

Evidence on spouse responses to illness as a guide to understanding and studying spouse responses to living organ donation

Although living kidney donors receive praise from friends and coworkers for their selflessness, recent studies report that members of the immediate family may not be as supportive. Reports of conflict surrounding living organ donation include divorce between the donor and the donor's spouse. The purpose of this review of the literature is to (1) discuss the spousal role when confronted with a partner's illness, (2) explore the current research describing the spouses of patients with heart disease and cancer, various transplant recipients, and living organ donors, and (3) identify the need for future research to explore the experiences and needs of the spouses of living kidney donors. Because the attitudes of donor family members, especially spouses, may affect the decision to donate and the satisfaction with recovery from donation surgery, it is critical to know how the spouses of living kidney donors view kidney donation. This knowledge may be instrumental in promoting family harmony and donor recovery and wellness. (*Progress in Transplantation*. 2006;16:117-126)

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Notice to CE enrollees:

A closed-book, multiple-choice examination following this article tests your ability to accomplish the following objectives:

1. Identify the spousal role during illness and recovery
2. Understand the psychological effects of spousal responses to living organ donation
3. Identify the top stressors related to spousal response to living organ donation and acute illness

In the past decade, the number of living kidney donors who are biologically related to the recipients has nearly doubled, and the number of living unrelated kidney donors increased nearly 15-fold.¹ New evidence suggests that familial emotional disequilibria occur during living related and unrelated organ donation.² Because the attitudes of donor family members, especially spouses, may affect the decision to donate and the satisfaction with recovery from donation surgery, it is critical to know how the spouses of living kidney donors view kidney donation. This knowledge may be

instrumental in promoting family harmony and donor recovery and wellness. The purpose of this review of the literature is to (1) discuss the spousal role when confronted with a partner's illness; (2) explore the current research describing the spouses of patients with heart disease or cancer, various transplant recipients, and living organ donors; and (3) identify the need for future research to explore the experiences and needs of the spouses of living kidney organ donors.

Spousal Role in Illness

Seventy percent of adult Americans are married or have been previously, and the most common support person identified by patients is their spouse.³ An individual's adjustment to illness and recovery are associated with the social, emotional, and physical adjustment of the spouse. Many studies have described the impact of spousal support on patient outcomes in the past several years; however, these studies have several limitations that are summarized in the Table. First, studies describing the effect of spouses on patient outcomes have primarily involved white populations and many have not reported the race and ethnicity

Research on spouses of patients with cardiac disease; heart, lung, and kidney transplant recipients; and living donors

Author(s)	Year	Purpose	Design	Sample size and characteristics
Kurz ³	2001	To explore what life is like for healthy spouses following their partners' lung transplantation	Based on symbolic interactionism	12 spouses from 8 states all from listerv of lung transplant candidates Age range, 40-66 years Time since transplantation, 4-60 months
Banithia et al ⁴	2002	To investigate the relationship between coping and distress levels of patients faced with prostate cancer	Longitudinal randomized clinical trial	154 couples; convenience sample; all spouses were women Mean age, 62 years 32.6% completed some college 82.9% were white
Martensson et al ⁵	2001	To describe decisive situations experienced by spouses of patients with heart failure	Critical incident technique	23 informants, 15 women and 8 men Spouses of patients with severe heart failure strategically chosen to ensure maximum variation in demographics 57% completed elementary school 26% completed college/university
Persson et al ⁶	1998	To explore spouses' views following the diagnosis of acute lymphocytic leukemia of partner	Taped interviews	9 participants, nonrandom, convenience sample Mean age of spouses, 60.5 years Mean age of partners, 63.3 years 4 spouses with gainful employment; 5 partners with no gainful employment
O'Farrell et al ⁷	2000	To determine prevalence of distress in spouses of patients undergoing cardiac rehabilitation, heart disease stressors, demographic variables, and specific intervention needs	Cross-sectional analysis	213 female spouses of patients undergoing cardiac rehabilitation
Baider et al ⁸	1998	To examine the adjustment of married couples to cancer in attempt to understand its dynamic over the course of 1.5 years from diagnosis	Interview, prospective study	133 married cancer patients and spouses 67 reached the T4 mark 80% of patients were men; 81% of patients were women
Bohachick et al ⁹	2001	To explore the psychosocial impact of heart transplantation on spouses and compare the adjustment of spouses and their partners	Panel design, with measurements taken at 2 time points for patients and their spouses	45 couples, waiting for a heart transplant 82.3% of patients were women Mean age, 48 years Completed high school, 40% 80% received a transplant within 6 months of participation
Collins et al ¹⁰	1996	To identify areas of spouse's life as affected by heart transplantation	Cross-sectional, comparative design with survey research methods	85 spouses; 90.5% were women and 94% were white Average age, 51 ± 8 years Mean time being married, 26 ± 11 years
McCurry and Thomas ¹¹	2002	To explore the experiences of spouses of heart transplant recipients using a qualitative design	Phenomenological	7 participants, nondirective interview methodology, all participants were women Age, 43-65 years Time since transplantation, 2.4-8.9 years; average, 4.3 years Education, 11-16 years

