ISSN 2348-3156 (Print)
International Journal of Social Science and Humanities Research ISSN 2348-3164 (online)
Vol. 8, Issue 2, pp: (130-134), Month: April - June 2020, Available at: www.researchpublish.com

Anger and Aggressiveness as a Factor of Personality in Patients Undergoing Dialysis

Rezalda Shehi[1], Sabina Tahsimi[1]

[1]Hygeia Hospital Tirana, Albania

***Abstract*: Chronic Renal Failure (CRF) is a public health problem that tends to take dimensions of epidemic and has serious impact on quality of patient's life. Anger and aggressiveness are common among patients with end-stage renal disease (ESDR). A number of psychiatric problems arise during the course of treatment by hemodialysis, both among patients, relations and members of dialysis teams. Factors of personality like anger are discussed, before the dialysis and after it. As the disease progresses patients show insomnia at night. They may be irritated, depressed, demanding, discontent, aggressive which add to the difficulties in their management by hospital staff. Researchers suggest that the neuro-psychiatric changes are probably concomitant with chemical changes. We reviewed the literature and studied 12 patients with chronic renal failure, interviewed their relatives, three doctors, the psychologist and five nurses to explore if anger and aggressiveness was the psychological impact of dialysis or part of their previous personality and their attitude toward the psychological support. Complexity and chronic nature of the disease affect the quality of life and personality of patients with CRF. All the twelve patients we study showed personality change because of dialysis, but aggressiveness and anger was more related to their temperament than to the impact of the disease. Dialysis patients show resistance to therapy, because it is difficult for them to deal with the end of their life. From the other side the patient's difficulty in joining out-of-site appointments and dialysis hours also corroborates that mental health-focused treatments take second place. The role of the Nephrology Unit is highly important for the implementation of effective nursing interventions and psychological support during their treatment.**

***Keywords:* chronic kidney disease, anger, aggressiveness, negative symptoms, hemodialysis treatment, counselling, opened interviews.**

I. INTRODUCTION

Hemodialysis (HD) is regularly offered to patients with insufficient renal disease in Albania, which cannot have a transplant. They are dialyzed irrespective of their age, education, medical comorbidities, socio-economical level, and demographic areas. All the expenses are covered by State. During our practice as psychologists, we have noticed that this variety of people can have confrontation, combating behaviours and conflicts at risks of physical harm. These conflicts rise between patients or patients and health care providers. Few authors mentioned these aggressive behaviours in their studies.

The most important thing is to understand the dynamics in HD Unit. MA Feely et al, [1] noticed in his article, that in the Hemodialysis Unit patients are treated simultaneously in the same room, where the behaviour of one patient can become difficult to manage, complicated and threaten the health and safety of other patients or staff (because of psychological related disorder or because the patient doesn't understand the consequences of their unsafe behaviour). Thus, clinicians are often faced with ethical challenges and increased numbers of complex situations that result when patients are maintained with HD, from clinically deteriorate owing to cognitive decline and behavioural lack of control, which in some countries is not regulated by policies (for example while the National Health Service in the United Kingdom has a "zero tolerance" policy regarding violent behaviour, European and Australian dialysis providers have issued excellent recommendations and implemented policies regarding the prevention and management of violent behaviour in dialysis units).

Marjorie et al [2], reflect on the attitude of health care providers in HD Unit toward patients in HD treatment who are dependent from the treatment and health care system. As a professional of mental health, he attempts to maintain a link between the doctor and his patient who are both caught up in transference and counter transference movements and tends at the same time to disengage himself as a psychologist from his own compassionate or sadistic feelings towards his patient. He analyses the psychoanalysts who distinguish between aggressiveness and violence, as two separate notions, and mention that Freud consider aggressiveness like common relationship manifestation that results of affective and hostile erotic motions of other.

