Mental Health In The ESRD Patient

ESRD Network 13
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This Session will Begin Momentarily.
The Session is Being Recorded. Please mute your phone lines.
Following the Presentation, Lines will be Open for Q & A.
Issues

1. Personality Disorders
2. Anxiety
3. Depression
Personality Disorders

- The lifetime prevalence of personality disorders in the general population is an estimated 10 to 13 percent.
- Based on structured surveys, the prevalence rates of personality disorders in primary care outpatient settings may be as high as 20 to 30 percent.

Personality Disorders

- The treatment of medical and psychiatric disorders is more complicated in patients with comorbid personality disorders.
- Studies have documented poorer treatment outcomes and health status, and higher rates of health care use and costs in patients with comorbid personality disorders.

Personality Issues

“Maladaptive eccentricities, emotional displays, and fearfulness can get in the way of getting along with others, and may be more common in people with depression.”

Zetin, Hoepner, Kurth pp66
“Personality evolves through a lifetime of experiences with learning mastery of new situations. A health personality involves a sense of being worthy of love, capable of learning new things, and mastering life’s challenges in work and relationships, able to relax and play, and able to experience close, loving relationships and a sense of trust with family and friends.”

Zetin, Hoepner, Kurth pp66
Dx Personality Disorder

“In order to be diagnosed with a personality disorder, the individual must have a long-standing, inflexible, pervasive pattern of personal and social or occupational areas and causes impairment or distress.”

Zetin, Hoepner, Kurth pp68
Dx Personality Disorder

“On a more informal basis, personality disorder are often considered problems that bother those around the patient more than the patient herself. The patient will often say that people don’t understand, are mean, are unfair, and that situations are constantly stacked against her. People who have a personality disorder very seldom say that their personality characteristics bother them, yet they may be quite aware that they don’t get along in the world as well as other people do.”

Zetin, Hoepner, Kurth pp68
Personality Disorders

“Often the simplest clue to diagnosing a personality style or disorder is to simply ask the patient, “How would you describe your personality most of your adult life? How would others who know you well describe you” Another key question is, “Are there any themes or patterns of problems that keep recurring in your romantic or work relationships?”
Paranoid Personality

- Long-standing distrust and suspiciousness and looks at others as having evil motives.
- Fear physician may harm, arguments, conflict

Clinical Approach: Adopt a professional stance, provide clear explanations, be empathetic to fears, avoid direct challenge to paranoid ideation.

Schizoid Personality

- Extremely detached from social relationships and have a restricted range of emotions.
- Delay seeking care, appear unappreciative

Clinical Approach: Adopt a professional stance, provide clear explanations, avoid overinvolvement in personal and social issues.

Schizotypal Personality

- Have social and interpersonal problems, discomfort, difficulty in close relationships, and odd or eccentric behavior
- Delay seeking care, odd beliefs, odd behavior

Clinical Approach: Adopt a professional stance, provide clear explanations, tolerate odd beliefs and behaviors, avoid overinvolvement in personal and social issues.

Antisocial Personality

- Pervasive pattern of disregard for, and violation of, the rights of others.
- Anger, impulsive behavior, deceit, manipulative behavior

Clinical Approach: Carefully investigate concerns and motives, communicate in a clear and nonpunitive manner, set clear limits.

Histrionic Personality

- Is excessively emotional and attention-seeking
- Overly dramatic, attention-seeking behavior, inability to focus on facts and details, somatization

Clinical Approach: Avoid excessive familiarity, show professional concern for feelings, emphasize objective issues.

Narcissistic Personality

- Demonstrates a need for admiration and a lack of empathy for others.
- Demanding, attitude of entitlement, denial of illness, alternating praise and devaluation of physician.

Clinical Approach: Validate concerns, give attentive and factual responses to questions, channel patient’s skills into dealing with illness.

Borderline Personality

- Characterized by unstable relationships and affect, with impulsivity, an unclear sense of self, and resulting lack of boundaries
- Fear of rejection and abandonment, self-destructive acts, idealization and devaluation of physician

Clinical Approach: Avoid excessive familiarity; schedule regular visits; provide clear, nontechnical explanations; tolerate angry outbursts, but set limits; maintain awareness of personal feelings; consult psychiatrist.