Tools	Potential strengths and limitations
Written surveys and taped telephone interviews Family Inventory of Life Events and Changes—before interview Center for Epidemiological Studies Depression Scale	<ul style="list-style-type: none"> (+) Length of interviews (+) Theme development (+) Men and women sample (-) Not exactly clear on methodological approach (-) Sample size (-) All participants had high incomes (-) Only presents view of 1 family member/spouse
Dyadic Adjustment Scale—quality of romantic relationships in married or unmarried couples Impact of Events Scale Revised—intrusion, avoidance and hyperarousal Profile of Mood States Prostate Cancer Index—urinary, bowel and sexual functioning	<ul style="list-style-type: none"> (+) Discussion of future directions (+) Theoretical/conceptual orientation presented (+) Psychometrics of tools discussed (+) Multisite (-) All spouses were women (-) Homogenous sample
Semistructured interviews in 2 cities in Sweden	<ul style="list-style-type: none"> (+) Critical incident technique (+) Conceptual orientation (+) Clinical implications discussed (-) Critical incident technique (-) Small sample
Tape-recorded interview for 1 hour; open ended and covered everyday life before disease, the practical implications of entire situation, and how couple solved problems	<ul style="list-style-type: none"> (-) Conceptual orientation of empowerment only briefly discussed
Brief Symptom Inventory Heart Disease Hassles Scale Coping Strategies Inventory Miller Intimacy Scale McMaster Family Assessment Device	<ul style="list-style-type: none"> (+) Theoretical orientation (+) Psychometrics of tools provided (-) Operational definitions (-) Nonrandom not necessarily representative (-) All female population (-) Length of time between cardiac event and actual participation was variable
Brief Symptom Inventory Family Adaptability and Cohesion Scales (FACES III) Impact of Events Scale	<ul style="list-style-type: none"> (+) Tables reflective of research findings (+) Psychometrics of tools offered (-) Lack of design description (-) Lack of conceptual orientation (-) Small groups (-) High drop out (-) Limited cultural/ethnicity
Psychosocial Adjustment to Illness Scale	<ul style="list-style-type: none"> (+) Theoretical framework (+) Psychometrics of tool discussed (-) Convenience sample (-) Primarily female sample
Spouse Transplant Stressor Scale Family Inventory of Resources for Management Jalowiec Coping Scale Ferrans and Powers Quality of Life Index 6-item rating form	<ul style="list-style-type: none"> (+) Conceptual orientation identified (+) Multiple centers (+) Psychometrics for tools identified (+) Pilot study (+) Implications for nursing practice (-) Nonrandom sample (-) Small sample size (-) Primarily female sample
N/A	<ul style="list-style-type: none"> (+) Discussion of conceptual orientation (+) Thematic development (-) All spouses were women

