

An-Najah National University

Faculty of Graduate Studies

**Stressors and Coping Strategies amongst
Hemodialysis Patients in North of West Bank**

By

Dina Tahseen Nimer Issa

Supervisor

Dr. Mariam AL-Tel

Co-supervisor

Dr. Jamal Qaddumi

**This Thesis is Submitted in Partial Fulfillment of the Requirements for
the Degree of Masters of Community Mental Health Nursing, the
Faculty of Graduate Studies, An-Najah National University, Nablus,
Palestine.**

2015

Stressors and Coping Strategies amongst Hemodialysis Patients in North of West Bank

**By
Dina Tahseen Nimer Issa**

This Thesis was Defended Successfully on 27/8/2015 and approved by:

Defense Committee Members

- 1. Dr. Mariam Al Tell / Supervisor**
- 2. Dr. Jamal Qaddumi / Co- Supervisor**
- 3. Dr. Wael Abu- Al Hassan / External Examiner**
- 4. Dr. Eman Al Shawish / Internal Examiner**

Signature

د. مريم التل
د. جمال قاضي
د. وائل أبو الحسن
د. إيمان الشويش

الإهداء

بسم الله الرحمن الرحيم

يحتار حرفي..ولا يدري كيف يسطر لكم كلمات الشكر التي تقي بحقكم..وتعبر عن مدى امتناني
لوقوفكم معي وبجانبني على مدار السنين.
فعبر عبير الورد .. وعطر الزهر .. وخالص الشهد
أسوق إليكم عظيم الشكر على ما بذلتموه معي من جهد
يا من أكن لكم فائق الحب والاحترام و الود
وأدعو لكم دوماً بجنت الخلد

إليك أبي الحبيب

إلى الحبيب الراحل...إلى قدوتي الأولى ، ونبراسي الذي ينير دربيإلى من علمني أن اصمد
أمام أمواج البحر الثائرة.....إلى من رفعت راسي عالياً افتخاراً به..إليك يا والدي الحبيب

أمي الحبيبة

إلى من لن أستطيع أن اكتب لها أكثر من عدد قطرات مياه بحار الأرض جميعاً،إلى الحنونة دائماً،
إلى شمسي وقمري، إلى أعلى كواكب الدنيا، إلى منارة الحب في كل أيام السنة ، إلى بهجة الفصول
الأربعة إلى نواره الدنيا بكل متاهاتها الممقّنة ... إليك أيتها الحبيبة دائماً وأبداً إليك والدتي
الغالية

زوجي العزيز

إلى الروح التي سكنت روحي، إلى رفيق دربي الذي ما كان لهذا العمل أن يكتمل دون مساندته،
إلى الإنسان الذي أحبته حباً لا يوصف، إلى من أعطى لقلبي الأمان .. وهو للوفاء عنوان إليك يا
زوجي العزيز

أخي العزيز

إلى من يحمل في عيونه ذكريات طفولتي وشبابي، إلى من يعيش ليلي ونهاري،إلى شاطئي عندما
أضيق، ومنبع الحنان عندما تقسو الأيام، وقلبي الكبير عندما أفقد كل القلوب إلى توأم الروح أخي
العزيز

ابنتي الغالية وابني الغالي

إلى القلب الطاهر الرقيق والنفس البريء إلى البسمة الأبدية رسمتها على شفتي يد الأقدار ..يا وردة
عبقت بأطايب العبير و تفتحت في داري إليك يا ابنتي الغالية أيلين، وابني روحي الغالي.

Acknowledgment

I am very much thankful to my supervisor, Dr. Mariam AL-Tel, and co-supervisor Dr Jamal AL Qaddumi, for their encouragement, guidance and support from the initial to the final level, enabled me to develop and understanding the subject. I would like to thank An-Najah National University for supporting this work, and allowing me to conduct my research, also I wish to pay my great appreciation to all kidney department nurses and patients for their cooperation. Finally, I offer my regards and blessings to all of those who supported me in any respect during the completion of this thesis.

الإقرار

أنا الموقع أدناه مقدمة الرسالة التي تحمل العنوان :

Stressors and Coping strategies amongst Hemodialysis Patients in North of West Bank

أقر بأن ما اشتملت عليه هذه الرسالة إنما هي نتاج جهدي الخاص، باستثناء ما تمت الإشارة إليه
حيثما ورد، وأن هذه الرسالة ككل، أو أي جزء منها لم يقدم لنيل أية درجة أو لقب علمي أو
بحثي لدى أية مؤسسة تعليمية أو بحثية أخرى .

Declaration

The work provided in this thesis, unless otherwise referenced, is the
researcher's own work, and has not been submitted elsewhere for any other
degree or qualification.

Student's Name:

اسم الطالب : رانيا محسنه نمر عيسى

Signature :

التوقيع: 

Date:

التاريخ: ١٨/١٥/٢٠١٥ م

Table Of Contents

No	Subject	Page
	Dedication	iii
	Acknowledgment	iv
	Declaration	v
	List of Tables	viii
	List of Annexes	ix
	List of Abbreviations	x
	Abstract	xi
	Chapter 1: Introduction	1
1	Introduction	1
1.1	Statement of Problem	3
1.2	Significance of the study	4
1.3	Aim of the study	5
1.4	Objective of the study	5
1.5	Hypothesis	6
1.6	Definition of concept	6
1.7	Definition	8
	Chapter 2: Literature Review	13
2.1	Source of stressors	13
2.2	Coping strategies	16
2.3	Mediating factors	19
3	Chapter 3: Methodology	24
3.1	Study Design	24
3.2	Setting	24
3.3	Sample and Sampling Method	25
3.3.1	Population size	25
3.3.2	Sampling and sample size	26
3.3.3	Inclusion Criteria	28
3.3.4	Exclusion Criteria	28
3.4	Data Collection	29
3.5	Validity	31
3.6	Reliability	32
3.7	Ethical Consideration	32
3.8	Field work	33
3.9	Statistical and analyzing methods	34
	Chapter 4: Results	36
4.1	Socio-Demographic Data	37
4.2	Hemodialysis Stress Scale Results	38
4.3	Jalowiec Coping Scale Results	40
4.4	Coping Helpfulness Results	47

4.5	Results of differences between stressors, and demographic characteristics	51
4.6	Results of differences between coping, and demographic characteristics	54
4.7	Results of differences between stressors, coping, and helpfulness.	60
5	Chapter 5: Discussion	
5.1	Socio-Demographic characteristics	63
5.2	Stress types	63
5.3	Coping strategies	65
5.4	Gender,(coping strategies and stressors)	66
5.5	Duration of treatment,(coping strategies and stressors)	68
5.6	Relation between the coping strategies and stressors among HD patients	70
5.7	Relation between the coping strategies and helpfulness of coping among HD patients	70
5.8	Conclusions	71
5.9	Limitation	72
5.10	Recommendation	72
5.11	Summary	73
	References	77
	Annexes	86p
	الملخص	ب

List of Tables

No.	Tables	Page
3.1	distribution of excluded and included patient's number within 4 hospitals	27
4.1	Distribution of frequency and percentage of participants regarding their socio-demographic data	37
4.2	Distribution of mean, SD, percentage, and Level of agreement	38
4.3	Distribution of mean, SD, percentage, and Level of agreement of coping strategies	41
4.4	Distribution of mean, SD, percentage, and Level of agreement of coping helpfulness	47
4.5	Differences of mean and SD for stressors types in regard to the gender	51
4.6	Differences of mean and SD for stressors types in regard to the age using ANOVA test	52
4.7	Differences of mean and SD for stressors types in regard to the duration of treatment using ANOVA test	53
4.8	Differences of mean and SD for coping strategies regard to the gender	54
4.9	Differences of mean and SD for coping strategies regard to the age using ANOVA test	56
4.10	Differences of mean and SD for coping strategies regard to the duration of treatment using ANOVA test	58
4.11	Pearson Chi Square test between Coping strategies and physiological stressors	60
4.12	Pearson Chi Square test between Coping and psychological stressor	61
4.13	Pearson Chi Square test between Coping and helpfulness	62

List of Annexes

No	Name	Page
1	Information and details Find	86
2	Hemodialysis Stress Scale	93
3	(J C S) Jalowiec Coping Scale	94
4	Permission Letter: Use of Hemodialysis Stressor Scale	98
5	Permission Letter: Use of Jalowiec Coping Scale	99
6	I.R.B Permission	100
7	M.O.H Permission	101
8	Consent Form	102

List of Abbreviations

Abbreviation	Full Name
AV	Arteriovenouse
ANOVA	Analysis of variance
CAPD	Continuous Ambulatory Peritoneal Dialysis
CCU	Cardiac Care Unite
CRF	Chronic Renal Failure
CT	Computerized Tomography
ESRD	End Stage Renal Disease
HD	Haemodialysis
HSS	Haemodialysis Stress Scale
ICU	Intensive Care Unite
IRB	Institutional Review Board
IV	Intravenous
JCS	Jalowiec Coping Scale
MRI	Magnetic Resonance Imaging
MOH	Ministry of Health
PHIC	Palestinian Health Information Center
SD	Stander Deviation
SPSS	Statistical Package for the Social Sciences
TP	Transplantation

**Stressors and Coping Strategies amongst Hemodialysis Patients in
North of West Bank**

By

Dina Tahseen Nimer Issa

Supervisor

Dr. Mariam AL-Tel

Co-supervisor

Dr. Jamal Qaddumi

Abstract

Aim: the aim of the study was to assess the stressors and coping strategies used among hemodialysis patients (HD). To find out whether there is any relation between these stressors; coping strategies used and patient characteristics in North of West Bank.

Methodology: A quantitative, cross-sectional, descriptive analytical study was carried out to achieve the aim of the study during the period between Januarys to March 2014. Data collection were took place at three governmental hospitals and one private hospital, on 120 HD patients of total 379, using the Hemodialysis Stress Scale (HSS) and Jalowiec Coping Scale(JCS).

Result: The finding showed that the HD patients were mildly to moderately stressed according to HSS, the greatest perceived sources of stress appeared to be "physiological stressors" (mean=2.655) but the item with the highest percentage was "limitation on time and place for vacation" (84.2%) which belong to psychological stress subscale, and the item stress with the least percentage was "dependency on nurses and technicians"(45%). According to the ways of coping mechanisms, HD

patients seemed to be resorting more to "optimistic coping" (mean=3.086) followed by "supportant coping" (mean=2.970) while "emotive coping" was the least coping strategy used (mean=2.125), the coping item with the highest percentage for using and helpfulness of using was "Prayed or put your trust in God" (94.8%) for using and (95.6%) for helpfulness of using. There were significant differences between the psychological stressors and duration of treatment and a significant difference between the stressors and coping strategy used, in addition to a significant difference between the coping strategies and helpfulness of coping.

Conclusion: Maintaining the level of stressors in individuals with ESRD at minimum and using a proper coping mechanism are the key factors. Investment in this area of knowledge was justified for their contribution to improving the quality of life, minimizing potential complications of this disease, survival of these people and decrease cost. In addition future researches should be directed at detecting the predisposing factors that lead the HD patients to be variant in experiencing the intensity of stress and coping strategies used.

Chapter1

Introduction

1. Introduction:

One of the chronic and life threatening diseases that affect 2-3% of the people around the world are involved in is chronic renal failure (CRF) (**Narimani et al. 2008**). This disease is a pathological process leading to an irreversible reduction in kidneys function which results in end stage renal disease (ESRD). So, these patients should undergo renal replacement therapies hemodialysis (HD), continuous ambulatory peritoneal dialysis (CAPD), or kidney transplantation (TP) for the rest of their life to prevent uremia and its complications (**Saunderson, 2007; Kasper, 2005**). These treatments will probably have different types of impact on patient and family life. In CAPD treatment, the patient will treat him/herself every day, four times a day at home, which requires equipment in the home (**Galpin, 1992**). In-centre HD treatment the patient is away from home approximately three times per week, several hours per treatment period (**Dunn, 1993**). For many spouses and patients, transplantation represents the fulfillment of a dream of a relatively normal healthy life (**Hayward et al., 1989; Galpin, 1992**).

Hemodialysis (HD) therapy is time-intensive, expensive, and requires fluid and dietary restrictions. Long-term dialysis therapy itself often results in a loss of freedom, dependence on caregivers, disruption of marital, family, and social life, and reduced or loss of financial income (**Lin, 2005**).

Hemodialysis alters the life style of the patient and family and interferes with their lives. The major areas of patients life affected by ESRD and its treatment includes employment, eating habits, vacation activities, sense of security, self-esteem, social relationships and the ability to enjoy life (**Smeltzer et al. 2004**). Due to these reasons, the physical, psychological, socioeconomic and environmental aspects of life are negatively affected, that leading to compromised quality of life (**Blake et al. 2000**).

Patients adopt various methods to cope with the stresses of the disease and treatment procedures. The manner of application in each of these coping methods depends on personal experiences, social support system, personal beliefs and the access of these support resources (**Finkelstein, 2000; Kimmel et al. 1998**).

In fact, coping for individuals with ESRD can be adaptive or maladaptive. Adaptive coping can produce desirable outcomes, such as employment and successful functioning within the family. If coping is maladaptive, marital and family dysfunction can occur, as well as depression, anxiety and loss of one's role and identity. Adaptive actions help the patients with chronic diseases to cope with existing concerns in order to reach an acceptable level of health and physical, mental and social function (**Ridder et al. 2001**).

The number of patients treated for end stage renal failure worldwide has continued to grow at a rate that is far in excess of the growth rate of the general population. Prevalence of this disease is increasing in the world;

the average global growth of this disease was 8% per year in the last 5 years (**Smeltzer et al. 2012**).

