Intervention Planning and Implementation in Renal Social Work

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The patient is a thirty-eight-year-old African-American female who has been a dialysis patient for over three years (Bellinger, 2017). After conducting the agency psychosocial assessment and the Kidney Disease Quality of Life (KDQOL) survey with the patient, it became apparent that she is at increased risk for a decreased quality of life and non-adherence to her dialysis treatment (Bellinger, 2017). The presenting risk factors for this patient include the presence of depressive symptoms, the presence of anxiety symptoms, and poor physical functioning (Bellinger, 2017). The patient's primary risk factor for nonadherence to her life sustaining dialysis treatment regimen is depression.

The patient is at risk for depression due to her status as a chronically ill dialysis patient (DiMatteo, Lepper, & Croghan, 2000; Furr, 1998) and due to the significant losses incurred in her life up to this point (Kimmel, 2001). Over the last three years, the patient has lost her mother, father, godfather, and most recently, her grandmother in 2017 (Bellinger, 2017). Prior to initiating dialysis, the patient also experienced a miscarriage late in pregnancy (Bellinger, 2017). She continues to grieve the loss of her child and the losses of several close family members (Bellinger, 2017). Since beginning in-center hemodialysis treatments, the patient has suffered the loss of kidney function, her career, and her ability to conduct peritoneal dialysis (PD). PD was this patient's preferred treatment modality prior to an infection which prevented continuation of that method. According to the patient, she had higher energy levels and felt more hopeful when undergoing PD as opposed to in-center dialysis.

The patient has reported increasing levels of hopelessness associated with beliefs that the dialysis treatments are pointless and that she has nothing to look forward to, a common sentiment among those undergoing dialysis (DiMatteo et al., 2000). As per the patient's case record, she has

dealt with depression for several years, undergoing some version of the social work intensive program with previous clinic social workers and being referred for outpatient mental health services. The patient did not follow up with referrals at the time and continues to decline these services (Bellinger, 2017).

In the initial assessment of the patient's depression, her score on a Patient Health Questionnaire-2 (PHQ-2) measure was four, indicating the possible presence of depression (Bellinger, 2017). The Center for Epidemiological Studies Depression (CES-D) 10 screener was then administered, resulting in a score higher than fourteen, indicating severe depression (Bellinger, 2017). According to Finkelstein, Wuerth, Troidle, and Finkelstein, individuals with CES-D scores in the range of fifteen to thirty have been associated with a higher risk of death, illustrating the importance of diagnosis and treatment of depressive symptoms in dialysis patients (2008). Depression in patients undergoing dialysis can lead to increased incidence of infection, non-adherence to the treatment regimen, increased hospitalizations, and increased incidence of death (McCool et al., 2011). Depression is also associated with increased missed or shortened treatments and withdrawal from the dialysis treatment regimen (McCool et al., 2011). Particular problem areas noted by results of this patient's CES-D included trouble keeping her mind on what she was doing, feeling depressed, not feeling hopeful about the future, restless sleep, feeling fearful, feeling unhappy, and feeling lonely (Bellinger, 2017).

The general goal in addressing the patient's risk factor of depressive symptoms is for the patient to learn to manage the symptoms and improve quality of life (Bellinger, 2017). Psychoeducation, resulting in patient self-awareness and the ability to verbalize her own symptoms and effects incurred, is helpful to this process (Bellinger, 2017). The patient reported several problem areas related to her depression, one of the identified issues being social isolation.

The patient resides alone and has indicated feelings of loneliness combined with deliberate acts of isolation from family and friends, stating that she does not want to bother them with her issues (Bellinger, 2017). Following the initial assessments, work involved contracting to establish potential SMART goals related to the presenting problem identified by the patient and the social work intern.