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Author(s)	Year	Purpose	Design	Sample size and characteristics
Manne et al ¹²	1996	To determine association between positive and negative aspects of spouses' responses and psychological adjustment	Descriptive, correlational	158 individuals with cancer; 88 were men and 94% were white Mean age, 56 years Median income, \$50 000 50% completed college
Collins et al ¹³	2000	To compare perceived QOL in spouses of heart transplant recipients before transplantation and 1 year after transplantation	Survey research methods	Nonrandom, convenience sample; 72 spouses of heart transplant patients; primarily white (94%) and women (89%) Mean age, 51.5 years Mean age of candidates, 53.9 years Mean time being married, 26.2 years Median income, \$40 000 Average time waiting for a donor, 222 days
Chen et al ¹⁴	2002	To explore the impact of in-home defibrillators on postmyocardial infarction patients and their spouses	Semistructured interview designed to probe perceptions	15 patients, and 16 significant others Patients' average age, 59 years Spouses' average age, 55 years 1 Latino
Starzomski and Hilton ¹⁵	2000	To examine process of patient and family adjustment to kidney transplantation To compare dialysis and no dialysis before transplantation	Exploratory study; longitudinal and cross-sectional design used simultaneously	20 recipients and partners; longitudinal and cross-sectional 3 points before transplantation, and 3 and 6 months after transplantation (all deceased donor organ) 47 recipients and partners cross-sectional at least 1 of 3 points in time (deceased donor organ and living donations) Mean age, 52 years
Schulz et al ¹⁶	2001	To answer how well and in which ways families cope with liver donation, either living or deceased donor organ	Retrospective pilot study	Of 50 participants, 20 received a living related liver donation, and 30 received a deceased donor organ Mean age of mothers, 42 years Mean age of fathers, 37 years Mean age of children in living related liver transplantation, 5 years Mean age of deceased donor organ recipients, 8

of the sample. Many studies lacked conceptual orientation regarding spousal support and there has been little consistency in the instruments used to measure this phenomenon. In addition, most studies have used quantitative approaches with few qualitative studies to explore spousal support in depth. Finally, and of particular relevance to the living donor population, most studies have focused on patients with chronic or life-threatening illnesses, and not those with acute conditions who are expected to recover fully.

The familial and social support literature has called attention to the relationship of marital support and well-being. Banthia et al⁴ report that the correlation between social support and effective coping with illness is stronger when the spouse provides support. It is believed that the married relationship helps ameliorate the consequences of stress, resulting in a more positive physical and mental response to illness than that of unmarried persons.⁵

Some authors assert that support provided by spouses stems from a perceived reciprocal obligation to support each other in difficult situations.⁶ Spouses often provide instrumental assistance with medica-

tions and activities of daily living.⁷ Apart from coping with the particulars of a life-threatening disease, the spouse is required to adjust family and occupational roles, lifestyle, and patterns of living to maintain family well-being.⁷

Psychological distress affects not only the patient, but may also expose spouses to risks as great as or greater than those experienced by the patient. Illness can place restrictions on spouses' lives and thrust them into new situations for which they may be unprepared.⁸ Spouses of ill patients may assume the role of caregiver, take on added household responsibilities, attend medical visits, and help make treatment decisions. They also are left with the burden of knowing that their loved one has a potentially life-threatening illness.⁹ Therefore, spouses have the ability to influence recovery, but may be less able to do so because of their own level of stress, adjustment challenges, and the coping demands placed on them.⁸

Spousal social adjustment has been shown to be associated with successful patient rehabilitation, even more so than demographic and disability related factors.⁶ Overall, studies have demonstrated that sustained

Tools	Potential strengths and limitations
Perceived supportive spouse behaviors Perceived negative spouse behaviors Functional disability Psychological distress and well being	(+) Theoretical orientation (+) Tables and figures (-) No operational definitions (-) Small sample
Quality of Life Index Spouse Transplant Stressor Scale Jalowiec Coping Scale 6-item rating form	(+) Quality of life defined (+) Psychometrics for tools identified (+) Variety of tools (-) No conceptual framework (-) Limits and implications for nursing not identified
Semistructured interviews; verbatim taped transcripts	(+) Review of literature that involved quantitative methods (+) Thematic development (+) Homogeneity of sample (-) All participants were women (-) Analysis description was minimal
Family Inventory of Life Events and Changes Family Inventory of Resources for Management Feetham Family Functioning Survey Sense of Coherence Scale Uncertainty Stress Scale Sickness Impact Profile	(+) Theoretical framework: family stress theory (+) Operational definitions of adjustment, family well being, uncertainty (+) Psychometrics for tools discussed (-) Nonrandom sampling implied (-) Small sample size (-) Lacking ethnocultural diversity
Family Impact Scale Coping Health Inventory for Parents Questionnaire on satisfaction with life Children: Quality of life questionnaire for children	(+) Theoretical orientation, quality of life (+) Generation of hypothesis (-) Small sample size (-) Operational definition (-) All recipients were children

