A Qualitative Approach of Psychosocial Adaptation Process in Patients Undergoing Long-term Hemodialysis

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Purpose: Professional hemodialysis (HD) nursing tends to be task-oriented and lack consideration of the client's viewpoint. This study aims to interpret the process of psychosocial adaptation to dealing with HD in people with end-stage renal disease (ESRD).

Methods: A grounded theory guided this study. Theoretical sampling included 15 people receiving HD at the HD center of a hospital from July to November 2010. Participants received an information sheet in writing, a verbal invitation, and informed consent forms before interviews were conducted. A constant comparative data analysis was analyzed using open, axial and selective coding. The computer software ATLAS.ti assisted data management. Credibility, transferability, dependability, and confirmability ensured the rigor of study process.

Results: This study identified "adopting life with hemodialysis", which captures the process of the psychosocial adaptation in people with ESRD as one transformation. Four categories that evolved from "adopting HD life" are (a) slipping into, (b) restricted to a renal world, (c) losing self control, and (d) stuck in an endless process.

Conclusions: The findings of this investigation indicate the multidimensional requirements of people receiving maintenance dialysis, with an emphasis on the deficiency in psychosocial and emotional care. The study's findings contribute to clinical practice by increasing the understanding of the experience of chronic HD treatment from the recipient's viewpoint. The better our understanding, the better the care provided will meet the needs of the people receiving HD.

Introduction

Professional hemodialysis (HD) nursing aims to provide holistic care to clients to achieve a better HD outcome. However, the care provided tends to be task-oriented and lack consideration of the client's viewpoint. Clients and their families have little information to help them prepare for and contend with their long HD journey [1]. Furthermore, clients are rarely asked for their opinions about HD treatment which has an impact on their daily living, although HD nurses sincerely care about them. Nurses and clients have their own perspectives on the management of HD and these often do not correlate.

Most studies on HD have focused on quality of life [2–4], well-being [5–7], and symptom management [8,9], but these studies reflect the objective evaluations of health professionals. A relatively small number of studies have considered the subjective views of clients with renal disease [10–12]. Studies concluded that there is a need for increasing nurses' commitment to understanding clients who are living with a chronic illness. It is vital to gain information from clients about their psychosocial adjustment experiences on HD in Taiwan.

This study aimed to interpret the process of psychosocial adaptation of people with end-stage renal disease (ESRD) undergoing regular HD. Questions that the researchers aimed to answer covered three broad topics: (a) what psychosocial adjustment experiences clients with ESRD undergoing regular HD have; (b) what needs are specific to these clients; and (c) what factors influence the psychosocial adaptation process to HD in these clients and how these are demonstrated.
Grounded theory guided this qualitative study with its roots in the concept of symbolic interactionism, which is about human behavior being determined by an adaptation to the environment. Constructivism is akin to symbolic interactionism; it focuses on how the self (in context) defines a situation and produces social actions, as well as how the self shares an understanding of an object in constructing its meaning. In order to understand the applicability of grounded theory to interpret the process of psychosocial adaptation to HD in people with ESRD, it is important to articulate the philosophy of symbolic interactionism.

Symbolic interactionism focuses on interaction and on the meanings of events to participants (their definitions of situations). From here, it goes on to emphasize the processes involved in human beings defining, acting, and using symbols (language) through interactions and responses to (thought) interactions with their environments. Blumer [13] articulated three central concepts of symbolic interactionism. The first concept maintains that “human beings act toward things on the basis of the meanings that the things have for them” [13]. The assumption here is that people interpret and define the actions of others, and their behaviors are a response to that. Therefore, people’s actions are taken based on the process of interpretation.

The second concept underpinning symbolic interactionism is that “the meaning of… things is derived from, or arises out of, the social interaction that one has with one’s fellows” [13]. Social interaction focuses on interactions between an individual and others, a process that can form and reform human behavior in the sense that the meanings underlying it can be derived through such interaction. That is, the outcome of interaction is a determinant of individual behavior. The third concept of symbolic interactionism is that “meanings are handled in, and modified through an interpretive process used by the person in dealing with the things” encountered [13]. This meaning of things is formed in the context of a person’s social interactions and modified by the interpretations that flow from these social interactions. What is significant about this world view is that it shifts the focus away from given or static norms and values to changeable and continually readjusting processes.

