

## Psychosocial Factors in Treating the Depressed Renal Patient

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*This paper will emphasize a preliminary approach to assessing, diagnosing and treating the depressed dialysis patient. The renal literature on depression has proven that depression is highly prevalent amongst dialysis patients and it has linked depression with mortality, treatment non-compliance and overall patient adjustment. Numerous studies have made it clear that the best way to address depression in this population is not yet clear. The renal literature on therapeutic treatment is sparse, the idea of what exactly coping and adapting entails is highly ambiguous, and a general understanding of the etiological factors underlying depression is relatively absent. This introductory theoretical paper will focus on the two psychosocial factors (internal and interpersonal dynamics) that are believed to have a strong influence on how the patient copes and adapts to his or her renal diagnosis. The etiological factors associated with the renal population will be explored and clinical material will demonstrate the role of self-esteem in depression.*

*In depression...the pain is unrelenting, and what makes the condition intolerable is the foreknowledge that no remedy will come—not in a minute, an hour, a day, or a month. It is hopelessness even more than pain that crushes the soul (Styron, 1989).*

Depression is one of the most important psychological problems the renal social worker can address, because if it goes undetected and untreated it can progress to termination of treatment or suicide. This paper will emphasize a preliminary approach to treating the dialysis patient based on an understanding of the psychosocial factors associated with depression. For the purpose of this paper, the two psychosocial factors I will focus on will consist of internal and interpersonal dynamics. Internal dynamics simply means that which is going on inside the mind of the patient, or the way in which the outer world, and all of its interpersonal interactions, is processed and represented inside the patient's mind. These psychosocial factors have a strong influence on how the patient copes and adapts to his or her renal diagnosis because they interact with one another to influence the patient's thoughts, feelings, and behaviors.

It will be important to look at how one assesses, diagnoses, and treats the depressed dialysis patient. The social worker can tailor his or her interventions and the way he or she works with a particular patient at a particular time only after they have some insight and understanding of the underlying causes of depression. One of the underlying causes that will be of focus will be the patient's level of self-esteem, but before I get into the symptomatic picture and its presumed etiology, let me first turn to the literature on renal depression.

### Renal Literature on Depression

The papers on depression are far too numerous and lengthy to permit any but the briefest and most circumscribed of outlines. According to the literature approximately 20-25% of dialysis patients are depressed at any one time (Lopes et al. 2002; Stewart, 1983) and depression has been linked with mortality and hospitalization (Lopes et al. 2002) either directly, or indirectly through treatment noncompliance. In other words, depression has been found to be a predictor of mortality, treatment effectiveness and overall patient adjustment. Approximately 1 of every 500 dialysis patients commits suicide and an indeterminate number of deaths in dialysis are brought on by dietary indiscretion or poor compliance with the treatment regimen (Kimmel & Levy, 2001).

Depression is related closely to nutritional status and could be an independent risk factor for malnutrition (Koo et al., 2003). It is also associated with poor compliance of fluid restriction and higher weight gain between treatments (Garcia et al., 2002). Long-term studies have indicated that higher levels of depression amongst dialysis patients are associated with increased risks of mortality (Kimmel et al., 2000).

Almost every study I reviewed made it clear that future research is needed to assess whether early identification and treatment of depression may help improve quality of life and survival in hemodialysis patients. It is not yet known whether early diagnosis and therapeutic intervention might benefit these patients and author after author has stated that more emphasis must be placed on well-designed treatment. Kimmel (1993) stated that the best way to address depression in hemodialysis patients is unclear, but further studies on the association of depression and its treatment and mortality are warrant-

ed. The sparse literature that exists on treatment is one of the reasons for writing this paper.

Estrada and Marjorie (1997) wrote an insightful article that showed the relationship between some predisposing factors, such as educational levels, feelings about their support systems and employment histories, and the patients level of depression. What I found most interesting is the authors think it would be advantageous to explore the patients' coping capacity and level of self-esteem to see if it relates to their level of depression. Nephrology social workers, in their attempts to work more effectively with dialysis patients, they state, must concern themselves with the patients internal and external systems and their abilities to cope with losses. I have not found any literature that thoroughly addresses these issues, therefore, this introductory theoretical paper will attempt to fill this gap by focusing on the dialysis patients internal and external systems (what I prefer to call internal and interpersonal dynamics), their level of self-esteem, and their methods of coping to demonstrate how they are all intricately related to depression.

