guilford Press;1993.

- ❖Identifies a deficient ability to regulate emotions
- ❖The deficiency is due to a neurobiological disposition
- ❖This deficit becomes manifest only when the preborderline child's experiences are not validated

3) "Failed Mentalization"

Fonagy P, et al. Affect Regulation, Mentalization and the Development of the Self. New York: Other Press;2002.

- ❖Posits that affect dysregulation, impulsivity, and unstable relationships constitute the core features of BPD
- ❖Due to inability to identify mental states in oneself or others
- ❖Begins early in childhood due to parental failure to validate child's feelings

Theories of Borderline Personality

4) "Interpersonal Hypersensitivity"

Gunderson JG, Lyons-Ruth K. J Pers Disord. 2008;22(1):22-41.

- Maintains that a genetic predisposition results in hypersensitivity and excess reactivity to interpersonal cues
- Patients perceive failures of support from others by feeling either that this is cruelly unfair ("bad other") or that he or she is inherently bad ("bad self")
- Being alone is intolerable, triggering either dissociative or paranoid experiences or desperately impulsive acts that force others to become involved

Theories of Borderline Personality

- The problem with theories is….they're just theories
- Some posit theories of etiology that are purely psychosocial

Crowell SE, et al. Psychol Bull. 2009;135(3):495–510.

- Others opine that the predisposition is neurobiological

Perez-Rodriguez MM, et al. Psychiatr Clin North Am. 2018;41(4):633–650.

- Yet most believe that some combination of genetic and developmental predispositions play a role in the etiology

Ryan RM. Dev Psychopathol. 2005;17(4):987–1006.

Gunderson JG, Lyons-Ruth K. Dev Psychopathol. 2008;17(4):987–1006.

Diathesis-Stress & Chronic Pain

- Sometimes an old model has to be “repurposed” as we study pain-related phenomena
- Flor & Turk conceptualized chronic pain as an interaction between biological and psychological predispositions (diatheses) and the stress of injury and resulting disability

Flor H, Turk DC. Pain. 1984;19(2):105–121.

Turk DC, Flor H. Pain. 1984;19(3):209–233.

  - Numerous studies in the following years supported this conceptualization

Weisberg JN, Keefe FJ. Personality, individual differences, and psychopathology in chronic pain. In: Gatchel RJ, Turk DC, editors. Psychosocial Factors in Pain: Critical Perspectives. New York: The Guilford Press; 1999:56–73. (Review)

Diathesis-Stress and Chronic Pain

- In the late 1990s, Weisberg and colleagues expanded this theory to personality disorders in chronic pain patients
  - Postulated that the stress of chronic pain affects the diathesis of predisposition to personality disorders previously latent, causing them to become manifest

Weisberg JN, Keefe FJ. Pain Forum. 1997;6:1–9.
Weisberg JN. Curr Rev Pain. 2000;4(1):60–70.

- Which explains the great prevalence of BPD in chronic pain patients
- And helps us understand why they're so challenging to treat!

Manifestations of BPD in Chronic Pain Patients

- A heavily researched area
- "BPD pain paradox" – While borderlines seem to be impervious to self-inflicted pain, their tolerance of non-self-inflicted pain has been found to be extremely low

Sansone RA, Sansone LA. Borderline personality and the pain paradox. Psychiatry (Edgemont). 2007;4(4):40–46. (REVIEW)

- Their emotional dysregulation contributes to pain sensitivity

Reynolds CJ, et al. Personal Disord. 2018;9(3):284–289.

- BPD patients are likely to report higher levels of pain than patients with other personality disorders

Biskin RS, et al. Personal Ment Health. 2014;8(3):218–227.

BPD and Substance Abuse

- A major concern….
- 15% of patients suffering from BPD found to have histories of opioid abuse or dependence 30 years ago

Dulit RA, et al. Am J Psychiatry. 1990;147:1002–1007.

- BPD in non-pain patients was associated with greater frequency and quantity of opioid abuse, as well as more severe opioid-related consequences & dependence features
  - The more severe the borderline features, the higher the risk of abuse

Tragesser SL, et al. J Pers Disord. 2013;27(4):427–441.

BPD and Substance Abuse

- Among outpatients with histories of opioid prescriptions, those with BPD were at greater risk for abuse of them

Sansone RA, et al. J Opioid Manag. 2013;9(4):275–279.

- In palliative care settings, patient with BPD were found to have excessive demands for opioids

Feely MA, et al. J Pain Symptom Manage. 2013;45(5):934–938.