In the Middle East incidence number of ESRD ranged from 64 patients per million populations in Yemen, 212 patients per million populations in Qatar, and 200 per million populations in Egypt (**Abboud, 2006**).

According to Palestinian Health Information Center (PHIC), in 2003, 255 patients from West Bank were under dialysis treatment; in 2010, this figure has been increased to be 800 patients (**PHIC, 2013**).

Patients with ESRD experience different levels of stress in response to various types of stressors. How stress is resolved is an important to this population because it can contribute to greater morbidity and even to earlier mortality (**Finkelstein, 2000**).

1.1. Problem statement

End stage renal disease is rapidly increasing among Palestinian, it is common health problem, and it is estimated to be eighth leading cause of death in Palestine, according to the Palestinian Health Information Center (**PHIC, 2013**). From the other side, in our country there is a lack of study that assess the stressors and coping among hemodialysis patients, study founded in (Alquds University, Abu Dees) on same topic, another study founded in (An Najah University, Nablus) assessing their quality of life. So hemodialysis patients need more attention on their stressors and coping strategies they use.

If hemodialysis was done effectively it will contribute to long-term survival (**Locatelli et al., 2001**). Maladaptive coping mechanisms that may lead to nonadherence to the prescribed regimen, and this is other common problem in hemodialysis that associated with increased morbidity and mortality rate and increased staff burden and costs. Knowledge of the most stressors facing hemodialysis patients and what coping mechanism used is useful for the multidisciplinary team. Also help multidisciplinary team to direct the control of the stressors inherent to the disease and to the hemodialysis, favoring the adaptation process of these people to the therapeutic regime.

Therefore, maintaining the level of stressors in individuals with ESRD at minimum and using a proper coping mechanism are the key factors. Investment in this area of knowledge was justified for their contribution to improving the quality of life, since true coping methods and effective adaptation with disease can increase the possibility of patient's rehabilitation (**Mahmoudi et al., 2004**), and improves his/her quality of life(**Lazarus & Folkman, 1984**). That may help to minimized potential complications of this disease, improve survival of these people and decrease cost.

1.2. Significance

Hemodialysis alters the life style of the patient and family and interferes with their lives causing variant stress. Therefore, and in addition to the lack of study found in Palestine about stress and coping among HD patients, this

study will give baseline data and information about variant stressors among patients with hemodialysis. From the other side, determination of the coping strategies and their perceived helpfulness among HD will help health members in identifying negative coping strategies, and positive coping strategies that will be encouraged for better treatment adherence. The results of this study will shed light on the relationship between stressors and coping strategies among Palestinian HD patients, which will help multidisciplinary team to direct the control of the stressors.

1.3. Aim of the study

To determine the possible causes of stress and coping strategies used among HD patients in North of West Bank

1.4. Objectives

1. To identify the major stressors among patients on hemodialysis.
2. To determine coping strategies used by HD patients in North of West Bank.
3. To determine the relationship stressors and coping strategies among patients on hemodialysis.
4. To identify the relationship between demographic data/ as gender, age, and dialysis duration and type of coping strategies.
5. To identify the relationship between demographic data/as gender, age, and dialysis duration and type of stressors.

1.5. Research Questions

What are the most hemodialysis stressors that could be rated as the most bothersome?

What are the most coping strategies that could be rated as most frequently used by hemodialysis patients?

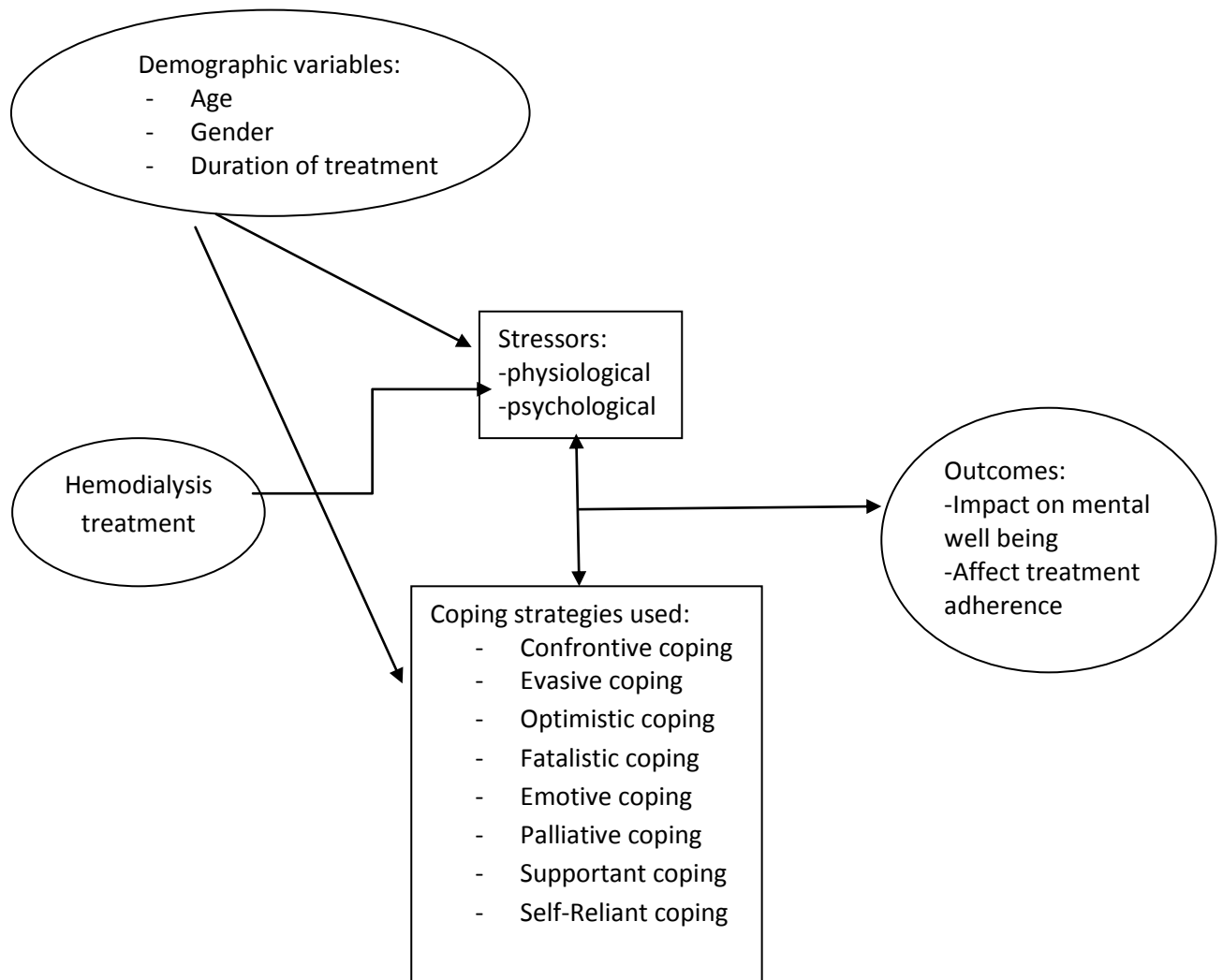
Which item of coping strategies perceived to be most helpful for hemodialysis patients?

1.6. Hypothesis

1. There is no significant difference between demographic data/ as gender, age, dialysis duration of HD patients and type of coping strategies used at level of ($p \text{ value} \leq 0.05$).
2. There is no significant difference between demographic data/as gender, age, dialysis duration of HD patients and type of stressors at level of ($p \text{ value} \leq 0.05$).
3. There is no significant difference between stressors of HD patients and coping strategies used at level of ($p \text{ value} \leq 0.05$).
4. There is no significant difference between coping strategies used by HD patients and helpfulness of these coping strategies at level of ($p \text{ value} \leq 0.05$).

Conceptual framework

Stressors and coping strategies amongst hemodialysis patients in North of West Bank



1.7. Definition

Coping strategies

Coping can be identified as a deliberate, planned and psychological effort to manage stressful demands (**Boyd, 2008**).

The coping process may inhibit or override the innate urge to act. Positive coping leads to adaptation, which is characterized by a balance between health and illness, a sense of wellbeing and maximum social functioning. When the person does not cope positively, maladaptations occur that can shift the balance towards illness, a diminished self-concept and deterioration in social functioning (**Boyd, 2008**).

Coping strategies are a collection of cognitive and behavioral personal struggles adopted to interpret, comment and modify stressful situations and result in the suffer relief of these situations. There are two main coping strategies, first one is emotion focused strategies including all attempts to regulate emotional outcomes of the stressful events and make an emotional balance through emotions control, second one is problem focused coping strategies that include self-constructive behavior in relation with stressful situations and try to detect or change the source of stress (**Ghazanfari, 2008; Ghoreyshi, 2010**).

Strategies classified as problem-focused coping are directed at defining the problem or threat, generating solutions, weighing the alternatives, and choosing among them, then acting to deal with the threat. These coping

strategies are more likely to dominate when an individual appraises that the external or internal demands of a situation are changeable and thereby hold the potential for control (**Lazarus & Folkman, 1984**). Strategies classified as emotion-focused coping serve to regulate the emotional response to a problem and are more likely to be used if an event is appraised as not being amenable to change. Emotion-focused coping is directed at decreasing emotional distress and includes strategies such as avoidance, distancing, and minimization (**Lazarus & Folkman, 1984**). Throughout any stressful encounter, both forms of coping have specific functions in helping individuals deal with the demands of an event and are often used simultaneously to enhance each other.

The Jalowiec Coping Scale (JCS) 1977 was developed in an attempt to measure the types of coping strategies used by hemodialysis patients and their perceived effectiveness. This scale is based on Lazarus and Folkman's theory. Two versions of this scale are available, a 40 item and a revised 60 item. In the 60 item scale, Jalowiec operationalizes coping in terms of eight coping styles. Confrontive coping includes strategies such as facing up to or confronting the problem as opposed to Evasive coping, which involves strategies, aimed at avoiding the problem. Optimistic coping is when the person maintains a positive attitude about the problem in contrast to Fatalistic coping in which a pessimistic attitude predominates. Emotive coping strategies include expressing and releasing emotions. Doing things to make yourself feel better (e.g. exercise, eating) are classified as Palliative coping strategies. Supportant coping involves accessing support

systems from professionals family/friends, or higher powers (prayer). Finally, Self-reliant coping involves depending on yourself rather than others to deal with the problem. Jalowiec's tool has been frequently used in the research literature.

End Stage Renal Disease (ESRD): is a term used when kidney reaches a complete or almost complete failure to function; kidney can no longer remove wastes, regulate and concentrate (Usami et al., 2000). In addition, Gregorio et al. (1999) defined ESRD as irreversible loss of kidney function. At the point where kidneys fail to sustain life, renal replacement therapy is required. Dialysis is the process of cleaning the blood and removing excess fluids artificially with special equipment called the dialysis unit.

Dialysis: End Stage kidney failure, most commonly treated by dialysis. Eventually, most patients with End Stage kidney failure require a kidney transplant. Dialysis is a procedure that is performed routinely on persons who suffer from acute or chronic renal failure, or who have ESRD (Goldsmith et al., 2007).

Hemodialysis (HD): Hemodialysis removes waste and excess fluid from the blood when the kidneys cannot do so sufficiently. Hemodialysis is the most common method used to treat kidney failure. It may be performed in a hospital or hemodialysis center, or at home. During hemodialysis, the blood is drawn intravenously, sent through a machine called a dialyzer, and returned to the body through a blood vessel. Inside the dialyzer, the blood

is passed over a membrane that filters waste and fluid into a dialysate solution. The dialysate is then pumped out to a disposal tank and new dialysate is pumped in. The process of removing excess fluid is known as ultra filtration. The blood is circulated and diffused numerous times during a dialysis session; each circulation through the machine removes more waste and excess fluid. Hemodialysis is usually performed three or more times a week for 4 hours or more (**Health Communities, 2015**)

Stress: Stress is defined as a psychobiological reaction of the body to physical or psychological demands that threaten or challenge the organism's wellbeing (**Laposa et al. 2003**).

Stress also defined as "our reaction to events, environmental or internal, that tax or exceed our adaptive resources". Each of us has a certain number of coping resources, and when those coping resources are challenged or exceeded, stress usually results. Stress reactions consist of both physical and emotional responses (**Lazarus & Folkman, 1984**).

Stress is a demand made by the internal or the external environment of an organism (such as you and me), that upsets its homeostasis (or equilibrium), the restoration of which depends on a non-automatic and not readily available energy-expending action (**Antonovsky, 1974**).

Coping: Coping has been defined in psychological terms by Susan Folkman and Richard Lazarus in 1984 as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands

that are appraised as taxing" or "exceeding the resources of the person" **(Folkman & Lazarus, 1984 p. 141)**. Coping is conceptualized as attempts as to reduce or eliminate the negative effects of stress on well-being **(Edwards, 1993)**.

Chapter 2

Literature Review

A loss of renal function requiring haemodialysis leads to dramatic life changes that would be expected to be stressful and to require major coping efforts.

A variety of studies have shown type of stress and coping strategies used by hemodialysis patients (**Cinar, Barlas, & Alpar, 2009; Logan, Pelletier-Hibbert, & Hodgins, 2006**).

2.1 Stressors

Many studies have been conducted on ESRD patients due to variant stressors they faced in their life, and to assess these stressors Hemodialysis Stress Scale are mostly used. The studies have found stressors to be both physiological and psychological stressors (**Al Nazly et al, 2014; Baldree, & Murphy, 1982; Tu et al, 2013**).

