



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

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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.

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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,

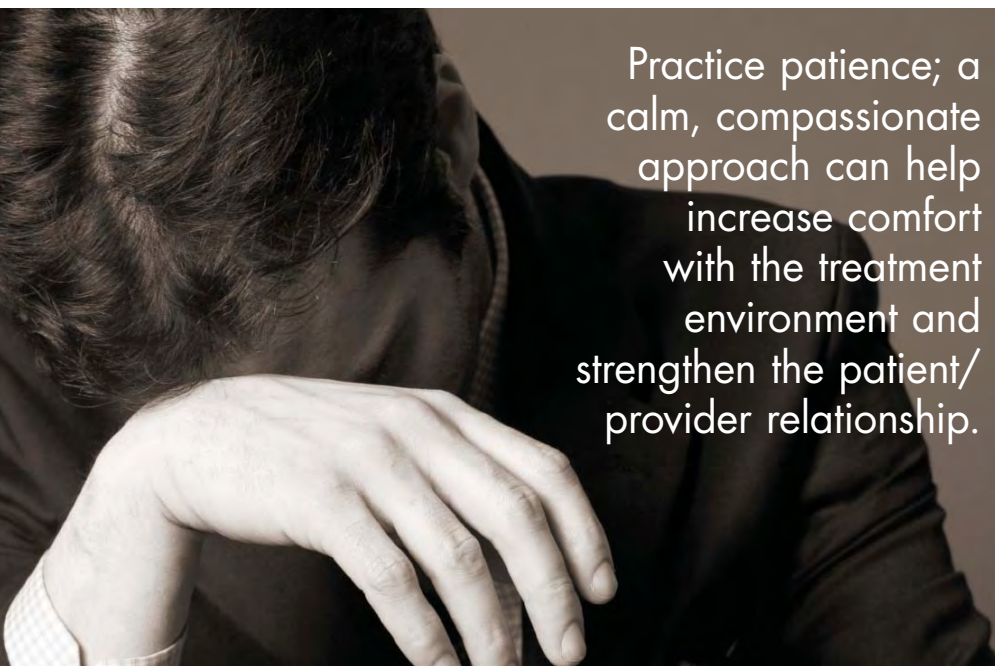
helping maintain patient self-esteem, and encouraging continued interest in understanding matters regarding their care, despite cognitive limitations.

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.

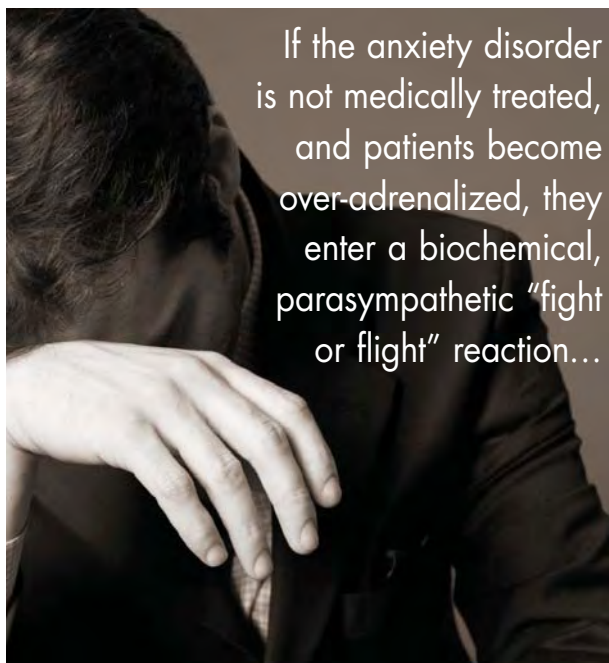
Members of the renal team can be trained to alert the social worker when patients present with mood changes, offering a protective system of surveillance for patients with this disorder. Simple questions such as, “Over the past four weeks, have you felt so down in the dumps that nothing could cheer you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

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



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.

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

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-

focused time for the facility social worker to make recommendations regarding staff response, or develop new strategies if current ones are not effective. Team meetings can also create a natural environment for team surveillance so that changes regarding mood or behavior are certain to be reported to the social worker.

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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