



Managing mental illness in the dialysis treatment environment: A team approach

MEGAN PRESCOTT, MSW

Abstract

Outpatient chronic hemodialysis facilities often serve large populations of patients in an open and sometimes fast-paced environment. Any sizeable group of people will contain a sample of mental illnesses—and the end-stage renal disease diagnosis can be accompanied by co-occurring or comorbid mental illness. Thus, it is important for professional teams to be able to effectively manage related issues arising in the dialysis clinic. Guided by Medicare mandates, dialysis clinics all employ a masters level social worker to respond to the myriad psychosocial needs of this population; MSWs are trained to recognize the signs and symptoms of mental illnesses, and can help guide the team response.

At the time this article was written, Ms. Prescott was a clinical social worker with the Renal Center at St. Joseph Hospital, Orange, Calif. She is currently with Fresenius Medical Care in Denver, Colo.

Introduction

The National Institute of Mental Health estimates that 22.1% of American adults (aged 18 and older) fit the criteria for a mental disorder in a given year. According to NIMH data, the most commonly diagnosed are depressive and anxiety disorders. Close to 10% of American adults (over 18 years of age) have a depressive disorder within a given year, while a slightly higher percentage (13.3% of adults age 18-54) are diagnosed each year with an anxiety disorder.¹

The incidence of mental illness in the dialysis environment could be higher, as studies indicate that ESRD patients experience depression more frequently than adults in the general population.^{2,3,4} One recent study suggested that 44% of patients in the early stages of dialysis treatment met the criteria for depression.⁵ The dialysis sample is also older than the general population, and therefore may present with more incidence of dementia, related and unrelated to ESRD.

Although it has not been thoroughly examined, most providers report an increase in the number of patients admitted to the dialysis clinic with ESRD secondary to cocaine, heroin, or methamphetamine use. One study confirms the often hidden incidence of drug-related renal failure.⁶

In the United States, mental illnesses are diagnosed based on criteria set forth by the Diagnostic and Statistical Manual, currently in its 4th Edition, Text Revision (DSM-IV-TR). In this manual, each mental illness has a set of diagnostic criteria, details about commonly associated features, and demographic data such as prevalence in the population, genetic patterns, age, and gender trends, etc.⁷ Masters level social workers are among the professional groups—which include psychiatrists, psychologists, counselors, and other mental health professionals—trained to recognize indicators of mental illness as defined by the DSM, and can serve a unique role on the renal team in helping to manage these patient issues in the dialysis setting. In fact, studies show that the majority of dialysis patients prefer to seek and receive treatment for

some mental illnesses (depression) from their dialysis clinic social worker. The trust and relationship established with their nephrology social worker appears to improve the odds they will seek needed treatment when compared to services available from a mental health provider in their community.

The dialysis environment

The dialysis treatment environment presents unique challenges to the management of patients with mental illness. The presence of a mental disorder can hinder patients' adaptability to the dynamic treatment environment. Small changes in the structure of treatments—like sched-

ule times or seating assignments—can be particularly upsetting to some. In comparison to other medical consultation and treatment environments, outpatient hemodialysis provides less privacy for discreet discussion, complicating management of personal matters and issues between patients and providers.

Direct patient care staff members in the dialysis setting are chiefly trained to provide dialysis treatments and manage the patient medically. They often request more support and training in responding effectively to patients with mental illness. Angella Perez, CHT, a patient care technician, states, "With dialysis patients, we are dealing with a whole varied list of problems and not all of them are related to the kidneys or other medical problems. Mentally ill patients can be a huge challenge. Sometimes minor details that most patients find insignificant can be very important to the patient with mental illness. It is important to stay sensitive to that."

The dialysis treatment regimen is also complex, and requires the patient's active participation for the best outcomes. Patients must follow a strict treatment schedule, adhere to complicated dietary

restrictions and recommendations, and often manage numerous medications. Mental illness can influence both motivation and ability to manage the complexities of the treatment regimen.

Despite the many challenges, the dialysis treatment setting—where patients are typically seen in the clinic three times a week—provides an almost ideal environment to monitor changes in mood, affect, behavior, and mental status in patients with co-occurring mental illness. The presence of a team member who is trained to recognize key indicators and guide intervention can help improve treatment potential for these patients. The ultimate goals for managing men-

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tal illness in the dialysis facility include keeping the staff and other patients as safe and comfortable in the treatment environment as possible, minimizing disruptions, and maximizing treatment outcomes for all patients.