From the above we see that symbolic interactionism provides a theoretical perspective for studying how individuals interpret objects and events that they encounter in their lives and how a process of interpretation leads to behavior or action in a specific situation. The use of a grounded theory approach in this study helps to understand how people with ESRD perceive and define the process of psychosocial adaptation to regular HD. Grounded theory is a research methodology compatible with the aims of this study as it situates problems in a social context and helps to examine how people with ESRD interpret and act upon HD in their lives.

**Methods**

**Study design**

Grounded theory aims to discover and interpret people’s action and interaction with the environment as a psychosocial process. Data of theoretical sampling from actual research formulates study findings by using constant comparative analysis which consents to data generated and data sets compared systematically and continually. Coding technique of grounded theory reduces the interview text to concepts, discovers relationships and patterns among the concepts, and generates a storyline. Moreover, researchers collect data and codes emerging categories to be a concept alternatively during the progress of study.

Grounded theory provides a theoretical perspective for studying how people with ESRD interpret HD in their lives, and how this process of interpretation leads to behaviors. Grounded theory is a methodology for the purpose of studying phenomena from the perspective of symbolic interaction. Understanding clients’ overt and covert behavior is an important goal in exploring the psychosocial-adaptation process of these clients in grounded theory.

**Setting and sample**

All residents in Taiwan are covered by National Health Insurance which includes the cost of HD treated in public or private hospitals. An HD unit in rural southern Taiwan gave the researchers permission to recruit participants from among its clientele. The 35-bed unit served about 200 clients with ESRD. The causes of ESRD among this unit’s clientele were diabetic mellitus (32.4%), high blood pressure (21.3%), and kidney diseases (46.5%) [14]. Most clients had HD treatment three times per week.

Theoretical sampling was performed throughout the process of data collection. Clients qualified for selection if they had a diagnosis of ESRD and received regular HD treatment. Participation was voluntary. Clients who met the selection criteria received an information sheet outlining the purpose of the study. Each interview lasted approximately 1 hour. The interview was audio-taped. Fifteen clients undergoing regular HD participated in this study, 10 men and 5 women, aged from 30 to 78 years. Demographic information of participants are shown in Table 1.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age</th>
<th>HD years</th>
<th>Past-health status</th>
<th>Marital status</th>
<th>Work status</th>
<th>No. of children</th>
</tr>
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<tr>
<td>F</td>
<td>51</td>
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<td>SLE</td>
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<tr>
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<td>60s</td>
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<td>Divorced</td>
<td>Civil service worker</td>
<td>2</td>
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<td>10</td>
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<td>Married</td>
<td>Factory worker to no work</td>
<td>NM</td>
</tr>
<tr>
<td>M</td>
<td>60s</td>
<td>3</td>
<td>DM, HTN</td>
<td>Single</td>
<td>Owned small business to no work</td>
<td>0</td>
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<tr>
<td>M</td>
<td>74</td>
<td>5</td>
<td>Herb medicine, renal disease, bladder tumor</td>
<td>Widower</td>
<td>Kungfu practitioner to no work</td>
<td>NM</td>
</tr>
<tr>
<td>F</td>
<td>55</td>
<td>9</td>
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<td>Married</td>
<td>Factory worker to no work</td>
<td>1</td>
</tr>
<tr>
<td>F</td>
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<td>Married</td>
<td>Never worked</td>
<td>3</td>
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<tr>
<td>M</td>
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<td>Crew to no work</td>
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<tr>
<td>M</td>
<td>70</td>
<td>5</td>
<td>Patent medicine taken from broadcast, renal disease, urine retention</td>
<td>Married</td>
<td>Factory worker to no work</td>
<td>NM</td>
</tr>
<tr>
<td>M</td>
<td>70</td>
<td>8</td>
<td>Urine retention, herb medicine regularly taken, HTN</td>
<td>Married</td>
<td>Civil service worker to no work</td>
<td>3</td>
</tr>
<tr>
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<td>30</td>
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<td>Single</td>
<td>Never worked</td>
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<tr>
<td>M</td>
<td>60</td>
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<tr>
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<tr>
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<td>Urine protein, depression</td>
<td>Married</td>
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<tr>
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<td>Fracture, renal disease</td>
<td>Single</td>
<td>Chef to no work</td>
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</tr>
</tbody>
</table>

