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# THE INFLUENCE OF SELF EFFICACY IN MANAGING DEPRESSION IN HEMODIALYTIC PATIENTS A PROPOSITION OF AN ALTERNATIVE INTERVENTION MODEL

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**Abstract:** *Depression in patients diagnosed with end stage renal disease and undergoing hemodialytic treatment is a psychological condition significantly related with mortality rate among this group of patients. The common intervention procedures focus on psychiatric assessment and medication. This situation is even more specific for a country like Romania, where the psychological assistance is not a common service for every health care institution. In this context, the alternative intervention model that we propose in this paper is based on the self efficacy theory and social persuasion as a source of increasing self efficacy. Based on previous research in the field, the model propose to increase the level of self efficacy in order to diminish the depressive symptoms using social persuasion as a source of self efficacy improvement. Further implementation of the model will validate this theoretical model.*

**Keywords:** *self efficacy, depression, hemodialytic patients, quality of life, social persuasion*

## 1. INTRODUCTION

Patients diagnosed with end stage renal disease (ERSD) undergoing hemodialytic treatment procedure have a significant impaired quality of life. This type of treatment exposes the patients to several significant constraints regarding the medical procedure, but also the personal lifestyle. The ESRD patients must undergo three - four treatment sessions per week, each of them lasting three –four hours. In addition to the length of time spent in the hospital for the hemodialytic treatment, the patients must submit themselves to a severe life style regarding the food consumed and the quantity of liquid ingered. The only justification for these privations is to maintain the body weight as constant as possible. At the end of each dialytic session the patients' weight is measured and it stands for a comparative indicator for the next measure, at the beginning of the next treatment session. The difference between the two measures

should be the smallest possible. In addition to these constraints, the quality of life of these patients is affected by some other factors: the loss of the kidney's hormonal functions, neurological and digestive disorders, and the decrease of cognitive and physical functions. To all these aspects, we may add the difficulty in maintaining the social, professional and family roles [4]. Only reading these lines, it is enough to understand why the depressive symptoms among the hemodialytic patients are so common [5].

As in the case of other depressive patients, the most fearful correlate of the depression is the suicide danger. Nevertheless, the direct connection between the depressive symptoms and the mortality rate among the hemodialytic patients is still a subject for discussion. The rate of depressive psychiatric diagnosed symptoms in the hemodialytic population is still insufficient documented, but specialists place it in the range of 5-10 % [5]. In this

framework, we can imagine that the depressive symptoms are even more frequent.

As for Romania there are no statistics, we will consider the data available for the United States population. These data document that more than 470.000 persons living with the ESRD diagnosis. Each year, more than 100.000 persons are diagnosed with ESRD, according to the data offered by United States Renal Data System, in 2008 [2].

## 2. SELF EFFICACY-CONCEPT AND CONNECTIONS

Self efficacy is a concept first introduced in the scientific literature by Albert Bandura, in 1977. This describes the trust that a person has in his/her own ability to manage the difficult tasks or obstacles or, as Bandura himself defined it, is the individual's belief in his own capacity of successfully fulfilling a task [1]. Self efficacy is a complex construct. Motivation is a principal component of self-efficacy construct, but it has to be differently understood in different context. In an academic setting for instance, motivation is connected to competition and performance while one person's motivation to improve his/her own health is probably connected to the fear of death or some other internal similar fears and cannot be connected to competition or performance [6]. Therefore, when considering the effect of self-efficacy upon people's performance, we have to consider some other moderating variables like the level of optimism, locus of control, level of self esteem, copying styles, learning styles, or some demographic variables like gender, race, culture, age, level of education [6].

Another important aspect in discussing about self-efficacy is the distinction between *specific self-efficacy* and *general self-efficacy*. General self-efficacy can be defined as the general confidence of one person in his/her own capacity to deal with different situations encountered. Investigating self-efficacy is more precise if it aims to consider specific self-efficacy, focusing on the performance in specific tasks and specific activities.

Moreover, there can be significant differences between the levels of general self-efficacy and specific self-efficacy measures for the same individual. For instance, a person with a high level of general self-efficacy, very confident that he/she can deal with life challenges, may have significant difficulties in adapting to a new or specific behaviour, like developing specific skills in public speaking.

A very important variable in influencing the treatment compliance, self-efficacy has four identified sources for its development: vicarious experience, mastery experience, social persuasion and physical and emotional states.

