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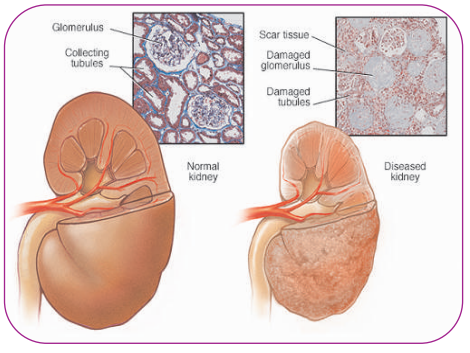
REVIEW OF RESEARCH

EFFECT OF PSYCHOLOGICAL COUNSELLING IN PATIENTS WITH CHRONIC RENAL DISEASE'S QUALITY OF LIFE



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ABSTRACT

The purpose of this study was to examine the effect of psychological counselling in patients with chronic renal disease's quality of life. According to National Kidney foundation, NKF (2002) Chronic kidney disease (CKD), also known as chronic renal disease, is a progressive loss in renal function over a period of months or years. Patients' perceptions of increased intrusiveness, and their perceptions of limited control over their life dimensions, increased negative and decreased positive mood, increased and contributes to the distress in the patients. Numerous studies have identified the effect of such factors as anaemia, age, co-morbidity, and depression on QOL. Most of these factors appear during the pre-dialysis period, and the adequate management of some of them could influence patient outcomes. Aim of the study was to find the effectiveness of psychological counselling in patients' quality of life. 40 chronic renal disease patients were purposively selected for the study from a kidney care hospital at Warangal. Pre-post interventional study design was used for the study. Socio-demographic data sheet, depression, anxiety and stress scale (DAAS), and Quality of life (QOL) scale was used as an assessment tool to measure the pre-post scores. Psycho education and psychological counselling was provided for three weeks (6 days) two hours, one by one to each of the patients. Result indicates significant improvement in the feeling of quality of life and also decreased the level of depression in most of the patients. On basis of this study we can conclude that psychological counselling is a helpful intervention in chronic renal disease.

KEYWORDS: *Chronic renal Disease, Depression, Quality of life, Psychological Counselling.*

INTRODUCTION:

Chronic renal disease is a progressive loss in renal function over a period of months or years. The symptoms of worsening kidney function are not specific, and might include feeling generally unwell and experiencing a reduced appetite. Often, chronic kidney disease is diagnosed as a result of screening of people known to be at risk of kidney problems, such as those with high blood pressure or diabetes and those with a blood relative with CKD. This disease may also be identified when it leads to one of its recognized complications, such as cardiovascular disease, anemia, or pericarditis. It is differentiated from acute kidney disease in that the reduction in kidney function must be present for over 3 months. Chronic kidney disease is identified by a blood test for creatinine, which is a breakdown product of muscle metabolism. Higher levels of creatinine indicate a lower glomerular filtration rate and as a result a decreased capability of the kidneys to excrete waste products. Creatinine levels may be normal in the early stages of CKD, and the condition is discovered if urinalysis (testing of a urine sample) shows the kidney is allowing the loss of protein or red blood cells into the urine. To fully investigate the underlying cause of kidney damage, various forms of medical imaging, blood tests, and sometimes a renal biopsy is required.

REVIEW OF LITERATURE

Thomas, Kanso, & Sedor (2007). Stated that chronic kidney disease (CKD) is a complex disease impacting more than twenty million individuals in the United States. Progression of CKD is associated with a number of serious complications, including increased incidence of cardiovascular disease, hyperlipidemia, anaemia and metabolic bone disease. They further suggested that CKD patients should be assessed for the presence of these complications and receive optimal treatment to reduce their morbidity and mortality. A multidisciplinary approach is required to accomplish this goal.