Note: HD — hemodialysis; SLE — systemic lupus erythematosus; HTN — hypertension; DM — diabetes mellitus; TB — tuberculosis; NM — not mentioned during interview.
Ethical considerations

This study received ethical approval from the institutional review board (99-IRB-002). The researcher obtained consent from administrative authority of HD center. The nurse in charge of the HD unit informed clients about the study, and the researchers invited clients who were interested to volunteer in person. Volunteers who met the selection criteria received an information sheet outlining the purpose of the study. When satisfied that the clients understood their role in the study, the researcher obtained a signed consent form from each person before interviewing commenced.

Data collection and procedure

Data were collected from July to November 2010. The researcher conducted an in-depth interview with each participant privately in a room of the HD unit before or following a treatment. Each interview was audio-taped. The technique of un-structured interview was adopted and initiated with two questions: “Could you please tell me what happened to your kidneys originally?” and “What does HD mean to you?” Further interview questions asked were from interviewees’ talking and the interviewer raising questions based on crucial data analysis from the previous interviews. Basically, participants effectively led the direction of the interviews, and the researcher followed the pattern and content of the participants’ own conversation. This helped to avoid any bias towards the researcher’s specific areas of interest.

Data analysis

Participant confidentiality was protected by restricting interview transcription to the researcher and allocating each interview a file number that incorporated the date of interview without interviewee detail. Fifteen files were created, each containing an interview tape and its transcript. The computer software ATLAS.ti (scientific software development gmbh, Berlin, May, 2006) was used to assist in data management. Data analysis continued until analytical saturation was achieved to interpret the participants’ experience of the psychosocial adjustment process.

Data analysis was based on a grounded theory method. Data organization began with the management of coded files. Each file represented a report of a psychosocial adjustment process of the HD client. The researcher began to read all reports of a client’s psychosocial adjustment line-by-line to obtain new insight into the data and by breaking through a standard way of thinking about the client’s experience reflected in the data [15]. Further questions would be raised when the researcher interacts with the data. Then, another interviewee who could possibly answer the newly-raised questions would be recruited. A total of 15 files were collected. All writings were carefully read several times and coded with open coding, all data with open coding systematically into new sub-categories based on their similar characteristics.

The next step was to group subcategories into categories based on its conditions, context, actions and interactions, and consequences. The categories were related to its subcategories and their relationships were tested by specifying the conditions under hypotheses. These categories provided a variation of hypothesis which could be generated as provisional and conditional relationships. The final step was to merge categories into a central category which represents a psychosocial adjustment process of HD. A diagram was utilized to assist the process of category integration. Moreover, the core category was abstracted to explain the main phenomenon through a process of conceptualization as generalizability was achieved.

Trustworthiness

To ensure the rigor of the study process, the researcher observed the criteria for judging the quality of qualitative research as recommended by Lincoln and Guba: credibility, transferability, dependability, and confirmability [16]. The qualifications of the principal researcher enabled her to credibly and reliably undertake all aspects of this investigation, including the interviewing. She is a trained counselor comfortable in undertaking interviews, a trained qualitative researcher, and has extensive work experience in clinical nursing and nursing education. The interviews were participant-centered and audio-taped. The data coding were discussed with the team members of the study regularly. Codes and themes were verified by two HD nurses. To meet the criteria of transferability and dependability, each interview transcript was augmented with “thick descriptions”, that is, transcripts were annotated with descriptions of interviewees’ nonverbal responses conveyed in the interview but not captured in the transcript. The thick data were identified on the basis of their relevance to the topic of study and congruence with participants’ point of view. Confirmability was concerned with the objectivity of the researcher for ensuring the trustworthiness of the process of the methods and procedures of this study. Therefore, the process of study was rigorous.