Then Settineri et al [3], mention the need to reinforce the ego (an attitude toward problems, predominant reaction toward frustration and ability to adapt in relation to one's emotional profile, [4-9], through psychological support, where non compliance to the treatment, is put in relation to the presence of negative emotions such as anger and feelings of discouragement, young age, family worries, lack of insight of illness. Ego strength in patients with Chronic Kidney Disease (CDK) is severely put to the test by the frustration caused by hemodialysis [10].This adaptation process, is based on the model biopsycho-social, because CKD is a biological complex disease, in which clinical and psychosocial factors interact differently with each other. Psychosocial factors e.g. the presence of social support, aspects of self-esteem, negative emotion e.g. anger and feelings of discouragement, perception of illness and religion, play an important psychological role in subjects with CKD and may also affect the clinical factors and the biological state of those patients [11-16]. In the end, few studies explore patients in HD treatment subjective experience. Angioletti et al [17] try to prove that there is a connection between degree and subjective sense of fatigue and the way patients cope and face their daily routine. The research of Dąbrowska-Bender et al, [18], showed that patients receiving hemodialysis indicated aggressiveness and felt limitations related to longer travelling outside the dialysis unit, drinking and dependence from the medical personnel, more frequently than patients receiving peritoneal dialysis.

As a psychologist, facing these issues (angry and aggressive behaviour between patients or toward health care providers), we wanted to understand and explore further the psychosocial challenges and provide recommendations to further assist nephrologists, dialysis personnel and psychologists in managing patients to resolve conflicts. We also wanted to understand the place and role of the psychologist in HD Department as well as the attitude of patients toward him.

II. METHODOLOGY

The investigation of patients' negative emotions like angry and aggressiveness was performed by holding opened questions interviews. 32 persons were enrolled in the study:

- a total of 12 Albanian hemodialysis patients, with a mean age 54.9 (13.5) years and range28-81 years. The mean time of hemodialysis was 3.8 years
- 5 relatives (spouses or parents),
- 15 health care providers:
  - 5 doctors (three nephrologists and two general doctors),
  - 6 nurses, the chef of nurses, and
  - two HD Department coordinators.

This took place in HD department next to Hygeia Hospital and American Hospital 1, in Tirana, Albania. This qualitative study use interviews and discourse analysis as method to elicit patients in-depth experiences and to analyse the content and presentation of patients' subjective experience.

Interviews were prepared by Department of Psychology Unit next to Hygeia Hospital. The selection of the patient was random and various regarding to their age, years in dialysis, socio-cultural level, demographic position and education, and history of life. The same criteria were used to select the staff in hospital. We tried to select a staff that varied in age, work experience (from 6 months to 9 years) and profession.

The questions prepared by the psychologists aimed to explore patients' perceptions, those of their relatives and staff in hospital (nephrologists, general doctors, psychologists, coordinators and nurses) if patient's reactions like angry or aggression were caused by the complexity and chronic nature of the disease or were a previous trait of personality. Furthermore, we aimed to study the attitude toward the psychologist or psychological service; if they considered

necessary the psychological support and if they thought that it was useful to implement the psychological service in the Nephrology Unit for patients that are treated in HD.

Containing of the interview

The interview was divided into three main sections on the basis of these areas:

a. Personal information and socio-demographic details:

- Name Surname
- Date of birth

b. Information related to the relation with the object (socio-relational aspects):

- Relationship between family support and disease
- Relation with psychologist, nurses

c. Information related to mental health problems (experience related to HD treatment):

- Impact of dialysis in mental health (depression, anxiety, mood change, psychosis etc)
- Patients coping in the end stage
- Angry and aggressiveness as a personality trait or related to the disease
- The impact of features like age, level of the education and demographic position etc

Patients were allowed to take all the time they need to answer the questions, in order to obtain deeper information during the interview. The interviewee clarified every question and tried to find an appropriate and confidential environment. The interview was realized in good climate of collaboration, friendliness and welcoming. It lasted about 20–30 minutes and each response was transcribed at the same time by the interviewee.

Each participant has been assessed with Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM) test Evans et al., [19] a psychological instrument tested and validated in Albania (from a licensed psychologist Blerta Bodinaku) that measure these dimensions of the personality: subjective wellbeing, symptoms/psychological problems, social functioning and harm toward oneself and others. Demographic, clinical, and laboratory data (age, gender, underlying renal disease, HD regime, and duration on dialysis) were recorded and controlled for each patient at the moment of the inclusion in the study.