social and familial support has a positive effect on long-term recovery.^{6,10}

Spouses of Patients With Cardiac Disease

The research literature indicates that spouses of patients with heart disease have been questioned about their experience. Using a qualitative method known as critical incident technique, Martensson et al⁹ approached 23 spouses of heart failure patients. Spouses acknowledged positive experiences when they felt included in decision making regarding the care provided to the patient, and when a member of the healthcare team listened to them. Callahan¹⁷ describes spouses of patients with heart disease as “vigilant illness partners” who deal with uncertainty of the ill spouse treatment outcome. Research involving spouses of heart transplant and lung transplant recipients have further supported the conclusions of Callahan that spousal education, information sharing, and social support play a key role in the well-being of the patient and minimize negative coping strategies.^{3,11,17,18}

Disengagement and negative coping strategies were reported in a cross-sectional analysis of 213 female

spouses of patients undergoing cardiac rehabilitation.⁷ Distressed spouses used significantly more negative coping strategies than the nondistressed spouses when faced with numerous stressors. The most common stressors reported by spouses were those related to (1) worry about treatment, (2) recovery and prognosis, (3) moodiness of patient, (4) returning to work, and (5) financial concerns. Sexual concerns, helplessness, or apathy on the part of the patient and increased spousal responsibility were also reported in other studies of spouses of individuals with heart disease.^{7,11} Distressed spouses reported less intimacy in their marriage, difficulties falling asleep, and statements of feeling tense. As mentioned earlier, spouses have the ability to influence recovery but may be less able to do so effectively as a result of the coping demands and other stressors placed on them in addition to their own level of stress.

Spouses of Patients With Cancer

Spouse functioning is a pervasive determinant of patient functioning and is well discussed throughout the cancer literature.^{4,6,8,12} Scores on measures of social support, distress, hopelessness, and uncertainty by the

well spouse have been found to account for a significant portion of the variance on the ill spouse's physical and emotional adjustment.⁸

The importance of negative responses by a family member in psychological outcomes of ill members can not be discounted.¹² Manne and colleagues^{12(p119)} examined 158 couples facing breast cancer. Their findings suggest that "perceived negative aspects of close relationships among patients with cancer should be the focus of further examination." Remarkably, negative spouse behaviors have been found to have stronger effects on mental health than positive spouse behaviors. These negative responses have been shown to influence the development and/or maintenance of psychological distress throughout the course of the disease.^{7,12}

Persson et al⁶ interviewed 9 spouses of persons with cancer regarding their everyday life experiences throughout their partner's illness and treatment. Spouses reported needing emotional first aid for their own well being, which in turn, would better enable them to support their ill partners. In addition, spouses wished to be more knowledgeable about the course of the disease. The notion of further education supports the findings of Wicks et al¹⁹ that spouses desire to fortify their ability to assist their partners and solve problems with greater knowledge.

Banthia and colleagues⁴ examined the effects of problem solving, coping styles, and strength of dyadic (married relationship) on the psychological distress in 126 couples confronted with prostate cancer. Their findings suggest that patients respond differently than their spouses to the demands associated with cancer. Further, the couples reported that a stronger dyadic relationship provided resiliency to overcome impositions to family functions.

Finally, in their prospective study of the relationship of cohesion and distress in cancer patients and spouses, Baider et al⁸ agree with Banthia⁴ that couples with weaker dyads report more frequent use of avoidance behaviors. All studies presented suggest that the development of screening tools could identify couples that are at risk for negative psychological outcomes. This identification would optimize resources for cancer patients as well as their spouses and therefore empower each member of the couple to help each other.

Spouses of Heart and Lung Transplant Recipients

Support persons for transplant recipients are considered vital to the success of treatment. In some centers, candidates for heart transplantation are required to name one primary support person, who agrees to share both the transplant experience and the responsibilities for ongoing care in the immediate posttransplant period (6 weeks to several months). Bohachick and colleagues⁹ report that in most cases, this individ-

ual is the recipient's spouse; again, underscoring the importance of this role and the need for study of the experience of the spouses in transplantation.

In 1996, Collins et al¹⁰ were the first to explore the common stressors experienced by 85 spouses of heart transplantation candidates. Preliminary psychometric data on their Spouse Transplant Stressor Scale indicated that almost two thirds of the spouses experienced a great deal of stress during the heart transplant waiting period. The top stressors of spouses were directly linked to the transplantation experience and its uncertainty, not socioeconomic stressors or responsibility stressors.

