In CONTROL
A Medical Education Institute/Life Options Publication
VOL. 4 | NO. 2
JUNE 2007

How to Use *In Control*

Each issue of *In Control* offers background, tips, and patient education material on one topic that is important to living well with kidney disease. The 2-in-1 format of *In Control* is designed to make it easy to find the information and share it with your patients.

For you, there are 4 pages of professional content (pages S1, S2, S7, and S8), along with practical tips for putting key concepts into practice.

For your patients, there are 4 pages (S3–S6) of easy-to-read information. There's also a quiz patients can use to test their knowledge.

We encourage you to make copies of *In Control*. Use it to supplement your own education materials, and call us at (800) 468-7777 if you want to reprint an article. Help your patients get "in control" of their kidney disease!

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Depression and Dialysis

Dialysis professionals are well aware that the most common psychological problems reported by hemodialysis (HD) patients are depression and depressive symptoms.[1] Even after years of study, however, estimates of the prevalence of depression among dialysis patients vary widely—from 5% to 50%.[1-5]

There are several explanations for these wide-ranging estimates:

- **Different screening tools**—Depression has been found in up to 50% of patients with the Beck Depression Inventory (BDI); in 10% using the Multiple Affect Adjective Check List (MAACL), but in only 5% when a diagnosis was made by psychiatric interview using American Psychiatric Association standards published in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM)].[4]
- **Different medical professionals**—In a British study, primary nurses diagnosed depression in 41.9% of patients, but the nephrology team in only 24.2%. According to BDI scores, the rate was 38.7%.[5]
- **Different cultural values**—DOPPS data show that physician-diagnosed depression rates ranged from 2.0% in Japan to 21.7% in the United States, but the rate of self-reported depression in these countries—using the Center for Epidemiological Studies Depression Screening Index (CES-D)—was similar (and much higher): 40.0% in Japan and 39.2% in the U.S.[1]
- **Different timing**—Experts have cautioned that the first 3-6 months of dialysis is an unstable period, and that levels of depression may change over time.[4]

Focus on Symptoms

The real problem behind the failure to accurately estimate the prevalence of depression is the use of different definitions. The psychiatric syndrome of "depression," also called "major depressive disorder," probably affects only about 5%-10% of HD patients.[4] The presence of "depressive affect," or symptoms of depression, involves many, many more.

Acknowledging this fact, some researchers have suggested that clinicians stop talking about "diagnosing depression," and focus instead on evaluating the level of depressive symptoms. According to Kimmel, shifting to a study of the types and levels of depressive symptoms and their impact on health, mortality, and quality of life "is the most important issue regarding depression in ESRD patients today."[4]

A commonly used screening tool for assessing those symptoms is the Beck Depression Inventory (BDI),[2] although experts recommend using a higher than usual cutoff score [10-18 of a possible 63 is considered mild or moderate depression][7] or deleting the questions that deal with physical symptoms[4,6] when this tool is used in dialysis patients. Other

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Classes Help Patients Manage Depression

Finding effective and practical ways to help dialysis patients who are struggling with depression is not an easy task. Social worker Cindy Miller, MSW, LCSW and her colleagues Jessica Cabness DSW, LCSW and Kia Flowers, MSW piloted a 6-week program of classes (based on models in the Outcomes Training Program developed by Stephanie Johnstone et al) in the dialysis clinic at the University of South Florida, in Tampa.

Enrolling Patients

Miller and Flowers distributed flyers about the upcoming classes to all 117+ patients in the clinic. Enrollees were entered into a drawing for gift certificates. Twenty-three patients signed up for the classes. The majority (62%) had been on dialysis for 1-2 years; 15% had been on dialysis for 7 months-1 year; and the remaining 23% had been on dialysis for 1-6 months. Participants ranged in age from 30 to 84 years old, and were predominantly (70%) African-American.

Program Description

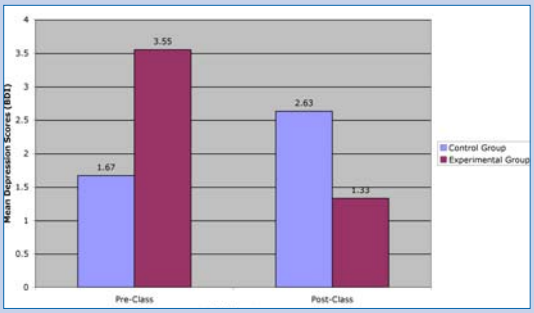
Study patients were randomly assigned to an experimental group (n=13) or a control group receiving usual care (n=12). Patients in the experimental group attended a 6-week series of classes held at 11:00 am on Wed. or Thurs. "The morning session patients could come after dialysis and the afternoon patients could come before their treatments," noted Miller. "Some patients chose to come on their non treatment day," she added.