Fatigue, physical limitations, and fluid and dietary restrictions have been consistently described in much of the research as most stressful problem perceived by hemodialysis patients (**Mok& Tam, 2001; Sensky, Leger,& Gilmour, 1996; Shahrokhi, 2014**).

Similar results were found also in a study performed by **Baldree, Murphy, and Powers (1982)** which aimed to assess the types and severity of stressors and methods of coping with stress for 35 patients on

hemodialysis. Results revealed that stressors experienced by the hemodialysis patient can be measured with an objective tool; psychosocial stressors have an impact equal to that of physiological stressors. Fluid restriction was ranked as the highest psychosocial stressor and the top physiological stressors were muscle cramps and fatigue. Also, **Tu et al. (2013)** found limitations of liquids, limitations of food, and fatigue to be the three most frequently stressors in their study.

Another study conducted on 102 black hemodialysis patients by **Burns (2004)**, the purposes of this study was to identify problems and coping strategies of blacks on hemodialysis and describe relationships among these patients' demographic characteristics, coping, and psychosocial and physiologic characteristics. Also found that the most frequently identified problems were fatigue, muscle soreness, and physical limitations, food and fluid restrictions were most bothersome stressors. Other studies have found also fatigue, fluid and food restriction to be the most bothersome stressors to hemodialysis patients (**logan et al. 2006; Shahrokhi et al. 2014**).

In Canada, a study conducted among hemodialysis patients aged over 65 years, with the purpose to identify the types of stressors experienced by in-hospital haemodialysis patients aged 65 years and older. Similar to previous research, the stressors of fatigue and fluid restrictions ranked highly as stressors in this sample. However, interference with social and recreational activities was stressors unique to this group. Findings challenge some common beliefs about haemodialysis patients. It is

commonly believed that these patients 'get used to' haemodialysis, and therefore the number and troublesomeness of stressors decrease over time (**Logan et al., 2006**).

Other stressors like vacation limitation, length of treatment and uncertainty about the future have been ranked within the top troublesome stressors in different studies. **Welsh & Austin (2001)** found that body appearance; uncertainty about the future; fluid limitations; length of treatment and vacation limitation are the most ranked stress. In addition, **Al Nazly et al. (2014)** conducted a study in Jordan, which aimed to assess stressors and coping among hemodialysis patients. Reported that limits on time and place for vacation was the most frequently reported stressor, followed by the second highest stressor, limitation of fluid intake and Length of dialysis treatment which had the same order. Similar to some previous results, a study conducted in Turkey by **Cinar et al. (2009)** aimed to assess the relationships among treatment-related stressors and coping strategies of chronic hemodialysis patients. Limitation of vacation (80.4%), followed by fatigue (79.9%) and uncertainty about future (79.0%) were the most frequent stressors reported.

Another study conducted in Australia by **Lok (1996)** to determine the significant stressors and coping methods which are related to quality of life in dialysis patients. The results revealed that limitation of physical activity was the most troublesome stressor followed by decrease in social life, uncertainty about the future, fatigue and muscle cramps.

2.2 Coping

Hemodialysis patients use different coping strategies to cope with their stressors, the kind of coping strategies they used depend on their internal and external resources. Most of studies used Jalowiec Coping Scale, to assess the coping strategies used by hemodialysis patients, some study described coping results as problem oriented, dealing with the problem that is causing the distress; and emotion-focused, serving to reduce the emotional discomfort, coping is classified into eight coping strategies (confrontive, emotive, fatalistic, self-reliant, palliative, evasive, optimistic, supportant coping).

A study by **Baldree, Murphy, and Powers (1982)** indicated that patients used problem-oriented coping methods significantly more than affective-oriented methods (p greater than .001). Optimism and controlling the situation were the two most common coping methods, and putting the problem out of one's mind and blaming someone else was the least important coping tool. Similar study by **Tu et al. (2013)** reported that patients used more problem-oriented coping strategies than affective-oriented ones.

Similar study done by **Lok (1996)** in Australia, aimed to identify the significant stressors and coping methods that related to quality of life in dialysis patients. Problem-solving methods were considered to be more effective than affective measures in dealing with stressors. CAPD patients were experiencing a higher quality of life than haemodialysis patients. Both haemodialysis and continuous ambulatory peritoneal dialysis (CAPD) patients their quality of life was perceived as below average. There was no significant relation between the length of time on the dialysis and coping behavior.

In addition, **Mok & Tam (2001)** conducted a study in Hong Kong, they found that the most common coping methods were 'accepted the situation because very little could be done', followed by 'told oneself not to worry because everything would work out fine' and 'told oneself that the problem was really not that important most results show a predominance to problem focused.

In contrast to the previous study results, a study done by **Bertolin et al. (2011)** about association between forms of coping and the socio-demographic variables of people on chronic hemodialysis, and they found there was a higher referral to the coping methods related to the factor Positive reappraisal, with a mean score of 1.41, and a lower reference to the coping methods related to the factor Confrontive coping, with a mean score of 0.60. There was a predominance of the emotion-focused coping methods.

In addition, **Blake and Courts (1996)** reported that patients aged 50–60 who were on dialysis for less than 8 years had an educational level of less than 12 years, showed no differences related to gender, and used more emotional coping strategies.

Pravan et al. (2015) conduct a study in Iran on 70 hemodialysis patients and peritoneal dialysis patients, to assess the coping strategies used among them. Results revealed that hemodialysis patients used coping strategies more frequently than the peritoneal dialysis patients, majority of patients used emotion –oriented coping strategies to deal with the stress.

Cinaret al. (2009) conducted a study in Turkey on 224 hemodialysis patients, to find out relationships among treatment-related stressors and coping strategies of chronic hemodialysis patients. The most frequently used coping strategies were turning to religion, active coping and suppression of competing activities. Physical treatment-related stressors were significantly related to behavioral disengagement.

Similarly, study done by **Burns (2004)** on 102 black hemodialysis patients aimed to identify problems and coping strategies, and to explain relationships among these patients' coping, demographic characteristics, and psychosocial and physiologic characteristics. Results revealed that putting trust in God was the most frequently identified strategy used among multiple strategies used to cope with the illness and its treatment. These findings help team members and specially nurses to improve the assessment of psychological and physiological stressors, and how to

intervene effectively in helping clients cope with the problems that are associated with the illness and its treatment.

2.3 Mediating factors

2.3.1 Gender

In Taiwan, a study had done on patients undergoing hemodialysis to examine whether gender differences in the stressor, coping strategies, and how they associate stress and copings among 875 elderly hemodialysis patients. The results found that the women had reported higher stress in response to physical and vessel problems and higher scores in using emotion-oriented and support-seeking coping strategies, while the men reported higher stress in reproductive system functioning and higher score in using avoidance as a coping strategy (**Yen et al., 2009**). Similar results in relation to stress have been found in a study conducted by **Lindqvist et al. (1998)** he reported that men viewed themselves as better able to cope with the physical aspect of the illness than women, while in a longitudinal study, that compared the stressors reported by 41 men and 45 women on hemodialysis. Results revealed no gender differences were recognized in the most highly rated stressors: fluid limitations, length of treatment, fatigue and vacation limitations. Only one of the 29 stressors was observed as statistically significant gender difference. Men reported to be more troubled by the stress associated with an uncertain future at Time 1 than women ($M = 2.41$ versus $M = 1.61$; no SD reported); however, this

difference was no longer evident after three months later at Time 2 (**Welch and Austin, 1999**).

According to coping strategies and gender, **Blake and Courts (1996)**, assessed the differences in coping strategies used by 15 men and 15 women on hemodialysis. Their results revealed no statistically significant gender differences were observed. The most common coping styles used by both were optimistic and confrontive. Although no gender differences were observed, the researchers noted that patients between the age of 50 and 60 years reported more emotion-focused strategies than those between the ages of 35 and 49 years.

In addition to a descriptive study by **Lindqvist et al. (1998)** aimed to identify gender differences with respect to the use and effectiveness of coping strategies by patients on CAPD versus hospital hemodialysis. They reported no gender differences in the coping styles used by patients in either dialysis group. Men and women both reported that an Optimistic coping style was most frequently used and considered most effective.

(Baldree et al. 1982; Gurklis & Menke, 1988) found that, men tend to use more problem focused coping than women.

Al Nazly et al. (2014) found that only confrontive coping strategy correlated positively with gender.

2.3.2 Duration of treatment

Cristovao's (1999) reported no correlation between individuals' length of time on hemodialysis and their stress, coping or quality of life. Similar results found in study by **Al Nazly et al. (2014)**, there were no significant correlations between length of time in years on dialysis and dialysis stressors. Negative correlation was found between length of time in years on dialysis and seeking social support, and with accepting responsibility. While other studies found positive correlation between duration of treatment and coping used and some study found positive correlation between duration of treatment and stressors.

Gurklis and Menke (1988) found a weak positive relationship ($r = .26$) between length of time and problem-oriented coping. **Lok (1996)** found no significant relation between the length of time on the dialysis and coping behavior. But found weak to moderate positive relationships between patients length of time on hemodialysis and their total stressor ($r = .35$) and psychosocial stressor ($r = .44$) scores, suggesting that people's stress levels tended to increase the longer they were on dialysis. No statistically significant association was observed however between length of time on dialysis and physiological stressors.

In addition, **Baldree, Murphy, and Powers (1982)** revealed in their study that patients on dialysis for one to three years indicated the greatest amount of stress.

Another longitudinal study by **Welch and Austin (1999)**, they measured stressors at the beginning of the study (Time 1) and three months later (Time 2), also separated participants into three groups in order to analyze differences in stressors by length of time on dialysis: those new to dialysis treatment ($n = 25$), those on dialysis for six to 18 months ($n = 23$), and those on dialysis for two to five years ($n = 38$). They found that new dialysis patients reported significantly higher levels of stress at both Time 1 and Time 2, insufficient information is provided to verify this conclusion (i.e. descriptive statistics by dialysis group were not reported). In addition, because the analysis was conducted at the item level as opposed to the total stressor score, multiple analyses were conducted which may have capitalized on chance differences.

Summery

People on hemodialysis experience a multitude of stressors and use various coping strategies. There is also limited understanding of the ability of variables such as sex, age and length of time on treatment to explain differences in people's stress and coping. Also it is an important area for investigation given the predicted growth in the number of people being diagnosed with ESRD and treated with dialysis. So investments in this area

of knowledge are important to help target nursing interventions specific to these individuals.

Chapter 3

Methodology

This chapter describes the research design, identification of population and sample, setting, instruments, ethical considerations, data collection procedures and statistical analysis.

3.1 Study design

A quantitative, cross-sectional, descriptive analytical study was carried out to achieve the aim of the study during the period between January to March 2014.

3.2 Setting

Data collection took place in three governmental hospitals and one private hospital in the North of West Bank, they are (Martyar Dr Khalil.S. hospital) in Jenin, (AL-Sheikh Nazal hospital) in Qalqyia, (Thabet Thabet hospital) in Tulkarm, and private (An-Najah University hospital) in Nablus.

(Martyar Dr Khalil.S. hospital) in Jenin was established in 1961 during the era of Jordanian government and was called AL-Amir Hassan hospital. In 2004 new departments were opened like operation rooms, x-ray department and reception, reaching 143 beds as total hospital number beds. Dialysis unit serve 102 hemodialysis patients, and they have just 14 dialyzer machines, which means that most patients do not have a big chance to dialyze for more than two times per week and only emergency cases.

(AL-Sheikh Nazal hospital) in Qalqyia. It consists of 56 beds and many departments; also it has a dialysis unit which consists of 9 dialyzer machines and serves 45 hemodialysis patients.

Thabet Thabet hospital was established in the period of British Mandate and Ottoman era, consisting of 56 beds and 5 major departments (surgery, medical, delivery, pediatric, and emergency departments). In the eighties number of bed increased to 65 beds and nowadays 132 beds. Dialysis unit serve a 66 hemodialysis patients, and they have 11 dialyzer machines.

An-Najah university hospital in Nablus was established in 2008 jointly with ministry of health as first Palestinian university hospital, with 120 beds and a total area of 17,000 square meters, the facility hosts a fully running intensive care unit (ICU), cardiac care unit (CCU), emergency room, dialysis treatment, X-ray, ultrasound, magnetic resonance imaging (MRI) and computerized tomography (CT) scan—making the hospital the most advanced provider of medical services in Palestine. Dialysis unit serve 166 hemodialysis patients, and have 30 dialyzer machines.

3.3 Sample and Sampling Method

3.3.1. Population

The population of this study was ESRD patients who underwent hemodialysis in North of West Bank hospitals, during the period between (20 January – 15 March\ 2014).

3.3.2. Sampling& Sample size

Sample size

All ESRD patients who underwent hemodialysis in 4 included hospitals, where included in the study, their number were 379 patients. For that sample was convenience one.

Sampling method

Convenient sampling method was used to select the sample participants from all setting. According to inclusion and exclusion criteria only 120 patients met the inclusion criteria of total 379 patients. Table (1) shows the distribution of excluded and included patients number within 4 hospitals.

Table (3.1) distribution of excluded and included patient's number within 4 hospitals.

