The Trauma of Life Threatening Illness and Kidney Transplantation

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With medical knowledge increasing and people living longer, illnesses that were once fatal are now becoming chronic. Although frequently denied, depression, anxiety and guilt are often experienced by people with chronic illnesses. Nevertheless, the psychological consequences of living with chronic illness are often misinterpreted or ignored by health care professionals who share a technical focus. The recognition and psychotherapeutic treatment of the traumatic aspects of illness on the mind as well as the body can be a crucial step in assisting these people to vastly improve the quality of life. This article will use treatment considerations with patients who suffer from kidney failure to illustrate the psychological issues associated with many chronic illnesses.

According to the National Kidney Foundation, there are more than 40 million people in this country who suffer from chronic kidney disease or one of the significant risk factors linked with it. Inevitably, the patient's psychological condition is affected by symptoms such as weakness, fatigue, nausea, physical limitations, loss of functioning and changes in appearance. These stresses are compounded by the frequent loss of employment, role, status, and income, and the cumulative impact of struggling to survive with a life threatening illness, end-stage renal disease (ESRD). Depression is often related to lowered immune functioning, alcohol and substance abuse, noncompliance, marital problems, and additional health problems. Strict dietary requirements add to the hemodialysis patient's struggles, due to deprivation and loss of pleasure. Diabetes and severe hypertension are the most common causes of ESRD, and with the epidemic of obesity in this country, the numbers of people with renal disease may increase. When ESRD is caused by diabetes, complications may include visual deterioration and circulatory impairment. Hemodialysis is also associated with a higher rate of suicide.

Frequently, ESRD patients struggle with anxiety. Somatization is common, as well as fears of loss of capacities, roles, independence, security, self-esteem, rejection, and loss of love. Shame and guilt are frequent, as are envy, blaming oneself, others, the world, and God. Many ESRD patients feel isolated and trapped, but keep these feelings to themselves.

Hemodialysis, peritoneal dialysis, and kidney transplantation are types of treatment for kidney failure, but they are not cures. Transplantation is considered to be the treatment of choice. However, unique psychological, family and societal dynamics play themselves out when the person needs a transplant. The prospective recipient must wait, often for years, for a compatible cadaverous kidney to become available, thereby benefitting from someone else's death, often accompanied by survivor's guilt. The recipient may wonder from whose body the kidney originated, and from what kind of person.

When there is a living kidney donor, the recipient may experience fear of harming the prospective donor, and resentment of family and friends who do not volunteer to donate. The prospective recipient needs to be mentally and emotionally capable of receiving. I have worked with a number of patients who refused to accept a kidney from a living donor. These were patients who tended to have prolonged illness, depression and suffering; who felt guilty and believed they were a burden to others. In psychotherapy, they maintained that they deserved to be punished for fantasized crimes and exaggerated misdeeds.

In considering these issues involved with kidney failure and other life threatening chronic illness, the professional places her own feelings of security in jeopardy. Countertransference feelings emerge when the therapist avoids dealing with her own feelings about massive loss, mutilation and dying.

Understanding the Patient's Coping Patterns

Denial is often used extensively to cope with the trauma of chronic life threatening illness, and can be adaptive. Denial may also lead to poor medical compliance, failure to report symptoms to the healthcare team, and problems in relationships. As therapists, we must take into account the character and temperament of the patient with chronic illness, as well as the reactions of family and friends. The suspicious or pessimistic patient, or one with a history of failed surgery or additional ailments which worsened must be viewed differently from a patient who was a previously secure person.

Although patients with chronic illness are seldom referred for psychotherapy, they can benefit enormously from treatment of the complex psychological aspects of their disease. I have come to feel challenged when given the opportunity to treat a new patient with chronic illness.

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