These groups met for about 90 minutes. Education was presented for about 45 minutes, followed by 45 minutes of group discussion and sharing. "Attendance was good," commented Miller, "the patients were very enthusiastic and got to know each other very well. They became a support group for one another and established a strong bond."

The class content focused on education about biological components of depression, psychotropic medications, and cognitive-behavioral techniques. According to Miller, these techniques are designed to "help patients increase their awareness of their thought process so they can change the way they think. If they can perceive situations differently—they may not always assume the worst." The 6-week, "Feeling Better Again!"* program included classes on:

1. Understanding depression and how to feel better again
2. Cognitive-behavioral training: how it works
3. Balancing your thinking
4. Practicing new skills
5. Reducing worry
6. Maintaining and moving forward

Comparison of Experimental & Control Group Mean Depression Scores



Positive Results

A comparison of patients' self-reports (using scores from the Beck Depression Inventory-Fast Screen) before and after the series of classes showed a significant *decrease* in depression in the experimental group. The control group, on the other hand, experienced an *increase* in mean depression scores over the 6-week period (see graph). "These scores are particularly meaningful," said Miller, "when you consider that we conducted the classes just before the holiday season—a time of the year when people are generally more depressed." These findings replicate those of a pilot study of the series by project consultant S. Johnstone, LCSW, in which 75% of class participants made a 5%-10% improvement in mood scores in 6 weeks.[1]

In addition, experimental group patient comments about the classes were overwhelmingly positive. More than 90% considered the classes to be helpful and 100% would recommend such classes to others.[2] "Being with other people with the same illness and listening to their problems made me feel that I was not alone," commented one participant.

Useful Model

Miller has found the model of teaching cognitive-behavioral techniques in small group sessions so effective that she has used it to develop other curricula, including a replication of Johnstone's fluid management class and her own class on shortening/missing treatments. Both have produced clinically significant results.

Reference

1. Johnstone S. Wellness programming: nephrology social work expands its role in renal disease management. *Nephrol News Issues* 19(12):59-71, 2005.
2. Cabness J, Miller C, Flowers K. Promoting resilience in ESRD: evaluation of a group cognitive-behavioral intervention for patients on hemodialysis. *J Neph Social Work* 25:30-36, 2006.

**"Feeling Better Again!" was developed by Stephanie Johnstone, LCSW and Susan Guzman, PhD, with funding and support from the NKF Council of Nephrology Social Workers. It is copyrighted by the NKF and national release is pending.*

Q & A:
Ask the Expert

An interview with Edward Silverhardt, LCSW, LSCW and Board Certified Diplomate in Clinical Social Work. Clinical Social Worker at DaVita-Sparks Dialysis Center, Sparks, NV

Silverhardt has years of experience assessing and treating depression in a variety of patient populations, including prison inmates, probationers, parolees, severe & persistently mentally ill, substance abusers, military personnel, chronic & complex medically ill, and the elderly. He is currently developing a specialized depression screening tool for dialysis patients.

Q: What tools do you recommend for depression screening in the dialysis clinic?

A: There are several good tools available. My personal favorite is the ***Geriatric Depression Scale (GDS)***. It has long and short forms that provide good screening data, and the results correlate well with other depression tools. And, it is available in 28 languages! Because it is in the public domain, you can use it at no cost. Social workers can find the tool, scoring guidelines and references on the Stanford University website at www.stanford.edu/~yesavage/GDS.html. Another good tool is the 9-question ***Patient Health Questionnaire (PHQ-9)***. It is quick to administer and has been validated in the dialysis population. The materials are available online at www.depressionprimarycare.org/clinicians/toolkits/materials/forms/phq9, and can be used without cost.

I have also used the ***Outcomes Questionnaire 45.2 (OQ45.2)*** with success. It is an easy tool to administer and score, but there is a licensing fee.

Many research studies use the ***Beck Depression Inventory (BDI)*** but, at 21 questions, it is a little long and may be difficult for some patients to take on their own. It is copyrighted and requires permission to use.