Team preparation

Lack of training in recognizing and responding to mental disorders creates a particular challenge for dialysis staff. In the busy dialysis environment, there is a tendency for team members to grow frustrated with challenging patient behaviors, and to react to signs and symptoms of mental illness in a defensive way. It is common for the team to interpret these patients as "difficult" or "manipulative," when in actuality they are seeking to meet their needs in the only way they know. In addition to being ineffective, these types of punitive responses can exacerbate problematic patient behaviors and potentially damage patient/staff relationships. The clinic team social worker, who is trained to recognize and respond to mental disorders and altered mental status, can consult with the team to respond to these patient behaviors in ways that will actually help the patient learn more effective

ways of managing their needs in the dialysis clinic. In team care planning meetings, social workers can play a pivotal role in identifying where mental illness is a barrier to clinical outcomes, psychosocial functioning, and appropriate behavior in the dialysis environment. They can then help guide the team response to stabilize patient behavior in these areas. These social work activities can build team skill and confidence in managing the mentally ill patient, which in turn will communicate optimism to the patient and relax the treatment relationship.

This article will now review several of the most common mental illness diagno-

ses presented in the dialysis clinic environment, and make recommendations for team management.

dementia to depression.^{2,8} A recent study showed as much as 30% of sampled dialysis patients were cognitively impaired, a figure much higher than the general population.⁸ Other studies connect cognitive limitation with low nutrition scores and increased hospitalizations. Clearly, clinical outcome determinants in the ESRD population are a blend of medical and psychological strengths and risk factors.⁹

Recommendations

Dementia will obviously have an adverse effect on a patient's ability to understand the treatment routine and manage the intricacies of dietary adher-

ence and medication management. It is important to ensure that each staff member is in contact with a designated caregiver to communicate all progress reports and new instructions. Care logs that travel between caregiver and the renal team (via the patient) can help to coordinate treatment changes and other information. Regular care planning telephone calls between skilled nursing, extended care, or day treatment facilities can help maximize overall treatment outcomes in the cognitively impaired patient. With regard to patient management, involving the patient directly can be helpful by keeping the patient engaged with staff,

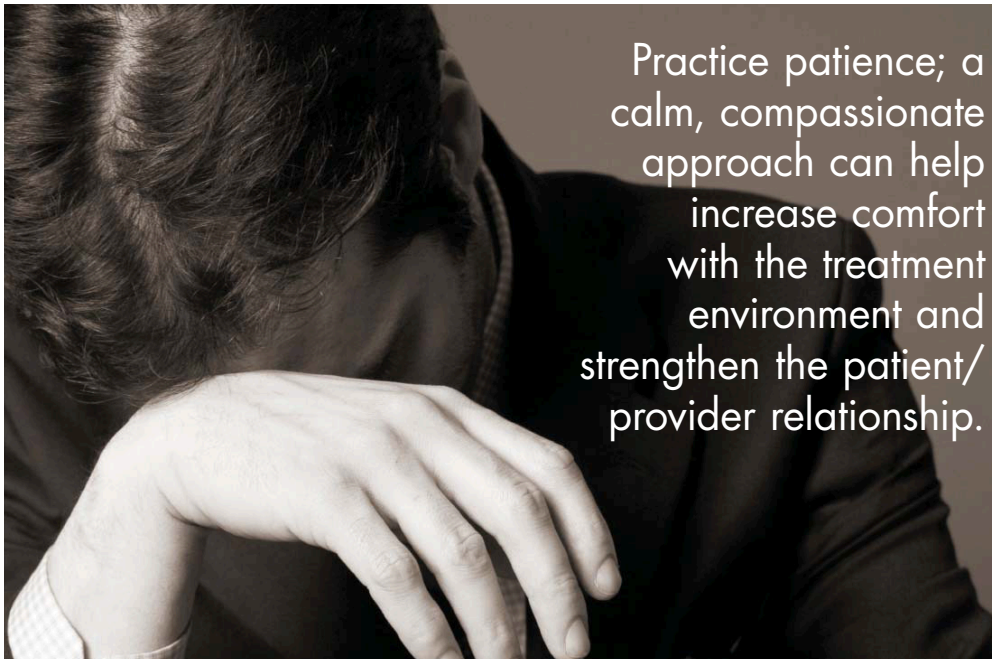
helping maintain patient self-esteem, and encouraging continued interest in understanding matters regarding their care, despite cognitive limitations.

All members of the team should take a similar approach with treatment structure to avoid confusion. This will instill a sense of routine, and reduce potential for anxiety and agitation. Cognitive impairment could be most evident during dialysis treatment, reducing the value of educational efforts while the patient is dialyzing. Depending on the patient, instructions should be given before or after dialysis whenever retention is a concern, and written down for later review. Patients with dementia have a tendency to ask redundant questions or require constant reassurance. It can be helpful to answer repetitive questions and respond to preservative thoughts the same way each time; this practice can be extended through the team by rehearsing a "script" with all involved staff. It is likely that patients with dementia will demand more time from nurses and technicians in the dialysis clinic. Staff members should expect that explanation and repetition will be part of the treatment protocol for these patients.

