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Understanding our peritoneal dialysis patients during COVID-19 pandemic and beyond

ABSTRACT

Providing information about advanced kidney disease diagnosis and the need for starting dialysis to the patient and their family can be a real challenge for healthcare professionals.

Nephrologists and nurses are usually not sufficiently prepared, from a psychological point of view, to understand emotional and mental status of patients starting dialysis. This understanding would allow patients to take a decision on which therapy is more suitable for them and help them to choose home dialysis, especially peritoneal dialysis (PD), more often. Learning about the significant change in one's life due to the necessity for renal replacement therapy (RRT) can be difficult enough to raise anxiety to a level triggering different personality defense mechanisms. To help patients to better understand healthcare professionals, one has to adjust our perspective and the way we perceive patients in order to empathize with their situation, their emotions, and reactions, communicate more efficiently, provide the information in a more understandable way, and achieve better patient compliance and clinical outcomes by involving patients in shared decision-making.

We describe potential reactions of people exposed to information about the overlapping dangers of kidney disease and the current COVID-19 pandemic, and death communicated through news, text messages, social media, the internet, and interpersonally, and similarities in the communication process experienced by PD patients, their families, and nephrology healthcare professionals.

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INTRODUCTION

Kidney disease patients are a large and very heterogenous group suffering either from acute kidney injury (AKI) [1] or chronic kidney disease (CKD) [2]. The disease may be a dramatic situation for the patient and their family, causing multiple emotional reactions. Peritoneal dialysis (PD) or hemodialysis (HD) largely affect not only physical well-being but also lifestyle, family life, and working ability, which means it is not only somatic health condition but also mental condition.

The severity of kidney disease is not the only factor influencing emotional and mental condition of CKD patients [3]. There are many other factors, as dynamics of the disease vary and subjective symptoms including pain, dyspnea, and leg swelling are variable. The clinical state in some patients may gradually deteriorate over the years up to the highest stage, and then they might have already adapted to the disease and its restrictions. In other patients, the disease might be less severe over. That is obvious to nephrologists but remembering that helps to better understand patients' emotions. The patients may not be aware of their illness for a long time, and then at a certain moment, the disease may rapidly get worse, causing enormous stress and deterioration of both physical and emotional well-being.

Recently most patients and healthcare professionals were facing a new and very stressful situation associated with the COVID-19

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pandemic, which affected lifestyles and emotions of people on all continents. This adds other aspects of how patients and healthcare professionals perceive their role and position in that rapidly changing environment. Among its additional aspects are quarantine or social isolation necessary for some individuals from both groups — patients and healthcare professionals [4].

Relationships and communication with healthcare professionals may significantly affect how patients perceive their status, disease, and prognosis. That might directly influence their ability to cooperate, compliance with medical recommendations, use of prescribed drugs, and fulfillment of dietary advice. The communication between healthcare professionals and dialysis patients is not only influenced by the severity of patients' disease and their emotional condition. Physicians and nurses might have their own emotional issues, especially during the pandemic, which influences mutual communication. Understanding those emotional factors and the status of both parties is crucial to providing patients with information and advice leading to a good and personalized choice of further treatment and to maintaining good clinical and mental status of patients.

SHARED DECISION-MAKING IN NEPHROLOGY

The important aspect of communication with PD patients is giving them the opportunity to participate actively in the process of deciding on their future treatment modality [5]. One has to take into consideration the perspective of patients and their families and respect them. It applies to both medical aspects, in which we as healthcare professionals are experts, and to the lifestyle, personal needs, patients' work, and family status [6]. As healthcare professionals, we often feel obliged to advise patients on what is better for them in terms of treatment methods but also on other aspects described above. However, beyond medical details, it is highly probable that we do not see the big picture. The patient and the family might see their situation in a completely different way and have different priorities [7].

In the choice of kidney replacement therapy (KRT), physicians and nurses are heterogenous in advising patients to choose either peritoneal dialysis PD or HD, and this is based not only on the official medical guidelines but also on the personal subjective experience of nephrological staff. There are many factors influencing therapy choices, such as level of personal education, trends in the country or region, local economics, and others. Some patients have some absolute and/or relative indications and contraindications to one method or another, but the vast majority may benefit from either modality [8]. Hence, a lot of stress is put on shared decision-making between the patient, family, and nephrological staff [9, 10]. The 2020 guidelines: "International Society for Peritoneal Dialysis (ISPD) practice recommendations — prescribing high-quality goal-directed peritoneal dialysis" [11] aim to overcome educational barriers. The education of patients and shared decision-making has a significant place there. Hence, understanding different aspects and respecting patients' and families' decisions plays a crucial role in achieving good clinical results.