Whatever tool you use, it's a good idea to enlarge the print size for those with vision difficulties. The GDS short form has a good record of success for reading to clients.

Q: When is the best time to screen for depression?

A: To me, the right answer is "over and over and over again." Depression screening during the first six months of a person's dialysis treatment is complicated because it is such a traumatic time. There is powerful, pervasive grief, and symptoms of uremia that need to be considered. Still, an initial clinical assessment provides a good baseline. Then, you should reassess every 3-4 months to see if there are any changes. For patients who are receiving counseling, the ideal assessment interval is every five sessions.

Q: What comes after a positive assessment?

A: In my opinion, that's a big question. Of course, you can refer him or her for therapy, but we know that many patients can't or won't seek counseling outside the clinic. You can also recommend that they seek medications from their physician.

One of the most valuable services social workers can perform is to help patients "choose and sort out" options—and help them decide what to do. Social workers who have a good rapport with their patients can work with them to put together a treatment plan. It doesn't have to be a long, involved plan—sometimes just a simple series of steps is all that's needed. If we had more time—and fewer patients and clerical distractions—we could also provide more "casework (one-on-one counseling) and groupwork services to patients and their families in dealing with the special problems associated with ESRD," as mandated by the Medicare Conditions for Coverage. These groups can be grief or caregiver support and self care with focus on emotion management or balancing dialysis while maintaining employment, etc.

Q: Is time the biggest challenge facing social workers who want to help their patients deal with depression?

A: There's no question that workloads and time pressures are an issue. The bigger challenge is getting the nephrology community to pay more attention to mental health issues like depression. It is just not a "burning issue" to anyone other than social workers.

I'd like to see a federal standard with guidelines and requirements—and insurance coverage—for screening and treatment of a variety of mental health issues like depression, trauma and grief etc in the dialysis setting. This type of focus, that has documented, positive results, could dramatically improve a patient's quality of life and other clinical outcomes. Until clinics and corporations focus more resources on depression or other mental health issues, the consistent clinical outcomes they seek will continue to be out of their reach.

(continued from page S1)

Depression and Dialysis

screening tools are available as well (see "Ask the Expert", page S7.)

Impact on Outcomes

Accurate identification and assessment of depressive symptoms in dialysis patients is vitally important because of the impact depression has on outcomes. DOPPS data have shown that patients who exhibit/report these symptoms are at significantly increased risk for all adverse outcomes, including mortality, hospitalization, and withdrawal from dialysis.[1] Depression may affect medical outcomes indirectly as well, by hindering patients' motivation to become partners in their treatment and to understand and absorb information about their condition and care.[8]

Depression has also been associated with decreased quality of life.[9] Undoubtedly this is because patients with depression experience personal suffering along with negative effects on productivity as well as on marital, family, and interpersonal relationships.

Unfortunately, despite the serious consequences associated with depression, it is both underdiagnosed and undertreated.[1] DOPPS researchers have reported that only about one third of patients who reported significant symptoms of depression had been diagnosed with this condition, and just 17%-34% of those were receiving medications.[1]

Good News

Although much work needs to be done to better identify and help dialysis patients who are suffering from depression, there is some good news. First, screening tools (see "Ask the Expert", page S7) can accurately identify those who need help. Second, medications (for example, sertraline HCl) can improve symptoms.[10] And finally, in dialysis center pilots, cognitive-behavioral therapy in the context of depression management programs has demonstrated success in improving mood, perception of coping, and satisfaction with care.[11]