In their follow-up study,¹³ the investigators noted that spouses reported significantly higher satisfaction with their families in the period after transplantation. Conversely, the spouse's overall level of perceived health showed a moderate decline. The literature affirms that a family member's health may decline after a life-threatening event involving another family member.^{12,13} The overall perceived quality of life in spouses did improve following the transplantation as did the specific factors influencing quality of life such as family satisfaction, coping styles, and socioeconomic satisfaction.

McCurry and Thomas¹¹ intensively explored the personal experiences of 7 female spouses of heart transplant recipients to examine coping strategies, stressors, and quality of life issues. Again, the spouse's experience was seen as one of vigilance with the "undertaking of functions such as paying bills, running the farm, and an increased reliance on faith." In their qualitative study of 7 female spouses of heart transplant recipients, Bohachick⁹ agree with McCurry and Thomas¹¹ and Kayler²⁰ that the transplant healthcare team should develop means to aid spouses lower their vigilance once their partners recuperated from surgery and survived the critical period for organ rejection. This kind of anticipatory guidance could enable the well spouse to effectively grapple with changes throughout the course of the transplant process.

Meanwhile, Kurz's³ interviews with 12 spouses of lung transplant candidates or recipients suggest that caregiver strain is evident with different events, such as new crises of infection or rejection. Spouses who were balancing multiple roles and tasks had shown the most caregiver strain.

Kurz³ recommends that transplant recipient comparisons across different types of organ transplantation be made cautiously. Primary disease symptoms, rates of survival and rejection, and postoperative complications differ significantly between heart, lung, and kidney transplantation. Notably, alternative treatments to delay death vary greatly by organ type. Kidney and heart transplant recipients have "technological bridges available to extend the time to transplant,"^{3(p354)} which are absent for liver transplant recipients. Healthcare providers ought to address these factors when assessing

the transplant family for increased caregiver strain and in assisting all family members to activate positive coping strategies.^{11,14,18}

Kidney Transplantation Successes

Because of increasingly positive outcomes of kidney donation, both living and deceased donor donations have increased significantly over the past few decades. Between 1988 and 1996, the 1-year survival rates for grafts from living donor and deceased donor organs were 93.9% and 87.7%, respectively. Transplant professionals at several transplant centers have also reported that the 10-year living donor graft survival rate is superior to deceased donor organ transplantation.²¹⁻²⁵ Furthermore, living kidney donation has also been associated with improved socioeconomic and quality of life outcomes in both the donor and the recipient. Several transplantation professionals currently conclude that the best treatment for end-stage renal disease is to avoid dialysis with preemptive transplantation using a living donor.^{1,21,26}

Positive outcomes of living donation coupled with technological advances such as the use of plasmaphereses to decrease rejection from donors formerly viewed as incompatible, have led several transplant centers to broaden the criteria for living kidney donors beyond blood relatives to highly motivated donors who have a strong emotional bond with the recipients such as spouses and friends.^{23,25-28} These developments, coupled with the growing acceptability of living donation, have resulted in an increase in the proportion of living kidney donors when compared with deceased organ donors. In the United States alone, the percentage of living kidney donations was close to 49% (N=6647) in 2006.²⁹

Spouses of Kidney Transplantation Recipients

In their exploratory study of 67 families and spouses of kidney transplant recipients, Starzomski and Hilton¹⁵ concluded that education is needed for both pretransplant and posttransplant patients and their partners as they balance multiple roles and tasks. Interdisciplinary education and support programs will help to activate positive coping strategies of the spouse and other family members.

Wicks et al¹⁹ interviewed 19 spouses of kidney transplant recipients of deceased donor organs, and their findings support Starzomski and Hilton¹⁵ and Kurz³ in that spouses identified increased burden following the transplantation. The caregiving spouses further acknowledged their desire to participate in educational sessions for enhancing positive recipient recuperation. More studies are necessary to fully examine the impact of the transplantation process on the spouse and family to optimize posttransplant outcomes.

Spouses of Living Kidney Donors

Research on the physiological well-being and the procedural safety of living kidney donation is well documented.^{1,30} However, there is a lack of information on the psychological impact of the living donation on the donor family. Different issues may arise depending on the circumstances of donation. For example, one spouse may be donating to another spouse, doubling the need for support as both spouses recover from surgery. In contrast, an individual may be cast into a caregiver role for a spouse who is donating outside the nuclear family.