Devins, Binik, Hutchinson, Hollomby, Barré, and Guttmann, (1984). The emotional impact of the intrusiveness of illness and patients' reduced control over several aspects of life were examined in the context of end-stage renal disease. A sample of thirty-five haemodialysis, ten continuous ambulatory peritoneal dialysis (CAPD), and twenty-five post transplant patients participated in a standardized interview in which a series of eight self-report measures of positive and negative mood, life happiness, self-esteem, depression, and somatic symptoms of distress were obtained. Attending staff also completed a depression rating scale for each participant. Data reduction via principal-components analysis yielded two factors, corresponding to negative and positive mood, and these were submitted to covariance analyses in which age, general nonretail health, and defensiveness were controlled statistically. Patients' perceptions of increased intrusiveness, and their perceptions of limited control over eleven life dimensions, each correlated significantly and uniquely with increased negative and decreased positive mood, suggesting that each of these two factors contributes importantly and independently to patients' distress. An “objective” continuum of intrusiveness, constructed by ranking the various treatment modalities represented in the sample, also related significantly to positive (but not to negative) mood levels

METHODOLOGY

Research design and Procedure:

Pre-post intervention research design was used for the study and 40 patients were selected by purposive sampling method. All samples were taken from Vishwas Hospital & Dialysis Centre, Warangal. Permission was obtained from Hospital Managing director. Purpose of the study was explained to the patients and their caregivers. Written consent was taken and some form of counselling was provided to all participants, study was done in one month. Initial week was set to establishment rapport information and base line assessment. Next three week counselling was provided to each of the patient in a one to one session three sessions each. Each session was for 2 hours. For counselling Roger's client centred approach was used and especial target was to improve their self confidence, self respect, and responsibility to maintain their health and well being. Finally end of the month post assessment was done.

Sample:

Forty patients were selected for the study. These patients were admitted with chronic renal failure in different hospitals located in Warangal district.

RESEARCH INSTRUMENTS

1. Depression, Anxiety and Stress Scale (Lovibon, & Lovibond, 1995): The DASS is a set of three self-report scales designed to measure the negative emotional states of depression, anxiety and stress. The DASS was constructed not merely as another set of scales to measure conventionally defined emotional states, but to further the process of defining, understanding, and measuring the ubiquitous and clinically significant emotional states usually described as depression, anxiety and stress. The DASS should thus meet the requirements of both researchers and scientist-professional clinicians. Each of the three DASS scales contains 14 items, divided into subscales of 2-5 items with similar content. The Depression scale assesses dysphasia, hopelessness, devaluation of life, self-deprecation, and lack of interest/involvement, anhedonia, and inertia. The Anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The Stress scale is sensitive to levels of chronic non-specific arousal. It assesses

difficulty relaxing, nervous arousal, and being easily upset/agitated, irritable/over-reactive and impatient. Subjects are asked to use 4-point severity/frequency scales to rate the extent to which they have experienced each state over the past week. Scores for Depression, Anxiety and Stress are calculated by summing the scores for the relevant items. As the scales of the DASS have been shown to have high internal consistency and to yield meaningful discriminations in a variety of settings, the scales should meet the needs of both researchers and clinicians who wish to measure current state or change in state over time (e.g., in the course of treatment) on the three dimensions of depression, anxiety and stress.

2. World Health Organization Quality of Life - (WHO QOL 100): This scale has consists of 100 Questions in four domains.

1. Physical Health: Activities of daily living, dependence on medicinal substances & medical aids, energy and fatigue, mobility, pain and discomfort, sleep and rest and work capacity.

2. Psychological: Bodily image and appearance, negative feelings, positive feelings, self-esteem, spirituality, religion feelings, beliefs, thinking, learning, memory and concentration.

3. Social relationships: Personal relationships, social support, sexual activity.

4. Environment and financial resources: freedom, physical safety and security, health and social care, accessibility and quality, home environment, opportunities for acquiring new information and skills, participation in and opportunities for recreation / leisure activities, physical environment, pollution, noise, traffic, climate) transport. Groups of statements pick out the one statement in each group that best describes the patient response. The rating scale is 1-5. 1 is not at all, 2 is a little, 3 are moderate, 4 are very much and 5 is an extreme amount.

PSYCHOLOGICAL COUNSELLING:

Psycho-education about the incidence, prevalence, course, progress and prognosis was discussed. Patient education produces important benefits in end-stage renal disease (Davins, et al., 2000). Client centred approach counselling was used to improve their mental well being. Especial target was to improve their self confidence, self respect, and responsibility to maintain their health as well as other issues. It was emphasized that their involvement is necessary in all activities as per fusibility.