Results

The study finding was summarized as “adopting HD life”, an interpretation of how regular HD treatment dramatically changed the clients’ daily life to a level of hardship that was difficult to accept. The process of life adjustment that this required was described as moving from an existence of many colors to one that was black and white, implying the loss of hope and choices, even opportunity, because of the high frequency of HD. The process of “adopting HD life” evolved Figure 1: (a) slipping into; (b) restricted to a renal world; (c) losing self control; and (d) stuck in an endless process. These four themes describe the process of the psychosocial adaptation in clients undergoing HD, from what reaction clients with ESRD had when hearing HD was needed, how they became restricted in the renal world, lost self control to how they circulated in an endless process of dialysis (Figure 1).

Theme 1: Slipping into

The theme of slipping into includes raising the veil and not knowing why. Raising the veil referred to the clients’ responses when they were told they needed regular HD, and the veil of ignorance was lifted, that is, they could now see what unhealthy lifestyles or poorly managed diabetes could lead to. However, they still did not understand how their unhealthy lifestyle could lead to the need of dialysis.

Some clients respond to the HD needed as accepting medical advice simply, and involves a sense of dependence on the health profession. Clients saw their need to receive dialysis treatment as a fate that they had limited power to fight against. However, a fate reflects no personal responsibility to be taken on dialysis. Some clients reacted to HD as a bolt from the blue and the end of the world. These experiences explained how disbelieving they were upon learning what had happened to them and how frustrated they were in that moment of confronting the doctor’s prescription of dialysis treatment.

On being advised that dialysis treatment was necessary, the clients immediately tracked back into their past to search for the reason “why”, which reflects their sense of that they knew little about the causes underlying their renal disease which was now
requiring HD. Some of the participants who searched for causes could only remember having had minor health problems in the past and they had neglected health warnings and misjudged their importance. When participants described feelings of their dialysis needed, they fell into the response of wondering about the causes.?

I had diabetes and did not take the medication regularly. I took it occasionally and I kept silent about my high blood sugar. … But it just happened without any warning. (Mr. Cheng, 60s)

The participants wondered if there was another way out of renal failure. Some of them had postponed dialysis treatment and taken herbal medicine for their physical discomfort with the hope that the disease was not advanced enough to warrant HD. People tended to consider dialysis as a treatment of last choice [11]. Those people were looking for an opportunity to overcome the problem so as to avoid self pity. For these participants, herbal medicine provided them with the possibility of doing something to improve their condition.

I went to a herbal store and bought some for the soreness in all my bones… Eucommia (Eucommia ulmoides) and Madeira-vine (Anredera cordifolia) are taken to relieve bone soreness. (Mr. Wang, aged 74)

Participants generalized all possible causes of their need for dialysis as fate, that is, one’s life destiny, what one’s life has to be. They were forced by fate to confront the challenge in their lives, and to accept HD treatment as their only means of fighting for their survival. As one participant stated, “I felt that in all likelihood it was… fate. You have to suffer ill health as the result of not caring enough for yourself in the past” (Ms. Yang aged 55). People were slipping into the need for dialysis as a means of survival and subsequently became restricted to the renal world.

Theme 2: Restricted to a renal world

When participants accepted dialysis treatment as essential to their survival, they commenced the process of adjusting to their new circumstances. However, the clients found their lives being restructured as the “dialysis life”. Dialysis turns out to be the central and most essential part of their daily activity. When undergoing dialysis, they experienced an overwhelming feeling and suffered discomfort associated with dialysis, which compelled them towards reshaping their daily lives.

The attitude of HD recipients to their treatment was ambivalent: they felt negative and pessimistic about HD, yet they knew their lives were dependent on it. The meaning of HD to clients undergoing dialysis was a routine to maintain life, to solve health problems, and to prevent complications. The HD-imposed routine makes for a life regulated by the clock and limits every decision that the person on HD makes and every step taken. There is no single part of the routine that can be skipped. The participants defined the level of restriction associated to HD as suffering.