UNDERSTANDING DIFFERENT LANGUAGE LAYERS WE ARE SPEAKING AND HEARING

To respect patients' choices, we must understand the language they are speaking. According to Friedemann Schulz von Thun's theory of interpersonal communication, we all speak and hear in four different layers of communication which he called "a four sides model" [12].

Let's take an example of a nurse who is educating the patient on how to connect to the PD system. The nurse (speaker) says to the patient (receiver): "You have to connect more quickly and more firmly". The first platform is the factual level, which contains statements that are a matter of fact. At that moment, it is the information that the connection has to be performed firmly. The second level is self-revealing or self-disclosure, which informs about the speaker — motives, values, and emotions. The nurse, like everybody else, might have certain emotions toward the patient, or or to experience emotions which are completely independent from the current situation. However, while delivering the message emotions might be incorporated. The third level is the relationship layer informing about the relationship between the speaker and receiver. The fourth level is the appeal. That is the desire, advice, and instruction to achieve effects that the speaker expects but also what the receiver thinks the speaker wants, which sometimes is not really the case. We are involving here the imagination of both the

speaker and the receiver on what are the intentions of the other person. What one understands depends not only on what has been said but also on how it has been communicated, on the tone of voice, body language, and choice of words. What and how we are speaking depends not only on what we want to achieve but also on what is our current mood and what is our relationship with the receiver. Similarly, what the receiver understands depends not only on these speaker-related aspects but also on the receiver. The receiver may be in a bad mood, not only because of the situation "here and now", as psychotherapists name this state but also because of many different aspects influenced by "there and then", such as what happened to them one hour ago, one week ago. It may be something that happened between the speaker and receiver, or what happened to the receiver in a completely different situation, and the speaker might even not be completely aware of that. To build a more complex picture, the speaker and the receiver might not be acting on the same communication platform at the same time. For instance, the speaker is on the factual level, whereas the receiver perceives that as communication on the relationship level — for example, who is allowed to advise and who has to accept advice.

A similar situation happens when the nephrologist or nurse communicates an important message to the patient, e.g., about the diagnosis of kidney disease and the necessity for dialysis, or about the risk of Coronavirus infection. The art of effective communication is to play a double role. The first one is the role of the speaker or receiver in this communication. The second is the ability to look at the situation from a meta-position perspective — to try to understand the interlocutor, not only what has been communicated but how it could be misunderstood taking into account a different mood of the receiver, a different understanding of the body language of the speaker, and many other aspects.

LOSS. HOW GRIEF/BEREAVEMENT MAY INFLUENCE COMMUNICATION WITH THE CKD PATIENT

As one speaks about grief, we usually think about the loss of a relative or a friend due to death [13–15]. Recently we have been facing a very difficult situation with COVID-19, which had different severity but often resulted in many fatal cases [16]. People react in a very inconsistent way, and their reaction depends on many different factors — what information has been provided, how close they are to the involved people and what is the severity of the situation. In such situations, one may also experience grief or bereavement, even if one did not lose a family member or a friend.

Hence, grief is not only a reaction to death. It may be a reaction to any significant loss. For instance, dialysis patients may lose their previous lifestyles, jobs, hobbies, or habits. If this is a sudden situation, the information about the disease and restrictions may be a complete shock and perceived as a disaster for patients and their families. The information about the need for dialysis may completely disorganize the patient's life and her/his emotional condition [17].

In cases where there is no formal structured Patient Education Program (sPEP), patients who are supposed to start either modality of dialysis are often provided with the information in a very blunt and coarse way which does not allow them to fully understand it [18]. The sPEP is not only to inform the patient about dialysis modality. It is the whole concept of how the information should be delivered. The studies show that with both a shared decision-making approach and sPEP patients can choose a better dialysis modality in a more informed and conscious way, which results in better compliance, lower frequency of complications, and a more frequent choice of home treatment, which is extremely important during the pandemic. The sPEP usually consists of 3 meetings. One should follow ISPD guidelines on teaching patients [19] which recommend that patient education should use the VARK Learning Style. It consists of four tools: visual (V), aural/auditory (A), read-written (R), and kinesthetic/motor (K). Patients should be able to learn by seeing, hearing, reading, and touching devices.

