Kidney Care and Depression

A Patient's Perspective on the Challenges of Chronic Kidney Disease

By James "Mike" Guffey

I am not sure there is a good way to start dialysis, but I am certain that crashing into it is not the way to go.

These impressions had nothing to do with the quality of care I received but reveal how overwhelming and impersonal the experience was, especially considering I was not functioning at top level when the situation began.

In one morning, I went from being on vacation away from home, thinking I had the flu while recovering from bronchitis and altitude sickness, to being admitted to the intensive care unit (ICU) with kidney failure.

How long have you had kidney issues? Is there a history of kidney disease in your family? How long have you been diabetic? Is there a history of diabetes in your family? Are your blood platelets usually this low? Is your BP always this high? How long have you had this edema in your legs? Have you been diagnosed with hepatitis? Do we need to test your blood for HIV?

These and many more questions like them greeted me in rapid fire in the emergency room. I barely got the chance to answer one before the next one came, with no chance to really process what was being asked. It was like being on the receiving end of a firehose as the team attempted to cover my entire medical history as quickly as possible. After all of the questions had been answered and I was admitted to the ICU, the situation did not greatly improve. The questions were replaced with an overflow of information.

What you have is officially called ESRD. Don't worry, that is just a classification used for insurance and treatment purposes. It might be acute and go away over time, or it might be chronic. We are going to take you to surgery in a few minutes to get you a catheter in your chest so you can start dialysis as soon as possible. We will also be putting you on a renal diet.

End stage does not sound good. That sounds terminal. Catheter? Dialysis? Can we slow this down so I can understand what you are talking about? It is my life and my body, and I am feeling totally overwhelmed and don't know how I will explain the situation to my family and close friends.

That afternoon, I was whisked away for catheter surgery and back to the ICU for an initial dialysis treatment. The next morning, I was having what seemed a great breakfast with bananas and strawberries. Then, the dialysis technician walked in, saw what I was eating, and took it away! The hospital had me on the heart-friendly diet and not the renal diet, and I had no clue what the difference was. I felt bad about eating the wrong thing, but I didn't know what the right thing was. This drove home the idea that a lot was changing, and I had a lot to learn to succeed in my new circumstances.

There were lots of things to learn quickly, and there were initially no documents I could read on my own time, nowhere I could go to look for answers to my own questions. Slowly, I got some of the answers from visitors (the dialysis technician, the nephrologist, the dietician), and materials started to trickle in. Over the next few days, I began to feel a little more comfortable with the hospital treatment.

Then, the next stage of feeling overwhelmed set in. There was a lot I needed to figure out before I was released. How soon could I go home? How would I be able to bathe myself every day without getting the catheter site wet? Where would I dialyze when I got home? Would I be cleared to work? (And if cleared, would I be able to work?) These were all major questions without immediate answers, and all needed to be resolved quickly. It was hard not to again feel powerless, overwhelmed, and depressed.

Thankfully, over time, the answers did come, including good information about websites I could visit to get my questions answered plus many that I did not know I had. I also was fortunate to have a good support team who helped me negotiate my way back home and back to work.

It is important to realize that there are two very different life changes that come with crashing into dialysis. The first is physical: adjusting to the requirements and potential limitations of life on dialysis—the fluid restrictions, the renal diet, the treatments, and their effect on your body. The second is psychological: finding ways to avoid allowing all of the physical changes to overwhelm you and drag you into depression. Although it is natural to feel overwhelmed when experiencing a major life change, such as ESRD, it is important to find ways to cope and not to fall into anxiety and/or depression. It is important to remember that, although there are parts of your lifestyle that are beyond your control, you can control how you respond and not let the situation control you.

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Screening for and Treating Depression in Patients with Chronic Kidney Disease

By Nicole C. Allen and Philip R. Muskin

Approximately one in five women and one in 10 men will suffer from depression over the course of their lives (1). Chronic illness generally confers an even greater risk for depression. Patients with chronic kidney disease (CKD) and in particular, those who are on hemodialysis (HD) are at a relatively high risk for depression. It is difficult to determine the exact rate of major depressive disorder (MDD) in patients with CKD because the somatic symptoms of depression are similar to the symptoms of uremia (e.g., decreases in appetite, energy, sexual interest, and sleep). Aches and pains are common in patients with CKD, patients on HD, and patients with MDD.

Depression is thought to be the most common psychiatric abnormality in HD patients, with the prevalence likely between 5% and 10% (2). Depression in patients on HD can stem from the variety of losses that these patients suffer, including loss of kidney function, employment, physical strength, and social function (3). Patients on HD with MDD are twice as likely to die or require hospitalization within a year as those without depression (4). The suicide rate in ESRD patients is also higher than that of the general population (5). Recently, the Centers for Medicare & Medicaid Services added a new requirement in its Quality Incentive Program to screen and follow up as indicated for depression in all patients 12 years of age and older with CKD on HD. The Centers for Medicare & Medicaid Services Quality Incentive Program does not require use of a specific screening tool, and it does not define which member of the care team must do the screening. Identifying and appropriately treating MDD can have an extraordinary effect on quality of life for patients with CKD.