Suffering discomfort caused by HD physically, emotionally, and socially created a boundary that entrapped the participants in their own renal world. Physical illness was the most common complaint of those on dialysis. The physical discomfort of HD was not easy to alleviate, the participants become emotionally depressed and pessimistic, which caused them to be inactive in their daily lives. They found themselves stayed in their own world. Casting doubt on the ability of health workers and others to understand the needs of those undergoing dialysis. Participants made statements such as, “Unless you are in our situation, you will not understand how hard it is” (Ms.Wang aged 51). Here was a lonely renal world that was not actually being understood.

The reshaping of daily psychosocial life explains these people’s experiences of vacillating between their renal world and the familiar world which encompassed their own psychosocial experiences and life-long beliefs and habits. People undergoing HD have had to change their diet, daily activity, physical appearance, job, health status, the way they relate to others and even their independence level to suit the dictates of the renal world. However, their concept of kidney function as a source of strength and their rigid idea about herbal medicine were not changed. As one participant described that “Kung Fu caused my bones to ache, so I took herbal medicine… At the same time, I also took western medicine for my aching bones” (Mr. Wang aged 74). As Mr. Wang mentioned, the clients on dialysis were losing their own self control.

Theme 3: Losing self control

The clients were restricted to a renal world. This resulted in them losing control of their daily activities, which depended on laboratory data and dialysis machine. Eventually, they would be
able to handle nothing. Losing self control encapsulates people’s sense of having limited authority over their HD treatment. They were dominated by clinical data or the weighing machine when dealing with the dialysis machine. Eventually, they found that they had nothing to do with, and were not making decisions about their own survival. The dialysis dose was the basic consideration behind all decisions being made about people’s lives.

Depended on the dialysis machine, as life-saving, however, they also identified the dialysis recipient with the machine is, therefore, crucial and indispensable. The recipients of dialysis perceived the dialysis machine as having less meaning to life. As participants identified that, “HD is meaningless to me. I have no idea about the meaning that vessel access and dialysis treatment have to my life” (Mr. Yao, 60s; Ms. Huang aged 61; Mrs. Huang aged 77). Dependent on the dialysis machine, people lose their sense of themselves as independent entities. In the end, they felt everything to do with their lives was out of their hands— they were able to handle nothing.

Handling nothing explores the weary inner feeling these people had towards dialysis treatment. Although they could make sense of the present by reflecting on the past, they perceived their current situation to be unchangeable. Regardless of the causes of their need for dialysis treatment, those undergoing dialysis have their lives scheduled around treatment, have fought illness, and dealt with machines while having limited power to control their lives. Past events become insignificant and they hold slim hopes for the future. The present is about being powerless— handling nothing to do with their treatment, illness or the dialysis machine, that is, the participants were having difficulties reversing their health status and dropping into an endless process of dialysis.

When I first discovered my health problem, I wondered about ending my life myself.... The journey of dialysis treatment has no end, and my life depends on the treatment. I feel so awful. (Mr. Cheng aged 78)

Theme 4: Stuck in an endless process

Eventually, the clients on dialysis were handling nothing but were stuck in an endless process with dialysis. People’s experience of dialysis and their wishes for the future is captured by being stuck in an endless process. People with ESRD face continual dialysis treatment unless they are among the few who undergo successful renal transplantation. Living day by day, waiting for the end, and invoking a good death interacted with losing self control in an endless process.

Generally, the participants described their dialysis life as living day by day. They placed themselves either as making the most of each moment or as having a colorless future. They were compelled to live in the moment in order to adapt to the hardship of being stuck in an endless process. It seems that people wanted a life free of dialysis because life on dialysis had no real future. The participants’ view of the dialysis life was a life that they muddled through. The experience of living day by day seemed to be more pessimistic; it was like counting down to the final day of life. As one participant put it, “My life is being counted down by day and is shaped by fate... To live day by day is the only thing I can do, and stay with HD as a part of my life” (Mr. Yao, 60s; Mr. Cheng, 60s). However, it seemed that people adopted HD as a part of their life as a psychosocial adaptation.