The use of SMART goals helps clients to make progress towards achieving overarching goals by maintaining a sense of accomplishment and motivation. A SMART goal to address an element of this patient's depression could be to initiate social contacts outside of the home at least twice a week with patient-identified social supports such as her brother, niece, cousin, and friends, thus enhancing feelings of social connectedness (Bellinger, 2017). This goal is specific, as it establishes who the patient will see, the amount of times it will occur, and the location where it will occur (Bellinger, 2017). It is also focused on a single element of the patient's depression, isolation and loneliness (Bellinger, 2017). The goal is measurable because it is designated that the patient will initiate contact twice per week and the patient can self-report her progress at each session (Bellinger, 2017). Twice per week is achievable for this patient as she reports she has a significant amount of free time, members of her self-identified support system reside locally, and the patient has her own vehicle for travel (Bellinger, 2017). The goal is realistic because it is a manageable stepping stone to the ultimate goal of improving the patient's depressive symptoms (Bellinger, 2017). The goal is timely, as the patient could report her progress on a weekly basis and work could begin immediately (Bellinger, 2017). The results of each weekly report can then inform future goals for the patient (Bellinger, 2017).

Interventions for successfully addressing depression in End Stage Renal Disease (ESRD) have not been extensively researched despite increased documentation of prevalence and

association with negative treatment outcomes (Finkelstein et al., 2008). Depression continues to be significantly underdiagnosed and undertreated among this population (Raymond, Wazny, & Honcharik, 2008; Shirazian et al., 2017). In studying comparisons between patients' medical records and results of depression screening tools, it is seen that 43% of patients presented with symptoms of depression yet only 13% had a physician diagnosis (Raymond et al., 2008). It is reported that depression can be treated through psychiatric counseling, medication, or cognitive behavioral therapy (CBT), but the literature also documents that treatment of clinical depression in dialysis patients is associated with complex obstacles (Finkelstein et al., 2008). Some difficulties include the logistical or financial barriers to patients getting obtaining proper evaluations and difficulties in completing prescribed courses of psychotherapy or medication (Finkelstein et al., 2008). This may be associated with decreased desire for the patients to incur additional medication burden or decreased availability of time to devote to counseling-based interventions due to the dialysis treatment schedule (Finkelstein et al., 2008).

Despite being one of the primary treatments for depression in the general population, pharmacological interventions have been understudied in Chronic Kidney Disease (CKD) and ESRD populations. This is in part due to exclusion from antidepressant clinical trials based on a lack of knowledge on safety of usage in this population (Hedayati, Yalamanchili, & Finkelstein, 2012). There are some risks that may be associated with medication usage in dialysis patients, including possible accumulation of toxic metabolic wastes which the kidneys are unable to filter due to decreased functioning (Hedayati et al., 2012). Other risks include possibly hazardous interactions with the myriad medications that many dialysis patients are prescribed (Hedayati et al., 2012). Research studying pharmacological interventions for this population are few in number and those conducted have exhibited limitations such as small sample sizes and the

nonexistence of control groups (Hedayati et al., 2012; Shirazian et al., 2017).

Several non-pharmacologic interventions have been found to show improvement of depressive symptoms despite providing challenges to healthcare providers due to limited resources available in some settings (Hedayati et al., 2012). The use of cognitive behavioral therapy (CBT) has been shown to have positive impacts on the occurrence of depression in dialysis patients by supporting rational thoughts and challenging destructive thoughts, behaviors, and moods (Hedayati et al., 2012). Randomized control trials of CBT in dialysis populations have shown improvement in scores on the Beck Depression Inventory (BDI) and these results were further supported by improvement in relevant areas of the Kidney Disease Quality of Life (KDQOL) survey (Hedayati et al., 2012). In addition to improving depressive symptoms, CBT has been seen to improve sleep quality, inflammation, overall quality of life, and adherence to the fluid restriction treatment regimen (Hedayati et al., 2012). Duarte, Miyazaki, Blay, & Sesso (2009) saw CBT to be effective in depression treatment with improvements seen in both the BDI and the KDQOL. Some studies have also seen improvement through group work utilizing CBT, which provides a more efficient treatment option for social workers burdened by high caseloads (Duarte et al., 2009).