Anxiety
Generalized Anxiety Disorder

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance)

B. The person finds it difficult to control the worry (My experience is that individuals can’t control the worry)
Generalized Anxiety Disorder

c. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). Note: Only one item is required in children
Generalized Anxiety Disorder

1. Restlessness or feeling keyed up or on edge
2. Being easily fatigued
3. Difficulty concentrating or mind going blank
4. Irritability
5. Muscle tension
6. Sleep disturbance
Generalized Anxiety Disorder

D. The focus of the anxiety and worry is not confined to features of an Axis 1 disorder....

E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
GAD Presentation

1. Worry is often future oriented (e.g. Will I go bankrupt)
2. Poor planning
3. Inability to relax, “can’t sit still”
4. Chronic
5. Physical Symptoms
   - Muscle Tension
   - Headaches
   - IBS/GI issues
Panic Attacks

A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes.
Panic Attack

1. Palpitations, pounding heart, or accelerated heart rate
2. Sweating
3. Trembling or shaking
4. Sensations of shortness of breath or smothering
5. Feeling of choking
6. Chest pain or discomfort
7. Nausea or abdominal distress
Panic Attack

8. Feeling dizzy, unsteady, lightheaded, or faint
9. Derealization (feelings of unreality) or depersonalization (being detached from oneself)
10. Fear of losing control or going crazy
11. Fear of dying
12. Numbness or tingling sensations
13. Chills or hot flushes
Depression
Looking Back

“We believe that dialysis patients’ depression and anxiety levels are closely tied to their physiological status”

Kutner, Fair, Kutner (1985) Assessing Depression And Anxiety In Chronic Dialysis Patients. Journal of Psychosomatic Research 29 (1) 23-31:
And Today…

“This (Depression) may be one of the last modifiable risk factors for poor outcomes we as nephrologists and mental health care workers can address.”

Kimmel P, Peterson R. Clinical Journal Depression in Patients with End Stage Renal Disease Treated with Dialysis: Has the Time to Treat Arrived? American Society of Nephrology 1:349-352, 2006
The Scope of the Problem?

“About 20-30% of dialysis patients present with depression”

Tossani, Cassano, Fava; Seminars in Dialysis, Volume 18, No. 2 (March-April) 2005
“Our results suggesting that almost half (44%) the patients with ESRD starting dialysis therapy were depressed....”

“We found an increased level of depressive affect correlated with both laboratory and behavioral markers of poor compliance. Decreased behavioral compliance with the dialysis prescription correlated with an increased level of depressive affect in prevalent HD patients”

### Factors Associated with Nonadherence

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Odds ratios (OR) by nonadherence measure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Skip</td>
</tr>
<tr>
<td>Smoker (yes vs. no)</td>
<td>1.53ᵇ</td>
</tr>
<tr>
<td>Depressed (yes vs. no)</td>
<td>1.62ᵇ</td>
</tr>
<tr>
<td>Married (yes vs. no)</td>
<td>0.90</td>
</tr>
<tr>
<td>Prior kidney transplant (yes vs. no)</td>
<td>0.79</td>
</tr>
<tr>
<td>Time on ESRD in years (per year)</td>
<td>1.02</td>
</tr>
</tbody>
</table>

ERSD is end stage renal disease; IDWG is interdialytic weight gain

ᵃAdjusted for continent of residence, age, sex, race, ethnicity, time on ESRD, 15 comorbid conditions, employment status, living status, marital status, prior kidney TX, and Kt/V

ᵇP < 0.05
Depression Is Associated With an Increased Risk of Mortality and Hospitalization in Hemodialysis Patients

Note: Data are from the US (142 facilities) and Europe (101 facilities) and were restricted to 5,256 patients who had a medical questionnaire completed by the nurse coordinator and a questionnaire completed by the patient. Lopes AA, et al. *Kidney Int.* 2002;62:199-207.
Depression

ESRD Patient

Detrimental Effect on Underlying Disease

Poor nutrition

Immune dysfunction

Decreased compliance

Worse Outcome
“Psychological symptoms of unipolar depressive disorders may also include anxiety, irritability, reduced concentration and motivation, feelings of hopelessness and helplessness, excessive guilt, thoughts of suicide, hypersensitivity to criticism, perfectionism, and indecisiveness.”

Tossani E, Cassano P, Fava M. Depression and Renal Disease. Seminars in Dialysis 2005; 18(2) pp 73-81
Symptom Frequency

Drayer, Piraino, Reynolds, et al. 2006

Depressed Pt’s
No Depression

% of Pt’s Reporting Symptoms

Symptoms:
- Depressed Mood
- Anhedonia
- Sleep
- Fatigue
- Appetite
- Guilt
- Concentration
- Psychomotor
- Suicide Idea

Bars represent the percentage of patients reporting symptoms.
Depression Is A Chronic Illness

“Depression is frequently a recurrent/chronic disorder, with a 50% recurrence rate after the first episode, 70% after the second, and 90% after the third.”