The committee of the International Hospital, where the research was conducted approved this study. Informed consent was obtained by patients according to the ethical medical and psychological standards (Order of Medical and Order of Psychologist).

III. RESULTS

According to results of tests, patients didn't manifest harm toward themselves or others, but they showed high levels of aggressiveness. The interviews showed sensitivity, anger and aggressiveness especially in the last hours of dialysis and post-dialysis, a very critical issue for patients as it is more reported in their clinical setting. Patients suffer the fact they are in dialysis, deny the end stage and transfer this aggressiveness and anger to the object (in our case health care providers: nurses and psychologist), because they are healthy, have more often contact with them and because of private hospital' policies are forced to tolerate them.

Another interesting finding was that we identify similar emotions and behaviours of health care providers with patients in HD treatment like angry, aggressiveness, and lack of patience. Sometimes because of conflicts they have, confrontation or bad experience, some health care providers (nurses) hold a different attitude with some patients.

From interviews with staff of Nephrology Unit we distinguished two groups that are holding different attitudes toward the psychologist. One group thinks that the psychological service is very important and has helped patients to feel more peaceful and calm. This group is generally composed by doctors and nephrologists or nurses with many years of experience. For example, nephrologists think that their job is facilitated since the psychologist has started to work there.

The other group composed by inexperienced nurses think that patients refuse the psychologist. As they weren't there from the beginning when the psychological service started to work, they cannot compare the actual patient's state with previous one. At the same time, this attitude reflects their mindset and approach toward psychological service in dialysis.

In fact, some of the patients in dialysis resist taking psychological counselling, because other needs, concretely basic needs are not fulfilled (like transport) or because it's difficult for them to follow counselling sessions after 3 or 4 hours in HD.

After, they consider the treatment of mental health problems like issues of secondary order, compared to medical treatment of the disease. Their mentality becomes a barrier; some of them think that "if you go to a psychologist, you are stupid". For others, it's difficult to cope with the end stage (many are in denial) and they avoid the psychologist as they don't want to face the truth.

In the end, even if they don't want to admit openly they acknowledge that the psychologist is useful and important and some people consult secretly.

Cultural differences were noticed between patients in dialysis in Albania. According some interviewers reports, the majority of Albanian patients are more jealous, have less gratitude and closed mindset. It's difficult for doctors and psychologists to work with patients who don't show recognition and gratitude.

IV. CONCLUSION

The complexity and chronic nature of the disease had impact in patients' personality and quality of life. The added value of this study is that it offered a comprehensively viewpoints of patients and professionals involved in HD treatment process, in order to facilitate the process and improve the dynamics.

It also aid to find out many unexplored psychosocial topics related to patients and staff wellbeing (such as "despite everything we give to the patient, they are not grateful", feelings).

Causes and interventions of angry and aggressiveness symptoms in patients undergoing chronic hemodialysis treatment aren't under debate and often neglected. According to this study, their personality changes from dialysis which is a major life event. Negative emotions like anger and aggressiveness transferred to health care providers, are more related to their character and previous personality than to the disease; the disease is an added factor that contributes to intensify this trait of personality.

The role of Nephrology Unit is very important in the implementation of effective medical intervention and psychological support during the treatment. Health care providers, especially nurses and psychologists should better understand the lived experience of patients with chronic kidney disease as well as the role of the psychologist, in order to better approach conflict resolution, prevent and manage violent behaviour and provide individualized and specific interventions. Each dialysis unit should have a clear, consistent, and systematic approach to conflict resolution, and we need to implement policies regarding prevention and management of violent behaviour in dialysis unit.

ACKNOWLEDGEMENTS

We are most grateful to all participants.