- Recent study – Patients with chronic pain with comorbid BPD were more likely to misuse prescription opioids
  - Authors attributed this finding to BPDs' unstable identities and self-harmful impulsivity

Reynolds CJ, et al. J Pers Disord. 2019;1–18

BPD Interactions with Medical Staff

- Even though BPD symptomatology is meant to engage others, given their tendencies toward unstable interpersonal relationships, extreme mood swings, and explosive anger, these relationships with healthcare providers are unlikely to be maintained

Sansone RA, Sansone LA. Innov Clin Neurosci. 2012;9(1):10–14.

- Patients with BPD are prone to provoking anger and frustration in others, potentially resulting in providers doubting the veracity of their symptoms

Kalira V, et al. Curr Pain Headache Rep. 2013;17(8):350.

And Then There's Suicidality…..

- Obviously puts patients at risk…but clinicians, as well
- Study determined that borderline personalities attempt suicide an average of 3 times during their lives – primarily involving overdoses

Soloff PH, et al. Am J Psychiatry. 2000;157(4):601–608.

- Other self-injurious behaviors (e.g., superficial wrist cutting purportedly to relieve emotional tension) are also common among those with BPD
  - Unfortunately, these "parasuicides" too often result in deaths

Brown MZ, et al. J Abnorm Psychol. 2002;111(1):198–202.

BPD and Suicidality

- Longitudinal data have suggested that up to 10% of those with BPD ultimately commit suicide

Paris J, Zweig-Frank H. Compr Psychiatry. 2001;42(6):482–487.

- A recent review concluded that there are no evidence-based guidelines for suicide prevention in BPD patients

Paris J. Medicina (Kaunas). 2019;55(6):E223.

  - As practitioners, we need to consider that chronic pain patients are 2-3X more likely to commit suicide – irrespective of personality disorder status

Tang NK, Crane C. Psychol Med. 2006;36(5):575–586.

BPD and Suicidality

- 2008 study – Found that even borderline personality traits were predictive of suicide among patients with self-reported chronic pain conditions

Braden JB, Sullivan MD. J Pain. 2008;9(12):1106–1115.

- 2015 – Initial study of the specific relationship between chronic pain, BPD, and suicidality published

Campbell G, et al. Gen Hosp Psychiatry. 2015;37(5):434–440.

  - Authors found BPD was associated with the utilization of higher dosages of opioids, use of benzodiazepines and antidepressants, and medication nonadherence
  - 6.6X greater likelihood of suicidal ideation, & 7.9X greater likelihood of a past-12-month suicide attempt than non-BPD pts

Having Fun Yet?!?!

Chronic Pain, BPD, & COVID-19

- A really bad storm….
- Diathesis-Stress Theory maintains that stress can result in previously latent BPD manifesting itself
  - Chronic pain is stressful
  - Is ANYONE NOT stressed by COVID-19?!?!?!
- Important to recognize that not only patients but those who treat them are overwhelmed

Hall H. JAAPA. 2020;33(7):45-48.

Chronic Pain, BPD, & COVID-19

- Although the deleterious impact of individual stress on pain has been studied extensively, little work has been done on the impact of societal stress

Arpaia J, Andersen JP. Front Psychiatry. 2019 Jun 7;10:379.

- Reduced access to interdisciplinary care due to the virus should be considered

Clauw DJ, et al. Pain. 2020[Epub ahead of print].

- Many PM&R docs shifted from pain management to rehabilitating frail COVID survivors

Balkaya IY, et al. Am J Phys Med Rehabil. 2020;99(6):480-481.

Chronic Pain, BPD, and COVID-19

- Questions regarding what to do with immunosuppressants for the treatment of rheumatology patients, as well as the “run on hydroxychloroquine”

Pope JE. Curr Treatm Opt Rheumatol. 2020[Epub ahead of print].

- We can’t forget about opioid-induced immunosuppression

Kosciuczuk U, et al. Clinics (Sao Paulo, Brazil) 2020;75:e1554.

- Interventional pain medicine essentially ground to a halt

Deer T, et al. Anesth Analg. 2020[Epub ahead of print].

  - Risk of infection associated with corticosteroid injection ought not be ignored

Gill JS, et al. Pain Med. 2020[Epub ahead of print].

Chronic Pain, BPD, and COVID-19

- Headache patients – Renin-Angiotensin System (RAS) inhibitors and NSAIDs have been linked to increased risk of COVID infection

MaassenVanDenBrink A, et al. J Headache Pain. 2020;21(1):38.

