were female, and the mean age of onset was 16 years.

Among 109 patients with chronic pain, patients’ perceptions that they were a burden to others as assessed with this question was the sole independent predictor of suicidal ideation even after depression and hopelessness were taken into account.

A model including perceived burden-someness, in addition to conventional risk factors, correctly classified 88% of the patients regarding the presence or absence of suicidal ideation.

“It’s important to consider perceived burden-someness in the patients that you see,” advised lead investigator Kathryn E. Kanzler, Psy.D., who is a captain in the U.S. Air Force and a psychologist at Lackland Air Force Base in San Antonio. “Just one question – that’s all it takes to get kind of a quick snapshot of what’s going on.

Patients with chronic conditions may be uniquely attuned to the impact of their health on their caregivers. Dr. Kanzler told attendees of the annual meeting of the Society of Behavioral Medicine. “Research has found that self-perceived burden … can have a direct impact on significant medical decision making,” she said, such as choosing to reduce or entirely skip dialysis.

In the study, she and her colleagues retrospectively reviewed the medical records of 109 outpatients with chronic pain who were referred to a psychology clinic for evaluation and possible behavioral and psychosocial interventions. All were active or retired military personnel, or their dependents or family members. The patients were age 42 years on average. The majority were married (72%), female (65%), and white (66%).

The leading primary cause of pain was headache/migraine (seen in 28% of patients), followed by chronic low back pain (16%), fibromyalgia (15%), temporomandibular or myofascial pain (9%), arthritis (3%), and complex regional pain syndrome (1%). The remaining patients (30%) had pain due to other conditions, such as cancer or orthopedic injuries.

The investigators used responses on the Beck Depression Inventory–Second Edition (BDI-II) to assess patients’ hopelessness, suicidal ideation, and depression.

Perceived burden-someness was assessed from responses to a single statement, “It would be better for everyone involved if I were to die,” with possible response options ranging from 1 (never or none of the time) to 5 (always or a great many times). Overall, 7% of patients were found to have suicidal ideation, Dr. Kanzler reported. A logistic regression model including age, sex, race, marital status, depression, and hopelessness improved the ability to predict suicidal ideation above a null model.

Adding patients’ perceived burden-someness to this model further improved the ability to predict suicidal ideation and also improved model fit.

When controlling for depression and hopelessness, perceived burden-someness was the sole independent predictor of suicidal ideation.

There was no difference in the findings between patients who did and did not have an identified caregiver, a finding that corroborated those from other studies suggesting that perceived burden-someness may apply to the people who are important in one’s life generally.

Perceived burden-someness performed better at correctly classifying patients without suicidal ideation (98%) than at correctly classifying those with suicidal ideation (63%).

“We hope this study adds to the understanding of the really complex relationship between chronic pain and suicide ideation,” Dr. Kanzler said. “Perceived burden-someness as a risk factor might help explain high rates of suicide ideation beyond the types of things that definitely, immediately come to mind.”

Importantly, she noted, perceived burden-someness is modifiable, in contrast to many of the other risk factors for suicidal ideation, such as age and sex. “Some kind of a cognitive intervention might be useful,” she proposed, such as intervening to change the meaning of the cognition of perceived burden-someness or to challenge the cognition itself.

Encouraging increased communication with the key people in a patient’s life may also be beneficial, according to Dr. Kanzler. “Sometimes, especially in our population, there is not necessarily an identified caregiver, but this perceived burden-someness kind of affects the whole group that surrounds that person,” she explained. “So that type of intervention might also be useful, going beyond the individual patient.”

More than two-thirds of the patients (68%) had a history of suicidal ideation, 32% had attempted suicide, and 53% had been hospitalized in a psychiatric unit. The most common lifetime comorbid disorder was major depressive disorder (85%), followed by social phobia (65%), and substance use disorders (50%).

Dr. Phillips also reported that 44% of patients had sought nonpsychiatric medical treatment for the perceived odor. “They went to dentists if they thought they had bad breath, to dermatologists if they thought they had a foul or offensive body odor that was noticed the odor (an olfactory hallucination). All of the patients reported practicing repetitive behaviors in an effort to camouflage the perceived odor, mostly with perfume or scented powder (90%), chewing gum (60%), deodorant (55%), and mints (55%).

“Some patients actually drank perfume,” she said. “Some of them constantly chewed gum, ate mints, or reapplied deodorant over and over throughout the day [and] used prescription strength mouthwashes frequently. Some patients showered for hours a day, using an entire bar of soap, trying to remove the odor they perceived.”

In addition, 74% reported that ORS symptoms led to avoidance of social interactions “because they felt so ashamed,” she said. “They worried that other people thought badly of them because they smelled.”

More than a third of the patients (40%) said that symptoms were so bad that they were housebound for at least 1 week. “They didn’t leave the house at all because they felt too embarrassed or ashamed,” she said.

More than a third of the patients (36%) have concurrent major depressive disorder, and 44% have sought nonpsychiatric medical treatment for their perceived odor.

Data Source: A study of 20 patients with olfactory reference syndrome.

Disclosures: Dr. Phillips disclosed that she has received grant and research support from the American Foundation for Suicide Prevention and the National Institute of Mental Health.

Small Study Highlights Olfactory Reference Syndrome

BY DOUG BRUNK

Patients with olfactory reference syndrome have high rates of clinical depression and other comorbid psychiatric disorders, and nearly half of them do not avoid social interactions “because they felt so ashamed,” she said. “They worried that other people thought badly of them because they smelled.”

More than a third of the patients (40%) said that symptoms were so bad that they were housebound for at least 1 week. “They didn’t leave the house at all because they felt too embarrassed or ashamed,” she said.

More than a third of the patients (36%) have concurrent major depressive disorder, and 44% have sought nonpsychiatric medical treatment for their perceived odor.

Data Source: A study of 20 patients with olfactory reference syndrome.

Disclosures: Dr. Phillips disclosed that she has received grant and research support from the American Foundation for Suicide Prevention and the National Institute of Mental Health.

More than two-thirds of the patients (68%) had a history of suicidal ideation, 32% had attempted suicide, and 53% had been hospitalized in a psychiatric unit. The most common lifetime comorbid disorder was major depressive disorder (85%), followed by social phobia (65%), and substance use disorders (50%).

Dr. Phillips also reported that 44% of patients had sought nonpsychiatric medical treatment for the perceived odor. “They went to dentists if they thought they had bad breath, to dermatologists if they thought they had a foul or offensive body odor that was noticed the odor (an olfactory hallucination). All of the patients reported practicing repetitive behaviors in an effort to camouflage the perceived odor, mostly with perfume or scented powder (90%), chewing gum (60%), deodorant (55%), and mints (55%).

“Some patients actually drank perfume,” she said. “Some of them constantly chewed gum, ate mints, or reapplied deodorant over and over throughout the day [and] used prescription strength mouthwashes frequently. Some patients showered for hours a day, using an entire bar of soap, trying to remove the odor they perceived.”

In addition, 74% reported that ORS symptoms led to avoidance of social interactions “because they felt so ashamed,” she said. “They worried that other people thought badly of them because they smelled.”

More than a third of the patients (40%) said that symptoms were so bad that they were housebound for at least 1 week. “They didn’t leave the house at all because they felt too embarrassed or ashamed,” she said.

More than a third of the patients (36%) have concurrent major depressive disorder, and 44% have sought nonpsychiatric medical treatment for their perceived odor.

Data Source: A study of 20 patients with olfactory reference syndrome.

Disclosures: Dr. Phillips disclosed that she has received grant and research support from the American Foundation for Suicide Prevention and the National Institute of Mental Health.