Taking into account the complexity of the process and the enormous change in patients' life, they may perceive starting dialysis as bereavement [20]. The literature about grief describes five phases — please see Table 1 [21].

The first phase is denial. Once patients learn about the disease and the ultimate need for dialysis, they may deny that. It takes some time for the patient to accept it happened to him.

The next step is anger. The person perceived to be responsible for the situation may be the physician who treated the patient, but

Table 1. Phases of bereavement [21]

1.	Denial
2.	Anger
3.	Bargaining
4.	Depression
5.	Acceptance, reconciliation

also the messenger — the person who informed the patient about his condition and its implications. In the current COVID-19 situation, these feelings may be leveled at a friend, a stranger coughing in a shop or bus, a neighbor, or the government. That is why patients are sometimes angry with us, healthcare professionals. However, we should take into account that we are part of the healthcare system, and patients might experience some real problems with that and perceive us as co-guilty co-guilty for either worsening of the health condition, or at least of inconvenience, e.g. long waiting list for procedures. Sometimes the patient is right — probably we were not respectful enough or we made a mistake. Admitting that shows our openness and sincerity. The anger could also be directed against god or fate, but also the patient himself.

After the person copes with this, the next stage would be bargaining. The patient is negotiating the conditions of the change in life — with the healthcare professionals, himself, and god. In case of a viral infection, additional feelings may raise due to the necessity of quarantine or hospitalization. An example was the violations of quarantine by some individuals. Different mechanisms may play a role here, like not respecting other people or their health status, but also "bargaining" with the diagnosis and discipline.

The next phase of bereavement is depression. This is associated with the perceived severity of the situation. It is very individual. One cannot state that the depression of PD patient is less or more severe than that of a SARS-CoV-2-infected patient. Feelings are hardly comparable between people. Dialysis could be understood as a necessity but also perceived as being close to death. Similarly, in the case of infection, with so much information about fatal cases, the patient might feel enormous fear resulting in a depressed mood.

Afterward, when help and support are provided to the patient, the last stage in the proper course of bereavement should be acceptance and reconciliation. This is true both for a dialysis patient who has to adjust to the new situation, or for the person who either personally experienced the risk of death, or it was in his close neighborhood.

The length of those phases is very individual and differs from patient to patient. Some patients may develop long-term depression and need psychiatric consultations, antidepressant pharmacotherapy, and/or psychotherapy. Nevertheless, nephrology healthcare professionals as well as infectious diseases professionals are front-line care providers who deal with these symptoms and can offer help and support. Fortunately, some dialysis centers cooperate with psychologists and psychotherapists, and this support can be offered to PD patients.

REACTION TO DIFFICULT FEELINGS AND STRESS

In 1979 David Malan [22] described the triangle of internal conflict. It consists of three elements: feeling, fear/anxiety, and defense.

The feeling is a reaction to an external stimulus, a so-called stressor — information about self, family, health status, politics, economics, etc. In 2013, Damasio and Carvalho [23] studied the psychoneurological nature of feelings. They have divided the feelings into three groups: psychosomatic, psychological, and social feelings. In the first group, there would be thirst, hunger, and need for air. The psychological group is the widest. The feelings in this group are either nice such as pleasure, happiness, and joy, or difficult, for example, anger, pain, irritation, fear, pain, disgust, and loathing. In the last category, social feelings, the authors mentioned contempt, shame, compassion, and admiration.

Difficult feelings usually result in fear or anxiety. According to Jon Frederickson et al., [24] fear is the reaction to something threatening and known — war, sickness, or aggressive people. Anxiety is much deeper and much more general and unexplained. The sources of anxiety may be either forbidden or threatening feelings, trauma, or a mixture of these. There are certain symptoms of anxiety that one may observe. These are body reactions that Frederickson divided also into three groups, depending on the depth of anxiety. The least serious are these from the striated or skeletal muscles: hand clenching, sighing to relieve tension in the intercostal muscles and diaphragm, tensions in arms, shoulders, neck, legs, and feet,

jaw clenching, biting, and yawning. It could be helpful to observe the patient during any conversation. Healthcare professionals can also experience such symptoms.