- Cancellation of myriad hip and knee arthroplasties

Brown TS, et al. J Arthroplasty. 2020;35(7S):S49-S55.

- Pain physician burnout was already severe prior to COVID-19
  - Burnout results in impaired connection with pain patients

Gallagher RM. Pain Med. 2020;21:[Epub ahead of print].

Chronic Pain, BPD, and COVID-19

- Quarantining and social distancing – no fun for anyone
  - Specific quarantine-related stressors include longer duration of confinement, fear of infection, frustration and boredom, inadequate home supplies and access to information, financial loss, and social stigma
- Brooks SK, et al. Lancet 2020;395:912-920.
- Quarantining and social distancing are likely to be particularly challenging for those with BPD, given their tendencies toward chronic feelings of emptiness and fears of abandonment

Chronic Pain, BPD, and COVID-19

- Job loss and economic insecurity associated with the COVID-related economic collapse associated with suicidality

Conejero I, et al. Encephale. 2020[Epub ahead of print].
Crayne MP. Psychol Trauma. 2020[Epub ahead of print].

- Greatest fear of chronic pain patients during COVID (per social media) seems to be a potential shortage of opioids
  - ❖No empirical data suggesting this, but patients with BPD rely upon opioids not just for analgesia, but for emotional soothing
- Failure to treat chronic pain puts patients at risk of seeking illicit opioids on the street

Eccleston C, et al. Pain. 2020;161(5):889-893.

  - ❖Those with BPD are at particular risk of self-destructive behavior

Chronic Pain, BPD, and COVID-19

- COVID is not going anywhere soon
- BPD patients, due to their struggles to maintain relationships, have reported problems finding physicians to consistently treat their chronic pain pre-COVID

Shapiro H, et al. J Pain Res. 2020; 13:1431-1439.

  - And their likelihood of doing so during this crisis?!?!

- Since the release of the 2016 CDC Guideline, many physicians have been looking for an excuse NOT to treat chronic pain

Lagisetty PA, et al. JAMA Netw Open. 2019;2(7):e196928.

Chronic Pain, BPD, and COVID-19

- Given that many borderline personalities are now more likely to manifest symptoms, we fear they'll be rejected wholesale due to commonly experienced symptoms
  - Medical staff members report feeling "beat up" after interacting with them

Wasan AD, et al. Reg Anesth Pain Med 2005;30:184-192.

  - Some "difficult patients" are prone to making threats of legal reprisals because of perceived medical negligence or improper treatment

Platt FW, Gordon GH. Field Guide to the Difficult Patient Interview. Philadelphia, PA: Lippincott Williams & Wilkins, 1999.

Chronic Pain, BPD, and COVID-19

- Social media since the onset of COVID-19:
  - Exponential increase in those being thrown out of practices
    - Always allegedly “for no reason whatsoever”
  - Exponential increase in chronic pain patient anger
  - Clear signs of decompensation in many – e.g. posts regarding turning physicians into medical boards, even threats of violence
  - WARNING – AVOID TWITTER UNTIL IT’S SAFE TO COME OUT!!!!!

What Can Providers Do at This Point?!

- There's no question that many chronic pain patients suffer from BPD
  - From a Diathesis-Stress perspective, it's easy to understand why they (and providers) are more likely to struggle during COVID-19
- Discriminating against them presents an ethical imbroglio
- Medical systems tend to place the blame on patients for behaviors associated with their personality disorders

Brunero S, Lamont S. Contemp Nurse. 2010;35(2):136–146.

What Can Providers Do?

- Such discrimination is also a violation of epistemic justice

Kyratsous M, Sanati A. J Eval Clin Pract. 2017;23(5):974–980.

Knaak S, et al. Healthc Manage Forum. 2017;30(2):111–116.

  - "Epistemic injustice" – refers to patients' senses that they've been marginalized because of providers' failures to listen to their concerns
  - Yet, who wants to listen to patients as they go off on angry rants?
- We routinely screen for depression and anxiety (as well as substance abuse) in pain medicine, so why not for BPD?
  - Doing so is a potential first step toward solving this dilemma….

Screening for BPD

- Our proposed paradigm for regular UDS – Not to exclude patients from treatment, but to determine which patients will benefit from a higher level of monitoring and support

DiBenedetto DJ, Wawrzyniak KM, Schatman ME, Shapiro H, Kulich RJ. J Pain Res. 2019;12:2239–2246.

  - We don't d/c patients from treatment for depression or anxiety
  - Can the same paradigm be used for patients with comorbid BPD?