References

1. Lopes AA, Albert JM, Young EW, et al. Screening for depression in hemodialysis patients: associations with diagnosis, treatment, and outcomes in the DOPPS. *Kidney Int* 66(5):2047-2053, 2004.
2. Watnick S, Kirwin P, Mahnensmith R, Concato J. The prevalence and treatment of depression among patients starting dialysis. *Am J Kidney Dis* 41(1):105-110, 2003.
3. Weisbord SD, Fried LF, Unruh ML, et al. Associations of race with depression and symptoms in patients on maintenance haemodialysis. *Nephrol Dial Transplant* 22(1):203-208, 2007.
4. Kimmel PL, Peterson RA. Depression in end-stage renal disease patients treated with hemodialysis: tools, correlates, outcomes, and needs. *Semin Dial* 18(2):91-97, 2005.
5. Wilson B, Spittal J, Heidenheim P, et al. Screening for depression in chronic hemodialysis patients: comparison of the Beck Depression Inventory, primary nurse, and nephrology team. *Hemodial Int* 10(1):35-41, 2006.
6. Cukor D, Peterson RA, Cohen SD, Kimmel PL. Depression in end-stage renal disease hemodialysis patients. *Nat Clin Pract Nephrol* 2(12):678-687, 2006.
7. Devilly GJ. Beck Depression Inventory (BDI). Accessed April 2007 from Swinburne University, Clinical & Forensic Psychology Website: *http://www.swin.edu.au/victims/resources/assessment/affect/bdi.html.*
8. Prescott M. Managing mental illness in the dialysis treatment environment: a team approach. *Nephrol News Issues* 20(13):32-41, 2006.
9. Drayer RA, Piraino B, Reynolds CF 3rd, et al. Characteristics of depression in hemodialysis patients: symptoms, quality of life and mortality risk. *Gen Hosp Psychiatry* 28(4):306-312, 2006.
10. Turk S, Atalay H, Altintepe L, et al. Treatment with antidepressive drugs improved quality of life in chronic hemodialysis patients. *Clin Nephrol* 65(2):113-118, 2006.
11. Roberts J, Johnstone S. Screening and treating depression: patient preferences and implications for social workers. *Nephrol News Issues* 20(13):43-49, 2006.

Quiz Answers

1. False. Depression is an illness that affects your body, mood, and thoughts.
2. True
3. True
4. True
5. True

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Depression and Kidney Disease

At some point, we all feel "down." We might even say, "I feel depressed today." But true depression is *not* just a once in a while "down" day—it is, says the National Institute of Mental Health, a "whole body" illness that affects body, mood, and thoughts for weeks or longer. About one out of four people on dialysis has depression—that's why we thought you should know more about it.

What Is Depression?

Depression is an illness that takes the joy out of life. With it, you may be less able to work, sleep, eat, or enjoy time spent with family. It steals your energy and can make you feel like there is no hope or reason to live. Each year, some people even stop dialysis because they are depressed.

Below are some symptoms of depression. If you have more than one of these for longer than 2 weeks, you could be depressed:

- Sad, anxious, or empty feelings
- Loss of interest in doing things you enjoy
- Fatigue, loss of energy
- Feeling worthless, helpless, or guilty
- Large weight loss—or gain
- Insomnia—or sleeping more than usual
- Feeling restless and irritable
- Having trouble with mental focus
- Thoughts of death or suicide

Some of these symptoms—like fatigue, loss of energy, weight loss, and sleep problems—can also be due to kidney disease or its treatment. "Situational" depression may occur due to the life changes of dialysis. Having less strength, energy, and freedom—and perhaps unwanted work and family changes—can lead to depression. Talk to your social worker about your symptoms and ask for help.

What You Can Do for a Better Life

If you are depressed, the good news is: there is hope. Depression *can* be treated. The two most common treatments are drugs and counseling—or both. Many drugs are cleared from the body by the kidneys, so talk to your nephrologist and a pharmacist about which ones are safe for you. With treatment, some people feel better in as little as 2-3 weeks.

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Melvin: Getting Over the Ups and Downs of Life

Melvin has gone through many ups-and-downs in his life, and was treated for depression after he started dialysis. Now, 65-year-old Melvin enjoys life and lives by a favorite quote: "I always pray that the worst days of my future are better than the best days of my past."

The Past

The third oldest of 17 children, Melvin grew up poor in an urban area of Virginia. When Melvin was 10, his father left and the family was fragmented. "I felt inferior back then," recalls Melvin, "but I had a good mind and felt I would be okay in life."

Melvin joined the military and was stationed in Puerto Rico and Cuba in the 1960s. After his deployment, Melvin began to toy with illegal drugs and alcohol. "In that era, the country was going through a lot and so was I," recalls Melvin. "I stopped the drugs and alcohol after about 5 years, and, in time, became an addiction counselor."

Life went on for Melvin—he was married (and divorced), and had children, grandchildren, and great grandchildren. In 1985, Melvin was found to have type 2 diabetes. "I know I did a lot of things that harmed me while I was having fun," reports Melvin.

Dialysis

During routine lab tests, Melvin's doctor noted that he had protein in his urine, and Melvin began in-center dialysis in 2000. "In the beginning, the treatment was very radical to me," Melvin recalls. "It took a while for me to acclimate because I never felt like a sick person before my kidneys failed." Melvin had problems with anxiety, fear, and high blood pressure. "I didn't know what was happening with my body!"