More severe are the symptoms from smooth muscles: dry mouth and eye, tachycardia, high blood pressure, migraine, red face as a vascular reaction, cold hands and feet, bladder urgency and frequency, paruresis (inability to pass urine), shivers, bronchospasm, hyperventilation and subsequent fainting, gastrointestinal spasm, constipation, diarrhea, irritable bowel syndrome, nausea, vomiting, dyspareunia (painful sexual intercourse).

The most severe reactions are described as cognitive-perceptual dysregulation: hallucinations, dissociation, thought blocking, tunnel vision, and tinnitus (perception of sound when no corresponding external sound is present). Sometimes patients look as if they were not mentally present. Usually, this is not a conscious or intentional lack of attention. It might be a symptom of stress or anxiety and an indication that one should adjust communication. Similarly, we may also observe this in ourselves, when we are losing attention and our thoughts are drifting somewhere else. It is worth trying to understand what caused that situation. The content of the discussion, the form in which things have been communicated, or some other external circumstances? The presence of the second and third groups of body reactions makes realistic thinking and communication hardly possible. All three groups may be felt by an individual but also observed in a patient by a healthcare professional. Before communicating anything to the patients one has to decrease this level of anxiety (Frederickson — Intensive Short-Term Dynamic Psychotherapy).

As a natural reaction to anxiety, one develops personality defensive mechanisms. The type of defense mechanism depends on the severity of anxiety, and either temporary or permanent ability of the person to study reality, observe processes and other people, control own actions, as well as the ability to distinguish internal problems from external ones. The most common are listed in Table 2 [25].

All of us may experience fear or anxiety as a reaction to difficult feelings caused by a stressor, and due to that, all of us develop defensive processes. We describe in detail only a few of them that are probably often observed in severe somatic disease patients but also in healthcare professionals.

Table 2. Personality defense mechanisms [25]

1.	Denial
2.	Repression
3.	Acting out
4.	Rationalization
5.	Intellectualization
6.	Moralization
7.	Projection
8.	Idealization/Devaluation
9.	Introjection/Identification
10.	Projective identification
11.	Sublimation
12.	Reaction formation
13.	Omnipotence/Omnipotent control
14.	Turning against the self
15.	Splitting of the Ego
16.	Extreme dissociation/Fugue/Amnesia
17.	Isolation of affect
18.	Sexualization
19.	Regression
20.	Somatization
21.	Displacement
22.	Undoing

DENIAL

One may deny important and very difficult feelings. It is when the person has been told about a catastrophe, loss of a family member, serious disease, or any other significant threat. The approach originates from early childhood: "If I don't acknowledge it, it isn't happening" [26]. It is important to stress, this is an unconscious process. In crisis or emergencies, a capacity to deny them emotionally can be lifesaving. For example, denial may permit even heroic actions, as it may happen during the war. In contrast to the protective function of denial, it may act also auto-destructively, e.g., when the PD patient is ignoring the risk of a peritonitis episode, infectious precautious measures, or dietetic requirements to "magically" avoid any risk.

REPRESSION

Repression is motivated by forgetting or ignoring. According to Freud [27] "the essence of repression lies simply in turning something away, and keeping it at a distance, from the conscious". It happens when the person admits he/she is ill or has a problem but afterward seems to forget about that. The ex-

amples are "war neuroses", currently known as post-traumatic stress reaction (in the more severe version posttraumatic stress disorder, PTSD). Potentially, the recent situation with COVID-19 might have resulted in a significant number of such cases. As the unconscious defense mechanism, repression becomes problematic when 1. the patient fails to function because keeping disturbing ideas out of consciousness does not allow accommodating the reality, or 2. anxiety disturbs positive aspects of living, or 3. the condition leads to exclusion of the more successful ways of coping, e.g. preventing any PD potentially avoidable complications.

RATIONALIZATION

It is probably the most popular defense mechanism. Benjamin Franklin said, "it enables one to find or make a reason for everything one has in mind to do" [28]. There are two types of this mechanism. The first occurs when something bad happens, and we decide it was not so bad. It is called the "sweet lemon rationalization". The other one is when one fails to get something wanted, and one concludes that it was not so desirable. This is called the "sour grapes rationalization". This mechanism can be observed in either group of patients described in this article and usually in those well-functioning.

