151) Abstract 940

TELEPHONE-DELIVERED COGNITIVE BEHAVIORAL THERAPY FOR CHRONIC BACK PAIN

Mark Slater, Ph.D., Psychology, Tatiana Chircop-Rollick, Ph.D., Shetal Patel, Ph.D., Matthew Golish, B.A., Anne Weickgenant, Ph.D., Research Service, VA San Diego Healthcare System, San Diego, CA, Donald Penzien, Ph.D., Psychiatry, University of Mississippi Medical Center, Jackson, MS, Thomas Rutledge, Ph.D., Psychology Service, Joseph H. Atkinson, M.D., Psychiatry Service, VA San Diego Healthcare System, San Diego, CA

The high prevalence of chronic low back pain (CLBP) in primary care requires alternatives to face-to-face specialty pain clinic-based care. In a proof-of-concept, Phase IIa randomized clinical trial we assessed efficacy of a telephone-delivered, "Minimal Therapist Contact", home-based behavioral intervention for chronic low back pain in primary care. Participants (N = 66) were randomized to either an 8-week, 8-hour, "Minimal Therapist Contact" Cognitive Behavioral Self Management Skills Training (CBSST) or a Supportive Psychotherapy control condition (SC) matched for contact time. Completers' analysis (CBSST N = 22; SC N = 28) indicated outcomes were significantly better for CBSST than SC at 8-weeks in terms of % Overall Improvement (p = .045), mean % "Improved" (p = .018) and proportion with >25% Improvement (p = .04). Gains were stable over 6-month follow-up. This suggests telephone-based CBSST may have a role in Stepped Care of chronic back pain in primary care.

152) Abstract 912

INDEPENDENT ASSOCIATION OF ANXIETY WITH EMERGENCY ROOM ADMISSION FOR NON-CARDIAC CHEST PAIN

Loes Smeijers, MSc., Center of Research on Psychology in Somatic Diseases (CoRPS), Medical Psychology and Neuropsychology (MPNP), Ivan Nyklicek, PhD, CoRPS/MPNP, Tilburg University, Tilburg, the Netherlands, Peter J. Notten, MD., Psychiatry, St. Elisabeth Hospital, Tilburg, the Netherlands, Susanne S. Pedersen, PhD, CoRPS/MPNP, Tilburg University, Tilburg, the Netherlands, Harm van de Pas, MD, PhD, Emergency Department, St. Elisabeth Hospital, Tilburg, the Netherlands, Willem J. Kop, PhD, CoRPS/MPNP, Tilburg University, Tilburg, the Netherlands

Background Non-cardiac chest pain (NCCP) accounts for more than half of the chest pain-related emergency department admissions in the US. NCCP is defined as chest pain similar to the pain observed in myocardial ischemia-induced angina pectoris, but in the absence of underlying heart disease as a causal factor. Anxiety and psychological distress play critical roles in the neurobehavioral processes involved in pain regulation, potentially contributing to NCCP. This study examines whether anxiety is associated with NCCP, independent of demographic, clinical and psychosocial risk factors.

Methods The study included 46 patients with NCCP (mean age 44.9±14.7; 67% women) and 1233 controls (mean age 55.2±14.3; 50% women). Anxiety was evaluated using the State-Trait Anxiety Inventory (STAI; continuous scores and cut-off for anxiety: ≥45=90th percentile). Distress-prone personality characteristics were assessed using the Type D scale (DS14) including negative affectivity and social inhibition. Information on clinical and demographic measures was obtained from medical records and self-report questionnaires. Associations between anxiety and NCCP were examined using logistic regression analysis and are presented as odds ratios (OR) with 95% confidence intervals (CI).

Results Elevated levels of anxiety were significantly associated with NCCP (OR=3.27, 95% CI 1.68-6.36; p<.001). We also found that the 'distressed personality' was more common in the NCCP group compared to healthy controls (OR=2.51, 95% CI 1.35-4.69; p=.004). Anxiety was more common in Type D than non Type D (35% vs. 6%, p<.001). In multivariable models, anxiety remained significantly associated with NCCP (OR=2.49, 95% CI 1.18-5.25; p=.016), whereas Type D was not independently associated with NCCP (OR = 1.82, CI .90-3.66; p=.09). Further adjustments for sex, age, marital status, smoking, and use of alcohol did not change the association between anxiety and NCCP.

Conclusions Anxiety is associated with non-cardiac chest pain. This association was independent of distress-related personality and other clinical and sociodemographic factors. Prospective studies are needed to demonstrate that screening and treatment of anxiety will decrease symptoms of non-cardiac chest pain.

153) Abstract 1007

DISCREPANCIES BETWEEN SELF-REPORTED AND OBJECTIVE SAMPLING DELAY FOR THE CORTISOL AWAKENING RESPONSE (CAR)

Nina Smyth, MSc, Psychology, University of Westminster, London, London, UK, Phil Evans, PhD, Lisa Thorn, PhD, Frank Hucklebridge, PhD, Angela Clow, PhD, Psychology, University of Westminster, London, England, UK

The CAR is frequently studied in participants' natural environment using self-collection of saliva samples. For measurement of the CAR accurate timing of saliva sampling is crucial; poor adherence to sampling protocol leads to misleading assessments of the CAR. Studies often rely on self-report and exclude samples rated as 10-15 minutes late. This study compared actimeter-determined awakening and electronic monitoring of sampling times with self-reported awakening and sampling times. It also explored demographic, situational or psychosocial correlates of delayed self-report of both awakening and sampling times. Fifty students (mean 21±4.4 y) collected saliva samples on 4 days at 0, 15, 30 and 45 minutes post awakening. Awakening times were determined by wrist-worn actimeters and sampling was monitored by electronic devices (Medication Event Monitoring: MEM). Participants were informed that these devices monitored their adherence to the protocol. Participants also reported their awakening and sample collection times using the usual diary report method. Actimeter-determined awakening was significantly earlier than self-reported awakening - average difference was 8.0±1.5 minutes, ($F(1,25)=37.666, p<0.001, K^2=.601$). Sampling delay was calculated as the average delay for all 4 samples, objective sampling delay was derived from actimeter-determined awakening and MEM. Self-reported delay was derived from self-reported awakening and sampling. Figure 1 shows that objective sampling delay was significantly longer than self-reported delay, ($F(1,25)=22.838, p<0.001, K^2=.477$). Across the 4 days the average objective delay was 10.0±3.6 minutes. Age, social-economic status, trait and state well-being and ill-being, busyness, sleep quality, waking time, and ease were not significantly correlated with either objective or self-reported delay for awakening and sampling. Results suggest that self-reported awakening and sampling delay differs to that determined by electronic monitoring, this was largely attributable to inaccuracy in determining awakening. Also, no measured variable was related to awakening and sampling delay, suggesting that it may be related to other factors such as sleep inertia following awakening.

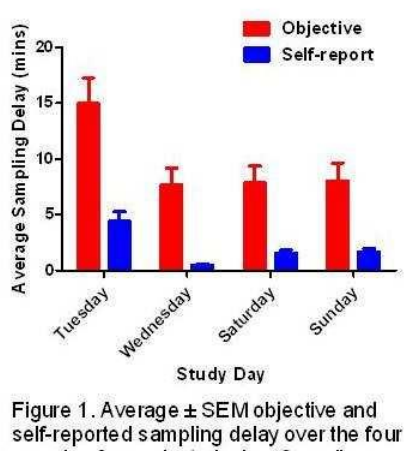

Figure 1. Average ± SEM objective and self-reported sampling delay over the four samples for each study day. Sampling delay was significantly higher for the objectively determined delay on each day.