- Screening for BPD sounds complex – but needn't take any more time than screening for depression or anxiety

Shapiro H, et al. J Pain Res. 2020; 13:1431-1439.

Screening for BPD

- Thorough assessment of BPD generally requires a lengthy, labor-intensive Structured Clinical Interview for DSM Disorders (SCID)
- Screening is quick and easy using the McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD)
  - 10-item measure specific to BPD
  - 5-10 minutes to administer and score
  - Simple – Can be administered by staff
  - Its balance of sensitivity (0.81) and specificity (0.85) have been determined to be good

Zanarini MC, et al. J Pers Disord. 2003;17(6):568–573.

MSI-BPD

1) Have any of your closest relationships been troubled by a lot of arguments or repeated breakups?
2) Have you deliberately hurt yourself physically (e.g., punched yourself, cut yourself, burned yourself)? How about made a suicide attempt?
3) Have you had at least two other problems with impulsivity (e.g., eating binges and spending sprees, drinking too much and verbal outbursts)?
4) Have you been extremely moody?
5) Have you felt very angry a lot of the time? How about often acted in an angry or sarcastic manner?
6) Have you often been distrustful of other people?
7) Have you frequently felt unreal or as if things around you were unreal?
8) Have you chronically felt empty?

MSI-BPD

9) Have you often felt that you had no idea of who you are or that you have no identity?
10) Have you made desperate efforts to avoid feeling abandoned or being abandoned (e.g., repeatedly called someone to reassure yourself that he or she still cared, begged them not to leave you, clung to them physically)?

- All items are scored “Yes” or “No”
- A score of 7 or greater is used as the cutoff
- Not perfect, but quite good!

Is Screening Sufficient?

- Screens are only…..screens, and should not be considered definitive
- Positive screening for BPD should be followed by formal and comprehensive evaluation by a mental health professional trained and experienced in working with patients with BPDs
- Two reasons why all patients in a practice should be screened:
  1) To avoid stigmatizing those suspected of having a BPD
  2) To identify those who potentially do suffer from a BPD yet have not manifested it in their interactions with a practice, yet have the potential to manifest the symptoms in response to high levels of stress

Screening During COVID-19 Crisis

- Particularly important due to:
  1) Ongoing “normal” stressors associated with chronic pain
  2) Remote treatment or total lack of treatment
  3) Concerns regarding medication shortage and lack of access to alternative and multimodal care

Eccleston C, et al. Pain. 2020;161(5):889–893.

- But is this a “double-edged sword”?
- Will it result in more stigmatization and marginalization of a large part of the chronic pain patient population?

Next Steps

- This approach can help chronic pain patients if done right!
- Analogy with chronic pain patients with SUDs:
  - An SUD should NOT mean that a chronic pain patient shouldn't be treated
  - Rather, they should be monitored more closely and receive concomitant treatment by an addictionologist and a chemical dependency counselor

Kaye AD, et al. Pain Physician. 2017;20(2S):S93–S109.
Vaughn IA, et al. Fed Pract. 2019;36(9):406–411.

Next Steps

- Chronic pain patients with comorbid BPDs should continue to receive treatment, provided that they concomitantly receive ongoing mental health treatment – ideally Dialectical Behavior Therapy
  - This can help them minimize the behaviors that have too often resulted in their discharge from pain care and often futile efforts to find new pain management specialists to treat them
- Questions to ask ourselves:
  1) Are outcomes under the current paradigm of treating all patients presenting for pain care satisfactory?
  2) Can risks to both patients and their physicians and staffs be further mitigated by screening for BPD?

Summary and Conclusions

- Patients with BPD are not going to “go away”
- The same is a possibility with COVID-19…..
- Together, chronic pain and BPD produce “the perfect storm”, and these patients are prone to severe decompensation
  - Profound somatic focus
  - Inappropriate anger
  - Manipulation
  - Self-harm/suicidality
  - Substance abuse

Summary and Conclusions

- These patients are the ones that health care provider dread seeing
- As is the case with your staffs
- The temptation to discriminate against these patients is substantial
- Yet is doing so not ethically problematic?
- Don’t all patients with chronic pain deserve a chance to experience a relatively positive quality of life?

Summary and Conclusions

- Screening and appropriate referral for definitive diagnosis and treatment is not that complex a process
  - The ideal for any pain practice is in-house mental health services, but if not possible, develop an external referral network
- Patients with chronic pain and those with BPD are marginalized
- Learn to manage these challenging patients more effectively
- The lessons you learn during the COVID-19 crisis will not help you only now, but hopefully post-COVID as well….

THANK YOU