Waiting for the end, as part of the experience of living day by day, represents a sad and passive approach to life. Being stuck in an endless process deprived the life on dialysis of hope. Although dialysis treatment keeps the participants alive, and death is inevitable for all humans, HD seemed to them like the final call of life. Consequently, the participants found that they were living one more day by anticipating their death and making a wish for a good death, that is, a death without suffering. One of the participants mentioned that, “I have no expectation for the future. I am waiting for my last day to come. My future has no hope” (Mr. Wu aged 60).

Invoking a good death explains the participants’ only wish for the future. A good death involves taking one’s last breath peacefully, without any suffering. Those on dialysis were not fearful of dying, but worried about confronting suffering. The participants had no control over how or when they lived or died. Fate was in control, and its instrument was the dialysis machine. The philosophy of life for these clients was muddling along or doing the best for the moment, and then God would do the rest for them. A participant stated that, “When my time comes, I hope to go peacefully. For me, the aim of HD is to allow me to ‘go back’ (pass way) comfortably. My only wish is to ‘go back’ easily” (Mr. Liso aged 70; Ms. Huang aged 68). It seems that dialysis treatment can grant clients the wish of peaceful death.

Despite the pessimism induced by the seemingly endlessness of dialysis treatment and hopelessness of the future, the participants focused on living rather than dying. Sadly, most clients on dialysis seemed to value their therapy only to the extent that it gave them confidence to invoke a peaceful death. Hope for a peaceful death possibly reflects a dread of more suffering during one’s remaining life. However, in traditional Chinese society, how and when a death might happen is not talked about — to do so may elicit a curse. Furthermore, suffering is considered as a punishment for an evil perpetrated by the sufferer in a past life.

Discussion

The process of psychosocial adaptation of the clients undergoing chronic HD found in this study are similar to those found by other researchers [2,5,17]. However, people on regular dialysis in an Oriental society such as the Taiwanese society tend to be pessimistic and lose their emotional resilience because of a lack of psychosocial support, which is less than that provided in Western societies [1,18,19]. In the Weng, Wu and Wu [19] study, they emphasized that positive cognitive strategies and social support are important measures for the psychological rehabilitation of those receiving long-term HD [20]. Although participants in this study had tried to use meaningful ways to value and control their dialysis-
transformed lives, they were often restricted by financial worries. Cheng's study found an association between people's perceptions of the lived experience of HD and their socioeconomic status [3]. However, the optimistic perception of being ill and undergoing dialysis among this study's participants was fatalistically based: suffering is caused by happenings in a past life, and requires acceptance in the present life to ensure it does not continue to a future life. In Buddhist thinking, this is a causal circle of life. Thus, these participants seemed to accept their illness and treatment. Those in this study with pessimistic attitudes thought they were not good enough or their illness was someone else's fault; they felt being prescribed HD treatment was a bolt from the blue and the end of their world. Blaming something else for the disease could be seen as a means to relieve illness-related anxiety.

This study found, as have other studies, that the dialysis machine plays a central role in the adjusting process of those on dialysis [17,21]. It dominates their life space and controls their life. Essentially, dialysis treatment dictates the participants' daily schedules; all their decisions must comply with the HD schedule, which varies little. The participants genuinely believe that the machine plays a central role in the adjusting process of those on dialysis and dominates their life space and controls their life. Dialysis among this study's participants was fatalistically based: suffering is caused by happenings in a past life, and requires acceptance in the present life to ensure it does not continue to a future life. In Buddhist thinking, this is a causal circle of life. Thus, these participants seemed to accept their illness and treatment. Those in this study with pessimistic attitudes thought they were not good enough or their illness was someone else's fault; they felt being prescribed HD treatment was a bolt from the blue and the end of their world. Blaming something else for the disease could be seen as a means to relieve illness-related anxiety.