Although studies of living donors reveal that many are married, research focusing on the living donor's spouse and his or her influence on the donor's well-being and decision-making process is limited. In a study of 120 living kidney donors, Schover et al³¹ found that 89% (n=106) of the living donors had a spouse or significant other. Further, 39% (n=41) of the married donors believed that the donation contributed to a change in their marital relationship, including feelings of conflict with their spouse. In addition, Jacobs et al³² found that 36% of 524 donors reported a change in their marital relationship following the donation process.

Yi,³³ in her grounded theory-based study of living kidney donors' decision-making processes, identified a dominant theme of "donor gratitude" to their spouses, in that donors felt thankful to their spouses and families for their understanding and support during the donation process. Because only 3 of the 14 subjects in this study were actually donating to their spouses, the support most experienced was during the donation to an individual outside the nuclear family. Findings further suggest that the decision to donate a kidney entailed numerous interpersonal factors, and Yi³³ highly encouraged other researchers to investigate the viewpoint of the spouses of living kidney donors.

Thus far, no study was found that focused on spouses of living kidney donors, and only 1 study was found that addressed the spouses of living liver donors. Schulz and colleagues,¹⁶ in their study of life and family stress in 50 families of children requiring a liver transplant, report that living liver donation created different kinds of anxiety in donors and spouses. Living liver donors expressed a great concern for the possibility of rejection in the recipient, whereas spouses of the donor expressed greater fear and anxiety regarding the operation on the donor. Eighty percent of the spouses strongly supported the donor's decision and no spouse reported having urged the donor not to donate.

Summary of Literature

The relationship between marital status, the availability of social support, and health outcomes is consistently seen throughout the field of health research. The Table provides several examples of primarily

quantitative studies of spouses and significant others of patients with various illnesses, including heart disease and cancer, that were published between 1996 and 2002. Though many limitations of spousal research are identified earlier, researchers do declare that married people demonstrate higher levels of physical and mental well-being than those who are single.¹² Therefore, marital support may enhance the ability of those who are ill to cope more effectively with their disease, and increase motivation to take new action to reduce emotional distress that may block other coping efforts.⁸

As healthcare systems cut costs and streamline production, the needs of spouses and family members are more likely to be ignored.⁴ It is important for nurses to recognize that interactions with well spouses are an investment, which, if managed correctly, can result in a more confident spouse. A more holistic approach that includes both the patient and his or her spouse as mutually committed participants, encourages freedom of choice in a difficult experience that enhances the positive effects for the patient, the spouse, and for both as a couple.³

Although no studies were found that directly address the effect of living donation on the spouse of the living kidney donor, much information can be gleaned from studies of spouses of heart disease and cancer patients, and heart, lung, and kidney transplant recipients. The findings presented in this paper suggest that the psychosocial needs of patients and spouses often differ and these differences highlight the importance of empathy in the clinical setting to the needs of spouses. Data presented further suggest that spouses of ill partners are as vulnerable to psychological distress and disruption in their lives as are the patients themselves. This information is critical in the holistic assessment of spousal factors that ultimately could affect pretransplant and posttransplant adjustment, compliance, and the medical regimen.⁹

Currently, the research related to living organ donation and transplantation within families and its psychosocial impact on the spousal relationship is limited, and what does exist focuses primarily on organ recipients.^{3,10,13,15,16,19,34,35} The experiences of the spouse of the living kidney donor remains overlooked while current research has shown that spouses contribute significantly to the well-being of their ill partners.^{5,16-18,33} In clinics, nurses spend more time with donors and their families than other transplantation professionals. Therefore, nurses hold a key position to assess the nondonating spouse in terms of his or her level of knowledge about the donation process, potential or actual stressors, and the daily coping strategies that can provide a framework for consistent and individualized care over the span of the donation process.

Nurses caring for seriously ill individuals should consider the needs of the spouses in order to foster the

spouses' ability to support the ailing partner, to help spouses preserve their own well-being and that of their families.^{6,7,12,35} Further research is needed to achieve a deeper understanding of living kidney donors' spouses and their perspective on coping with an acutely, though seriously ill partner. Variables such as gender, age, dyadic strength, and socioeconomic status should be examined as these factors influence how well donors and their spouses respond to the illness. An understanding of the experiences of spouses of living kidney donors could aid in improving their own well-being as well as their capacity to be supportive of the donor.