University of Michigan Health Systems: Guidelines for Clinical Care-Depression
What Causes Depression
“The mechanisms of complex disorders such as depression cannot be defined by simple etiological models. With burgeoning neurobiological information, it is evident that depression is a disorder of multiple neurobiological systems involving molecular, cellular, neuroanatomical, neurochemical, neuroendocrinological, neurophysiological, and neuropsychological domains mediated by multiple etiological factors including genetic vulnerability, developmental insults, and psychosocial stressors”

Risk Factors in Depression. Keith Dobson and David Dozois. Elsevier 2008
A conceptual framework of risk factors for depression.

- **Biological factors:**
  - Genetics
  - Structural dysfunction
  - Process dysfunction (e.g., neurotransmission)
  - Regulatory dysfunction

- **Psychological factors:**
  - Cognitive schemata, beliefs, assumptions
  - Information processing; attention and memory
  - Optimism/pessimism
  - Rumination
  - Explanatory style and hopelessness theory
  - Problem-solving

- **Social factors:**
  - Attachment and temperament
  - Early trauma and loss
  - Life events and hassles
  - Parental psychopathology and parenting style/attachment
  - Marriage and relationship issues
  - Social support and network
  - Stress generation and social rejection
  - Reassurance-seeking and negative feedback-seeking
  - Avoidance and social skill

**Setting factors:**
- Gender
- Age
- Socioeconomic status
- Race
- Culture
Depression Is Frequently Not Diagnosed
## Prevalence of Physician Diagnosis of Depression and CES-D ≥ 10, by Country

<table>
<thead>
<tr>
<th>Country (N)</th>
<th>Prevalence (%)</th>
<th>Ratio of CES-D ≥10 to depression by physician diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physician-diagnosed depression (n/N)</td>
<td>CES-D score ≥10 (n/N)</td>
</tr>
<tr>
<td>Australia/NZ</td>
<td>17.4 (75/430)</td>
<td>40.2 (173/430)</td>
</tr>
<tr>
<td>Belgium</td>
<td>18.2 (81/445)</td>
<td>42.3 (188/445)</td>
</tr>
<tr>
<td>Canada</td>
<td>15.9 (68/428)</td>
<td>42.8 (183/428)</td>
</tr>
<tr>
<td>France</td>
<td>10.6 (44/416)</td>
<td>43.5 (181/416)</td>
</tr>
<tr>
<td>Germany</td>
<td>13.3 (66/495)</td>
<td>47.3 (234/495)</td>
</tr>
<tr>
<td>Italy</td>
<td>15.5 (85/547)</td>
<td>62.3 (341/547)</td>
</tr>
<tr>
<td>Japan</td>
<td>2.0 (29/1473)</td>
<td>40.0 (589/1473)</td>
</tr>
<tr>
<td>Spain</td>
<td>14.5 (82/555)</td>
<td>42.2 (233/552)</td>
</tr>
<tr>
<td>Sweden</td>
<td>19.8 (89/449)</td>
<td>39.4 (177/449)</td>
</tr>
<tr>
<td>UK</td>
<td>15.5 (70/452)</td>
<td>40.9 (185/452)</td>
</tr>
<tr>
<td>US</td>
<td>21.7 (282/1300)</td>
<td>39.2 (519/1300)</td>
</tr>
<tr>
<td><strong>All DOPPS</strong></td>
<td>13.9 (969/6,987)</td>
<td>43.0 (3003/6,987)</td>
</tr>
</tbody>
</table>

DOPPS II (2002-04): Prevalent cross-section of patients with information on depression diagnosis and who had completed a CES-D instrument. Mean country CES-D scores ranged from 8.4 to 11.7.

Screening Tools

- Beck Depression Inventory (BDI)
- Geriatric Depression Scale
- Zung Self-Rated Depression Scale
- Patient Health Questionnaire (PHQ-9)
Why the PHQ-9

- Free (www.depression-primarycare.org)
- Valid and reliable in ESRD patients
  Watnick, Wang, Demadura, Ganzini, *Validation of 2 depression screening tools in dialysis patients.*
  American Journal of Kidney Diseases, 46(5-November) 2005: pp 919-924
- Self-administered
- Available in multiple languages
- Easy and quick to score
PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ___________________________  DATE: ___________________________

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✓" to indicate your answer)

<table>
<thead>
<tr>
<th>1. Little interest or pleasure in doing things</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

add columns: + + +

TOTAL: ___________________________

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
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<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>
PATIENT HEALTH QUESTIONNIARE PHQ-9 FOR DEPRESSION

USING PHQ-9 DIAGNOSIS AND SCORE FOR INITIAL TREATMENT SELECTION

A depression diagnosis that warrants treatment or treatment change, needs at least one of the first two questions endorsed as positive (little pleasure, feeling depressed) indicating the symptom has been present more than half the time in the past two weeks.

In addition, the tenth question about difficulty at work or home or getting along with others should be answered at least "somewhat difficult."