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Practice patience; a calm, compassionate approach can help increase comfort with the treatment environment and strengthen the patient/provider relationship. A rotation of team members, even during each dialysis treatment, can reduce the risk of team frustration and burnout with these patients. If patient behaviors reach a point of disruption, the social worker can team up with the nephrologists to pursue a brief stay in a mental health unit of an acute hospital to pursue psychiatric evaluation and intervention. This brief stay can provide medication changes that will allow a patient suffering from dementia to continue on dialysis therapy.

Social work skills should also be utilized to provide the renal team with information and support regarding family decision making in these cases. Renal team members can grow confused and frustrated in deciding to continue dial-



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Dementia

With a steadily aging ESRD population—more than 50% of patients on dialysis are now over age 65—the incidence of dementia will likely continue to rise, including mental impairment from Alzheimer's disease, vascular dementia, and altered mental status from other causes.² The dialysis population has elevated risk factors for stroke associated with hypertension and diabetes, and some data now links elevated risk for

ence and medication management. It is important to ensure that each staff member is in contact with a designated caregiver to communicate all progress reports and new instructions. Care logs that travel between caregiver and the renal team (via the patient) can help to coordinate treatment changes and other information. Regular care planning telephone calls between skilled nursing, extended care, or day treatment facilities can help maximize overall treatment outcomes in the cognitively impaired patient. With regard to patient management, involving the patient directly can be helpful by keeping the patient engaged with staff,

ysis for a patient with dementia that requires this level of management. Social work consultation can assist the team in understanding the developmental family dynamics that lead to these decisions, so that they can approach care with more understanding and acceptance. Brief social work roundtables to discuss professional ethics and personal/professional values can also be helpful to the team when working with patients suffering from advanced dementia.

Social workers can utilize the Mini Mental Status Exam, available through PAR, (<http://www.minimental.com>) to determine the nature and extent of cognitive dysfunction, and measure improvement or decline over time. This information can be used to inform the team how to better relate to the patient and can help determine the need for increased team support and treatment planning.

The prevalence of dementia in the dialysis population also points toward the importance of early discussions with patients and families about the benefits and rationale of advance directives. It is difficult to develop meaningful documentation of advanced planning and personal health care preferences once a person's ability to understand the process and implications is impaired; an early education effort is recommended for all patients, as cognitive impairment could progress over time on dialysis.²

Depression

Depression is the most common psychological problem among dialysis patients, and is becoming a more prevalent topic in the literature due to growing understanding of its link to increased mortality.¹⁰ The dialysis social worker can be useful in helping the team to identify clinical depression and differentiate the symptoms from those of uremia, which can appear quite similar. Lack of energy, low appetite, and difficulty sleeping are present in both, and can confuse the clinical picture, especially in patients new to dialysis when both are most likely to be present. While "distress" is a nearly universal experience in patients with ESRD from time to time, depression

occurs in up to 40% of ESRD patients.¹¹ The distinction between psychological distress and clinical depression is an important one. When a physician or renal team member remarks, "Of course s/he is depressed, s/he is on dialysis!" it is important to point out that between 60%–75% of patients on dialysis are *not* depressed. Depression is *not* a "normal" condition for dialysis patients. It is a serious co-morbid medical illness that calls for treatment. Depression is easily treated in most patients with ESRD, and is likely to improve treatment outcomes.¹²

It is important for direct care staff members to understand the physiological and psychological symptoms of depression, how these symptoms interplay, how they can affect a patient's engagement in the dialysis treatment regimen, and how they may relate to the renal team. Depressed patients can experience difficulty with concentration, which can affect their ability to absorb and integrate education about the treatment regimen. Cognitive changes can leave patients suffering from depression with feelings of hopelessness and

inadequacy, hindering their motivation to become partners in their treatment. It is important for the team to recognize that a patient who is depressed is likely to need persistent, compassionate, and repetitive educational efforts. Showing open frustration with a patient's inability to integrate important treatment information into action will most likely reinforce the negative thinking that accompanies depression. Irritability and anger can also occur in patients suffering from depression, and be triggered by small upsets. Learning to expect this reaction and responding calmly can be helpful.