### **The Depressed Patient—Internal Dynamics**

All of us, I think, in one way or another had the opportunity to experience the subtle nuances of depressed feelings and moods. Sadness, unhappiness, loneliness, helplessness, weakness, worthlessness, grief, emptiness and a number of other terms are all labels we use to communicate our own depressed states. It is commonly understood today that there are different levels and different types of depression. The treatment of depression introduces the renal social worker into some of the most powerful emotions. Day after day we sit with our patients and look directly into the faces of so much pain and suffering. Maybe this helps us understand why there has been so much research on this topic, which tends to be detached, and very little therapeutic treatment, which would require more intimate involvement.

One way to assess for depression is simply to review the diagnostic criteria under the DSM IV. When doing this one should keep in mind that depression in people in these circumstances is legitimate, expectable, and understandable. The patient who is new to dialysis may require an initial period of adjusting, therefore, in order for these symptoms to have pathological overtures they must occur nearly every day and become chronic. The depressed patient may have a depressed mood most of the day (feels sad or empty); feel a markedly diminished interest or pleasure in all, or almost all activities; expe-

rience significant weight loss or weight gain; they may have difficulty sleeping or sleep too much; experience psychomotor agitation or restlessness; fatigue or loss of energy; feelings of worthlessness or excessive or inappropriate guilt; or diminished ability to think or concentrate. The depressed patient may have recurrent thoughts of suicide. The patient must demonstrate at least five of these symptoms to warrant a diagnosis of depression.

A basic depressive response is considered one which could occur at any time in the patient's life, it is a passing mood that is almost a universal phenomenon and it should not be confused with those forms of depressive illness that are more severe and crippling. For instance, when a patient is diagnosed with Renal Failure there is a dramatic change in life-style, which could include impaired social or occupational functioning, leading up to financial problems and a lower-standard of living because of a loss of income. Often there is frustration from the fundamental gratification offered by eating and drinking that is denied, leaving some to suffer from severe oral deprivations. We are all familiar with the multiple losses a dialysis patient endures such as loss of functioning, loss of income, status, body parts, love, and identity. What I think is most significant, and what distinguishes depression from everyday misery, is that in depression all of these losses lead up to a break down, or a decrease in the patient's self-esteem.

In the literature, it was not uncommon to read, and numerous authors shared the belief that the dialysis patient must come to terms with how his or her loss of functioning and need for dialysis fits into his lifestyle. While on the surface that sounds like a reasonable and simple task to accomplish, with closer scrutiny I wondered, what does this really mean? What would this look like? Of course it would involve coping, but even that concept can come across as somewhat broad and ambiguous, so I think it is important to try to understand what all this might entail.

Think for one moment about the physical trauma one goes through when one loses a body part and its functions. There is not only a loss of intactness of the body, there is also a loss of integrity. An illness hits home and it changes your feelings of invulnerability forever; some patients will never be able to think of themselves in the same way again (R. Lasky, personal communication September, 2003). These patients have lost their capacity to function in an ideal state (Joffe & Sandler, 1965).

An ideal state, for one patient, can simply mean a feeling of well being, while for another patient, it could be a feeling of omnipotence. It can be closely linked with feelings of safety and security, and, it is the exact opposite of what many patients feel when undergoing dialysis. Typical feelings include anxiety, discomfort and pain.

If a patient reacts to an experience of pain, pain being anything from being told you have to wait to get on the machine to the physical pain of some cannulations, he or she could become the typical unhappy and complaining patient with whom we are all familiar. We tend to experience these patients as difficult. I think it is important to understand what makes them so difficult. In this case the inner source of discontent, which most likely has a long history, is displaced into the environment. This patient has no recognition of an inner source of pain and finds it more comfortable to harass and berate the staff. One way to understand this example is to think of this type of patient as someone who is attempting to maintain his or her sense of well being. He or she is in a painful state, there is a loss of well being, and by attempting to control the environment with anger, this patient is striving to restore their ideal state. As you can see, patients may attempt to mobilize certain defenses, such as displacement or denial to restore that ideal state.