Hospitals	Total pt number	Exclusion criteria						Excluded number	Sample number
		Above 65 years	Under 18 years	Less than 3 times/ week	Treatment duration less than 3 months	Tired physically	Refuse To participate		
Tulkarm	66	23	-	15	3	-	2	43	23
Nablus	166	59	6	1	20	7	12	105	61
Qalqilya	45	11	-	12	1	2	3	29	16
Jenin	102	9	1	60	6	3	3	82	20
Total number	379	102	7	88	30	12	20	249	120

Total ESRD patients number who underwent hemodialysis in 4 included hospitals in North of West Bank are 379 patients, not all were included in the research, only 120 patients met the inclusion criteria. From total number 20 patients refused to fulfill the questionnaire, 102 patients above 65 years old, 7 patients below 18 years old, and 88 patients dialyzed less than 3 times per week, 30 patients had been on hemodialysis for less than 3 months, and 12 patients were tired and unable to participate in research.

3.3.3. Inclusion Criteria

- Over 18 years and under 65 years of age.
- On hospital hemodialysis for at least 3 month.
- Admitted to selected hospital

3.3.4. Exclusion Criteria

- Have a cognitive impairment, as assessed by head nurse or senior shift.
- Dialysis less than 3 times per week.
- Participants who are younger than 18 years old.

Patients who are below 18 years old, receiving dialysis less than three times, and on dialysis for less than 3 month were excluded from the study for following reasons:

Patients below 18 years old are not authorized to sign on consent form, patients who are receiving dialysis less than three times per week are not exposition to severity of stress same to those who are three times per week.

3.4 Data collection tools

Face to face Interview using a structured questionnaire (ANNEX 1) has been conducted with the patients by researcher herself. Patients who are educated fulfill the questionnaire alone; those who are not educated, all of them were asked the questions by the researcher in constant manner to avoid the bias.

The questionnaire consisted of two parts:

1. The first part included demographic profile such as (Gender, Age, and dialysis duration).
2. Second part, consisted of two scales that have been adapted to measures the stressors and coping strategies among hemodialysis patients. They are:

1. Hemodialysis Stressor Scale (HSS)

Hemodialysis Stressor Scale (HSS): developed by Baldree, et al. (1982) this scale measure the level of stress experienced by hemodialysis patients. It consists of 32-items that describe the stressors which hemodialysis patients mostly face in their life. The items consisted of 4-point Likert scale ranging from (1-4) with higher scores indicating the greater severity of stress experienced. The 32-items scale is grouped into two stressors sub-scales: psychosocial (25-items) stressors, and physiological (7-items) stressors (ANNEX 2).

2. Jalowiec Coping Scale (JCS)

The JCS tool is consisting of 60 items, each is a statement of 4-point Likert scale ranging from 1 (never used / not helpful) to 4 (always used / very helpful) was used. Higher scores indicated a higher frequency of use and perceived helpfulness of coping strategies. Participants answered each item in two ways: (1) frequency of use and (2) perceived helpfulness. The positive side of using this scale is that the content validity of this instrument is supported by the systematic manner in which the tool was developed. This included a comprehensive review of the literature as well as input from a variety of health care professionals, chronically ill individuals, including hemodialysis patients, and family members (Jalowiec, 1995).

The scale is representing eight coping styles (ANNEX 3);

1. Confrontive (10 items/strategies).
2. Evasive (13 items/strategies).
3. Optimistic (9 items/strategies).
4. Fatalistic (4 items/strategies).
5. Emotive (5 items/strategies).
6. Palliative (7 items/strategies).
7. Supportant (5 items/strategies).
8. Self-Reliant (7 items/strategies).

3.5 Validity

3.5.1. Translation

The questionnaire or scales have been translated in special English translation center (Academic of Language and Translation), in addition they were revised by two psychologist doctors who are specialized in psychology, one of them check the translation from English to Arabic and another doctor made back translation from Arabic to English, he is considered experts in the English language, and reviewed by 2 nursing academic doctors, and one psychiatric nurse. They accept the translation without any comments change.

3.5.2. Pilot study

A pilot study was conducted with ten hemodialysis patients, in order to identify potential problem, clarity of questions translation, understanding of questionnaire, and time required to complete the questionnaire. Pilot participants comments on 2 items in coping scale were founded culturally not suitable. These items were number 8(got mad let off steam), and number 34(took drink to make yourself feel better) they were excluded from the scale. Pilot sample were not included within the total sample and time required to accomplished the questionnaire according to pilot estimated to be 20-30 minutes.

3.6. Reliability

HSS: The internal consistency Cronbach's alpha for the total stress scales from previous studies was 0.89 indicating good internal reliability Baldree, et al., (1982). The internal consistency (Chronbach Alpha) in this study found to be, (0, 83) for hemodialysis stress scale

JCS: The internal consistency Cronbach's alpha for the total use and effectiveness scales from previous studies were (0, 88) and (0, 91) respectively indicating good internal reliability (Jalowiec, 1995).

The internal consistency (Chronbach Alpha) in this study found to be (0, 80) for coping scale, and (0, 67) for helpfulness of coping scale, they are good and satisfy the purpose of the study.

3.7. Ethical consideration

Written permission to use both HSS and JCS scales were taken via email from their original authors (ANNEX 4, 5).

Permission obtained from Institutional Review Board (IRB) from the Faculty of Graduate Studies (ANNEX 6), and approval letters were attained from the Palestinian Ministry of Health (M.O.H) (ANNEX 7), to conduct this study and to use the facilities in 3 governmental hospitals in North of West Bank, and other approval letter was taken from An-Najah University Hospital to conduct the study in their hospital.

Permissions and signed informed consent obtained from each participant after discussing with each of them the purpose of the study (ANNEX 8). All the patients informed that obtained data is confidential and only for research purposes. If participant became tired or feel uncomfortable during the interview, I will stop the interview immediately until the patient improve better and be able to participate again taking in consideration his agreement and acceptance in continuing the interview.

Data Storage: data is stored in locked locker for 1 year then I will burn them.

Copy of results will be sent to the M.O.H and to participated hospitals.

3.8. The Study Fieldwork

After getting the acceptance from (I.R.B) and(M.O.H)allowing to conduct the research, the study was conducted during the period of time between January2014- March 2014, in 3 governmental hospitals and 1 private hospital in North of West Bank.

All hospitals matrons were met before data collection, to explain importance and aim of the study, and then participants were met in dialyses room to explain the aim, ethical issues and interest of the study. A signed informed consent was obtained from the participant who expressed interest in the study at the time of the meeting. Face to face interviewed conducted in dialyses room, some of participants interviewed during dialyses and

some of them after dialyses, each interview approximately took 20-30 minutes.

1-AL-Najah Hospital in Nablus: 4 visits /week have been conducted in each visit 7-12 patients were interviewed. The field work in this hospital finished within 2 weeks resulted in interviewing 61 patients.

2- Jenin Hospital: 4 visits /week have been conducted in each visit 5-6 patients were interviewed. The field work in Jenin hospital took 1 week resulted in interviewing 20 patients.

3- Tulkarem Hospital: 4 visits /week have been conducted in each visit 5-6 patients were interviewed. The field work in Tulkarem took 1 week resulted in interviewing 23 patients.

4- Qalqyia Hospital: 3 visits /week have been conducted in each visit 5-6 patients were interviewed. The fieldwork in Qalqyia hospital took 1 week, resulted in interviewing 16 patients.

3.9. Data analysis

Data was entered and analyzed by specialized person in analysis, and revised by another one for validity, using Statistical Package for Social Science (SPSS). Chi-square test was used for the relationship between stressors type and coping strategies, and relation between coping and helpfulness of coping; t-test and ANOVA were used to test the relationship between stress types, coping styles and demographic characteristics.

Scoring level for agreement

80% and more=very big

79.9%-60%=big

59.9%-40%=middle

39.9%and less= little

This reflected the agreement among participants regard each item based on the statistical knowledge.

Summary

This chapter is devoted to specify the steps and the methodology taken in carrying out the research endeavor. In this chapter the researcher presents research design, study population, sample, instrument, data collection procedures, ethical issues and the statistical analysis.

Chapter 4

Results

Introductions

This chapter presents the results of the study: part (1) analysis of various demographic data, part (2) analysis of stressor scale, part (3) analysis of coping strategies scale, part (4) analysis of relationship between coping and demographic data, part (5) analysis of relationship between stressors and demographic data, part (6) analysis of relationship between stressors and coping strategies, and finally between coping and helpfulness of coping.

4.1 Socio-Demographic Data

Table (4.1): Distribution of frequency and percentage of participants regarding their socio-demographic data

Demographic Data			
Variables		No	(%)
Gender	Male	77	64.2
	Female	43	35.8
AGE	18 -30 years	16	13.3
	31 to 39 years	16	13.3
	40 to 49 years	44	36.7
	50 years to 65 years	44	36.7
Duration of treatment	less than 3 years	52	43.3
	3 to 5 years	45	37.5
	6 to 8 years	10	8.3
	9 years and more	13	10.8
Total		120	100%

Table (4.1) showed that 64.2% of the HD patients were males, and 36.7% of them were in the age groups of (40-49 and 50-65) years old. Regarding their duration of treatment, 43.3% of them having a period of less than 3 years, while 8.3% of them having it from 6 to 8 years.

4.2-Hemodialysis Stress Scale Results

Table (4.2): Distribution of mean, SD, percentage, and Level of agreement

The order	No.	Items	Mean	± Std D	Percentage %	Agreement
scale(2-1):Physiological stressors						
6	1	Feeling tired	3.0420	1.00334	76.1	Big
7	2	Loss of body function	3.0252	1.06136	75.6	Big
3	3	Muscle cramps/soreness	2.6833	1.09224	67.1	Big
2	4	Nausea and vomiting	2.5667	1.21429	64.2	Big
5	5	Stiffening of joints	2.4958	1.14147	62.4	Big
4	6	Itching	2.4083	1.22643	60.2	Big
1	7	Arterial & venous stick	2.3277	1.06651	58.2	Middle
Total Mean for scale 1			2.6552	.66529	66.4	Big
scale(2-2): Psychological stressors						
23	8	Limits on time and place for vacation	3.3667	1.10715	84.2	Very Big
12	9	Decrease in sexual derive	3.2906	.94741	82.3	Very big
9	10	Limitation of food	3.0840	.95296	77.1	Big
22	11	Transportation to and from the unit	3.0500	1.20817	76.3	Big
31	12	Decreased ability to have children	3.0360	1.10312	75.9	Big
32	13	Length of treatment	2.9286	1.16800	73.2	Big
11	14	Interference with job	2.8889	1.22318	72.2	Big
13	15	Limitation of physical activity	2.7667	1.10563	69.2	Big
10	16	Limitation of fluid	2.7563	1.25527	68.9	Big
18	17	Uncertainty about the future	2.7000	1.20643	67.5	Big
29	18	Feelings related to treatments example;(feeling cold)	2.7000	1.14202	67.5	Big
8	19	Decrease in social life	2.6667	1.11772	66.7	Big
21	20	Cost of treatment /transportation to treatment /or other cost factors	2.6471	.97066	66.2	Big
14	21	Sleep disturbances	2.6250	1.09285	65.6	Big
20	22	Limited in style of clothing	2.5917	1.28662	64.8	Big
28	23	Fear of being alone	2.5085	1.18210	62.7	Big
24	24	Frequent hospital admission	2.5	1.15285	62.5	Big
15	25	Changes in family responsibilities	2.3950	1.21585	59.9	Middle
17	26	Reversal in family roles with the children	2.3417	1.23326	58.5	Middle
30	27	Boredom	2.2167	1.35463	55.4	Middle

19	28	Changes in body appearance	2.1583	1.22300	54.0	Middle
16	29	Reversal in family role with spouse	2.0684	1.22985	51.7	Middle
27	30	Dependency on physicians	1.9083	1.11518	47.7	Middle
25	31	Dialysis machine and /or equipment	1.8487	1.17631	46.2	Middle
26	32	Dependency on nurses and technicians	1.8000	1.12720	45.0	Middle
Total mean scale2			2.6250	.48822	65.6	Big
Total mean			2.5989	.47509	65.0	Big

Table (4.2) shows the mean, standard deviation, percentage, and level of agreement of HD patients on stress scale. Total mean score was 2.5989it revealed big agreement (65.0%) in using by HD patients.

Regarding to HSS items, the percentage for the highest item according to the total scale "Limits on time and place for vacation" was rated as most84.2%troublesome stressors items.

According to the subscales, in physiological stress subscale," Feeling tired "was rated as most (76.1%) troublesome stressors items, followed by "Loss of body function"(75.6%), while the stress item with the lowest score was "Arterial & venous stick" (58.2%).

In psychological stress subscale items "Limits on time and place for vacation" was rated as most (84.2%) troublesome stressors items, followed by(Decrease in sexual derive) (82.3%), while the stress item with the lowest score was (Dependency on nurses and technicians) (58.2%).

4.3 Jalowiec Coping Scale Results

Table (4.3) shows the mean, standard deviation, percentage and level of agreement of HD patients on coping scale; total mean score was 2.6513 it revealed big agreement (66.3%) in using by HD patients.

According to subtypes of coping scale the percentage for the highest coping strategies used was (Optimistic coping) with (77.2%), followed by (Supportant coping) with (74.3%), followed by (Fatalistic coping) with (71.3%), while (Emotive coping) appeared to be with least percentage (53.1%).

Regarding to JCS items, the percentage for the highest item according to total JCS was, “Prayed or put your trust in God” was rated as most (94.8%) coping strategies used, followed by “Tried to keep your life as normal as possible and not let the problem interfere” (90.0%), while the coping item with the lowest score was “Did something impulsive or risky that you would not usually do” (29.2%).

Table (4.3): Distribution of mean, SD, percentage, and Level of agreement of coping strategies.