RESULTS AND DISCUSSION:

Table: 1:- Pre-Post Intervention Depression, Anxiety, and Stress Scores

	Depression		Anxiety		Stress	
Range	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**
Normal	00	02	00	07	00	07
Mild	10	15	00	15	01	09
Moderate	14	17	21	08	02	16
Severe	06	04	13	09	13	06
Extremely severe	10	02	06	01	24	02

Table 1 shows pre- post scores on DAAS. Scores during pre assessment on depression domain was 25% mild, 35% moderate, 15% severe and 40% extremely severe. On anxiety scale 0% mild, 52.5% moderate, 32.5% severe and 15% extremely severe. On stress scale 2.5% mild, 5% moderate, 32.5% severe and 60% had extremely severe level of stress. Post assessment scores indicate improvement in all three domains respectively. On all three scales (depression, anxiety and stress) normal range 0 score was found while on post assessment 5% in depression, 17.5% in anxiety and 17.5% in stress scale during was found. At mild level post assessment scores were 37.5%, 37.5%, and 22.5% was found respectively on three scales. At moderate level 42.5%, 2%, and 40% scores was found. At severe level 10%, 22.5% and 15% was found. While at extremely severe level 5%, 2.5% and 5% was found. On the basis of pre assessment scores we can say most of the patients are having extremely severe level of distress, depression and anxiety. This supports the earlier researches finding of co-morbid conditions in

chronic medical illness. Stein, et al., (2006) stated that there is a strong association at the population level between major depression and health-care use and role impairment among persons with chronic physical disorders. They also point to the significant impact of co-morbid major depression on health-care seeking, disability and work absence in persons with chronic physical illness, underscoring the need for greater efforts to design and test the impact of detection and treatment.

Table 2:- Pre-Post Intervention scores on Quality of Life

	Number of patient scored on different Domains							
	Domain 1		Domain 2		Domain 3		Domain 4	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Not at all	00	01	00	05	03	07	02	02
Little	02	16	00	12	11	21	02	08
Moderate	03	13	02	14	09	05	07	06
Very much	07	08	13	09	06	04	17	14
Extreme	28	02	25	00	11	03	12	10

Table 2 shows pre-post assessment scores of quality of life scale in five ranges. Pre assessment scores, first column indicates no complaints with quality of life and on domain 1 and 2 no participants were happy with the condition while on domain three 7.5%, four 5% patients having no complaints with their quality of life. The second rating (little distress) 5% patients having complaints in physical health area, 27.5% patients having complaints in social relationship, and 5% patients having problems in environmental and financial area, while no patient having difficulty in psychological area. On moderate level feeling of difficulty was found in 7.5% physical domain, 5% psychological domain, 22.5% social relationship and 5% in environmental and financial conditions. On very much rating scale 17.5% patients having difficulty in physical domain, 35% having in psychological domain, 15% having social relationship and 42.5% having difficulty in environmental and financial conditions. On extremely severe difficulty scale 70% patients were having difficulty in physical domain, 62.5% in psychological, 27.5% social relationship and 30% having difficulty in environmental and financial conditions. On post assessment scores first rating (not at all) 12.5%, 17.5% and 5% patients were reported respectively in psychological, social and environment and financial conditions. This indicates that psychological counselling is helpful in increasing feeling of psychological well being and that is facilitating better social interpersonal relationship. Second rating scale feeling of little discomfort in number of patients was found in 40% (physical health), 30% (psychological), 52.5% (social relationship) and 20% in environmental and financial condition. Third rating scale feeling of very much distress, 20% patients having difficulty in physical health, 12.5% in psychological, 10% in social relationship and 35% in financial condition. On extremely poor condition was rating 5% patients in physical health, 7.5 in social relationship, 25% in environmental and financial condition and no patients remain in psychological area in this category. Result indicates significant improvement in all four domains and especially in psychological domain after intervention 100% improvement was found in fifth rating (extremely severe distress) on quality of life scale. Second highest impact of psychological counselling is found on domain 3 (social & interpersonal relationship).

CONCLUSION:

On the basis of pre-post assessment scores we can say that psychological counselling is helpful in improving quality of life. It is also found effective in reducing other psychological co-morbid conditions. These co-morbid psychological factors are worsening the condition because persistent distress gives birth to cognitive errors and negative feeling toward life and environment. Therefore there is a strong need to address these co-morbid conditions with medical treatment.

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