The new experience of dialysis and Melvin's lack of trust in the staff frightened him. "Looking back, I believe that was truly the start of depression for me," says Melvin. "I kept to myself more, was restless, couldn't sleep, and ate more than I should. Sitting in the dialysis chair also gave me time to mull about my life and problems."

Another difficult thing for Melvin was giving up his job. "I had worked for a long time as a community activist, mostly focused on black-on-black crime in the community—giving up my job was a very big move for me," explains Melvin. "I wasn't even 62 yet, so my Social Security hadn't kicked in. Getting the disability check was the deepest part of the depression for me."

All of these things, plus problems with sleep apnea and life-threatening episodes of congestive heart failure, depressed Melvin even further.

Looking Happy

To his friends and family, Melvin seemed to be handling dialysis well. "No one ever made any comments, because I was sociable and didn't look emaciated," says Melvin.

"I think I have a strong presence with my family and friends and I always tried to look strong and didn't let them know how bad I was feeling—I was laughing when there wasn't anything funny!"

Melvin says he "had to be told" he was depressed. "My doctor told me I had symptoms of depression and suggested I take prescription drugs," says Melvin. "I was determined not to take medication and instead went to see a psychiatrist through the drug rehabilitation system. I also prayed a lot."

Now, Melvin says he understands that the only way to get better was to allow himself to trust the healthcare staff. "They gave me the information to help myself—I really began to see who I was and was able to work things out."

Switching Treatments

In 2005, Melvin had the chance to be one of the first patients to do nocturnal in-center dialysis in Pennsylvania—and he grabbed it. "I liked that I would be able to enjoy more of the day since the schedule was Sunday, Tuesday, and Thursday from 8:00 p.m.-4:00 a.m.," says Melvin. "It's a longer and slower treatment but it cleans the blood more and can pull more fluid off without as much strain on my body." Melvin takes a shared ride service offered by Medicaid and sleeps during his treatments. Once home, he rests for a bit and then goes for long walks.

Now, Melvin stays positive and writes in a journal about all of the things he's gone through in his life. One day, he hopes to convert that journal into a book. "I'm always trying to move myself above my conditions," he says. "I also know to talk about my feelings when I'm depressed—it really helps."

Advice

The most important tip Melvin has for those new to dialysis is to "find someone on dialysis that you can nurture a friendship with—someone you can call and share your problems with." Melvin knows first hand that support is vital. "My friends, family, and kids were a key support system for me," shares Melvin. "Those without support don't do as well."

Melvin remembers the days when people died of kidney failure because there was no treatment. "With the progress in treatment options, you can have a second chance at life—a chance to reinvent who you are and still enjoy life," explains Melvin. "Perhaps you took things for granted before dialysis, but remember that you're still in charge of your life—perhaps for the first time in your life!"

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Depression and Kidney Disease

Taking charge of your life by choosing a home form of dialysis can also help ease depression—and help you to have more energy, fewer diet and fluid limits, and perhaps even go back to work if you are working-age.

People who have a good support system do better, and even live longer, than those who don't. Reach out to family and friends, a social worker, a religious counselor, or a support group in your center. Or, meet new friends: call the American Association of Kidney Patients (AAKP) at 800-749-2257 or the National Kidney Foundation (NKF) at 800-622-9010 to ask about chapters near you.

Learn More

With the right support and treatment, life can get better. To learn more about depression and kidney disease on the Internet, visit these websites:

- Kidney School Module 5: *Coping with Kidney Disease*, by Life Options, at www.kidneyschool.org
- Depression fact sheet, by Life Options, at www.lifeoptions.org/catalog/catalog.php?prodCat=teachingTools
- *Coping Effectively: A Guide for Patients and Their Families*, by the National Kidney Foundation, at www.kidney.org/atoz/atozTopic_br.cfm

Depression and Dialysis Quiz

Now that you've read about depression and dialysis, try to answer the true/false statements below to see how much you've learned (answers are on page S8).

1. Depression is an illness that affects only your mood. ❒ True ❒ False
2. Losing interest in doing things you enjoy can be a symptom of depression. ❒ True ❒ False
3. Sleeping more or less than usual can be a symptom of depression. ❒ True ❒ False
4. Drugs and counseling are the most common treatments for depression. ❒ True ❒ False
5. People who have a good support system do better on dialysis, and even live longer, than those who don't. ❒ True ❒ False

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