The order	No.	Items	Mean	SD ±	Percentage %	Agreement
Scale 3-1: Confronted coping style						
16	1	Tried to keep the situation under control	3.2185	.81469	80.5	Very big
27	2	Tried to find out more about the problem	3.0500	1.17287	76.3	Big
13	3	Tried to look at the problem objectively and see all sides	2.9748	.84835	74.4	Big
43	4	Practiced in your mind what had to be done	2.6667	1.06379	66.7	Big
29	5	Tried to handle things one step at a time	2.5417	.95174	63.5	Big
4	6	Thought out different ways to handle the situation	2.4583	1.18034	61.5	Big
25	7	Tried to change the situation	2.2333	1.09800	55.8	Middle
45	8	Learned something new in order to deal with the problem	2.0593	1.09617	51.5	Middle
38	9	Set up a plan of action	1.8376	1.03355	45.9	Middle
33	10	Tried to work out a compromise	1.7797	.89763	44.5	Middle
Total mean scale3-1			2.4946	.57294	62.4	Big

Table (3-1) shows the mean, standard deviation, percentage, and level of agreement of HD patients on confronted coping strategies; it revealed big agreement (62.4%) in using by HD patients.

“Tried to keep the situation under control” found to be most usable item (80.5%), while “Tried to work out a compromise” was found to be least used(44.5%).

Scale 3-2: Evasive coping style						
58	11	Wished that the problem would go away	3.5417	.81885	88.5	Very big
35	12	Let time take care of the problem	3.5167	.76678	87.9	Very big
10	13	Tried to put the problem out of your mind and think of something else	2.9167	.94898	72.9	Big
14	14	Daydreamed about a better life	2.9167	1.22016	72.9	Big
40	15	Put off facing up to the problem	2.8833	.98887	72.1	Big
7	16	Tried to get away from the problem for awhile	2.6410	1.06238	66.0	Big
55	17	Told yourself that this problem was really not that important	2.6017	1.13333	65.0	Big
48	18	Tried to ignore or avoid the problem	2.5593	1.18785	64.0	Big
18	19	Tried to get out of the situation	2.4000	1.07218	60.0	Big
21	20	Waited to see what would happen	2.2167	1.07049	55.4	Middle
28	21	Slept more than usual	2.1261	1.23202	53.2	Middle
56	22	Avoided being with people	1.8083	1.01498	45.2	Middle
20	23	Told yourself that the problem was someone else's fault	1.6387	1.14041	41.0	Middle
Total mean scale3- 2			2.5796	.30704	64.5	Big

Table (3-2) shows the mean, standard deviation, percentage and level of agreement of HD patients on evasive coping strategies; it revealed big agreement (64.5%) in using by HD patients.

“Wished that the problem would go away” found to be most usable item (88.5%), while “Told yourself that the problem was someone else's fault” was found to be least used(41.0%).

Scale 3-3: Optimistic coping style						
30	24	Tried to keep your life as normal as possible and not let the problem interfere	3.6000	.69088	90.0	Very big
39	25	Tried to keep a sense of humor	3.5333	.70928	88.3	Very big
47	26	Thought about the good things in your life	3.4500	.68415	86.3	Very big
50	27	Tried to think positively	3.3083	.85794	82.7	Very big
32	28	Told yourself not to worry because everything would work out fine	3.2000	.98390	80.0	Very big
2	29	Hoped that things would get better	2.7227	1.17115	68.1	Big
5	30	Told yourself that things could be much worse	2.7167	1.08607	67.9	Big
49	31	Compared yourself with other people who were in the same situation	2.6833	.81975	67.1	Big
54	32	Tried to see the good side of the situation	2.5424	1.07532	63.	Big
Total mean scale 3-3			3.0864	.45699	77.2	Big

Table (3-3) shows the mean, standard deviation, percentage, and level of agreement of HD patients on optimistic coping strategies; it revealed big agreement (77.2%) in using by HD patients.

“Tried to keep your life as normal as possible and not let the problem interfere” found to be most usable item (90.0%), while “Tried to see the good side of the situation” was found to be least used (63.0%).

Scale3-4: Fatalistic coping style						
12	33	Accepted the situation because very little could be done	3.5417	.78746	88.5	Very big
9	34	Expected the worst that could happen	3.1092	1.00667	77.7	Big
23	35	Resigned yourself to the situation because things looked hopeless	3.1000	1.81682	77.5	Big
60	36	Told yourself that you were just having some bad luck	1.7373	1.10498	43.4	Middle
Total mean scale3- 4			2.8500	.66865	71.3	Big

Table (3-4) shows the mean, standard deviation, percentage, and level of agreement of HD patients on fatalistic coping strategies; it revealed big agreement (71.3%) in using by HD patients.

“Accepted the situation because very little could be done” found to be most usable item (88.5%), while “Told yourself that you were just having some bad luck” was found to be least used (43.4%).

Scale3-5: Emotive coping style						
1	37	Worried about the problem	2.8167	1.20212	70.4	Big
24	38	Took out your tensions on someone else	2.6083	1.11744	65.2	Big
51	39	Blamed yourself for getting into such a situation	1.9573	1.29584	48.9	Middle
46	40	Did something impulsive or risky that you would not usually do	1.1695	.57446	29.2	Little
Total mean scale3- 5			2.1250	.64141	53.1	Middle

Table (3-5) shows the mean, standard deviation, percentage, and level of agreement of HD patients on emotive coping strategies; it revealed middle agreement (53.5%) in using by HD patients.

“Worried about the problem” found to be most usable item (70.4%), while “Did something impulsive or risky that you would not usually do” was found to be least used (29.2%).

Scale 3-6: Palliative coping style						
36	41	Tried to distract yourself by doing something that you enjoy	3.2650	.87487	81.6	Very big
44	42	Tried to keep busy	3.2500	.74755	81.3	Very big
26	43	Used relaxation techniques	2.4958	1.09602	62.4	Big
3	44	Ate or smoked more than usual	1.6723	1.03424	41.8	Middle
6	45	Exercised or did some physical activity	1.5462	.96329	38.7	Little
53	46	Took medication to reduce tension	1.5299	1.03867	38.2	Little
Total mean scale 3-6			2.2725	.42367	56.8	Middle

Table (3-6) shows the mean, standard deviation, percentage, and level of agreement of HD patients on palliative coping strategies; it revealed middle agreement (56.8%) in using by HD patients.

“Tried to distract yourself by doing something that you enjoy” found to be most usable item (81.6%), while “Took medication to reduce tension ”was found to be least used (38.2%).

Scale 3-7: Supportant coping style						
17	47	Prayed or put your trust in God	3.7917	.48326	94.8	Very big
42	48	Talked the problem over with someone who had been in similar situation	3.0339	1.06964	75.8	Big
11	49	Talked the problem over with family or friends	3.0168	1.10456	75.4	Big
15	50	Talked the problem over with a professional person (such as a doctor, nurse, minister, teacher, counselor)	2.8067	1.11445	70.2	Big
59	51	Depended on others to help you out	2.1864	1.13942	54.7	Middle
Total mean scale 3-7			2.9704	.61115	74.3	Big

Table (3-7) shows the mean, standard deviation, percentage, and level of agreement of HD patients on supportant coping strategies; it revealed big agreement (74.3%) in using by HD patients.

“Prayed or put your trust in God”found to be most usable item (94.8%), while “Depended on others to help you out” was found to be least used (54.7%).

Scale3- 8: Self – reliant coping style					
41	52	Tried to keep your feelings under control	3.2712	.76974	81.8 Very big
52	53	Preferred to work things out yourself	3.2185	.90347	80.5 Very big
37	54	Told yourself that you could handle anything no matter how hard	2.8898	1.09999	72.2 Big
57	55	Tried to improve yourself in some way so you could handle the situation better	2.5417	1.09157	63.5 Big
31	56	Thought about how you had handled other problems in the past	2.4083	1.05716	60.2 Big
22	57	Wanted to be alone to think things out	2.3750	1.13065	59.4 Middle
19	58	Kept your feelings to yourself	1.9160	1.11674	47.9 Middle
Total mean scale3- 8			2.6576	.49805	66.4 Big
Total mean			2.6513	.32266	66.3 Big

Table (3-8) shows the mean, standard deviation, percentage, and level of agreement of HD patients on self-reliant coping strategies; it revealed big agreement (66.4%) in using by HD patients.

“Tried to keep your feelings under control” found to be most usable item (81.8%), while “Kept your feelings to yourself” was found to be least used (47.9%).

4.4 Coping Helpfulness Results

Table (4.4): Distribution of mean, SD, percentage, and Level of agreement of coping helpfulness

order	NO	Items	Mean	SD±	%	Agreement
1	17	Prayed or put your trust in God	3.8250	.42332	95.6	Very big
2	39	Tried to keep a sense of humor	3.4958	.67490	87.4	Very big
3	30	Tried to keep your life as normal as possible and not let the problem interfere	3.4957	.62455	87.4	Very big
4	11	Talked the problem over with family or friends	3.4717	.63557	86.8	Very big
5	36	Tried to distract yourself by doing something that you enjoy	3.4609	.65275	86.5	Very big
6	50	Tried to think positively	3.4464	.75742	86.2	Very big
7	47	Thought about the good things in your life	3.4174	.70066	85.4	Very big
8	32	Told yourself not to worry because everything would work out fine	3.3982	.64835	85.0	Very big
9	12	Accepted the situation because very little could be done	3.3684	2.94571	84.2	Very big
10	44	Tried to keep busy	3.2017	.68371	80.0	Very big
11	10	Tried to put the problem out of your mind and think of something else	3.1887	.69163	79.7	Big
12	41	Tried to keep your feelings under control	3.1681	.78459	79.2	Big
13	16	Tried to keep the situation under control	3.1491	.76693	78.7	Big
14	42	Talked the problem over with someone who had been in similar situation	3.1333	.79743	78.3	Big

15	14	Daydreamed about a better life	3.0900	.88871	77.3	Big
16	2	Hoped that things would get better	3.0521	.88698	76.3	Big
17	37	Told yourself that you could handle anything no matter how hard	3.0463	.86882	76.2	Big
18	35	Let time take care of the problem	3.0420	.81714	76.1	Big
19	27	Tried to find out more about the problem	3.0392	.83157	76.0	Big
20	52	Preferred to work things out yourself	3.0381	.71956	76.0	Big
21	15	Talked the problem over with a professional person (such as a doctor, nurse, minister, teacher, counselor)	2.9608	.80741	74.0	Big
22	7	Tried to get away from the problem for awhile	2.9592	.89579	74.0	Big
23	40	Put off facing up to the problem	2.9266	.93002	73.2	Big
24	55	Told yourself that this problem was really not that important	2.9247	.89972	73.1	Big
25	57	Tried to improve yourself in some way so you could handle the situation better	2.9238	.81683	73.1	Big
26	26	Used relaxation techniques	2.9029	.73451	72.6	Big
27	6	.Exercised or did some physical activity	2.8983	.86493	72.5	Big
28	13	Tried to look at the problem objectively and see all sides	2.8376	.84033	70.9	Big
29	49	Compared yourself with other people who were in the same situation	2.8241	.77132	70.6	Big
30	43	Practiced in your mind what had to be done	2.8190	.87465	70.5	Big
31	29	Tried to handle things one step at a time	2.8125	.78879	70.3	Big

32	48	Tried to ignore or avoid the problem	2.8068	.84225	70.2	Big
33	58	Wished that the problem would go away	2.8053	1.00764	70.1	Big
34	31	Thought about how you had handled other problems in the past	2.7700	.99346	69.3	Big
35	5	Told yourself that things could be much worse	2.7547	.95430	68.9	Big
36	38	Set up a plan of action	2.6923	.97111	67.3	Big
37	18	Tried to get out of the situation	2.5745	.84865	64.4	Big
38	25	Tried to change the situation	2.5543	.84339	63.9	Big
39	54	Tried to see the good side of the situation	2.5370	.82514	63.4	Big
40	22	Wanted to be alone to think things out	2.3370	.81574	58.4	Middle
41	45	Learned something new in order to deal with the problem	2.3214	.90728	58.0	Middle
42	23	Resigned yourself to the situation because things looked hopeless	2.3137	1.08071	57.8	Middle
43	56	Avoided being with people	2.2346	1.04009	55.9	Middle
44	21	Waited to see what would happen	2.2135	.88513	55.3	Middle
45	28	Slept more than usual	2.1348	.99076	53.4	Middle
46	33	Tried to work out a compromise	2.0921	.85131	52.3	Middle
47	4	Thought out different ways to handle the situation	2.0707	.88355	51.8	Middle
48	59	Depended on others to help you out	2.0543	.88161	51.4	Middle
49	24	Took out your tensions on someone else	1.9510	1.06592	48.8	Middle

50	53	Took medication to reduce tension	1.9167	.86928	47.9	Middle
51	19	Kept your feelings to yourself	1.8795	.81746	47.0	Middle
52	20	Told yourself that the problem was someone else's fault	1.7273	1.01596	43.2	Middle
53	9	Expected the worst that could happen	1.5664	.84384	39.2	Little
54	46	Did something impulsive or risky that you would not usually do	1.5660	1.06535	39.2	Little
55	51	Blamed yourself for getting into such a situation	1.5263	.88655	38.2	Little
56	60	Told yourself that you were just having some bad luck	1.4063	.68357	35.2	Little
57	3	Ate or smoked more than usual	1.3768	.64401	34.4	Little
58	1	Worried about the problem	1.3208	.68379	33.0	Little
Total average			2.7637	.37414	69.1	Big

Table (4.4) shows the mean, standard deviation, percentage, and level of agreement of HD patients on the helpfulness of coping strategies; total mean score was 2.7637 it revealed big agreement (69.1%) in using by HD patients.