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CE Test Test ID 4000-J44: Evidence on Spouse Responses to Illness as a Guide to Understanding and Studying Spouse Responses to Living Organ Donation

Learning objectives: 1. Identify the spousal role during illness and recovery 2. Understand the psychological effects of spousal responses to living organ donation 3. Identify the top stressors related to spousal response to living organ donation and acute illness

1. Which of the following are associated with an individual's adjustment to illness and recovery?

- a. Financial, psychological, and emotional adjustment of the spouse
- b. Social, emotional, and physical adjustment of the spouse
- c. Physical, psychological, and financial adjustment of the spouse
- d. Physical, psychosocial, and emotional adjustment of the spouse

2. Which of the following statements best describes amelioration of the consequences of stress?

- a. Married persons have a more positive physical and mental response to illness
- b. Being married has no more bearing on the consequences of stress than being unmarried
- c. Unmarried persons have equal positive physical and mental responses as married persons
- d. Unmarried persons have far more stress and increased negative physical and mental response to illness than married persons

3. Family well-being is dependent on which of the following?

- a. The spouse is required to adjust financial, social, and physical roles during illness.
- b. The spouse is required to adjust family, lifestyle, social, and physical roles during illness.
- c. The spouse is required to adjust family and occupational roles, lifestyle, and patterns of living.
- d. The spouse is required to search for means of coping with lifestyle, financial, psychosocial, and patterns of living.

4. Spouses may be less able to influence recovery because of which of the following?

- a. Own stress level, inability to maintain finances, and lack self-confidence for coping
- b. High adjustment levels, social support, and lack of family support during illness
- c. Own stress level, adjustment challenges, and coping demands
- d. Own stress level, lack of family support, and adjustment challenges

5. Which of the following offer the best responses to the well-being of the patient and minimize negative coping strategies with cardiac disease?

- a. Patient education, journaling, and group therapy
- b. Spousal education, group therapy, and family counseling
- c. Spousal education, information sharing, and social support
- d. Family education, social support, and information sharing

6. The most common stressors identified in spouses of patients with cardiac disease include which of the following?

- a. Worry about treatment, recovery and prognosis, and financial concerns
- b. Financial concerns, moodiness of family, and lack of information from healthcare providers
- c. Recovery and prognosis, lack of information from healthcare providers, and delayed treatment regimes
- d. Moodiness of patient, helplessness and apathy of the patient, and decreased social support

7. What were the findings in patients with cancer in the study by Banthia et al?

- a. Couples reported that increased stress in dyadic relationships created decreased resiliency to overcome the impositions to the family.
- b. Couples reported that a stronger dyadic relationship provided resiliency to overcome impositions to the family.
- c. Couples in nonmarried relationships reported no increase in resiliency.
- d. Couples in new nonmarried relationships had increased resiliency in managing psychosocial stability.

8. Which of the following were reported as stressors for spouses of patients with heart and lung transplants?

- a. Socioeconomic and responsibility stressors
- b. Transplantation experience and uncertainty
- c. Financial and insurance stressors
- d. Loss of social support and lack of family help

9. Caregiver strain was noted to be increased in the Kurz study by which of the following?

- a. Spouses who were lacking the education of the disease and their role responsibilities
- b. Spouses who had conflicts with healthcare providers and prognosis of disease
- c. Spouses who were balancing multiple roles and tasks
- d. Spouses who maintained their health and social support

10. According to Starzonomski and Hilton, which of the follow best describes the need for education in kidney transplantation recipients?

- a. Pretransplant education
- b. Posttransplant education of the patient
- c. Pretransplant and posttransplant for spouses
- d. Pretransplant and posttransplant for both patients and their partners

11. Which of the following best describes critical care nurses' role in caring for seriously ill individuals?

- a. Consider the needs of the patient and other caregivers when making assignments
- b. Recommend the need for medical social workers and clergy
- c. Consider the needs of the patients to foster better clinical outcomes and preserve their own well-being
- d. Consider the needs of the spouses to foster the spouses' ability to support the ailing partner and preserve their own well-being

Test answers: Mark only one box for your answer to each question. You may photocopy this form.

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