ACTING OUT

Acting out is a reaction seemingly not directly associated with a certain stress, feeling, or situation. It is the regulation of emotions in the areas or actions which are completely different from the original cause. Sometimes the acts are very aggressive, auto-aggressive, or even auto-destructive. They may reveal themselves in acts such as crushing plates, a chair or table, beating a partner, car speeding, risky sexual behaviors, breaking the rules of quarantine, extensive use of alcohol or other psychoactive agents or drugs outside the locally accepted frames, or drinking excess of water in case it's been prohibited, which may result in fluid overload, or even self-mutilation [29, 30].

PROJECTION

Projection and introjection represent two sides of the same psychological coin. In both, there is a lack of the psychological boundary between the self and external objects which, in psychology, represent other people. In the projection, feelings or attitudes generated inside the self are perceived as if they come from outside [31]. In some unfavorable circumstances, the patient does not like his own thoughts, attitudes, or reactions because he knows they are immoral, dangerous, unpolite, or just not fashionable, and is accusing the partner, the healthcare professional, or any other person of these intentions.

OMNIPOTENCE AND OMNIPOTENT CONTROL

Jean Piaget (1937) [32] and Peter Fonagy (2003) [33] described the phenomenon of primary egocentrism in the small child. A feeling that one can influence the whole surroundings is a critical dimension of self-esteem. One may experience infantile and unrealistic fantasies of omnipotence. In an adult person, this is associated with regression to childhood. The person seems to be aware of a certain issue or problem but desperately wants to control it fully or believes in his/her ability to control everything, whereas that ability is limited. One seems to believe that with some special means, one can do anything to change cruel fate, to reverse the disease or any other stressful fact or situation. "Although I am suffering from kidney disease, this will not change my life at all". "The diagnosis of COVID-19 has been made for me, but it doesn't mean anything. I will live my life as of now, without changing my lifestyle. I am a strong person, and this will neither impact me nor my family".

IDEALIZATION AND DEVALUATION

Small children, after a period of fantasies about their own omnipotence, gradually move towards fantasies about the omnipotence of the caregiver [34]. At this stage, the belief that parents are able to protect the child from all the dangers in life is very important. Later in our life, significant fears may create a need to believe that somebody will control these dangers to protect us. This is the moment when we use idealization, to protect ourselves from dangerous feelings. However, again, there is another side to this coin, which is devaluation. These two reactions are very close to each other although they are each other's opposite. The person who is experiencing serious anxiety may at one moment idealize the physician, nurse, family member, caregiver, or god, and on another day may completely devaluate the same person accusing him/her of worst intentions or behaviors, e.g., wrong medical treatment.

SUBLIMATION

This mechanism leads to shifting unliked or not-allowed feelings (or at least perceived by the individual as such) into some other areas or fields. This can be art, science, or work [25]. People can express their feelings in a way that their meaning can be channeled through acceptable activities. One can write poems and draw pictures. Some realize their emotions doing research. This mechanism of defense is perceived as a healthy one because, besides the psychological effects for the individual, it may bring positive values to society.

TURNING AGAINST THE SELF

This expression has been developed by Anna Freud in 1936 [35] and means redirecting the negative affect or attitude from an external object towards the self. For instance, the patient has been diagnosed with kidney disease or COVID-19 and is accusing himself of mistreatment or avoidance of some medical procedures or wrong lifestyle. Sometimes it is substantiated, sometimes exaggerated. However, patients may accuse themselves of the situation, which can lead to a significantly depressed mood, full depression, or even suicide. This mechanism is turned on when the correct directing of the feeling to the guilty person may be perceived as too dangerous, e.g., in the case of domestic violence, when it is much safer to accuse oneself than the aggressor. Some patients may use this mechanism also when the experience of disease is too difficult.

SPLITTING OF THE EGO

It is also called just splitting [25]. It has its origin in the preverbal period of the development of the person when the infant does not understand that caregivers may have both positive and negative features, good and bad experiences. The person who is using this mechanism may simplify the understanding of the reality or people by allocating either entirely good or entirely bad images to the person or situation. After the second world war, clinical studies on the authoritarian personality showed its deep consequences in helping to understand the world and its position. Hence, simplifying the perception of reality and dividing it into good and bad might help to decrease anxiety. Some authors associated this mechanism with a conservative right-wing attitude, but then it has been revealed that authoritarian personality has also liberal or left-wing forms.