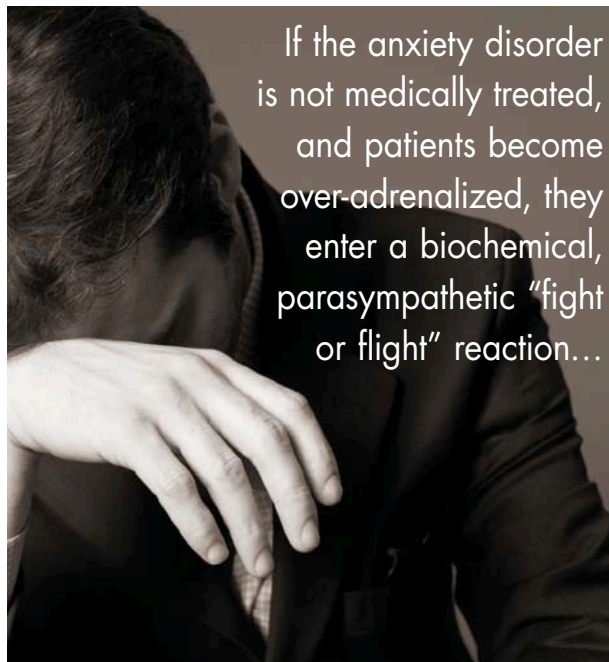
An additional task of the renal team, when working with depressed dialysis patients, is to carefully assess when comments are made regarding "giving up" or terminating treatment. Withdrawal from dialysis is not uncommon, occurring in nearly 20% of dialysis patients before their death.¹⁰ To dialysis professionals, this is not typically interpreted as a suicide, but as a rational decision in line with a patient's rights to self-determination.

However, when a patient who desires to withdraw from dialysis is clearly suffering from clinical depression, it is reasonable to evaluate whether the symptoms of depression are treatable before the decision is acted upon. These symptoms can contribute to perceptions of “energy” and a sense of “hopelessness” about the future, and can influence a patient’s will to live. Treatment, with medications or psychotherapy, or both, can significantly improve a patient’s ability to cope with chronic medical illness and thus, should be encouraged prior to decision-making regarding termination of treatment. Consideration of a patient’s right to self-determination, medical complications, family support, perceived quality of life, potential for clinical improvement, and other factors will play a part in this highly personal and individualized decision.¹³ Literature suggests that major depression for the dialysis patient can become a downward spiral in complex, emotional, and physical ways, and can increase mortality by staggering percentages.¹⁴

Another type of depression, known as manic depression or bipolar disorder, is typified by discreet periods of depression and mania. Bipolar disorder is successfully treated with medication, though adherence to mood stabilizing medications for bipolar symptoms can be problematic, especially during manic phases. ESRD patients with bipolar disorder in either depressed or manic phases will have difficulty managing dialysis demands, and careful consideration of adherence patterns is important for transplant candidates. Social work interventions can be utilized to improve medication management and monitor for mood swings. Due to a high incidence of co-occurring drug/alcohol dependence, the social worker should also monitor for signs and symptoms of substance abuse. With consent from the patient, maintaining contact with the primary care physician or psychiatrist (whoever is most involved in

managing medication to control bi-polar symptoms) could help provide better continuity of care.

Members of the renal team can be trained to alert the social worker when patients present with mood changes, offering a protective system of surveillance for patients with this disorder. Simple questions such as, “Over the past four weeks, have you felt so down in the dumps that nothing could cheer you up?” and “Have you felt downhearted and blue?” have been shown to predict



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depression and to be a valid first-line screener of depression.¹² Screening questions such as “Recently, have you not felt like your usual self?” or “Have thoughts raced through your head or have you had difficulty slowing your mind down?” can be taken from public domain measures and used as simple screeners to alert the team of the need for further evaluation (www.dbsalliance.org/survey).

Recommendations

When symptoms of depression are present, the social worker should be referred to do a thorough assessment and evaluate clinical risks. Team meetings can be the ideal place to discuss patient’s depressive symptoms, and the impact on adjustment or treatment outcomes.

Such regular discussions may help foster a better understanding among direct care staff about the impact of depression on dialysis patients in both adjustment and chronic stages. Social workers can provide patients with psycho-educational support to facilitate understanding of their symptoms, as well as cognitive behavioral counseling to combat negative thinking and increase enjoyable activities and social contacts. These interventions have been found to improve both mood and patient satisfaction with care in the dialysis clinic.¹⁶

Patients started on antidepressant medication can benefit from educational support to promote better adherence. A social work case management model can be effective when medication is prescribed by a primary care physician or psychiatrist to ensure remission of symptoms within the first 12-week phase of treatment.

Anxiety disorders

Unlike normal anxiety that is a part of everyday life, in the form of stress and worry, anxiety disorders are disruptive and overwhelming. Anxiety disorders can be caused by a variety of factors, alone or in combination, including genetics, changes in the brain, or environmental stressors. A major medical crisis can be a contributing factor in the onset or exacerbation of an anxiety disorder. Anxiety symptoms are also common features of major depression, and an assessment should determine the primary source of the symptoms. Patients with anxiety disorders are faced with the daunting task of learning to function in a busy medical treatment environment that may cause them considerable emotional distress while offering little time for team reassurance. If the anxiety disorder is not medically treated, and patients become over-adrenalized, they enter a biochemical, parasympathetic “fight or flight” reaction, and present to staff as “demanding” or disruptive. They can

suddenly seem inappropriate or use foul or loud language. These behaviors can be involuntary and internally driven to reduce a state of physiological stress.