### **Defense Mechanisms**

As I was trying to shed some light on the ambiguous statement about dialysis patients coming to terms with their loss of functioning and need for dialysis, I introduced a number of different concepts, therefore, it might be helpful to pull these different ideas together by looking back briefly. In my example I described a patient who is using denial and displacement as a defense, and there are a whole gamut of different devices the patient can use to protect him or herself from experiencing any reality that is potentially too painful or overwhelming. These protective devices or defense mechanisms are the way one shields oneself. Defenses are mechanisms that all of us use to force out of awareness or eliminate any thoughts that would arouse unpleasurable feelings such as pain or depression. The defenses operate unconsciously; this means that the patient is not always aware of the mechanisms he or she is using to ward off the emergence of depressive affect. Defense mechanisms are coping skills that play an incredibly important role in the patient's ability to endure their illness, therefore, upon evaluation we need to figure out which ones are better left untouched because they are helping the patient cope, and which

ones need to be addressed because they are interfering with the patient's life.

Now we can see, that by using certain defense mechanisms, the dialysis patient is able to protect him or herself from a feeling that would be experienced as painful. This I believe, is just the beginning of a process in which the patient comes to terms with his or her loss of functioning, need for dialysis, and feelings of helplessness and hopelessness that could be aroused when they do not attain their ideal state.

True coping involves not only giving up the wish for past ideal states but also the development of new reality-adapted ideals. What we are asking of the dialysis patient is somewhat similar to the situations that most of us have encountered in one form or another. For instance, take the birth of a sibling, an illness, hospitalization, a major surgery, parenthood, menopause, a mid-life crisis or bereavement; all of these situations require us to give up previously held secure states of mind and adapt to some sort of changed situation (Joffe & Sandler, 1965). Before we go any further with how one copes with dialysis, let us think about the depressed patient, the one who is having a hard time coping. Why do some patients become depressed? What might be considered the essence of depression?

### **Self-Esteem**

Earlier I mentioned that depression is brought on by a breakdown or decrease in self-esteem. It is important to understand that self esteem can be diminished in any number of ways. Let's say the patient's ideal state is made up of the wish to be loved; the wish to be good, not hostile and angry with the staff; the wish to be clean, not dirty with vomit or blood; the wish to be strong, great or superior, not to be weak and out of control of your body (Bibring, 1953). The lack of fulfillment of any of these aspirations could lead to a feeling of helplessness, a decrease in self esteem and inevitably, depression.

An example of this is the dialysis patient with multiple scars on her neck, chest and arms who has the wish to be attractive and nice looking. One might point to the discrepancy between her ideal self and the effect of her imagined devalued or distorted body image on self-esteem. Reality plays into the depression as well. Every time she looks in the mirror there is some damage to her ideal state or when people on the street see and judge her as imperfect and far from the ideals of beauty.

Another example is the person, while wondering why he became depressed, said, could it be because I turned 65, or could it be a dissatisfaction with the way in which my life is going? Within these questions, perhaps, one can begin to hear a man who thinks he has not fulfilled his life aspirations, and the larger the discrepancy between one's aspirations on the one hand, and his feeling of helplessness or incapacity to live up to them on the other hand (real or imagined), the more severe the depression.

### **Clinical Material**

Here is another example of how self-esteem can be diminished. In my work with dialysis patients I have noticed that many of them experienced early, and or repeated loss. Let's take for instance a patient I will call Mr. D. Mr. D was a 54-year-old, single, male, hemodialysis patient that was referred to me by a renal colleague. He was seeking treatment because he was having a hard time getting over a recent rejection by a woman he loved. During the consultation phase he described his sense of excruciating loneliness, in the past five years he lost all five of his siblings and now his mother, the only surviving family member, was going crazy and required hospitalization. Upon further consultation it became apparent that this man came to treatment because he was suffering from depression. The recent loss of the woman appeared to have triggered unresolved pain from the five previous deaths, which in turn, reactivated multiple losses he endured as a child.

As the treatment progressed he spoke quite passionately about both his early childhood and recent experiences. He told me that he was not raised by his parents, instead, he was turned over to the care of an aunt. Many of his stories were filled with fear, hurt and a sense of his own fragility. He talked about how terrified he was to call his mother in the hospital, and how his time was better spent at the gym.

Just a moment ago I said self-esteem can be diminished when one does not live up to their ideal state (a sense of well being), and now I can imagine that you must be wondering, how does this apply to Mr. D? We can see, that Mr. D had the wish, like most of us, to be loved. He came into treatment when he learned that this woman did not love him. Another common wish, which I mentioned earlier, is the wish to be strong, or invulnerable, and this, I think, explains why Mr. D, while in the midst of a depression, would take time to tell me how "big" of

a man he was, and how he planned on joining the gym to pump up. Perhaps this was his attempt to demonstrate his strength and power, and understandably, it was his bid to reestablish his self-esteem and begin to cope with his loss of strength. Therefore, in some way it could be considered an adaptive defense, so, despite the fact that he walked with a cane because his legs were weak, I decided not to challenge or analyze these ideas of power and size.