ISOLATION OF AFFECT

Another measure to deal with anxiety and painful state is the isolation of feelings from thoughts. The affective aspect, experience, or idea can be sequestered from its cognitive dimension. In 1968 Lifton called it “psychic numbing” [36]. The experience is not obliterated from conscious experience, but its emotional meaning is cut off. The person who is in very serious danger looks as if he does not understand the seriousness of the situation and does not take it into account. The person is laughing it off, telling jokes as if that was not his difficulty or danger. This may be very annoying to the interlocutor because as healthcare professionals we want to help the patient and make him understand to cooperate in the course of their treatment. We, as physicians or nurses, may feel it is a malicious reaction leveled at ourselves. However, one has to understand that there is enormous anxiety underneath, and this is just a reaction. If we want the patient to cooperate — we have to decrease this anxiety first, and the way to do it is not to explain that the person is wrong, unprofessional, childish, or irresponsible. It may be helpful just to express that we see it, understand, empathize, and take it seriously. Once we decrease the patient’s anxiety, then we can try to inform the patient about the medical conditions or give our medical recommendations from a perspective that would be understood. Sometimes simple words work, like “I see you are very stressed” or “I see it may be difficult for you”. Sometimes we may realize we cover our own anxiety by talking too much. Sometimes it would work if we just waited until the patient reacts to what we are saying.

EXTREME DISSOCIATION, FUGUE, AMNESIA

The most difficult situations and emotions are sometimes too difficult for our brain to be consciously dealt with. The most difficult situations in childhood might be forgotten not because they were unimportant. On the contrary, they might have been too important and too stressful to be kept in the memory. They are not totally erased unless there is physical damage to the brain or its part, but they are kept deeply to protect the person from this emotion. Sometimes they come to consciousness in an uncontrolled way, and then they may completely disorganize the patient’s emotions,

personality, and life. That is why in extreme situations one may unconsciously use the dissociative defensive process to protect oneself from those emotions [37, 38].

REGRESSION

Every mother or father observed her or his child behaving in a difficult or stressful situation in a way that would be more appropriate for a much younger and less mature person. It means that the person returns to earlier behaviors due to anxiety. Also, adult people may use this mechanism [25]. I may appear as inappropriate or immature reactions, like laughing, which is an abnormal reaction to difficult information, or crying. It can be understood as a nonverbal call for help, typical of children.

SOMATIZATION

Sometimes difficult feelings and emotions may be realized as a somatic reaction of the body [25]. Anxiety is unconsciously moved to the body resulting in acute reactions or even chronic diseases. The acute reactions may include high heart rate, high blood pressure, headaches, abdominal pain, diarrhea, and constipation. They may disappear when the stress has been removed. Some people suffer from psychosomatic diseases, like peptic ulcers, coronary artery disease, different types of pain, or even fibromyalgia. First, we have to exclude real somatic reasons like infections, cancer, or vasculopathy before we diagnose these symptoms as psychology based.

DISPLACEMENT

One may observe that the person who has been reprimanded has later reacted with anger to another person, animal, or thing. People displace anger toward other people when the reaction to the person or situation that was the real reason is inappropriate, not allowed, or impossible [25]. Also, fear may be displaced, and might result in the development of different phobias: arachnophobia, cancerophobia, claustrophobia, agoraphobia, and acrophobia.

UNDERSTANDING DEFENSE MECHANISMS AND THEIR IMPLICATIONS

The difficulty of facing our interlocutor's defense mechanism is understanding they are the result of the patient's anxiety. They are neither aggression against us, nor blocking intentionally our help, nor trying to stop us or put us off. They are mostly unconscious reactions to a difficult situation. The most successful, but also difficult, way to decrease anxiety is just to tell the patient what we see their anxiety or anger caused by it. However, we have to adjust our communication to avoid the patient's feeling of being accused, assessed, or ignored. It is the time when we should be able to see the situation from the meta-position to understand what is happening. We experience our anxiety. However, once we understand this, our anxiety is lower than the patient's. We may control it — either to help ourselves or to help the patient to control the situation, and to allow us to help him or her. Putting ourselves in the meta-position may help us to understand that we are not always the real target of the patient's reaction. The real target might be his/her anxiety even though it looks as if the patient is fighting against us as healthcare professionals.

CONCLUSIONS

Patients suffering from CKD or serious infection may experience plenty of anxiety at different stages of their disease. Their reactions may also be very different, presented as defense mechanisms. We, healthcare professionals, should be able to help patients cope with their anxiety and to facilitate decision-shared while choosing the most suitable treatment modality.