Largely absent in the literature are studies which observe the outcome of combined psychotherapy with pharmacological approaches for depression treatment in patients undergoing dialysis. In non-ESRD populations, the response rate to a combination of both CBT and medication was seen to be 73% while response to the individual treatments was 48% (Shirazian et al., 2017). It has been found that psychotherapy may be used in addition to medication management to improve depressive symptoms and medication adherence (Raymond et al., 2008) which could prove beneficial in improving adherence to dialysis-related medications as well. For

the general population and chronically ill populations, psychosocial outcomes and depressive symptoms both see significant improvements when treated with either medication or psychotherapy. Additional improvement is seen upon use of a combination of both treatment modalities (Shirazian et al., 2017).

McCool et al. (2011) have developed a technique called Symptom Targeted Intervention (STI) to treat depression in dialysis patients. The technique uses behavioral, cognitive, and mindfulness techniques to recognize and treat the most significant symptom of the depression (McCool et al., 2011). With interactions between the client and clinician remaining brief, social workers can efficiently conduct work at chairside while concentrating on outcomes (McCool et al., 2011). This work manages one symptom at a time and helps to concentrate work that can often become complicated due to the multitude of psychosocial difficulties encountered by dialysis patients (McCool et al., 2011). STI involves collaborating with clients to analyze the problem, providing psychoeducation, and creating a plan for behavior activation (McCool et al., 2011). One study conducted in 2011 showed that STI improved scores on patients' KDQOL, CES-D, and the Symptom Severity Scale (Sledge et al., 2011). STI is based on the systems theory, identifying depression as a system, with several working parts, suggesting that change in one element of the system will result in change in the overall system (McCool et al., 2011).

Another intervention believed to improve several quality of life measures for dialysis patients is adjustment of the dialysis treatment schedule. In one study, it was seen that by changing patients' schedules to accommodate shorter treatment times for six days a week rather than longer treatment times three days a week, scores on the Beck Depression Inventory (BDI) improved over the span of four months (Hedayati et al., 2012). These improved scores on the BDI remained stable at a twelve-month re-screen (Hedayati et al., 2012). Later studies in this

area have shown that more frequent dialysis treatments can improve self-reported mental health but do not necessarily improve outcomes for depressive symptoms (Shirazian et al., 2017), therefore, further evaluation in this area is needed.

An additional intervention with potential success in treating depression in patients with End Stage Renal Disease (ESRD) is exercise training programs (Hedayati et al., 2012; Shirazian et al., 2017). These programs have the potential of not only improving depression but also improving incidence of low physical functioning, a well-documented risk factor among ESRD patients (Hedayati et al., 2012). Multiple studies have acknowledged the improvement of BDI scores and physical functioning following implementation of an exercise regimen (Hedayati et al., 2012). Despite this, results remain mixed as to the effectiveness of exercise and the feasibility of treating patients with depression using this method due to lower levels of motivation (Shirazian et al., 2017).

Due to the length of time many patients spend idle during dialysis treatments, exploration of music and art therapies to treat depressive symptoms may benefit from further analysis (Hedayati et al., 2012). A 2016 research study conducted in Iran showed evidence of improved depressive symptoms, as well as anxiety symptoms, in response to listening to particular selections of calming music (Salehi et al., 2016). Authors of the study acknowledge that results may be subject to limitations such as differences of culture, differences of geography, and small sample sizes (Salehi et al., 2016). While the results of the study are positive and would provide an intervention with minimal expense and effort required of either patient or clinician, further studies are needed to validate its claims (Salehi et al., 2016).

When choosing appropriate interventions for clients, barriers to treatment particular to the situation must be evaluated. Dialysis patients may be reluctant to add new medications when

they already incur a high medication burden (Shirazian et al., 2017). Additionally, nephrologists may be hesitant to prescribe anti-depressants, preferring for the patient's primary care physician to prescribe these medications (Shirazian et al., 2017). There are also barriers related to the level of resources accessible to clients, such as a lack of clinicians available to provide therapy due to limited training or language barriers (Shirazian et al., 2017). With renal social workers carrying large caseloads, there is less time available for clinicians to provide extensive in-clinic sessions. This lends preference to more efficient and outcome-focused interventions which consider the distinct challenges faced by dialysis populations (McCool et al., 2011).