“Prayed or put your trust in God” found to be most usable item (95.6%), while “Worried about the problem” was found to be least used(33.0%).

4.5 Results of differences between stressors, and demographic characteristics

Table (4.5): Differences of mean and SD for stressors types in regard to the gender.

Scale	Sex	N	Mean	Std ±	Df	t	P value
Scale 1 Physiological	Male	74	2.6062	.64878	114	-1.053	.294
	Female	42	2.7415	.69288			
Scale 2 Psychology	Male	66	2.6667	.46076	94	1.244	.217
	Female	30	2.5333	.54068			
Mean stressor	Male	77	2.6422	.44129	118	1.343	.182
	Female	43	2.5212	.52678			

Table (4.5) shows t-test results of the difference between stressors types according to HD patients gender; the mean score of stressors for male was (2.64 ± 0.441) and for female was (2.52 ± 0.526) with no significant difference (*p value .182*).

Regarding the stressors subscale, the mean score of physiological stressors for male was (2.60 ± 0.648), and for females was (2.74 ± 0.692), while the mean score of psychological stressors for male was (2.66 ± 0.460), and for females was (2.53 ± 0.540) with no significant difference.

Table (4.6): Differences of mean and SD for stressors types in regard to the age using ANOVA test.

		N	Mean	SD±	F	P value
Scale 1 Physiological	18 to 30 years	16	2.5179	.71690	.370	.775
	31 to 39 years	15	2.6476	.70580		
	40 to 49 years	41	2.6411	.63255		
	50 to 65 years	44	2.7208	.67707		
	Total	116	2.6552	.66529		
Scale2 Psychological	18 to 30 years	13	2.6154	.54149	.109	.955
	31 to 39 years	13	2.6154	.43067		
	40 to 49 years	35	2.6617	.48665		
	50 to 65 years	35	2.5954	.50780		
	Total	96	2.6250	.48822		
T Stressor	18 to 30 years	16	2.5343	.55050	.194	.900
	31 to 39 years	16	2.5559	.44739		
	40 to 49 years	44	2.6256	.50432		
	50 to 65 years	44	2.6112	.43776		
	Total	120	2.5989	.47509		

Table (4.6) shows ANOVA test of the difference between stressors type and age. It illustrates that the mean score for stress scale was (2.62) for age group (40-49), and (2.53) for age group (18-30) with no significant difference (*p value 0.900*).

Regarding the stress subscale, the mean score of physiological stressors was (2.72) for age group (50-65), while psychological stressors the mean score was (2.66) for age group between (40-49), with no significant difference.

Table (4.7): Differences of mean and SD for stressors types in regard to the duration of treatment using ANOVA test.

Stress types	Duration of treatment	N	Mean	Std. Deviation	F	P value
Scale 1 Physiological	less than 3 years	50	2.6429	.69403	.519	.670
	3 to 5 years	43	2.5980	.66734		
	6 to 8 years	10	2.7000	.64751		
	9 years and more	13	2.8571	.58612		
	Total	116	2.6552	.66529		
Scale 2 Psychological	less than 3 years	43	2.5135	.45195	4.401	.006
	3 to 5 years	42	2.8019	.46075		
	6 to 8 years	6	2.2200	.45378		
	9 years and more	5	2.5840	.61031		
	Total	96	2.6250	.48822		
Total stressor	less than 3 years	52	2.5129	.47351	3.054	.031
	3 to 5 years	45	2.7356	.45458		
	6 to 8 years	10	2.3387	.37382		
	9 years and more	13	2.6694	.50900		
	Total	120	2.5989	.47509		

Table (4.7) shows ANOVA test of the difference between stressors types and duration of treatment. It illustrates that the mean score of stress scale for duration of treatment from (3-5 years) was (2.735) and for duration of treatment from (6-8 years) was (2.338) with significant difference for duration of treatment from (3-5 years) (*p value 0.031*).

Regarding the stress subscale, the mean score of physiological stressors was (2.85) for duration of treatment from (9 years and more) with no significant difference.

While psychological stressors the mean score was (2.80) for duration of treatment from (3-5years), and (2.220) for duration of treatment from (6-8 years) with significant difference for duration of treatment from (3-5 years)(*p value 0.006*).

4.6 Results of differences between coping, and demographic characteristics

Table (4.8): Differences of mean and SD for coping strategies regard to the gender.

Scale	Gender	N	Mean	SD±	Df	<i>t</i>	P value
Scale 1 Confrontive coping style	Male	74	2.5189	.50820	110	.624	.030
	Female	38	2.4474	.68684			
Scale 2 Evasive coping style	Male	74	2.5925	.32827	112	.608	.062
	Female	40	2.5558	.26561			
Scale 3o Optimistic coping style	Male	75	3.0489	.46508	115	-1.189	.432
	Female	42	3.1534	.43964			
Scale 4 Fatalistic coping style	Male	76	2.7829	.53126	116	-1.474	.018
	Female	42	2.9714	.85797			
Scale 5 Emotive coping style	Male	74	2.0574	.59037	114	-1.514	.248
	Female	42	2.2440	.71459			
Scale 6 Palliative coping style	Male	75	2.2578	.45462	113	-.507	.029
	Female	40	2.3000	.36241			
Scale 7 Supportant coping style	Male	74	2.9811	.62036	113	.250	.984
	Female	41	2.9512	.60130			
Scale 8 Self-reliant coping style	Male	77	2.6327	.50477	114	-.758	.732
	Female	39	2.7070	.48716			
Mean coping	Male	77	2.6279	.28797	118	-1.060	.222
	Female	43	2.6930	.37701			

Table (4.8) shows t-test results of the difference between the coping strategies used among HD patients and their gender. The mean score of coping scale for male was (2.62 ± 0.287) and for female was (2.69 ± 0.377) with no significant difference (*p value* .222)

Regarding the analysis of coping subscale and gender the mean score of fatalistic and palliative coping for females was (2.97 ± 0.85) and (2.30 ± 0.36) respectively, with significant difference for females (*p value* .018 and .029) respectively.

According to confrontive coping the mean score for males was (2.51 ± 0.50) and for females was (2.44 ± 0.68) with significant difference between male and females; for males (*p value*.030).

Table (4.9): Differences of mean and SD for coping strategies regard to the age using ANOVA test.

Scale	Age	N	Mean	Std±	F	P <.001
Scale 1 Confrontive coping style	18 to 30 years	14	2.5071	.68440	1.384	.252
	31 to 39 years	15	2.3333	.44347		
	40 to 49 years	41	2.6268	.65728		
	50 to 65 years	42	2.4190	.46760		
	Total	112	2.4946	.57294		
Scale 2 Evasive coping style	18 to 30 years	13	2.7101	.41561	.904	.442
	31 to 39 years	15	2.5692	.18797		
	40 to 49 years	42	2.5531	.29876		
	50 to 65 years	44	2.5699	.31139		
	Total	114	2.5796	.30704		
Scale 3 Optimistic coping style	18 to 30 years	13	3.1538	.54156	.153	.927
	31 to 39 years	16	3.0417	.59056		
	40 to 49 years	44	3.0934	.37273		
	50 to 65 years	44	3.0758	.46760		
	Total	117	3.0864	.45699		
Scale 4 Fatalistic coping style	18 to 30 years	14	2.4643	.75865	2.059	.110
	31 to 39 years	16	2.8438	.49896		
	40 to 49 years	44	2.9670	.74287		
	50 to 65 years	44	2.8580	.58419		
	Total	118	2.8500	.66865		
Scale 5 Emotive coping style	18 to 30 years	13	2.5846	.57423	2.219	.090
	31 to 39 years	15	3.1333	.58391		
	40 to 49 years	44	3.0000	.60694		
	50 to 65 years	43	3.0000	.60945		
	Total	115	2.9704	.61115		
Scale 6 Palliative coping style	18 to 30 years	15	2.8095	.54710	1.156	.330
	31 to 39 years	16	2.5982	.56477		
	40 to 49 years	42	2.7143	.48471		
	50 to 65 years	43	2.5714	.46448		
	Total	116	2.6576	.49805		
Scale 7 Supportant coping style	18 to 30 years	12	2.3125	.26382	1.576	.199
	31 to 39 years	16	2.2188	.56917		
	40 to 49 years	44	2.1989	.66817		
	50 to 65 years	44	1.9659	.69171		
	Total	116	2.1250	.64141		

Scale 8 Self-reliant coping style	18 to 30 years	13	2.4231	.33758	.952	.418
	31 to 39 years	16	2.1771	.40583		
	40 to 49 years	42	2.2381	.51816		
	50 to 65 years	44	2.2955	.34451		
	Total	115	2.2725	.42367		
Mean coping	18 to 30 years	16	2.6871	.35357	.772	.512
	31 to 39 years	16	2.5974	.30208		
	40 to 49 years	44	2.6991	.39352		
	50 to 65 years	44	2.6100	.22842		
	Total	120	2.6513	.32266		

Table (4.9) shows ANOVA test of the difference between coping strategies and age, it illustrates that the mean score for coping scale was (2.69) for age group (40-49), and (2.68) for age group (18-30), and it was (2.59) for age group (31-39) with no significant difference (*p value 0.512*).

Regarding coping subscale, the mean score of confrontive, fatalistic coping strategies were (2.62) and (2.96) respectively for age group (40-49). In regard to evasive, optimistic, palliative, supportant, and self-reliant coping strategies the mean score were (2.71), (3.15), (2.80), (2.31), and (2.42), respectively for age group (18-30), while for emotive coping strategies the mean score was (3.13) for age group (31-39) with no significant difference.

Table (4.10): Differences of mean and SD for coping strategies regard to the duration of treatment using ANOVA test.

Coping style	Duration of treatment	N	Mean	Std. Deviation	F	P value
Scale 1 Confrontive coping style	less than 3 years	48	2.5708	.50569	1.376	.254
	3 to 5 years	43	2.4674	.57641		
	6 to 8 years	8	2.1375	.46579		
	9 years and more	13	2.5231	.79598		
	Total	112	2.4946	.57294		
Scale 2 Evasive coping style	less than 3 years	47	2.5270	.29791	.793	.500
	3 to 5 years	44	2.6171	.32275		
	6 to 8 years	10	2.6308	.25845		
	9 years and more	13	2.6036	.32461		
	Total	114	2.5796	.30704		
Scale 3 Optimistic coping style	less than 3 years	50	3.1289	.44972	.984	.403
	3 to 5 years	44	2.9975	.44926		
	6 to 8 years	10	3.2111	.56035		
	9 years and more	13	3.1282	.42756		
	Total	117	3.0864	.45699		
Scale 4 Fatalistic coping style	less than 3 years	51	2.8539	.77543	.199	.897
	3 to 5 years	44	2.8352	.53086		
	6 to 8 years	10	2.7500	.58926		
	9 years and more	13	2.9615	.74893		
	Total	118	2.8500	.66865		
Scale 5 Emotive coping style	less than 3 years	50	2.9520	.60415	.479	.698
	3 to 5 years	43	2.9907	.65021		
	6 to 8 years	9	3.1556	.26034		
	9 years and more	13	2.8462	.69835		
	Total	115	2.9704	.61115		
Scale 6 Palliative coping style	less than 3 years	48	2.6667	.50815	1.539	.208
	3 to 5 years	45	2.6984	.47500		
	6 to 8 years	10	2.3429	.24467		
	9 years and more	13	2.7253	.63208		
	Total	116	2.6576	.49805		
Scale 7 Supportant coping style	less than 3 years	48	2.0573	.61937	1.123	.343
	3 to 5 years	45	2.1778	.64319		
	6 to 8 years	10	1.9250	.52770		
	9 years and more	13	2.3462	.77418		
	Total	116	2.1250	.64141		
Scale 8	less than 3 years	48	2.2812	.39673		

Self-reliant coping style	3 to 5 years	44	2.2689	.50478	.132	.941
	6 to 8 years	10	2.2000	.28109		
	9 years and more	13	2.3077	.33226		
	Total	115	2.2725	.42367		
Mean coping	less than 3 years	52	2.6698	.31313	.308	.819
	3 to 5 years	45	2.6376	.30811		
	6 to 8 years	10	2.5747	.26113		
	9 years and more	13	2.6830	.45641		
	Total	120	2.6513	.32266		

Table (4.10) shows ANOVA test of the difference between coping strategies and duration of treatment, it illustrates that the mean score for coping scale was (2.68) for duration of treatment from (9 years and more), and (2.66) for duration of treatment from (less than 3 years), and it was (2.57) for duration of treatment from (6-8 years) with no significant difference (*p value 0.819*).

Regarding coping subscale, the mean score of confrontive coping style was (2.57) for duration of treatment from (less than 3years). In regard to evasive, optimistic, and emotive the mean score were (2.63), (3.21), and (3.15) respectively for duration of treatment from (6-8 years), while for fatalistic, palliative, supportant, and self-reliant coping style the mean score were (2.96), (2.72), (2.34), and (2.30) respectively for duration of treatment from (9 years and more) with no significant difference.

