Transplant Psychiatry

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Relationship between mental disorder and transplantation

• Pre-transplant  Mental disorder may generate need for transplant
  
  Directly eg via ingestion of toxic substances
  Indirectly eg IDDM complicated by Eating Disorder
  As a result of treatment eg long-term lithium use
  Chronic illness may trigger mental disorder
  Mental disorder (past or present) may be entirely coincidental

• Peri-transplant  Organic mental disorder as a result of surgery and medical treatment
  Delirium
  Hallucinosis due to immunosuppressants
  ‘Steroid psychosis’, steroid-induced mood disorder

• Post-transplant  Mental disorder secondary to surgery and its consequences
  Adjustment disorder, post-traumatic stress disorder, Mood disorder
  Relapse of mental disorder that led to need for transplant – BPAD, DSH
  Behavioural problems threatening graft survival
  Non-adherence, substance misuse
Psychiatrist’s role

• **Widen the live donor pool** eg
  – hx mental disorder
  – no mental disorder but relationship appears dysfunctional
  – altruistic

• **Select among potential recipients** eg
  – Loss of previous transplant due to nonadherence
  – Bipolar affective disorder, substance misuse

  *ie discriminate against patients on basis of likely outcomes rather than entire groups*

• **Improve transplant outcomes**
  – Adjustment
  
  *adaptation to transplantation is a lengthy process*
  – Adherence
Indication for referral for psychiatric opinion

Substance misuse

Non-adherence

Mental illness

Previous deliberate self-harm

In case of LD, dysfunctional family relationships
PSYCHOSOCIAL CONTRAINDICATIONS TO TRANSPLANTATION

ABSOLUTE CONTRAINDICATION

• When the patient has **permanent incapacity** such that they are unable to, and will never be able to, consent to the treatment as in:
  - severe (but not mild) dementia
  - severe (but not mild) learning disability
  - severe, chronic, refractory psychosis

• Active substance misuse, particularly if intravenous

• An active, consistently expressed, wish to die, unless this is clearly due to a mental illness that is treatable

• Refusal of transplant

• Repeated non-adherence with medical care
PSYCHOSOCIAL CONTRAINDICATIONS TO TRANSPLANTATION

RELATIVE CONTRAINDICATION

• Any mental disorder that may affect the patient’s ability to
  – understand what is happening and
  – what is required of them,
  – and/or their ability to cope with or care for a graft
OTHER RENAL REFERRALS

• Most referrals come from the dialysis unit/wards/renal clinic for issues other than transplant eg

  • Diagnostic
    – sorting out the interplay between medical problems (sepsis, anemia, delirium, etc) and psych symptoms
    – excluding depression in cases of dialysis refusal
    – assessing capacity

  • Treatment
    – Management of acute behavioural disturbance
    – Treatment of mood disorders
SYMPTOM LEVEL

MULTIDISCIPLINARY TEAM inc.
Transplant Coordinators, Medical,
Nursing, OT, Physio

INTERVENTION

Transient distress

Mild - Moderate distress
Eg adjustment problems, difficulty coping,
mild-moderate depression/anxiety, family
work, ambivalence re renal transplant

Mild - Moderate distress
Eg depression, OCD, non-compliance, personality
assessment, psychological formulation

Severe distress

Organic states/ suicidal/ psychosis
eg pharmacotherapy, complex delirium, complex capacity issues

Education/Training of Patients/ Families by MDT/IKA

Renal Counsellor
Social work

Clinical Psychology

Psychiatry

STEPPED CARE APPROACH
Impact of Renal disease on Psychological Wellbeing

• Huge variety (individual and over time)

• Mild to severe, acute or chronic
Normal Reactions to an Abnormal Situation

- Shock
- Anger and Irritability
- Denial
- Sadness
- Acceptance
Variety of Responses
Distress is “Normal”

- Continuum of Distress

- Mild               Moderate               Severe
  (Normal, adaptive) (Disabling)
Health problems and Distress

- 1. Distress is “normal”
- 2. Do not want to “medicalise” distress
- 3. Do not want to miss significant psychological problems
Why is distress missed?

- ‘Understandability’ of emotional response
- Confusion re possible organic aetiology
- Unsuitability of clinical setting for discussion
- Stigma ‘Don’t ask, don’t tell’
Why does it matter?

• Associated with increased disability
• Associated with poorer outcomes
• Increased use of healthcare resources
• Good response to treatment
When Emotional Difficulties become overwhelming…
1/4 to 1/3 patients have disabling psychological problems
Impact

- Uncertainty regarding the future
- Meaning of what has happened
- Loss of control
- Loss of independence
- Helplessness
- Fatigue
- Fear
- Death
Impact

**Relationships** – family partner (sexuality, fertility) children friends

**Body Image**
- disfigurement
- scaring
- Imagined

**Leisure/Work**

**Self-esteem**
- sick role
- disability
- change
- loss
- financial
- holidays
When Emotional Difficulties become overwhelming...