It is important to note that this is a fine way of adapting if it is the best you feel the patient can do, or if it is all they want to do. However, you may recall that true coping requires of us to give up previously held secure states of mind and adapt to the changed circumstances. When Mr. D attempted to minimize the significance of his mother's hospitalization, and perhaps pending death, I spoke to him about it. Eventually he was able to call his mother in the hospital. From a therapeutic perspective, I was helping Mr. D construct a more reality-adequate image of his mother by coming to terms with her pending death. This came about as we began to explore his fears that he might be "loco" (psychotic) like his mother. We will come back to Mr. D in a moment.

Freud (1917) was the first writer to distinguish depression (melancholia) from normal mourning. He stated that the significant difference between the two is that in ordinary grief or mourning the external world is experienced as diminished in some way, whereas in depression, the person experiences an internal loss, something inside of them is missing. When a loved one dies, because you have identified with them, or taken them into yourself, you don't just lose them, you lose part of yourself, and in essence, experience a diminished inner world. Mr. D, a man who took pride in his relationships, and who took pride in his health and strength, could no longer feel that way. The more one is aware of these changes and losses, the bigger the drop in self-esteem, and the bigger the drop in self-esteem, the more severe the depression because one is not living up to their ideal state. Initially, Mr. D became depressed because of a loss, he was rejected by the woman he loved, this had an effect on his self-esteem and he felt like less of a man at a time when he needed to feel more powerful, this in turn was depressing. Stated differently, the drop in self-esteem and the depressive response became mutually reinforcing.

## Differential Diagnosis

Although it is not going to be the focus of this paper, it should be noted that there are many ways to conceptualize and understand a patient's depression. Another view describes depressed patients as hating themselves out of proportion for their actual shortcomings. This dynamic is known as the aggression turned inward model and it is often thought about when, for instance, you have a patient that seems to experience an excessive amount of guilt or a pervasive sense of culpability and a feeling that one is bad or has done something wrong. Take again, for instance, the case of Mr. D. On a number of different occasions he told me the story that he believed led up to the loss of the woman he loved. One day he sent a card and flowers to her place of employment, to his dismay, she did not accept the gift or read the card.

Here again, we get the sense of a reality distortion, not only does the woman he loves not love him back, but she wants nothing to do with him. We could spin this out further and link it back to his need to bolster his self-esteem by believing he is loved, but the point here is Mr. D felt like he had committed the most dreadful of sins by sending the flowers. Session after session I heard how upset he was with himself. Later on in the treatment, after being encouraged to get in touch with his anger and other negative feelings, Mr. D became very upset with me one day and accused me of not helping him. I understood and considered this to be a sign of therapeutic progress. On the recovery from depression it is not uncommon that the patient begins to regain their self-esteem and the feeling of strength; when this happens the aggressive impulses are released. His violent thoughts, for the moment, were not turned painfully inward as they were with the flower story or as he spoke about the multiple ways in which to kill himself. Now he found a way to direct the aggression outward, and this could be seen as a source of change.

Earlier when I was talking about diagnosis and the DSM IV criteria, I failed to mention that the renal social worker needs to take into account the similarity of the symptoms of depression to those of a medical problem, and we must make a distinction between physical pain and psychological suffering. Kimmel (1994) has pointed out that the cognitive aspects of depression may be a more important marker of the psychological status in medical patients. In other words, because the dialysis patient suffers from a variety of physical symptoms it is easy to confuse them with the somatic symptoms that are commonly associated with depression. Sleep, sexu-

al and appetite dysfunction, and fatigue are not enough to warrant a diagnosis of depression without assessing for the typical cognitive beliefs such as feelings of guilt, disappointment, sadness, hopelessness, etc.

## Interpersonal Dynamics

One way to understand the dialysis patients' interpersonal dynamics is to think back to your own experiences while working with a depressed patient. One of the reactions a social worker might have is a feeling of benign affection for the patient accompanied by rescue fantasies that they can be, for instance, the good mother the patient never had. On the other end of the continuum, another typical reaction is to feel incompetent, impotent, diminished, hopeless and not adequate enough to help the patient. This type of reaction might be more common with the demanding, provocative and insensitive depressed patient. Some patients have a proclivity to complain, and this may eventually get to the healthiest of health care providers or family members and friends.