**Vicarious experience** uses social modeling and sharing of experience. If people see others similar to themselves succeed through persistent effort, they may come to believe they, too, can succeed in similar activities [1]. **Mastery experience** is the most efficient source in developing the self-efficacy. It refers to the previous personal experiences that give the person the sense of expertise and a success feeling. Succeeding in overcoming successive tasks, people reach a certain level of expertise. This is the most authentic proof that the person has the resources to do whatever is necessary to succeed. Success experience helps in constructing self-efficacy while failure, minimizes it.

**Social Persuasion** is the third source for developing a strong sense of efficacy. People can convince others, through suggestion, to believe they have the ability to do what is necessary to accomplish a certain outcome. While social persuasion is not as effective as mastery or vicarious experiences, often people can be verbally persuaded that they possess the ability to master certain activities. People who are persuaded in this manner are more likely to sustain effort and try harder when faced with obstacles.

**Physical and Emotional States** is the fourth source for developing a strong sense of efficacy. It refers to reducing stress and depression while increasing physical state of



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wellbeing. People use their physical and emotional states to judge their capabilities. An elevated mood can enhance self-efficacy, while a negative mood may diminish it. People tend to associate stress, tension, and other unpleasant physiological signs with poor performance and perceived incompetence.

### 3. SELF EFFICACY IN HEMODIALYTIC PATIENTS

A common consequence in the depressive states of hemodialytic patients is the decrease of treatment adherence. This concept is defined as «the measure in which one's behavior meets the medical advise or the health prescriptions» [3]. The treatment compliance is essential for the dialysed patients due to its connection to mortality [7]. Studies in the scientific literature have documented a significant correlation between self-efficacy and treatment adherence or depression in the sense that a high level of self-efficacy is associated with high levels of compliance and low levels of depression.

### 4. ALTERNATIVE MODEL OF INTERVENTION IN DECREASING THE INTENSITY OF DEPRESSIVE SYMPTOMS – A PROPOSAL

The usual procedure in addressing depressive symptoms in hemodialytic patients specifies the role of the psychiatric intervention. Rarely, the patients are referred for a psychological assessment and intervention. But, the legal framework in Romania doesn't specify the obligation for the hospitals or private hemodialytic centers to offer psychological support to the patients. In this context, our model of intervention ignores the usual procedure of treating depression and focuses on increasing the levels of self efficacy, using

one of the self-efficacy sources: social persuasion.

Stages in implementing the proposed model :

1. Selecting the hemodialytic patients participating in the study.

Selection criteria consider inclusion, but also exclusion characteristics.

*Inclusion criteria :*

- over 18 years old
- undergo dialysis for three-four times a week
- undergo treatment for at least six months
- able to eat and walk alone
- live in a family setting
- are willing to participate in the study

*Exclusion criteria:*

- hospitalised patients
  - patients with psychiatric disorders and cognitive impairment,
  - assisted in self care
2. Identifying the patients with high levels of self-efficacy and low intensity of depressive symptoms. In this stage, specific assessment instruments are used.
3. Selection of the patients with high levels of self-efficacy levels.
4. The patients with high level of self-efficacy levels participate in a videotaped interview focusing on the resources used in managing the life and treatment constraints. They are encouraged to say how they succeed in managing a privative life style as examples to be followed.
5. While undergoing hemodialytic therapy, the patients with lower levels of self efficacy see the filmed interviews.
6. The interviews are reviewed by the same patients with lower levels of self efficacy once a week for three weeks.
7. After the intervention procedure, the participants in the study undergo the same assessment stage, for assessing the levels of depression and self-efficacy.

8. The expected results are that the intervention procedure has lowered the levels of depression as compared with the initial measures (before the intervention) and has also increased the level of self-efficacy as compared with the initial stage, (before the intervention).

## 5. CONCLUSIONS

The model is a theoretical one and is based on the data revealed by the previous literature. Further research is needed in order to validate the model proposed. The implementation of such a model in every health care institution providing hemodialytic treatment in Romania is motivated by the lack of resources available for patients in their process of adapting to the disease constraints. The health care system doesn't provide for these patients psychological assistance in addressing the depressive symptoms. The only procedure used in such cases is the psychiatric treatment. For chronic patients like those with ESRD with a significant impairment of quality of life, the additional medication and its side effects would further contribute to the perceived increase of stress. Furthermore, we believe that depressive symptoms would be better managed through psychological assistance than by medication.

The benefits for implementing such a model are clear at theoretical level, but they need to be validated through specific intervention and subsequent scientific research.

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