Anxious patients often feel shame following these sudden disruptions, and they can impact interpersonal relationships, including those with the treatment team. The team can be helpful to the patient when responding with concern for them and seeking to understand what they need in that moment. This usually diffuses the situation quickly and restores trust in the treatment relationship for both the patient and team member.

Recommendations

For patients suffering from an anxiety disorder, including generalized anxiety, panic disorder, phobias, obsessive-compulsive disorder, and post-traumatic stress disorder, small changes can bring big distress. It is important to take time to explain any changes in the treatment plan. For patients with a known pattern of anxiety responses, social workers can partner up with the team to inform patients of changes to schedule or seat assignments. Social workers can help the patient process their response and create a strategy to tolerate the change. If choices can be offered, the social worker may help the patient feel more in control of and capable of tolerating the change. A thorough assessment for the presence of phobias in new patients is important, especially needle phobia or claustrophobia, both of which are likely to be particularly challenging for dialysis patients.

Personality disorders

Given the prevalence of personality disorders in the U.S. (10%-15% of adults fall into one of the 10 formal categories), the likelihood of encountering personality disordered patients in ESRD treatment is high.⁷ These patients will most likely have difficulty with adapting to new patterns and expectations, and present with an “inflexible, deeply ingrained style of behaving and responding to situations.”¹⁷ Most of these individuals lack ability to be introspective regarding their

own issues and behaviors, consistently identifying problems as stemming from other people and situations. This rigid pattern of perception and behavior can present the renal team with great challenges in terms of managing their own professional reactions and personal feelings in the dialysis clinic.¹⁷

Recommendations

Although mental health treatment of personality disorders has grown more promising,¹⁷ the renal team must remember that the disorder is most likely longstanding, and change in behaviors associated with the disorder are slow to occur.

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Due to the nature of the disorder, it is likely that the same types of behaviors and problems will occur over and over again in the dialysis clinic. The renal team should work together to compose a professional strategy and response to a recurring situation to avoid burnout and team stress. It is critical for the team to keep communication open at all times to avoid team division or “splitting” (particularly in cases of borderline personality disorder). Teams can rehearse responses such as, “Mr. Jones, I really want you to feel cared about and comfortable here; let’s start again.” These responses can be very effective in calming the interpersonal fears and confusion of a patient with a personality disorder. It can also help these patients practice more effective ways of meeting their needs in the dialysis setting, where their dependency

on others creates a nearly impossible challenge for them. It is advisable for social workers to meet with the treatment team upon admission and on a regular basis to maintain team confidence and skill in working with dialysis patients that suffer from personality disorders. It is also helpful for the social worker to examine adherence behavior and work with patients to maximize their skills for adherence, given their difficulties with rigidity and impulsivity. If, historically, the patient has demonstrated difficulty, and they are not responsive to skill building, transplant candidacy may be compromised.¹⁷

Other common mental illnesses

Other mental illnesses are likely to emerge in the ESRD population, but are not well represented in the literature. These include substance abuse disorders, schizophrenia, eating disorders, attention deficit hyperactivity disorder, and others. Social workers can consult with and assist staff as issues arise, as well as provide patients with resources and counseling to maximize their adjustment and outcomes in the dialysis environment.

General guidelines for working with dialysis patients with mental disorders

With patients formally diagnosed with or exhibiting symptoms of mental illness, it is important to keep communication open between team members. Cohesive team efforts must be made to maintain trust between the patient and the treatment team. These patients are likely to experience the dialysis clinic environment as one of the greatest challenges to living with mental illness. It is imperative to maintain professional composure in the face of behavioral problems from patients with known mental illness, and avoid “gossip” about these sensitive patient matters. The social worker and team members should be kept abreast of behavior changes, mood changes, or disruptions even if they seem inconsequential. These could inform past or future issues by painting a clearer clinical picture of problematic behavior and direct, appropriate

and consistent responses. Prevention of disruption is a key goal when effectively managing patients with mental illness in the dialysis clinic. Episodes of aggression or angry outbursts cannot only result in creating fear among those in the clinic, but can damage the patient-team relationship. Even worse, these can lead to a discharge from dialysis clinics, ultimately preventing access to care for this fragile population of ESRD patients. Frequent and brief team trainings can be provided by the dialysis clinic social worker to maintain team skill in working with mentally ill dialysis patients.

orders in the dialysis environment are depression, dementia, and anxiety disorders, and appear far more often than in the general population. Long-term survival on dialysis is determined by a combination of physical and psychosocial factors.⁸ In patients with mental illness, the psychological factors can bear even more weight in determining treatment outcomes.