Working with depressed patients can be extremely difficult because it could be draining. Some of these patients have a remarkable capacity for interpersonal insensitivity, treating the social worker as merely another object that can be manipulated to meet their own excessive demands and needs. We tend not to like these patients, we label them as difficult, and do everything possible to avoid them (which includes hoping they are asleep when we do our rounds!). As I stated earlier, we must keep in mind that patients in these situations tend to deflect their aggression elsewhere, perhaps at the social workers, and this usually aids the patient in being less depressed. If we can consider this as a perfectly natural way to handle depression, we can feel sanguine about the beneficial effects the patient derives from using us as a punching bag, and we no longer need to see them as difficult patients.

We can see that unless one has the capacity to step back and reflect on the patient's state of mind, a vicious cycle can develop where a patient's demand or need can lead to an inconsistent or irrational response by the worker who feels taken advantage of or manipulated. When one's functioning is impaired by his or her emotional reaction to the patient some supervision or personal therapy can restore the prospects of a rich, informative and better outcome.

Recognition of any subtle resentment and rejection of the patient can also be dealt with within the professional relationship. Once the social worker admits that this is a problem that can be harmful to the patient, it could be more beneficial to bring out the patient's irrational demands into the open, label and discuss them with the patient (Mendelson, 1960). For instance, let us say the social worker has a particular problem saying no to the patient's demands or enforcing some policy issue he or she has (i.e. how much advance notice one requires for transient arrangements); you may say to yourself... now this patient is acting like a shark that smells blood in the water. This will not only alert you to your vulnerability, but it will also allow you to realize that this patient senses it as well, and is trying to take advantage of it. This topic brings us into our next area of discussion which has to do with treating the depressed patient.

### **Treating the Depressed Patient**

Some patients will give up their tie to previously held ideals in the process of moving on with their life. The turning to more realistic ideals, as we saw with Mr. D's relationship to his mother, will allow for personal growth. Some depressions do not require treatment and are limited to sporadic feelings or moods which change as time goes on. With this type of depression you may be able to focus on educating the patient about their renal illness, or connect them to the resources that might help them feel less isolated. Becoming involved with a support group or just talking to fellow patients may decrease their feelings of despair, loneliness and isolation, but, on the other hand, it may not.

Some patients who have been educated (and reeducated!) about their health needs or connected with social networks will simply not follow up with the social workers recommendations, these are the patients who are at risk of using maladaptive defenses. They may turn to drugs or withdraw from life in order to ignore painful emotions. This I believe tells us that at times the patients' mood is not due to a lack of information or resources. While talking to the patient, if one hears enough of the DSM factors outlined earlier, and this patient is not new to dialysis, you can begin to talk to the patient about the function of psychotherapy treatment. For instance, you can ask them: do you have someone to talk to; do you think talking would be of help; do you wish you could talk to someone? If you seem to be getting a positive response, next you can tell them that you raise these questions because you know that people who talk tend to feel better than those who

don't talk. Once you get to some sort of agreement, only then should you use the label of psychotherapy. I prefer to do it in this sequence because an initial recommendation for psychotherapy could generate a negative reaction if the patient hears it as a criticism, they can feel like something is wrong with them, and this could lead to a further loss of self-esteem.

If you decide to counsel a depressed patient, whether chair-side in the unit or in your office, the first thing you want to do is provide the patient with an environment that is non-threatening and conducive to allowing him or her to share his or her feelings and concerns. Mendelson (1960) recommends that the social worker adjust his or her responses to the patients psychological rhythm and be careful not to let empty silences grow. Being supportive, reflective, approving, empathetic, and respectful is critical to helping the depressed patient, however, the social worker must do more.

It has been well documented that a basic nonjudgmental, accepting attitude is not enough to help a severely depressed patient. This reminds me of something that was once said by a depressed patient with a strong support system; "if love were the cure, I would have been healed already." When working with depressed patients the social worker must get into the patient's fantasies and talk to them about unachieved aspirations or their multiple losses, as I did with Mr. D. This can invalidate their worst fears and help them feel better about themselves. In many cases treating depression involves helping the patient bring into play more suitable or less maladaptive defense mechanisms.