4.7 Results of differences between stressors, coping, and helpfulness.

Table (4.11): Pearson Chi Square test between Coping strategies and physiological stressors

Scale	Q ²	Df	P value
Scale 1:Confrontive coping style and physiological stressor	707.365(a)	475	.000<.001
Scale 2:Evasive coping style and physiological stressor	443.153(a)	304	.000<.001
Scale 3:Optimistic coping style and physiological stressor	423.879(a)	380	.000<.001
Scale 4:Fatalistic coping style and physiological stressor	411.903(a)	247	.000<.001
Scale 5:Emotive coping style and physiological stressor	388.523(a)	228	.000<.001
Scale 6:Palliative coping style and physiological stressor	393.086(a)	266	.000<.001
Scale 7;Supportant coping style and physiological stressor	290.456(a)	190	.000<.001
Scale 8:Self-reliant coping style and physiological stressor	308.416(a)	228	.000<.001
Mean coping and physiological stressor	1430.961(a)	1064	.000<.001

Table (4.11) shows Pearson Chi Square test between coping strategies used and physiological stressors, it indicated that there were statistically significant differences between the physiological stressors and all coping strategies.

Table (4.12): Pearson Chi Square test between Coping and psychological stressor

Scale	Q ²	Df	P value
Scale 1:Confrontive coping style and psychological stressor	1136.018(a)	925	.000<.001
Scale 2:Evasive coping style and psychological stressor	785.094(a)	592	.000<.001
Scale 3:Optimistic coping style and psychological stressor	862.525(a)	684	.000<.001
Scale 4:Fatalistic coping style and psychological stressor	546.642(a)	456	.000<.001
Scale 5:Emotive coping style and psychological stressor	564.469(a)	456	.000<.001
Scale 6:Palliative coping style and psychological stressor	731.854(a)	532	.000<.001
Scale 7:Supportant coping style and physiological stressor	450.661(a)	342	.000<.001
Scale 8:Self-reliant coping style and physiological stressor	572.829(a)	456	.000<.001
Mean coping and psychological stressor	2281.867(a)	1900	.000<.001

Table (4.12) shows Pearson Chi Square test between coping strategies used and psychological stressors, it indicated that there was statistically significant differences between the psychological stressors and all coping strategies.

Table (4.13): Pearson Chi Square test between Coping and helpfulness

	Q²	Df	P value
Pearson Chi-Square	5911.333(a)	4872	.000<.001

Table (4.13) shows Pearson Chi Square test between coping strategies used and helpfulness of these coping strategies, it indicated that there was statistically significant differences between coping strategies and helpfulness of these coping strategies.

Chapter 5

Discussion

This chapter discusses the main finding of research questions.

5.1 Socio- Demographic characteristics

According to demographic characteristics of HD patients (Table 1) more than two third of HD patients were male, and one third of them were in the age groups of (40-49 and 50-65) years old, regarding to their duration of treatment about half of them having a period of less than 3 years which reflect the rapid increase of ESRD patients, while (8.3%) of them having it from 6 to 8 years.

5.2 Stress types

According to the HD patients stress types (Table 2), about two third of patients were experienced mild to moderate level of total stress but physiological stress was slightly more (SD 0.665) stressful than psychological (SD 0.488), similar finding were found in a study done by **Mok and Tam (2001)**, they reported the mean score for the physiological stressors was 1.50 (SD=, 63) and for the psychological stressors was 1.30 (SD=, 58). In addition to study done by **Tu et al. (2013)**, also found that patients had more physiological stressors than psychosocial stressors. In contrast, (**Al Nazly et al. 2014; Shahrokhi et al. 2014**) found psychosocial stressors to be more prominent than physiological stressors.

Common stressors

The findings (Table 2) illustrated that the stress item with the highest percentage was (Limits on time and place for vacation) 84, 2%, which was similar to others studies by (**Cinar, Barlas, &Alpar, 2009; Logan, Pelletier-Hibbert, & Hodgins, 2006; Shahrokhi, 2014**). This could be related to the intensive treatment hours per week, which make patients unable to travel couple a day, and lack of recreation places for spending vacation due to the settlement.

The second source of stress was (decrease in sexual derives) 82,3%, which is in agreement with (**Leny, 1973; Procci, 1981**) which found prevalence estimates of sexual dysfunction range from 9% in predialysis to 70% in dialysis patients of either sex. In the other hand, the result different from **Shinde et al. (2014)** that found item (decrease in sexual derives) cause mild stress to HD patients and not ranked within the top major stressors.

This might be that the sexual dysfunction is much more common in patient with ESRD than in general population, this due to the nature of the disease such as anemia and uremia, those are the organic factors that affect the erectile dysfunction. In addition, to chronic fatigue, anxiety and a decline in self-esteem that also contribute in decrease of sexual desire.

In addition, (feeling tired) was rated a top five stressors which is consistent with other studies (**Baldree et al., 1982; Bihl et al., 1988; Eichel, 1986;**

Gurklis & Menke, 1988; 1995; Lok, 1996; Mok & Tam, 2001; Welsh & Austin, 1999).

The least stressful scale items were,(dependency on nurses and technicians) 45%,(dialysis machine and/or equipment) 46.2%, (dependency on physicians) 47.4%, this results were different from **Shinde et al. (2014)** that found 86.7%patients had the stress of dependency on staff.

These results might related to recurrent patients visit to the hospital for treatment that might increase the relation between the team stuff and patients and make them more familiar to each other, so patients will not feel stressed in demanding and requesting from the nurses or physicians.

5.3 Coping strategies

The study results revealed different coping strategies used among HD patients. The coping strategies with the highest percentage for use (Table 3) was "Optimistic coping strategies" 77.2%, which is defined by **Jalowiec (1995)** as thinking positively, maintaining a positive outlook, and positively comparing yourself to others in similar situations. This finding is supported with studies done by (**Logan et al. 2006; Shahrokhi, 2014**) and other studies involving renal patients (Lindqvist et al., 1998; Lindqvist & Sjoden, 1998).

The second most coping strategies used (Table 3-7) was "Supportant coping strategies" 74.3%, which is defined by **Jalowiec (1995)**, as allowing

individuals to accept and seek support from various sources. These results were similar to study done by **Logan et al., (2006)**. The high reporting of the use of supportant coping strategies might be related to that the item (Prayed or put your trust in God) ranked number one as the majority 94.8% of participants recorded its use.

The two coping items with the highest percentage were (Prayed or put your trust in God) 94.8% which belong to supportant coping strategies. Similar finding were reported in others study within the top five coping strategies (**Burns, 2004; Cinar, Barlas, & Alpar, 2009; Muayyad & Eman, 2014; Parvan et al, 2015; Shahrokhi, 2014**).It is known that all patients were Muslims so they believe in seeking help and support from God, also praying give them feeling of security, strength and acceptance.

The second item (Tried to keep your life as normal as possible and not let the problem interfere) 90.0% which belong to optimistic coping strategies. These two items were recorded to be the most used and most helpfulness of use in the coping scale.

5.4 Gender,(coping strategies and stressors)

5.4.1 Coping strategies and gender

The mean score of coping strategies (table 5-1) was approximately equal between male (2.62 ± 0.287) and female (2.69 ± 0.377) HD patients, with no significant difference between male and female ($p = 0.22$). These results

were in agreement with (**Logan, 2006; Lindqvist, 1998**). In addition to a study done by **Blake and Courts (1996)** who examined the differences in coping strategies used by 15 men and 15 women on hemodialysis. No statistically significant differences by gender were observed. The most common coping styles used by male and female were optimistic and confrontive.

In contrast, **Bertolin et al. (2011)** revealed in his study that women mean score were higher in all coping style than men.

Regarding the coping subscale and gender (table 5-1) in this study, the mean score for confrontive coping strategies for males was (2.5189) and for females was (2.4474) with significant difference between male and females; for males ($p=.030$). In agreement with **Klang et al. (1996)** who found that men used more confrontational styles of coping than women. In contrast, **Al Nazly et al. (2014)** study revealed that women had used confrontive coping behavior which is characterized as a problem-focused coping behavior more than men.

5.4.2 Stressors and gender

According to stress types and gender, the mean score of stressors types (Table 6-1) for male was (2.64 ± 0.441) and for female was (2.52 ± 0.526) with no significant difference ($p = .182$). In agreement to this study, a study done by **Shahrokhi et al. (2014)** in Iran, found no significant difference between stressors and gender. A longitudinal study done by

Welch and Austin (1999) compared the stressors reported by 41 men and 45 women on hemodialysis. No gender differences were identified in the most highly rated stressors. Also a study done by **Tu et al. (2013)**, found no gender differences in the total stress level or coping strategies of these patients, except that female patients had greater psychosocial stressors than male patients.

But **Yeh et al. (2009)** found in his study that the women had reported higher stress in response to physical and vessel problems, while the men reported higher stress in reproductive system functioning.

5.5 Duration of treatment,(coping strategies and stressors)

5.5.1 Coping strategies and duration of treatment

The mean score for coping scale (Table 5-3) was (2.683) higher for duration of treatment from (9 years and more), with no significant difference ($p=0.819$). In agreement to the study (**Cristovao's, 1999; Lok, 1996; Shahrokhi, 2014**) reported no correlation between individuals' length of time on hemodialysis and their coping strategies used.

In contrast, **Al Nazly et al. (2014)** found negative relation between duration of treatment and some coping strategies, the longer the participants have been on hemodialysis, they tend to use less of the “seeking social support” and “accepting responsibility” as coping strategies. In addition to **Gurklis and Menke (1988)** they found a weak positive relationship ($r= .26$) between length of time and problem-oriented coping.

5.5.2 Stressors and duration of treatment

According to stressors and duration of treatment, significant difference were found between psychological stressors and duration of treatment from (3-5 years) (Table 6-3), the mean score of stress scale for duration of treatment from (3-5 years) was (2.735) and for duration of treatment from (6-8 years) was (2.338) with significant difference for duration of treatment from (3-5 years) ($p = 0.031$).

Lok (1996) reported weak to moderate positive relationships between patients length of time on hemodialysis and their total stressor ($r = .35$) and psychosocial stressor ($r = .44$) scores, and he suggested that peoples stress levels tended to increase the longer they were on dialysis, but in this study a negative correlation was found, patients who were on dialysis on duration of treatment from (3-5 years) reported significantly higher levels of stress than who spent long time on dialysis or new on dialysis. In agreement, **Tu et al. (2013)** found that longer the patients had received hemodialysis, the lower stress level they had.

This may resulted from prolonged time on dialysis that make adjustment and adaptation, even more acceptance increased to the situation because little or nothing could be done, according to new dialysis patients may some of them still not oriented to the consequences of dialysis or still in denial phase. While **Cristovao's (1999)** reported, there is no correlation between individuals' length of time on hemodialysis and their stress.

These conflicting findings may be attributable to the differences in the age range of participants as well as the range of treatment time from research to other.

5.6 Relation between the coping strategies and stressors among HD patients

In general there is statistically significant difference between coping styles and physiological, and psychological stressors (Table (7-1)-(7-2)), in agreement to this study, **Gurklis and Menke (1988)** reported positive relationships between physical stressors and emotion-focused coping and between psychosocial stressors and problem-focused coping. Conversely, **Baldree et al. (1982)** found no relationship between amount of total stress and coping behaviors. In addition, **Shahrokhi et al. (2014)** found no significant difference between stressors and coping strategies used by hemodialysis patients

5.7 Relation between the coping strategies and helpfulness of coping among HD patients

In general there is statistically significant differences found in this study between coping strategies used and helpfulness (Table 7-3), for example the two highest items in coping scale that have been recorded as mostly used among HD patients (Prayed or put your trust in God) 94.8% and (Tried to keep your life as normal as possible and not let the problem interfere) 90.0%, they also found to be most helpful in use.

Few studies found on the helpfulness of coping (**Logan et al. 2006; Parvan et al. 2015**), because most of studies used old version of 40- items scale that do not measures the perceived helpfulness of coping as do new version of 60- items scale. **Lazarus and Folkman (1984)** assert that it is not the number of coping strategies used by individuals that determines the success of coping, but rather it is the helpfulness of whatever strategies are used within the context of a situation.

Logan et al. (2006) found negative association between coping and helpfulness. For example, although participants in her study reported using the “Optimistic” coping strategies of “hope things will get better” and “told yourself not to worry, everything will be fine”, as most highly rated items in use, but these strategies were rated as not at all helpful in the same study.

5.8 Conclusions

The study findings indicated that:

The mean of coping strategies used by HD patients was mild to moderate, in addition to the mean of stressors and helpfulness of coping there mean also were moderate.

It also found that there were:

- Significant difference between the psychological stressors and duration of treatment.
- Significant difference between the stressors and coping strategy used.

- Significant difference between the coping strategies and helpfulness of coping.
- No significant difference was found between participants according to their gender, age and duration of treatment in all coping strategies.
- No significant differences were found between participants according to their age and gender in all stress types, but the higher mean score of physiological stressors was for female, while in psychological stressors the higher mean score was for male.

5.9 Limitation

1. The questionnaire was too long and most of patients start to feel bored.
2. Most of patients were not educated or old in age and could not read alone.
3. The response rate was low, 120 participants (31%).
4. Few studies were found that discussed and used the new version of the 60 items JCS and measures the effectiveness of coping scale.

5.10 Recommendation

1. The present study has identified the types and intensity of stressors experienced by HD patients, and coping strategies used. But it does not measures the predisposing factors that lead HD patients to be variant in the intensity and severity of stressors they feel or coping they used, so future research should be directed at detecting the predisposing factors that lead

the HD patients to be variant in experiencing the intensity of stress and coping strategies used.

2. M.O.H has to implement training program for HD patients on how to control their stressors and how to use positive coping strategies within the plan of treatment. In addition, there is a need to employ psychiatric nurses in the hospitals, for better intervention and treatment.