Social workers have an important role in guiding the team management of mental illness in the dialysis setting. Regular discussion of these patients as part of team care conferences can allow a

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Tips for responding to aggressive behavior can be provided. These trainings should keep the following guidelines in mind.

- ▶ Clear communications to patients with mental illness regarding clinic rules and norms and changes is important.
- ▶ Maintaining professional boundaries with all patients to avoid confusion about interpersonal relationships is essential.
- ▶ Avoid any approach to problem behavior that is authoritarian or punitive.
- ▶ When there are multiple patients with risk of aggression or severe upset, they should be separated in the dialysis setting if at all possible.
- ▶ Once you identify the beginning stages of an escalation, address it immediately with a firm, but calm and caring demeanor.
- ▶ Ongoing strategy and support to the entire treatment team is vital in order to align and manage the mentally ill patient on dialysis.

Conclusions

The dialysis team should carefully consider when mental illness may be a factor in patient behavior, adjustment to dialysis, and management of treatment regimen. The most common mental dis-

orders in the dialysis environment are depression, dementia, and anxiety disorders, and appear far more often than in the general population. Long-term survival on dialysis is determined by a combination of physical and psychosocial factors.⁸ In patients with mental illness, the psychological factors can bear even more weight in determining treatment outcomes.

It is essential that the social worker provide education about the mental illness process to help team members better understand the patient's needs, avoid taking irritable or aggressive behavior personally, and respond with the most effective approach. When seen through this lens, it is easier for the team to manage challenging patient behavior with compassion, and avoid burnout. ♦

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Screening and treating depression: Patient preferences and implications for social workers

JENNIFER ROBERTS, MSW • STEPHANIE JOHNSTONE, LCSW

SINCE THE INITIATION OF TREATMENT FOR end-stage renal disease, depression has been identified as one of the most common mental health problems for dialysis patients.¹ Over the last decade, literature has strengthened its focus on depression in dialysis patients and further defined the impact of depression on their wellness, survival, and health care utilization.²⁻⁶

We now know that a significant number of patients on dialysis suffer from depression at some time over the course of their treatment.^{7,8} We also know that many of these patients are measurably depressed at the time of, or shortly after the initiation of dialysis.⁸ Many of them suffer from moderate to severe depression, with effects on patient survival of the same order of magnitude as medical risk factors.⁸⁻¹⁰ Many others suffer from mild depression, making it especially difficult for the health care team to identify it against some of the similar symptoms of uremia.

Studies have shown us that very few patients in either of these groups have received treatment for their depression.^{3,8} Finally, we are closing in on the variables of social support, disease burden, perception of illness, perceived stigma, and self-illness schema, among others, as those that can impact a patient's risk of becoming depressed.^{7,11,12}

As this knowledge of depression as an outcome barrier has solidified, the renal industry's attention has shifted away from the percentage of patients on dialysis who are measurably depressed, and toward

seeking models of treatment that might be effective in screening for and managing depression in patients with CKD.^{13,14}

Are nephrology social workers the professionals best equipped to screen for and treat depression? And is the dialysis clinic the best location to do so?

The Council of Nephrology Social Workers in San Diego, Calif. examined these questions at two intervals over an eight-year period with a large sample of hemodialysis patients treated in multiple non-profit and for-profit centers.

ment environment made a difference in that willingness.

Methods: The CNSW-San Diego Inquiry

Phase 1 of the inquiry was conducted in January 1998. More than 1,100 patients in 11 dialysis clinics were randomly sampled to form a survey group. Of this group, 110 patients were selected to participate by completing a three-item questionnaire with a five-point Likert scale. The questionnaire was also translated into Spanish, which was provided accord-

Table 1. Estimated number of patient referrals to community mental health providers and patient follow-through outcomes in sample of CNSW members

(January 2006-August 2006) (N=7 social workers)

Number of patients referred to by SWs to community mental health provider: 134
Number and percentage that pursued the referral: 29 (21.6%)

Like nephrology social workers across the country, the CNSW San Diego group had continually struggled to get dialysis patients to pursue their referrals to community mental health providers for depression treatment. Table 1 displays this struggle by showing the estimated number of these referrals made by a subgroup of the San Diego CNSW group over an eight month period prior to the survey, against the percentage of patients that actually pursued those referrals. Table 2 displays some reasons commonly given to the San Diego social workers by dialysis patients for their reluctance to pursue a referral to a mental health provider in their community for the treatment of depression. The CNSW chapter sought to examine patient willingness to receive treatment for depression and to see if the treatment provider or the treat-

ing to patient preference. The survey was delivered by the facility social worker, who explained that it was a self-report measure and instructed them to return the survey anonymously so as to prevent bias. Because of these requirements, patients that could not complete the survey independently were excluded from the inquiry, which included blind patients, patients that did not read or write English or Spanish, patients that were too frail to hold a writing instrument, or patients with altered mental status.