However, to help others one needs to understand his/her own emotions, anxieties, and defense processes. Certainly, we, as nephrology healthcare professionals, are not fully prepared from a psychological point of view. We do not have enough psychological knowledge, experience, or enough time. Nevertheless, understanding what is happening emotionally to our patients and ourselves might decrease our own anxiety and anger, which would result in improvement in communication, potentially resulting in better preparation of patients for the therapy, better commitment and compliance, less frequent complications, lower hospitalization rates for medical emergencies.

CONFLICTS OF INTEREST

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References

1. Ronco C, Bellomo R, Kellum JA. Acute kidney injury. Lancet. 2019; 394(10212): 1949–1964, doi: 10.1016/S0140-6736(19)32563-2, indexed in Pubmed: 31777389.
2. Delles C, Vanholder R. Chronic kidney disease. Clin Sci (Lond). 2017; 131(3): 225–226, doi: 10.1042/CS20160624, indexed in Pubmed: 28057893.
3. van Haalen H, Jackson J, Spinowitz B, et al. Impact of chronic kidney disease and anemia on health-related quality of life and work productivity: analysis of multinational real-world data. BMC Nephrol. 2020; 21(1): 88, doi: 10.1186/s12882-020-01746-4, indexed in Pubmed: 32143582.
4. Brooks SK, Webster RK, Smith LE, et al. The psychological impact of quarantine and how to reduce it: rapid review of the evidence. Lancet. 2020; 395(10227): 912–920, doi: 10.1016/S0140-6736(20)30460-8, indexed in Pubmed: 32112714.
5. Clark AM, Lissel SL, Davis C. Complex critical realism: tenets and application in nursing research. ANS Adv Nurs Sci. 2008; 31(4): E67–E79, doi: 10.1097/01.ANS.0000341421.34457.2a, indexed in Pubmed: 19033741.
6. Wieling E, Negretti MA, Stokes S, et al. Postmodernism in marriage and family therapy training: doctoral students' understanding and experiences. J Marital Fam Ther. 2001; 27(4): 527–533, doi: 10.1111/j.1752-0606.2001.tb00345.x, indexed in Pubmed: 11594020.
7. Bello AK, Levin A, Lunney M, et al. Status of care for end stage kidney disease in countries and regions worldwide: international cross sectional survey. BMJ. 2019; 367: l5873, doi: 10.1136/bmj.l5873, indexed in Pubmed: 31672760.
8. de Jong RW, Stel VS, Heaf JG, et al. Non-medical barriers reported by nephrologists when providing renal replacement therapy or comprehensive conservative management to end-stage kidney disease patients: a systematic review. Nephrol Dial Transplant. 2021; 36(5): 848–862, doi: 10.1093/ndt/gfz271, indexed in Pubmed: 31898742.
9. Ladin K, Pandya R, Perrone R, et al. Characterizing Approaches to Dialysis Decision Making with Older Adults. Clinical Journal of the American Society of Nephrology. 2018; 13(8): 1188–1196, doi: 10.2215/cjn.01740218.
10. Wearne N, Kilonzo K, Effa E, et al. Continuous ambulatory peritoneal dialysis: perspectives on patient selection in low- to middle-income countries. Int J Nephrol Renovasc Dis. 2017; 10: 1–9, doi: 10.2147/IJNRD.S104208, indexed in Pubmed: 28115864.
11. Brown EA, Blake PG, Boudville N, et al. International Society for Peritoneal Dialysis practice recommendations: Prescribing high-quality goal-directed peritoneal dialysis. Perit Dial Int. 2020; 40(3): 244–253, doi: 10.1177/0896860819895364, indexed in Pubmed: 32063219.
12. Schulz von Thun F. Miteinander reden: Störungen und Klärungen. Psychologie der zwischenmenschlichen Kommunikation. Rowohlt, Reinbek 1981.
13. Freud S. Mourning and melancholia. In: Freud S. ed. The standard edition of the complete works of Sigmund Freud. Volume XIV. The Hogarth Press and the Institute of Psycho-Analysis, London 1964.