The social worker can help the patient gradually develop a consistent and relatively realistic view of himself and others. As with Mr. D, there is often a desperate need to deny loss and to seek immediate and direct replacement like drugs, alcohol, or, in his case it was food. It is our job to help the patient subscribe to new ideal states, more realistic states, because their feelings of inferiority, weakness, impoverishment and helplessness is a major psychological problem behind their depression.

Acceptance of oneself can be achieved if one can feel satisfied with one's own accomplishments and with the acceptance that one can continue to feel good about oneself independent of physical strength or appearance. What really counts is whether or not the social worker can help the patient acquire the necessary tools to deal

with their changed circumstances, so the patient's self image is based on an inner feeling of goodness rather than on manifest features of the body.

Many patients feel initially more friendly towards the medical management of their moods while other patients prefer to stay away from any sort of medication management. The social worker and patient will find the combination that works best. Studies have shown that patients with a severe degree of depression benefit from medications. In addition to the rewarding and successful work, which rendered excellent results, I have referred some depressed patients for a medication evaluation as an adjunct to the talk therapy. On a terrifying note, I have heard many stories where an overtly depressed patient talks to his nephrologist about his or her sleep disturbance and comes back with a prescription for Ambien or Ativan as a bedtime aid. This could be damaging to the patient because, it has been said, certain tranquilizers are capable of depressing the mood or precipitating a major depression.

For those dialysis patients who opt for psychiatric care only and cannot advocate for themselves, or are too depressed to accurately assess their mental state, it is extremely important that the social worker act like the eyes and ears for the psychiatrist. In other words, we are in a position to see how and if the prescribed medication is working, and we should collaborate with the psychiatrist (who will most likely only see the patient for 15-20 minutes once a month!) to let him or her know what is going on with the patient.

### Conclusion

I have discussed some of the reasons why dialysis patients get depression and I have focused mainly on the interactional effects of the illness, the treatment, loss of self-esteem and depression. I pointed out that there are all kinds of ways people get depressed, and loss of self-esteem is most certainly not true for all depressed dialysis patients; there are without a doubt cases of depression in which an unusual severity of anger and harshness is directed at those who are closest to the patient. This hostility is also directed against oneself and it is frequently accompanied by self-accusations and self-reproaches.

A more extensive investigation of the different types of depression amongst dialysis patients may serve to further our understanding of how best to treat this population. This, however, is the subject for another discus-

sion, but it does bring us to one last point that is worthy of mention. For different authors depression has different meanings and different purposes. For one author depression is made up of rage and guilt, for another it is the self torment of emptiness and loneliness, and yet for another it has to do with the loss of self esteem. My experience thus far as a dialysis social worker has led me to believe that different types of depression are interrelated on a continuum; at one point in the treatment the drop in self-esteem is the essential element while at another point the social worker must deal with the patient's anger before it destroys the treatment or the patient.

Some of the material I presented clearly shows that a drop in self-esteem and depression are often related. I tried to demonstrate how one causes the other to occur, but most of the time the two are mutually reinforcing. My vignettes focused on the interventions that could be useful, but the truth of the matter is one could take any section of this paper and develop it into a full paper. We just scratched the surface, and the next step, in my opinion, is to put the above mentioned theory to the empirical test to determine the association between self-esteem, depression and therapeutic treatment.

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## Notes

<sup>i</sup> Self esteem is the expression of self-evaluation, it represents the degree of discrepancy or harmony between one's actual image and ones wished for idea of themselves. The larger the discrepancy between one's wished for state, and one's actual state, the bigger the drop in self-esteem.

<sup>ii</sup> Fortunately for Mr. D, he had not reached the depths of depression when one begins to act out.

<sup>iii</sup> I don't mean to imply that the social worker should do this for all of their angry patients, however, it would be most useful to those who could benefit from this sort of containment.

<sup>iv</sup> We should keep in mind that we are not just educating the patient, but we are trying to find out what is preventing them from acquiring certain basic knowledge about the treatment. Sometimes fear prevents learning; when this is the case the social worker can help the patient be less afraid of what they are going through so the patient will be in a position to gain knowledge, and this will have an effect on self-esteem.

<sup>v</sup> The social worker should attempt to determine which talents are present and which are absent. These talents or tools can consist of impulse control, frustration tolerance or the capacity to imagine that one deserves good treatment.

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