Participants then completed the self-survey on three items. First, they were asked a question that assessed their willingness to seek treatment for depression from an "outside" mental health provider (not located in their dialysis clinic). Secondly, they were asked about their willingness to seek treatment for depres-

The authors, from Fresenius Medical Care-San Diego, collaborated with members of the San Diego Chapter of the Council of Nephrology Social Workers in preparing this article. The San Diego Chapter of the Council of Nephrology Social Workers thanks Lynne LeSage Walrath, MSW, MPH, for her research assistance in Phase 1 of this study

sion from the nephrology social worker (the mental health provider on their dialysis clinic team). Finally, they were asked if they would be willing to receive treatment if they were “approached” by the nephrology social worker offering depression treatment services in their dialysis clinic.

In phase 2 of the inquiry, conducted in July 2006, 218 patients in 22 dialysis clinics were randomly surveyed. Using the same methods, the participants were all asked the same three basic questions, with the added support in question No. 1 that they would be “referred” by their nephrology social worker to an outside mental health provider for help with depression (see Table 3). This question was amended in an effort to make sure they would have support in accessing an outside mental health provider. The questionnaire was also translated into Spanish in phase 2. Demographic data was collected on all patients in this phase. Table 3 displays the results of the survey from both phases of data collection.

Results

Both study periods confirmed that a larger number of hemodialysis patients prefer to receive depression treatment from their dialysis clinic social worker, as well as a further preference toward being solicited into assistance rather than seeking help themselves. An increase is noted in the number of patients willing to seek treatment outside the dialysis clinic in phase 2 (2006).

Demographically, as noted in Table 4, the data suggests that women, diabetics, whites, blacks, those with less time on dialysis, younger ages, less educated, and unmarried patients appear more likely to seek treatment outside the dialysis clinic. These trends were similar in the group that would be willing to seek out the dialysis clinic social worker for help with depression, with the exception of a larger number of married patients preferring to seek help from the clinic social worker. A significantly larger number of patients reported feeling most comfortable with the nephrology social worker approaching them to offer help for

their depression. Patients on dialysis for longer periods of time, higher educated, and older patients as well as Asian and Pacific Islander patients reported much more comfort with this treatment option. These demographic findings are only speculations and require further, more formal analysis.

Discussion: Implications for nephrology social work practice

The results of the inquiry made by the San Diego Chapter of CNSW confirmed what nephrology social workers and other members of the renal team

nations for this finding. First, it is possible that this increase reflected the addition of the concept of “being referred to an outside provider by the nephrology social worker” to question No. 1, which might be perceived by patients as more supportive than the 1998 survey question which suggested the patient would be “self-seeking” a provider in the community. Secondly, it is possible there is a trend toward less stigma and resistance to depression treatment leading to an increased comfort with the use of all mental health providers eight years later. With the lack of actual follow up after

Table 2. Most common reasons for not pursuing referral to depression treatment outside the dialysis clinic as reported to NSWs by patients

1. I don't feel comfortable telling a stranger all this, I would rather keep working on the problem with you (nephrology social worker)
2. I don't think I am depressed enough to see an outside mental health provider
3. I just don't have the energy for any more scheduled appointments
4. I don't have transportation to get there
5. I don't have the money to pay for it (Medicare has a co-pay and Medi-Cal (Medi-Caid) providers won't accept Medi-Cal
6. I don't believe in treatment for depression (medication or psychotherapy)

had both observed and suspected. A significant percentage of dialysis patients are more comfortable addressing the issue of depression within the relationship they have already established with their nephrology social worker, and in the clinic where they receive the majority of their care. This follows similar findings in medical settings, which have supported the trend toward on-site depression programming in primary care settings.¹⁵

The increase in the number of patients willing to seek support for depression outside the dialysis clinic between the two study periods was significant, especially in light of the poor actual follow up rates reported by their nephrology social workers. There are several possible expla-

referral in this geographic area, however, it is likely that a third possibility would explain this increase in item No. 1. It is possible that patients did not want to be viewed as non-adherent following a “referral” from a member of their medical team (the nephrology social worker) and thus felt compelled to report favorably on item No. 1 when the word “referral” was added to the item. This explanation would support the actual experience of the San Diego social workers who reported that, over the last eight months, only 21.6% of the patients they served had followed through on their referrals to outside mental health professionals for treatment of depression. When discussing the results of the sur-

vey at a CNSW chapter study, the social workers felt certain that this was the probable explanation.