14. Bowlby J. Attachment and loss. Tavistock Institute of Human Relations Published by Basic Books, A Member of the Perseus Books Group 1982.
15. Onofri A. Il lutto. Psicoterapia cognitivo-evoluzionista e EMDR. Giovanni Fioriti Editore, 2015 .
16. Lai CC, Shih TP, Ko WC, et al. Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and coronavirus disease-2019 (COVID-19): The epidemic and the challenges. Int J Antimicrob Agents. 2020; 55(3): 105924, doi: 10.1016/j.ijantimicag.2020.105924, indexed in Pubmed: 32081636.
17. Karkar A. The value of pre-dialysis care. Saudi J Kidney Dis Transpl. 2011; 22(3): 419–427, indexed in Pubmed: 21566294.
18. Marrón B, Ostrowski J, Török M, et al. d.PD Clinics Eastern Europe. Type of Referral, Dialysis Start and Choice of Renal Replacement Therapy Modality in an International Integrated Care Setting. PLoS One. 2016; 11(5): e0155987, doi: 10.1371/journal.pone.0155987, indexed in Pubmed: 27228101.
19. Figueiredo AE, Bernardini J, Bowes E, et al. A Syllabus for Teaching Peritoneal Dialysis to Patients and Caregivers. Perit Dial Int. 2016; 36(6): 592–605, doi: 10.3747/pdi.2015.00277, indexed in Pubmed: 26917664.
20. O'Hare AM, Richards C, Szarka J, et al. Emotional Impact of Illness and Care on Patients with Advanced Kidney Disease. Clin J Am Soc Nephrol. 2018; 13(7): 1022–1029, doi: 10.2215/CJN.14261217, indexed in Pubmed: 29954826.
21. Kübler-Ross E. [Elisabeth Kübler-Ross in Lausanne. Learning life thanks to the dying. Interview by Brigitte Kocher]. Krankenpfl Soins Infirm. 1985; 78(11): 77–78, indexed in Pubmed: 3853025.
22. Malan D. The Dialogue of Psychotherapy and the Two Triangles. Individual Psychotherapy and the Science of Psychodynamics. 1979: 74–94, doi: 10.1016/b978-0-407-00088-9.50014-1.
23. Damasio A, Carvalho GB. The nature of feelings: evolutionary and neurobiological origins. Nat Rev Neurosci. 2013; 14(2): 143–152, doi: 10.1038/nrn3403, indexed in Pubmed: 23329161.
24. Frederickson JJ, Messina I, Grecucci A. Dysregulated Anxiety and Dysregulating Defenses: Toward an Emotion Regulation Informed Dynamic Psychotherapy. Front Psychol. 2018; 9: 2054, doi: 10.3389/fpsyg.2018.02054, indexed in Pubmed: 30455650.
25. McWilliams N. Psychoanalytic Diagnosis. Understanding Personality Structure in the Clinical Process. Second Edition. The Guilford Press, New York, London 2011.
26. Fraiberg S. The Magic Years: Understanding and Handling the Problems of Early Childhood. Fireside, New York 1959.
27. Freud S. Repression. Standard Edition, 14 1915: 147.
28. Silverman K. Benjamin Franklin: Autobiography and Other Writings. Penguin, New York 1986.
29. Aichhorn A. Wayward youth. Putnam, London 1936.
30. Fenichel O. The Psychoanalytic Theory of Neurosis. Norton, New York 1945.
31. Kernberg OF. Object Relations Theory and Clinical Psychoanalysis. Jason Aronson, New York 1976.
32. Piaget J. The Construction of Reality in the Childhood. Basic Books, New York 1937.
33. Fonagy P. Genetics, Developmental Psychopathology, and Psychoanalytic Theory: The Case for Ending Our (Not So)

Splendid Isolation. Psychoanalytic Inquiry. 2003; 23(2): 218–247, doi: 10.1080/07351692309349032.
34. Bergmann MS. The Anatomy of Loving: The Story of Man's Quest to Know What Love is. Columbia University Press. Columbia University Press, New York 1987.
35. Freud A. The Ego and the Mechanisms of Defence. International Universities Press, New York 1936.
36. Lifton RJ. Death in Live: Survivors in Hiroshima. Random House, New York 1968.
37. Boulanger G. Wounded by Reality: Understanding and Treating Adult Onset Trauma. Mahwah, NJ Analytic Press, The Analytics Press, Mahwah NJ 2007.
38. Grand S. The Reproduction of Evil: A Clinical and Cultural Perspective. Hillsdale, NJ Analytic Press 2000.