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Psychiatric Problems of Haemodialysis: Their Treatment by Hypnosis

By DAVID L. SCOTT

Renal dialysis has been a life-saving miracle for the 'chosen few', but has created major moral, social, financial, psychological and interpersonal problems.

Initially, technical problems dominated the literature. As dialysis became more routine, other aspects have been covered. Cramond, Knight and Lawrence (2) noted that psychological issues had only been briefly referred to. By 1967 the only observations by psychiatrists were by Wright, Sand and Livingston (10), and Shea, Bogdan, Freeman and Schreiner (8), who considered that the emotional reaction could constitute the biggest obstacle to successful rehabilitation. The fundamental question is: having saved a human life—what quality of life is it to be?

De-Nour, Shaltiel and Czaczkes (4) considered that dialysis can create inexpressible aggressive feelings; that the defence mechanisms mobilized against these are brittle, and consequently that small stresses can lead to anxiety and depression, and so considerably raise the suicide risk. Abram, Moore and Westervelt (1) noted life-threatening tendencies in 192 out of 3,478 dialysis patients (21 successful suicides).

Tiredness (aggravated by chronic anaemia), headaches and fleeting pruritus—which may become continuous—can also occur. Worry about dialysis coupled with itching easily initiates insomnia. Improving the patient's morale is not only of immense benefit to him; it also raises staff morale and improves interpersonal relationships (Halper (6)).

The Intensive Care Unit at Whiston Hospital has facilities for emergency haemodialysis and peritoneal dialysis. The chronic haemodialysis of just one patient keeps the staff trained, and has also saved the life of this patient. The writer has no opportunity to treat other haemodialysis patients.

Case History

Housewife, aged 31. Two children. Acute nephritis at age 14. April 1969—maintenance haemodialysis commenced; initially 2 × 10 hours weekly, occasional 3 × 10. Since January 1972, 3 × 10 weekly at nights. Insomnia: poor sleep since 1968. Originally on promethazine (Phenergan)—dosage unknown; progressive drug changes and increases, up to methaqualone (Mandrax), 1,000 mg., at night. When seen to assess value of hypnosis (March 1971), had been on glutethimide (Doriden), 750 mgm plus diazepam (Valium) 30 mg. nightly since October 1970 (still not sleeping well!)

Insomnia not the only problem. Continual pruritus drove her 'screaming mad at times'. Anaemia (6·0 gm. %) led to lethargy; she was depressed—found once with her shunt disconnected (? suicide attempt). Home and hospital interpersonal relationships very bad.

Hypnotherapy

Commenced 14 March 1971—initial session 45 mins. Nine more sessions of 10–15 mins. up to 19 April. Aims:

(i) Conditioning of hypnosis, so that induction took only seconds.

(ii) Training in autohypnosis—patient using this at home to aid onset of sleep (by letting hypnosis 'drift' into sleep).

(iii) Morale-boosting by ego-strengthening (Hartland (7)).

(iv) Training to 'control' pruritus and tension headaches (through autohypnotic relaxation).

(v) Instruction in Calvert Stein's clenched first technique (9)—used to gain confidence prior to coming to hospital for dialysis.

19 April. Handed in remaining sleeping tablets to physician. Staff noted she was much brighter. Still mild pruritus—taking diazepam 10 mg. nightly for this. Two reinforcing hypnotic sessions December 1971. Since January on night dialysis, taking methaqualone 250 mg. on dialysis nights. Recently many problems—shunt failures—worried and depressed; has become disinterested in hypnosis. Past 2 months, taking chlormethiazole (Heminevrin), 1,000 mg. at night (writer was not informed about this). Home and staff relationships have remained good.

Comments

Psychiatrists are becoming increasingly involved in psychiatric problems of haemodialysis. Drug therapy may lead to polypharmacy, which is undesirable in these patients. Hypnosis can offer a better alternative.

One cannot compare these circumstances—one isolated patient—an 'outsider' doing the hypnosis—few of the medical staff even knowing about this—with a proper dialysis unit using an hypnotically-orientated psychiatrist as part of the team with full recognition and co-operation at all staff levels; also the tremendous advantage of inter-patient mutual aid (as seen in obstetric-hypnosis clinics).

Another possible use of hypnosis is modification of the patient's attitude towards food. Shea *et al.* (8) noted that these patients often asked for non-permitted foods and became aggressive when these were refused. Fogelman and Crasilneck (5) describe this use of hypnosis.

In this case, hypnosis was carried out during dialysis. Theoretically it is better for this to be done the day *after* dialysis (writer's hindsight?); the patient would then be in peak condition and more attentive to the therapist; uraemia clouds the mind.

The hypnotherapist should be a doctor working *outside* the team; rapport should *not* be passed on to dialysis staff. DeNour and Czaczkes (3) noted that they become possessive and overprotective—writer considers this contraindicates staff involvement with hypnosis.

Techniques of hypnotic induction, deepening and conditioning, etc., are described in standard text-books. The writer thanks Dr. E. Sherwood-Jones, physician in charge, I.T.U., Whiston Hospital, for permission to treat and quote his case.

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