PSYCHOLOGICAL IMPACT OF CHRONIC KIDNEY DISEASE ON DIALYSIS TEAM

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INTRODUCTION

Psychosocial research (Shipper, 2011; Pruchno, 2009) produces more contributions about the psychological impact of Chronic Kidney Diseases (CKD) in patients than in dialysis teams, even if the teams have a pivotal role in the care process. A deeper comprehension of the functioning of the dialysis teams may help the whole care process. This qualitative research aims to assess the psychological impact of CKD on physicians and nurses to highlight their strengths as well as their difficulties.

AIMS

Three goals:
1.To search for issues of dialysis teams
2.To evaluate specific relational differences between physicians and nurses
3.To compare the functioning of the peritoneal dialysis (PD) team and the hemodialysis (HD) team

METHODS

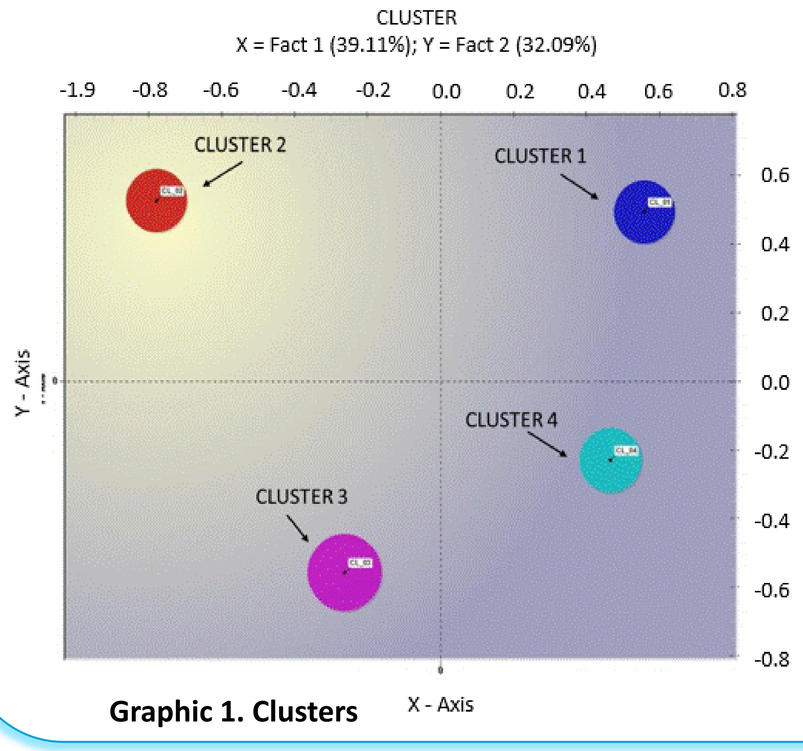
Two Focus Groups were conducted: the first one with PD team and the second one with HD team from ASST Spedali Civili in Brescia. Focus Groups were videotaped and transcribed.

ANALYSIS

The transcripts were analyzed using the textual analysis software T-LAB (Lancia, 2004). Two different analyses were performed:
1. Thematic Analysis of elementary contexts
2. Specificity Analysis.

RESULTS

The thematic analysis of contexts implemented overall corpus of interviews showed a four-cluster solution (Graphic 1). Clusters identify four thematic areas about physicians and nurses perceptions. As for the first aim all clusters show issues that PD and HD teams take on with the chronic patients and their family, we labeled these clusters "**Emotional Distress & Risks**", "**Resources & Limits**", "**Patient Education & Training team**" and "**Chronic Disease & Relationship Care**" (Table 1). Clusters explained, 33%, 23%, 23% and 22% of the data variance. As for the second aim the specific analysis showed the differences between physicians and nurses in perspective care: The nurses show more resources (for example, to get help from caregiver) and more fatigues (for example, to work for many years with the chronic illness without the psychological support) than physicians by supporting the patients. Regarding the third aim the differences between the two dialysis teams seem less important than the ones between physicians and nurses.



Graphic 1. Clusters

CLUSTER 1 23% Patient Education & Training Team	X²	CLUSTER2 22% Chronic Disease & Relationship Care	X²	CLUSTER3 33% Emotional Distress & Risks	X²	CLUSTER 4 23% Resources & Limits	X²
UNDERSTAND	30.73	PROBLEMS	38.82	EMOTIONAL DISTRESS	20.03	DINAMIC	23.84
TREATMENT	23.11	WORK	36.33	HEALTH WORKER	16.23	RESOURCE	22.12
TRAINING	22.35	WIFE	25.16	SPACES	16.23	RELATIONSHIP	20.12
RESEARCH	22.35	AGE	20.69	ROOM	14.06	FEAR	17.64
MEENING	20.25	TURN	18.90	MACHINE	14.06	TO CARE	16.38
PERSPECTIVE	19.73	ONLY	18.90	LOST	9.76	OWN	14.90
DOGGIE	19.15	PLESURE	18.90	ILL	9.17	TO LEAVE	14.23
NEEED	18.69	HOME	18.21	DIALYSIS PATIENT	9.17	EMBRACE	12.62
RELATIONSHIP	18.20	TIPOLOGY	17.87	WEEK	9.17	DISEASE	11.28
SETTING	17.84	SON	15.12	INSTRUMENT	8.89	PSYCHOLOGICAL	8.95

Table1. Lexical Units of Each Cluster

CONCLUSION

The peritoneal dialysis (PD) team and the hemodialysis (HD) team are exposed to different risks like burnout and dehumanization towards the patients. In both teams the relationship care is the most challenging resource for physicians and nurses to improve not only patient's well being and caregiver's well being but dialysis teams' well being too. In addition, in HD and PD teams it is important to talk about "Emotional distress and Risks" during the care-work to discover "Recourses and Limits". This is one possible way to go beyond the patient or team demotivation care. Moreover the clusters do not identify specific differences between dialysis teams functioning but among the role of nurses and physicians in patient education. In both teams only nurses discussed about the importance of "Patient Education". Whereas, the PD and HD physicians explained, in particular, the issues of working in a team because there aren't the adequate settings or an effective training team. A deeper knowledge of these aspects may help to implement psychosocial intervention to prevent the burnout of the dialysis teams and to improve its functioning, job satisfaction and quality of relationships with patients and caregivers (Bertoni et al., 2015). Another advantages of psychological intervention are to prevent psychopathology risks, to promote multidisciplinary care and to develop a more efficient process to patient and caregiver education as well.

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