When a depression diagnosis has been made, patient preferences should be considered, especially when choosing between treatment recommendations of antidepressant treatment and psychotherapy.

<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Provisional Diagnosis</th>
<th>Treatment Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-9</td>
<td>Minimal symptoms*</td>
<td>Support, educate to call if worse; return in 1 month.</td>
</tr>
<tr>
<td>10-14</td>
<td>Minor depression † †</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dysthymia*</td>
<td>Support, watchful waiting</td>
</tr>
<tr>
<td></td>
<td>Major depression, mild</td>
<td>Antidepressant or psychotherapy</td>
</tr>
<tr>
<td>15-19</td>
<td>Major depression, moderately severe</td>
<td>Antidepressant or psychotherapy</td>
</tr>
<tr>
<td>≥ 20</td>
<td>Major depression, severe</td>
<td>Antidepressant and psychotherapy (especially if not improved on monotherapy)</td>
</tr>
</tbody>
</table>

* If symptoms present ≥ two years, then probable chronic depression which warrants antidepressant or psychotherapy (ask, "In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?").

† † If symptoms present ≥ one month or severe functional impairment, consider active treatment.
Too Busy?
Ask These Two Questions…

1. Over the past two weeks, have you felt little interest or pleasure in doing things?

2. Over the past two weeks, have you felt down, depressed, or hopeless?

Treatment Options

- Antidepressants
- Psychotherapy
Do Antidepressants Work?

“The magnitude of benefit of antidepressant medication compared with placebo increases with severity of depression symptoms and may be minimal or nonexistent, on average, in patients with mild or moderate symptoms. For patients with very severe depression, the benefit of medications over placebo is substantial.”

Antidepressant Drug Effects and Depression Severity: A Patient-Level Meta-analysis. JAMA, January 6, 2010 – Volume 303, No. 1
Antidepressants

- Medication should be taken for minimum 4-6 weeks before gauging effectiveness
- Medication should not be stopped because patient feels better
- Medication should be taken as prescribed
- Medication might need adjustments, changes, and in some cases augmentation
Medication Management

- Dosing adequacy
- Medication efficacy
- Adjustments/Monitoring
- Psychiatry consult
Psychotherapy

- Effective on its own in mild and moderate depression
- Beneficial in treating patients who only have a partial response to therapy
- Often preferred by patients
- Critical component in treating major depression
In a nutshell, the cognitive model proposes that dysfunctional thinking (which influences the patient’s mood and behavior) is common to all psychological disturbances.

Cognitive Behavior Therapy: Basics and Beyond. 2011 Guilford Press
How CBT Works

“When people learn to evaluate their thinking in a more realistic and adaptive way, they experience improvement in their emotional state and behavior.”

Cognitive Behavior Therapy: Basics and Beyond. 2011 Guilford Press
Other Approaches

- Exercise
- Light Therapy
- Diet
- Sleep
- Mindfulness/Meditation
- Acupuncture
- Group
Building A Plan Of Care

1. Involve Medical Director and Administrator!!
   - Do they even believe its an issue?
     - Adherence
     - Mortality/Morbidity
     - Decreases ability to manage disease
     - Expensive to ignore
     - Decreases QOL
Building A Plan of Care

2. Patient Education/Support
Patient Education - Depression

- Very real condition and common
- Is treatable, but can be difficult to treat
  - Unpredictable nature of antidepressants
  - Side-effects
  - Drug to drug interactions
  - Dosing, class, and add-on drug issues
- Is psychotherapist qualified and using evidence-based approaches?
Patient Education-Depression

- Requires the patient to:
  - Examine belief systems
  - Engage support networks
  - Consider additional counseling and psychiatric intervention
  - Make lifestyle adjustments (e.g. exercise, diet, sleeping patterns)
Why Won’t People Get Treated?

- Don’t know where to turn
- Lack of recognition of the problem
- Access to care issues
- Cultural Barriers
- Denial
- Embarrassment and Shame
Direct Interventions

- Support and “normalization” of disease
- Challenging misperceptions/cognitive dysfunctions
- Behavioral
  - Alcohol/drug use/sleep
  - Activities/Socialization
  - Peer Support!
Concluding Thoughts

- Significant clinical issue
- Complex
- No single answer
- Requires Team-Based Approach!
Thank You

MarkM@Equalicare.com
Or
612.600.3953
To Obtain CEU’s

The Survey Must be Completed!
- CEU’s are only available for live session attendee’s
- Your name will be populated on your certificate as entered in the Survey
- Once the survey is closed CEU’s will no longer be available

You will be dropped off in the survey when you close out of the session.
If you are attending in group setting email to receive a link to the Survey
If you experience any problems contact
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  Phone: 816-880-1709