REFERENCES

[1] Feely M. A, Albright R, Thorsteinsdottir B, Moss A. H, and Swetz M (2014). Ethical challenges with hemodialysis patients who lack decision-making capacity: behavioral issues, surrogate decision-makers, and end-of-life situations. Kidney International 86, 475–480; doi:10.1038/ki.2014.231;

[2] Marjorie, R and François, P. (2011). Les enjeux de l'agressivité dans la relation transféro-contre-transférentielle en milieu médical : l'exemple de l'hémodialyse, Psychothérapies, 2, 31, 143-149. DOI : 10.3917/psys.112.0143

[3] Settineri, S., Mento2, C., Santoro, D, Mallamace, A., Bellinghieri , G., Savica, V., Ricciardi, B., Castellino, S., Mallamace,D. (2012). Ego strength and health: An empiric study in hemodialysis patients. Health, 4, 1328-1333. http://dx.doi.org/10.4236/health.2012.412194

[4] Vaillant, G.E. (1971) Theoretical hierarchy of adaptive ego mechanisms. Archives of General Psychiatry, 24, 107-118. doi:10.1001/archpsyc.1971.01750080011003

[5] Lazarus, R.S. (1991) Emotion and adaptation. Oxford University Press, New York.

[6] Hillman, J. (1999) The force of character. Random House, New York.

[7] LeDoux, J. (1996) The emotional brain: The mysterious underpinnings of emotional life. Simon and Schuster, New York.

[8] Sanz Guajardo, D., Orte, L., Gomez-Compderà, F., Fernandez, E., Aguilar, M.D., Làzaro, P. and Inesir, Group. (2006) Quality of life in patients with chronic renal failure influence of nephrologist's early intervention and predialysis clinical visit consultation. Nephrology, 26, 56-65.

[9] Sayin, A., Mutluay, R. and Sindel, S. (2007) Quality of life in hemodialysis, peritoneal dialysis and transplantation patients. Transplantation Proceedings, 39, 3047- 3053. doi:10.1016/j.transproceed.2007.09.030

[10] Friend, R., Hatchett, L., Shneider, M.S. and Wadhwa, N.K. (1997) A comparision of attributions, heath beliefs and negative emotions as predictors of fluid adherence in renal dialysis patients: A prospective analysis. Annals of Behavioral Medicine, 19, 344-347. doi:10.1007/BF02895152

[11] Cukor, D., Cohen, S.D., Petersonr, A. and Kimmel, P.L. (2007) Psychosocial aspects of chronic disease: ESRD as a paradigmatic illness. Journal of the American Society of Nephrology, 18, 3042-3055. doi:10.1681/ASN.2007030345

[12] Livneh, H. and Antonak, R.F. (1997) Psychosocial adaptation to chronic illness and disability. Aspen Publishers, Giathersburg. and motivational issues. Health Psychology: sagepub.com/journals-permissions DOI: 10.1177/2055102918809761

[13] Thong, M.S.Y., Kaptein A.A., Krediet, R.T., Boeschoten, E.W. and Dekker, F.W. (2007) Social support predicts survival in dialysis patients. Nephrology Dialysis Transplantation, 22, 845-850. doi:10.1093/ndt/gfl700

[14] Patel, S.S., Shah, V.S., Peterson, R.A. and Kimmel, P.L. (2002) Psychosocial variables, quality of life, and religious beliefs in ESRD patients treated with hemodialysis. American Journal of Kidney Disease, 40, 1013-1022. doi:10.1053/ajkd.2002.36336

[15] Symister, P. and Friend, R. (2003) The influence of social support and problematic support on optimism and depression in chronic illness: A prospective study evaluating self-esteem as a mediator. Health Psychology, 22, 123-129. doi:10.1037/0278-6133.22.2.123

[16] Timmers, L., Thong, M., Dekker, F.W., Boeschoten, E.W., Heijmans, M., Rijken, M., Weinman, J. and Kaptein, A. (2008) Illness perceptions in dialysis patients and their association with quality of life. Psychology & Health, 23, 679-690. doi:10.1080/14768320701246535

[17] Angioletti, L., Bossola, M., De Filippis D., and Balconi, M. (2018). Lived experiences of patients on hemodialytic treatment: A discursive perspective on fatigue

[18] Marta Dąbrowska-Bender, M., Dykowska, G., Żuk, W., Milewska, M., Staniszewska, A. (2018). The impact on quality of life of dialysis patients with renal insufficiency. Patient Preference and Adherence. 12 577–583

[19] Evans, C., Mellor-Clark, J., Margison, F., Barkham, M., Audin, K., Connell, J., & McGrath, G. (2000). CORE: Clinical outcome in routine evaluation. Journal of Mental Health, (9)3, 247- 255.