Generally, it makes sense to screen for depression anyone who looks unhappy, bearing in mind that not everyone who looks unhappy has a psychiatric disorder. It is important to differentiate between MDD and an appropriate sad reaction to a difficult life situation, because the therapeutic approach will be different. Patients who have just received a difficult diagnosis or who have had a recent health crisis may be quite upset; however, this reaction often does not progress to MDD (i.e., a psychiatric disorder). People who are ill but not depressed will retain interest in things that have historically brought them joy. For example, a devoted Yankees fan who is chronically ill but not depressed may be sad, because he cannot stay awake to watch a game on television; however, he will still be interested in the score. When that same patient seems completely uninterested in baseball season for days at a time, depression may be the culprit.

Any health care provider can do a basic screening for depression. To start, ask the patient how things are going and how he has been sleeping. Any patient who has had difficulty falling or staying asleep in the absence of difficulty breathing, frequent nighttime urination, pain, etc., should then be asked if he is feeling sad or blue and if he has lost interest or pleasure in things he usually finds fun. These two questions, each rated on a scale of zero to three over the last 2 weeks with zero being never and three being nearly every day, constitute the Patient Health Questionnaire-2 (PHQ-2). The PHQ-2 is a very brief, basic version of the more comprehensive PHY-9, a nine-question screening tool commonly used to quickly assess for symptoms of depression (Figure 1). The PHQ-9 is available in many languages. A patient who scores three or more on the PHQ-2 should be asked to fill out a PHQ-9. The PHQ-2 has 97% sensitivity and 67% specificity in adults, whereas the PHQ-9 has 61% sensitivity and 94% specificity in adults (6). Almost 90%

of patients who score 10 or higher on the PHQ-9 have MDD; generally, scores of 5, 10, 15, and 20 correspond to mild, moderate, moderately severe, and severe depression, respectively (7).

The most concerning outcome of MDD is suicide. Some people worry that assessing for suicide can give a patient the idea to kill himself. This fear is unfounded; there is no evidence that screening for suicide leads to an increased risk of suicide. Another concern that can lead health care providers to avoid screening for depression is the fear that asking the patient about sadness will lead to an emotional crisis (opening Pandora's box), which the provider will be obligated to manage. This fear is not accurate; sometimes probing an emotional subject can lead to an expression of feelings by the patient, but this outcome, although potentially intimidating to the provider, is optimal in that it can lead to the patient getting necessary treatment for depression.

Treating major depressive disorder

In general, the two strategies for treating MDD are psychotherapy and medication. Choosing a treatment strategy depends on a variety of factors, including the severity of the illness, the patient's preference, treatment availability, and the patient's ability to engage in certain forms of psychotherapy. For patients with very mild depression or who are reacting to a recent health crisis, having a space to talk about their experience with a compassionate listener is most helpful; medication alone is typically not effective in symptom reduction for these patients (8). For patients with mild to moderate depression, psychotherapy alone or in combination with medication can be useful. There are multiple types of psychotherapy that can be helpful for patients with CKD and MDD; for example, cognitive behavioral therapy can help patients address overvalued fears and misconceptions about themselves and their illness while providing patients with coping mechanisms to use in times of stress. Coping mechanisms such as deep breathing can also be taught alone. The advantages of psychotherapy are that there are no medical downsides and that the techniques learned can be remembered and used at later times (9). The disadvantages of psychotherapy are that it requires a skilled psychotherapist, a minimum level of patient engagement (including cognitive capacity and motivation), and regular, relatively frequent sessions.

Antidepressant medication should, with minimal exception, be prescribed to patients with severe depression and may be helpful either alone or in combination with psychotherapy in patients with mild to moderate depression. Psychotherapy alone is not useful in patients with severe depression. Medications that are metabolized by the kidneys, such as paroxetine and venlafaxine, should be avoided in patients with CKD. Citalopram and sertraline can be considered first-line medications, and duloxetine can be considered for patients with coexisting neuropathic pain. Dosages of most antidepressants should be initially reduced given that the kidney generally excretes the liver metabolites of antidepressants (10). It is important to remember that antidepressant medication can take 6 to 8 weeks to be maximally effective and that many patients will require doses higher than the starting dose to get better. When patients do not respond to therapeutic doses of antidepressants, are suicidal, or have a history of episodes of mania or hypomania (bipolar disorder), consider consulting with a psychiatrist in managing the care of the patient.

Screening for MDD is a simple process that can be accomplished by any health care provider. Although discussing emotions in the setting of a difficult medical diagnosis can be intimidating, treatment for MDD is effective, and the positive effect on patient outcomes can be tremendous.

Figure 1. Patient Health Questionnaire for Depression

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. 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.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, 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?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐

PHQ-9* Questionnaire for Depression Scoring and Interpretation Guide

For physician use only

Scoring:
Count the number (#) of boxes checked in a column. Multiply that number by the value indicated below, then add the subtotal to produce a total score. The possible range is 0-27. Use the table below to interpret the PHQ-9 score.

Not at all (#)_____ x 0 =_____
Several days (#)_____ x 1 =_____
More than half the days (#)_____ x 2 =_____
Nearly every day (#) _____ x 3 = _____

Total score: _____

Interpreting PHQ-9 Scores		Score	Actions Based on PH9 Score
		Score	**Action**
Minimal depression	0-4	< 4	The score suggests the patient may not need depression treatment
Mild depression	5-9		
Moderate depression	10-14	> 5 - 14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment
Moderately severe depression	15-19		
Severe depression	20-27		
		> 15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.

* PHQ-9 is described in more detail at the McArthur Institute on Depression & Primary Care website www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/

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