It should be noted in this study that nearly two-thirds of patients in 1998 and nearly one-third of patients in 2006 reported they did not feel comfortable seeking treatment for depression outside of the dialysis clinic. The demographic data suggest that male, married, educated, and long-term dialysis patients may be the least comfortable with that treatment option. It also points to American Indian, Latino, Asian, and Pacific Islander patients as less likely to accept treatment for depression from a community provider. In contrast, it is notable that between 87% and 91% of patients reported comfort with the option of being approached by the nephrology social worker in their dialysis clinic for help with depression. The results of this randomized survey confirmed that nephrology social workers are likely to remain the lead mental health providers of care to hemodialysis patients, and that the trend toward on-site programming is likely to be of benefit to patients that suffer from depression.

The timing for this inquiry could not have been better. In preparing for

their role in renal disease management, National Kidney Foundation's Council of Nephrology Social Workers has released a video-based outcome training program on interventions that identify and reduce depression for dialysis patients. Included in this training are interventions designed by nephrology social workers to be delivered by their colleagues onsite at the dialysis facility to improve access to depression screening and treatment. To accompany the Outcomes Training Program, CNSW has also designed a series of depression management programs that have been effective in improving mood, perception of coping, and satisfaction with care in dialysis center pilots.^{16,17} These programs are designed to be delivered live, chair-side, or by audio CD by nephrology social workers to patients onsite at the dialysis clinic, which is likely to overcome many of the barriers identified by patients in this study, and improve access to depression treatment for all hemodialysis patients. One of these interventions, which uses cognitive-behavioral and problem-solving therapy to treat depression, is woven into the "People Like Us: Stepping Back Into Life" program, recently released by the National Kidney Foundation.¹⁸ This unique wellness pro-

gram will be used by nephrology social workers in a pilot study to help emotionally rehabilitate Hurricane Katrina survivors in Louisiana. Nephrology social workers are awaiting its release nationwide.

Conclusion

As the industry continues to focus on the importance of depression treatment in improving patient outcomes, nephrology social workers are called on to continue to drive the on-site interventions that can successfully modify this outcome barrier. ♦

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Table 3. Patient responses to survey questions in Phase 1 and 2 of inquiry

PHASE 1 1998 (N=110)		PHASE 2 2006 (N=218)	
survey question	% patients willing	survey question	% patients willing
If I were depressed and knew I needed help...		If I were depressed and knew I needed help...	
...I would seek out the services of a psychiatrist, psychologist, or other mental health professional in my community for help.	36%	...and my nephrology social worker referred me to a psychiatrist, psychologist or other mental health professional in my community, I would go to their office for help.	70%
...I would seek out the services of my dialysis clinic social worker to help me.	76%	...I would ask to talk to the social worker at my dialysis clinic.	85%
...and if my nephrology social worker approached me with help for my depression, I would utilize his/her services.	87%	...and if my dialysis clinic social worker asked to speak to me about my depression, I would accept the services he/she offered to help with depression.	91%

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Table 4. 2006 CNSW study demographic data

	Question 1	Question 2	Question 3
TOTAL	70%	85%	91%
Men (n=117)	69%	82%	88%
Women (n=101)	71%	88%	94%
Diabetic (n=109)	73%	86%	92%
Nondiabetic (n=109)	66%	83%	91%
Time on dialysis			
less than 1 yr (n=54)	75%	87%	89%
1-2 yrs (n=78)	74%	87%	92%
3-4 yrs (n=54)	70%	81%	91%
5-6 yrs (n=12)	67%	75%	100%
6+ yrs (n=18)	50%	83%	94%
Education			
Less than 12 yrs (n=60)	70%	85%	88%
High School (n=82)	73%	87%	89%
OTP (n=10)	50%	80%	80%
College degree (n=41)	70%	85%	93%
Other (n=25)	72%	72%	96%
Age			
15-25 (n=6)	67%	67%	67%
26-40 (n=18)	89%	78%	94%
41-55 (n=64)	66%	88%	92%
56-70 (n=78)	69%	90%	91%
70+ (n=52)	69%	81%	90%
Marital status			
Single (n=47)	72%	79%	89%
Married (n=110)	69%	89%	90%
Living w/ Partner (n=6)	50%	50%	20%
Divorced (n=25)	76%	92%	100%
Widowed (n=30)	70%	77%	77%
Race			
White (n=73)	74%	86%	92%
Latino (n=77)	66%	84%	83%
Pacific Islander (n=15)	67%	87%	100%
American Indian (n=3)	33%	67%	67%
Asian (n=16)	69%	81%	100%
Black (n=31)	74%	84%	94%
Other (n=3)	100%	100%	100%