After significant contemplation, the patient decided to proceed with the use of medication as treatment for her depressive symptoms. After discussion with the patient's nephrologist, it was advised that she follow up with her primary care physician to obtain a prescription, a common phenomenon identified by Shirazian et al. (2017). The patient then met with her primary care physician and obtained a prescription for an antidepressant. This step was achieved after several weeks of motivational interviewing and exploration with the patient. Despite taking the steps to obtain the prescription, she decided not to fill the prescription at this time. The patient cites beliefs that the medication will change her and leave her worse off than she is now. This serves as an example of how clinical work with clients can proceed. Practice is not typically linear and reassessment and contracting occur repeatedly throughout the process. Literature supports the use of both medication and psychotherapy to treat depression but due to the patient's current preferences for non-medication usage, a nonpharmacological approach appears to be the best treatment option at this point in time.

While it is documented that the application of psychotherapy is sometimes difficult to achieve in the dialysis setting due to lack of resources, it is far from impossible. Effective

interventions require active planning and focus on behalf of both the clinician and the patient. This patient tends to struggle with remaining focused on a single issue. This prompts sessions to move in a way in which the patient pursues newly self-identified issues while not settling on one particular problem to address long-term. She has also expressed a sensitivity to attaching clinical labels to her experiences, reporting that use of the terms makes her feel "crazy." For these reasons, implementing STI with the patient may be particularly beneficial. STI is specifically designed to work well in the dialysis setting. It is particular to focusing on the symptoms and there is no emphasis on the clinical diagnosis, which this patient continues to struggle with delaying the progress of the work (McCool et al., 2011).

STI is also the preferable intervention for this patient due to its ability to easily be conducted in short sessions at the patient's chairside. Because the patient harbors beliefs that her life revolves around treatments, coming to the clinic at times outside of her regularly scheduled dialysis may exacerbate that belief. The dialysis clinic offers a nine-week social work intensive program, during which patients should be met with weekly. This time frame could allow for the patient to work on multiple symptoms of depression depending on how quickly the work moves. In the implementation of STI, several cognitive and behavioral techniques are used, some of which include psychoeducation, behavior activation, cognitive restructuring, relaxation techniques, mindfulness techniques, and patient homework (Sledge et al., 2011). As needed, the patient could be re-enrolled in social work intensive. As studies have shown that relapse within the first year of treatment is high for depressed patients, it would be important to follow up with the patient regularly to continue the work and prevent relapse (Duarte et al., 2009).

Because the work thus far with the patient has revolved around monitoring stages of change, motivational interviewing, and bearing witness to the client situation, a therapeutic

alliance has been formed. This relationship can be supportive of empowerment and self-efficacy in the patient, providing a sense of control over health outcomes which previously felt out of the patient's grasp (McCool et al., 2011). The patient has reported several issues related to her depression but a portion of the work has focused on feelings of social isolation. Following the steps outlined for STI, work with this symptom would involve collaboration with the patient to analyze how she is spending time outside of dialysis treatments, providing psychoeducation about the connection between depression and social isolation, and developing a plan for behavior activation (McCool et al., 2011), which could include the SMART goal outlined above. Following implementation, progress would be monitored and evaluated.

If successful, it would be possible to conduct STI focusing on additional symptoms that the patient reports. Based on previous interactions with this patient, it is possible that she may struggle with the completion of assigned homework tasks. Therefore, to be sure of her readiness, the patient may benefit from additional motivational interviewing prior to initiation of STI. Despite accepting that these problems exist, the patient still appears to move back and forth within the contemplation and preparation stages of change (Bellinger, 2017). While open to discussing issues and the setting of goals, the patient remains ambivalent about initiation of changes, especially in regards to medication management, external referrals, and homework (Bellinger, 2017). For this reason and due to a disclination to incur additional treatment burden as cited by Cukor, it may be more beneficial and efficient for psychosocial intervention with this patient to take place during dialysis treatments (2007). As observed while engaging with this patient, when the available evidence, patient preferences, and agency resources are carefully considered and integrated, intervention planning and implementation can be an effective and efficient experience for all.

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