- Affect quality of life
- Ability to manage cancer treatments
- Fatigue, insomnia, low self-esteem, inactivity, depression...
- Adjustment disorder commonest
Depression

- 4x general population (10-20%)
- Response to perceived loss
- Diagnosis of cancer may precipitate feelings similar to bereavement

- Loss of eg
  - parts of the body
  - the role in family or society
  - impending loss of life
Anxiety

• Response to a **perceived threat**
  – Apprehension, uncontrollable worry, restlessness, panic attacks, and avoidance
  – Overestimate risks

  – Heighten perceptions of physical symptoms (such as breathlessness in lung cancer)
  – Post-traumatic stress symptoms (with intrusive thoughts and avoidance of reminders of cancer)
Increased risk

if

- Personal/family hx of mental health problems
- Substance misuse
- Adverse social circumstances
- Previous Hx of cancer
- Unpleasant/demanding Rx
- Certain drug Rx eg steroids

May exacerbate physical symptoms
Impact of Health problems and Psychological factors on activity level

Level of Activity

Medical / Physical Problems

Psychological Problems

Time

Previous Level of activity
Most vulnerable

- Around time of diagnosis
- Treatment issues- awaiting, change, end
- Discharge
- Recurrence/progression
- End of life
Sword of Damocles
Treatment

- Information
- Social support
- Addressing worries
- Anxiety management
Specialist Treatments

• Problem solving discussion

• CBT for
  – psychological complications
  – to help cope with chemotherapy and other unpleasant treatments

• Joint/ family interviews

• Group support and treatment

• Effective medication for pain, nausea etc

• Antidepressant meds
• Cognitive-behavioural treatments are effective in relieving distress, especially anxiety, and in reducing disability

• Psychological interventions can be effective in relieving specific physical symptoms such as breathlessness and fatigue

• Antidepressants are effective in treating depressed mood in physically ill patients
Fatigue

Previous Level of Functioning

Level of Activity

Time
Myths

“I must be positive all the time if I am going to beat my health problems…..”

No correct way to cope with cancer
Everyone experiences “low times” and “bad days”
No evidence that this will affect health
Myths

“My personality or stressful life caused my health problems…..”

Human nature to search for a reason
Blaming can create false sense of security that we can control uncontrollable events
Can increase psychological difficulties
Myths

“Talking to my partner or family will only upset them…..”

Usually know
Increase distress
Difficult to get help
Myths

“Only “mad” people or “failures” seek psychological support…..”

Fear about health shakes the strongest individual

Uncertainty very difficult
It’s the THOUGHT that counts
**EG of Simple CBT Model**

**Thoughts**
- “making myself worse”
- “cancer is back”

**Emotions**
- Anxiety
- Fear
- Depression

**Behaviour**
- Avoid
- hypervigilent

**Physiology**
- Reduced activity tolerance
- Panicky
Unhelpful Thinking Mistakes

• *When we are distressed our thinking often becomes distorted.*

• Have thoughts that are not true or not completely true

• See problems where there are none

• Blow real problems out of proportion
Unhelpful Thinking Mistakes

• Overestimate danger and setbacks
• Underestimate our ability to cope

• Thinking mistakes cause us to feel low, anxious and angry
All or Nothing Thinking

Black or White

• When we are distressed we see things as if there were only two possibilities

If treatment not 100% successful = useless

Enjoyed golf, walking, socialising

Energy low

Gave up everything
Catastrophising

Fortunetelling

• Thinking the worst – So afraid not able to think of other more likely outcomes

Waiting on results: they will be bad, I can’t cope, I will die

Tired and irritable: My partner won’t put up with me, he’ll leave me
Overgeneralisation

- Focus on one negative thing and decide that everything is wrong

- Forget one appointment: cancer has affected my brain, can’t be trusted to remember anything anymore
Jumping to Conclusions

Superstitious thinking

• When distressed we tend to jump too quickly to negative conclusions-

• Believe without having facts, without considering alternatives

Invited into office early: must be bad news
Magnifying and Minimising

- Exaggerate or magnify the negatives while down playing the positives

- Fatigue: Does housework, shopping but can’t get back to work – I’m useless
Mind Reading

• Assume you know what others are thinking about you.

• Husband and wife following transplant

“my husband is no longer interested in me”
Changing Unhelpful Thinking Mistakes

• 1. Become aware of when we are making unhelpful thinking mistakes

• 2. Question the truth or helpfulness of the thought

• 3. Establish new more realistic or helpful thoughts

• 4. Positive effect on mood
Psychological problems – highly treatable, understandable reactions to the abnormal, unpredicted and unprepared-for experience of being a cancer patient.
With thanks to

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