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In this study, participants' gender seemed an important variable in the adjustment to dialysis life. Although dialysis treatment significantly affected the life situations of both males and females, male clients tended to be under more pressure than females regarding social-role adjustment. The pressure men felt was caused by the traditionally rigid ideas of kidney function and social roles in Oriental society. When a male participant's role as breadwinner broke down and he lost his independence, his confidence in his place in society changed and he felt in conflict with his new role. However, it is hard to prove that this experience is a result of the influence of gender; it may reflect individual differences. During interviews male participants seemed more emotionally distressed than the females were. This may indicate that women feel less insecure in a socially dependent role than men do, or it may challenge the traditional view that females in Oriental society are more emotionally demonstrative than males are. Consistent with the research of Tijerina [12], this study's findings strongly suggest that, irrespective of gender, psychological distress is common among people requiring chronic HD. This supports the claim that care of clients with ESRD being treated with HD is incomplete unless long-term and regular counseling is available. Currently, counseling is not routinely offered as part of HD treatment.

Many people receiving HD have an unacceptable symptom burden, indicating that palliative care should be an integral part of renal nursing services. HD recipients are also often senior, ill or dependent on others, and hence, should be given information about, and the option to elect hospice care [14]. This study found that many of those on dialysis commence their treatment after they retire. In their thinking, they have more or less met their personal responsibilities to family and society. Those who think their days of family and other responsibilities are past, are less likely to seek renal transplantation; they wait and hope for a good death and consider a good death as the only means of terminating the physical, psychological and emotional sufferings resulting from HD. These people are at risk of being seen as noncontributors to society, devalued and discriminated against. As a result, their emotional and physical distress may not be taken seriously. Hospice care for people in these circumstances would give them the opportunity to alleviate their symptoms, produced or not relieved by HD. People who accept HD treatment in the hope that it will ease them through the last period of their lives would be better served if their treatment incorporated a palliative care program, as would all those contending with the discomforts of HD. Hospice care also provides an opportunity to improve the lived experiences of "adopting HD life".

Limitations

This research offers a preliminary view of the process of psychosocial adaptation in clients undergoing HD. However, it was carried out in a rural HD center, where the socioeconomic and educational status of participants, which were not emphasized in this study, may have influenced their processes of HD adaptation. Comparative studies are needed to elicit demographic influences. Timing of interviews may also be a limitation of the study. Each interview was conducted immediately before or after a dialysis session. Participants may not have fully communicated their concerns because they were either preoccupied by the imminent HD session or suffering from post-HD tiredness. This preliminary study may indicate that there is much to be learnt about the psychosocial needs of HD recipients from research into how they cope with their experiences of the HD life. An area demanding further research highlighted by this study is the potential of end-of-life care to mitigate patients' feelings of uncertainty and ambivalence about HD, including their experiences of dis empowerment and of having their lives drained of meaning.

Conclusion

This study verifies the significance of understanding the process of psychosocial adaptation of those undergoing HD. Contemporary health professionals tend to provide technical care from their own viewpoint rather than the perspective of those experiencing dialysis, and focus on technical outcomes more than the patient's psychosocial and emotional concerns. Modern knowledge and the power of health professionals over care have forced clients to believe and accept the treatment opinions of health professionals, and to put their feelings and their participation in authorizing treatment aside. Clients lack power to influence care decisions and adapt to their illness in ways that preserve enough familiarity, balance and harmony from their old lives to make the present and future worthwhile. Dialysis health professionals should be alerted to this issue. The findings of this investigation indicate the multidimensional requirements of patients receiving maintenance dialysis, with an emphasis on the deficiency in psychosocial and emotional care. Dialysis treatment maintains people's lives physically, and is advocated by dialysis health professionals. Alleviating the emotional burden and addressing potentially inadequate psychosocial support that results from changes to family and social traditions are not weighted equally with physical care. Counseling, end-of-life care, adequate care education and providing support resources to those undergoing dialysis are emphasized and recommended to assist people to optimize their adaptation to HD.
Conflict of Interest

The authors declare no conflict of interest.

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