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Could psychiatric assessment before hematopoietic stem cell transplantation predict the need for psychiatric consultation during transplantation period?

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ABSTRACT

Psychiatric morbidity seems to be a significant concern associated with all stages of hematopoietic stem cell transplantation (HSCT). We aimed to understand whether psychiatric consultation before HSCT procedure could predict the need for psychiatric support during isolation period. Seventy-eight patients undergoing HSCT were included in the study. Patients were diagnosed according to the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV). Standard anxiety and depression scores were performed. Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI) and State and Trait Anxiety Inventory (STAI) were performed. Psychiatric consultation was required for 45 (58%) patients during hospitalization. Only pre-HSCT STAI trait scores were higher in patients who were found to have psychopathology at consultation during hospitalization compared to patients without established psychopathology. Sixteen (76%) and 29 (51%) patients needed consultation with and without pre-HSCT psychopathology, respectively. Our study showed that the psychiatric consultation request rate during the transplantation process was higher for cases previously diagnosed with psychopathology and who had high trait anxiety scale scores before HSCT.

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1. Introduction

Hematopoietic stem cell transplantation (HSCT) is a complex procedure used in the treatment of a variety of hematological disorders, immunodeficiency states and some solid tumors [1]. Cancer patients undergoing either autologous or allogeneic HSCT present distinctive and diverse characteristics. Although both HSCT types are considered as potentially curative treatments, they may be associated with life-threatening complications including, but not

restricted to treatment-related toxicities and infections. Allogeneic HSCT may be also complicated by the onset of aggressive manifestations of graft versus host disease, with long-lasting and lethal consequences [2]. During both types of HSCT, patients undergo invasive medical procedures, which can cause distressing physical symptoms, changes in body image and sense of loss of personal control [2,3]. Furthermore, the long-lasting immunodeficiency status induced by these procedures requires prolonged hospitalization in protective isolation for 3–5 weeks depending on conditioning regimen, donor source, transplant complications and general health status of the patient. Besides being a physical limitation for patients, protective isolation also restricts physical contact with family members, who are viewed as a potential vehicle of infection [2,4]. All of these factors serve as significant source of stress for patients [5].

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Some psychometric studies have demonstrated emotional distress [6], psychiatric symptoms [7] and affective disturbances [8] following HSCT. Psychosocial variables such as depression and social support may affect the outcome of HSCT and survival [3]. Sullivan et al. reported that mortality was associated with psychological factors prior to HSCT [9]. In both autologous and allogeneic HSCT patients, anxiety and depression negatively affect quality of life [10,11], treatment adherence, symptom burden, pain intensity [12], length of hospital stay [13], health-care costs and survival rates [14–16]. Therefore, knowledge of psychiatric issues may be helpful in early recognition and treatment, which may, in turn, affect the success of the procedure.

Psychiatric morbidity associated with HSCT is frequently reported in literature. Although most prospective studies have assessed distress during the post-transplantation period [14,17,18], some studies have examined psychological adjustment during transplantation [2,13]. Prieto et al. found that the proportion of probable anxiety cases decreased from the point of hospital admission for HSCT (22.7%) until 14 days post-admission (8.0%), whereas the proportion of probable depression cases increased over the same time period (11.4 vs 16.6%) [15]. The researchers found that the most common diagnoses during transplantation were adjustment disorders (22.7%), mood disorders (14.1%), and anxiety disorders (8.2%) [13].

Trask et al. stated that approximately half of patients at the time of initial consultation for HSCT already experience significant levels of psychological distress [19]. Fife et al. reported that the greatest emotional distress occurred after admission to the hospital and before the bone marrow infusion [3]. According to Lee et al., pre-transplant detection of distress predicted detection of post-transplant distress [14]. Previous prospective research has shown that during hospitalization, around 40% of HSCT patients develop clinically significant psychopathological disorders [13,20], with anxiety and depression accounting for at least half of the psychiatric conditions diagnosed. Samantha et al. reported that although few patients (6%) met the criteria for moderate or higher depression before HSCT, nearly one-third (31%) met the criteria for moderate or higher depression when assessed at 6 to 7 weeks post-HSCT [21].

During the isolation period in the transplantation unit, high incidence (37.5%–54%) of psychiatric morbidity was observed in several studies [15,20,22,23]. Sasaki et al. reported agitation, psychological distress, insomnia, delusions and confusion in isolation period in half of the patients who previously had no psychiatric diagnosis [20]. Tecchio et al. confirmed that both anxiety and depression represent a relevant problem for HSCT patients during isolation. Although anxiety levels tend to remain substantially stable over time, depressive symptoms significantly worsen during isolation [24].

Psychiatric morbidity seems to be a significant concern associated with all stages of HSCT, which indicates the importance of psychiatric assessment and intervention at several time points during the HSCT procedure. At our center, psychiatric assessment is routine for every patient before HSCT, but psychosocial care following HSCT is heavily reliant on clinical detection of distress during medical visits. Psychiatrists and psychologists are involved on an as-needed

basis as perceived by the transplant physicians. In our study, psychiatric assessment was performed for all of the patients before HSCT. We aimed to understand whether psychiatric consultation before HSCT procedure could predict the need for psychiatric support during hospitalization period by retrospective evaluation of psychiatric consultations records. We also compared the psychiatric status of these patients before and during transplantation and tried to reveal the association between depressive/anxiety symptoms and some socio-demographic variables.

2. Methods

This study was conducted between November 2010 and January 2012 at Ankara Oncology Hospital HSCT Clinic. All adult patients (age >18 years) who were HSCT candidates and referred to our Psychiatry Outpatient Clinic for routine psychiatric assessment before HSCT procedure were included in the study. Illiterate patients (n = 4), patients with psychosis (n = 1) and mental retardation (n = 1) were not included. A dedicated psychiatrist performed psychiatric evaluations and patients were diagnosed according to the diagnostic criteria of The Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV). In our practice, Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI) and State and Trait Anxiety Inventory (STAI) are routinely performed. These scales are not diagnostic scales and just measure anxiety and depression scores of the patients.

2.1. Beck Depression Inventory (BDI)

This tool measures physical, emotional, cognitive and motivational symptoms observed in depression. It includes 21 items, which are rated by a 3-point Likert type scale. 0–9 points are included within normal range. Higher total scores indicate increased severity of depression [25]. Turkish adaptation, validation and reliability studies were performed by Hisli et al. who reported 17 as the cut-off point [26].

2.2. Beck Anxiety Inventory (BAI)

It is a self-assessment tool used to determine frequency of anxiety symptoms experienced by an individual, which was developed by Beck et al. in 1988 [27]. It includes 21 items, which are rated by a 3-point Likert type scale. The total score ranges from 0 to 63. Turkish reliability and validity studies were performed by Ulusoy et al. in 1998 [28].

2.3. The State Trait Anxiety Inventory (STAI)

This scale was developed by Spielberger et al. [29]. The STAI consists of two sub-scales, each composed of 20-items, measuring state and trait anxiety. The STAI state sub-scale (STAI-S) asks responders to rate how they feel at the moment of assessment using a 4-point scale (1 = not at all, 4 = very much so) in response to a series of self-descriptive statements. The STAI trait subscale (STAI-T) asks responders to rate how they feel in general using a 4-point scale (1 = almost never, 4 = almost always) in response to relevant statements (Chronbach's $\alpha = 0.90$). The STAI-S measures the transitional emotional status evoked by a stressful

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