3. Mental health professional should increase attention especially to the needs and stressors that HD patients face.

4. Need to develop new resources specifically aimed at helping ESRD patients complete important life transition.

5.11 Summary

Hemodialysis (HD) therapy is a distressing treatment for the patients; it alters the life style of the patient and family and interferes with their lives. The major areas of patients life affected by ESRD and its treatment includes employment, eating habits, vacation activities, sense of security, self-esteem, social relationships, and the ability to enjoy life (**Smeltzer et al.2004**). Due to these reasons, patient will experience different levels of stress in response to various types of stressors which contribute to greater morbidity and even to earlier mortality; there are two types of stressors psychological and physiological stressors.

It's important to resolve the stressors by adopting various methods to cope with the stresses of the disease and treatment procedures. The manner of application in each of these coping methods depends on personal experiences, social support system, personal beliefs and the access of these support resources (**Finkelstein, 2000; Kimmel, 1998**).

The number of end stage renal disease is rapidly increasing among Palestinian, and it is common health problem and eighth leading cause of death in Palestine by the Palestinian Health Information Center (PHIC, 2013), so hemodialysis patients need more attention.

This study aim to assess HD patients stressors and coping strategies they used, and to find out whether there is any relation between stressors, coping, and demographic data (gender, age, duration of treatment) in the North of West Bank.

A quantitative, cross-sectional, descriptive analytical study was carried out to achieve the aim of the study during the period of time between January to March 2014. Data collection took place in three governmental hospitals and one private hospital in the North of West Bank, they are (Thabet Thabet hospital) in Tulkarm, (AL-Sheikh Nazal hospital) in Qalqyia, (Martyar Dr Khalil.S. hospital) in Jenin, and private (An-Najah University hospital) in Nablus. The sample size was 120 HD patients (M=77, and F=43) of total 379, the Hemodialysis Stress Scale was used to assess the stressors and Jalowiec Coping Scale was used to assess the coping strategies among hemodialysis patients.

The finding showed that the HD patients were mildly to moderately stressed according to HSS, the greatest perceived sources of stress appeared to be "physiological stressors" (mean=2.655) but the item with the highest percentage were "limitation on time and place for vacation" (84.2%) which belong to psychological stress subscale and the item stress with the least percentage were "dependency on nurses and technicians"(45%).According to the ways of coping mechanisms, HD patients seemed to be resorting more to "optimistic coping"(mean=3.086) followed by "supportant coping" (mean=2.970) while "emotive coping" was the least coping strategy used (mean=2.125), the coping item with the highest percentage for using and helpfulness of using were "Prayed or put your trust in God" (94.8%) for using and (95.6%) for helpfulness of using. There were significant difference between the psychological stressors and duration of treatment and a significant difference between the stressors and coping strategy used, in addition to a significant difference between the coping strategies and helpfulness of coping. No significant difference were found between participants according to their gender, age and duration of treatment in all coping strategies and no significant difference were found between participants according to their age and gender in all stress types, but the higher mean score of physiological stressors was for female, while in psychological stressors the higher mean score was for male.

Maintaining the level of stressors in individuals with ESRD and using a proper coping mechanism are the key factors taking in consideration individual variation. Investments in this area of knowledge are justified for

their contribution to improving the quality of life, minimizing potential complications of this disease, survival of these people and decrease cost. In addition future researches should be directed at detecting the predisposing factors that lead the HD patients to be variant in experiencing the intensity of stress and coping strategies used.

References

- Abboud, O. (2006). **Incidence, Prevalence, and treatment of ESRD in the Middle East.** *Ethn Dis*, 16(2), 2-4.
- Antonovosky, A. (1974). ***Health, stress and coping.*** San Francisco: Jossay-Bass.
- Al Nazly, E., & Ahmad, M. (2014). **Hemodialysis: Stressors and coping strategies.** *Psychology, Health & Medicine*, 20(4), 477-487.
- Baldree, KS., Murphy, SP., & Powers, MJ.(1982). **Stress identification and coping patterns in patients on hemodialysis.** *Nurs Res*, 31(2), 107-12.
- Bertolin, DC., Pace, AE., Kusumota, L., & Haas, V. (2011). **An association between forms of coping and the socio demographic variables of people on chronic hemodialysis.** *Rev Esc Enferm USP*, 45(5), 1068-74.
- Bihl, M., Ferrans, C., & Powers, M. (1988). **Comparing stressors and quality of life of dialysis patients.** *ANNA Journal*, 15(1),27-37.
- Blake, C., Codd, M.B., Cassidy, A.,& O'Meara, YM. (2000). **Physical function, employment and quality of life in end-stage renal disease.** *J Nephrol*, 13(2), 142-149.

- Blake, C., & Courts, N. (1996). **Coping strategies and styles of hemodialysis patients by gender.** *ANNA Journal*, 23, 477-507.
- Burns, D. (2004). **Physical and psychosocial adaptation of blacks on hemodialysis.** *Applied Nursing Research*, 17(2), 116-124.
- Boyd, M.A. (2008). *Psychiatric nursing, contemporary practice (4th ed.)*. Philadelphia: Walters Kluwer/Lippincott, Williams & Wilkins.
- Cinar, S., Barlas, GU., & Alpar, SE. (2009). **Stressors and coping strategies in hemodialysis patients.** *Pak J Med Sci*, 25(3), 447-452.
- Cristavao, F. (1999). **Stress, coping and quality of life among chronic haemodialysis patients.** *EDTNA/ERCA Journal*, 25(4), 35-38.
- Dunn, Sh.A. (1993). **How to care for the dialysis patient.** *American Journal of Nursing*, 93(6), 26-33.
- Edwards, J.R. (1993). *The measurement of coping with stress: construct validity of the ways of coping checklist and the cybernic coping scale.* Work & Stress. Darden Graduate School of Business Administration: University of Virginia; p.17-31.
- Eichel, C. (1986). **Stress and coping in patients on CAPD compared to hemodialysis patients.** *ANNA Journal*, 13(1), 9-13.

- Finkelstein, FO., & Finkelstein, SH. (2000). **Depression in chronic dialysis patients: Assessment and treatment.** *Nephrol Dial Transplant*, 15(12), 1911–3.
- Folkman, S., Lazarus, RS., Dunkel-Schetter, C., DeLongis, A., & Gruen, RJ. (1986). **Dynamics of a stressful encounter: Cognitive appraisal, coping, and encounter outcomes.** *J Pers Soc Psychol*, 50(5), 992-1003.
- Galpin, C. (1992). **Body image in end-stage renal failure.** *British Journal of Nursing*, 1, 21-33.
- Ghazanfari, F., & Kadampoor, A. (2008). **The relationship between mental health and coping strategies in citizenship of Khoramabad city.** *J FundamMent Health*, 10, 47–54.
- Ghoreyshi, RF. (2010). **validation of Endler and Parker coping scale of stressful situations.** *J BehavSci*, 4(1), 1–7.
- Gregorio, T., Arora, P., Kausz, T.A., & Ruthazer, R. (1999). **Level of renal function at the initiation of dialysis in the U.S. ESRD population.** *Kidney International journal*, 56(6), 2227–2235.
- Goldsmith, D., Jayewardene, S., & Ackland, P. (2007). *ABC of kidney disease.* Blackwell Publishing Ltd; p. 5-8.

- Gurklis, J., & Menke, E. (1988). **Identification of stressors and use of coping methods in chronic hemodialysis patients.** *Nursing Research*, 37(4),236-239.
- Gurklis.J., & Menke, E. (1995). **Chronic hemodialysis patient's perceptions of stress, coping, and social support.** *ANNA Journal*, 22,381-388.
- Hayward, M.B., Kish, J.P., Frey, G.M., Kirchner, J.M., Carr, L.S., & Wolfe, C.M. (1989). **An instrument to identify stressors in transplant recipients.** *American Nephrology Nurses Association Journal*, 16(2), 81-85.
- Health Communities.(2015). **Chronic renal failure.** Retrieved from <http://healthcommunities.com/chronic-renal-failure/hemodialysis.shtml>
- Jalowiec, A. (1995). ***Psychometric results on the 1987 Jalowiec Coping Scale.*** Unpublished Supplementary Materials, Loyola University of Chicago,Westmont, IL.
- Kasper, DL.,Braunwald, E., Fauci, AC., Hauser, SL., Longo, DL., &Jameson, JL. (2005). ***Harrison's principles of internal medicine.*** New York: McGraw-Hill Companies; p. 1653.
- Kimmel, PL., Thamer, M., Richard, CM., & Ray, NF. (1998). **Psychiatric illness in patients with end-stage renal disease.** *Am J Med*, 105(3), 214–21.

- Klang, B., Bjorvell, H., & Cronqvist, A. (1996). **Patients with chronic renal failure and their ability to cope.** *Scandinavian Journal of Caring Science*, 10(2), 89-95.
- Laposa, JM., Alden, LE., & Fullerton, LM. (2003). **Work stress and post traumatic stress disorder in ED nurses/personnel.** *J Emerg Nurs*, 29(1), 23-8.
- Lazarus, R., & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer publishing Company; p. 456.
- Leny, NB. (1973). **Sexual adjustments to maintenance dialysis and renal transplantation. National survey by questionnaire. Preliminary results.** *Trans Am Soc Artif Int Organs*, 19, 138–143.
- Lin, CC., Lee, BO., & Hicks, FD. (2005). **The phenomenology of deciding about hemodialysis among Taiwanese.** *West J Nurs Res*, 27(7), 915-29.
- Lindqvist, R., & Sjoden, P. (1998). **Coping strategies and quality of life among patients on continuous ambulatory peritoneal dialysis (CAPD).** *Journal of Advanced Nursing*, 27(2), 312-319.
- Lindqvist, R., Carlsson, M., & Sjoden, P. (1998). **Coping strategies and quality of life among patients on hemodialysis and continuous ambulatory peritoneal dialysis.** *Scandinavian Journal of Caring Sciences*, 12(4), 223-230.

- Locatelli, F., Marcelli, D., Conte, F., Damico, M., Vecchio, LD., Limido, A., Malberti, F., & Spotti, D.(2001). **Survival and development of cardiovascular disease by modality of treatment in patients with end-stage renal disease.** *J Am Soc Nephro*, 12, 2411–2417.
- Logan, S., Pelletier-Hibbert, M., & Hodgins, M. (2006). **Stressors and coping of in-hospital haemodialysis patients aged 65 years and over.** *Journal of Advanced Nursing*, 56(4), 382–391.
- Lok, P. (1996). **Stressors, coping mechanisms and quality of life among dialysis patients in Australia.** *Journal of Advanced Nursing*, 23(5),873-881.
- Mahmoudi, G., Shariati, RA., & Behnampour, N. (2004). **Relationship between quality of life and coping among hemodialysis patients in hospitals.** *J Gorgan Univ Med Sci*. 5(12), 43-52.
- Moeller, S., Gioberge, S., &Brown, G. (2002). **ESRD patients in 2001: global overview of patients, treatment modalities and development trends.** *Nephrol Dial Transplant*, 17, 2071–2976.
- Mok, E., &Tam, B. (2001). **Stressors and coping methods among chronic haemodialysis patients in Hong Kong.** *Journal of Clinical Nursing*, 10(4),503-511.

- Narimani, M., & RafighIrani, S. (2008). **A survey of relationship between coping styles and mental health in patients undergoing hemodialytic treatment.** *Fundam Mental Health*, 2(38), 117–22.
- (PHIC) Palestinian Health Information Center,(2013). **Health annual report.** Palestinian ministry of health, Nablus, Palestine.
- Parvan, K., Ahangar, R., Abdollahzadeh, F., Hosseini, FA., & Jasemi, M. (2015). **Coping methods to stress among patients on hemodialysis and peritoneal dialysis.** *Saudi J Kidney Dis Transpl*, 26(2), 255-262.
- Procci, WR., Goldstein, DD., Adelstein, J., & Massry, SG. (1981). **Sexual dysfunction in the male patient with uremia. A reappraisal.** *Kidney Int*,19,317–323.
- Ridder, D., & Schreurs, K. (2001). **Developing interventions for chronically ill patients: Is coping a helpful concept?.** *Clin Psychol Rev*, 21(2), 205–40.
- Saunderson, CA., & Brener, TH. (2007). **End of life: A nurse's guide to compassionate care.** Philadelphia: Lippincott Williams and Wilkins; p. 175.
- Sensky, T., Leger, C., & Gilmour, S. (1996). **Psychosocial and cognitive factors associated with adherence to dietary and fluid restriction**

regimens by people on chronic haemodialysis. *Psychotherapy and Psychosomatics*, 65, 36-42.

Shahrokhi, Z., Rayyani, M., Sabzevari, S., & Haghdoost, AA.(2014). **Stressors and coping strategies in dialysis patients.** *Iran J Crit Care Nurse*, 7(3), 184-193.

Shinde, M., & Patil Mane, S. (2014). **Stressors and coping strategies among patients undergoing hemodialysis.** *International Journal of Science and Research*, 3(2),2319-7064.

Smeltzer, S.C., Bare, B., & Brunner. (2004). ***Textbook of medical-surgical nursing***. Philadelphia: USA: Lippincott Williams & Wilkins; p. 2234.

Smeltzer, S., & Bare, B. (2012). ***Bruner and Suddarth 's***. Text Book of Medical Surgical Nursing.9ed. Mosby.

Tu, HY., Shao, JH., Wu, FJ., Chen, SH., & Chuang, YH. (2013). **Stressors and coping strategies of 20–45-year-old hemodialysis patients.** *Australian College of Nursing*,21(3),185–192.

Usami, T., Koyama, K., Takeuchi, O., Morozumi, K., & Kimura, G. (2000). **Regional variations in the incidence of end-stage renal failure in Japan.** *Journalof the American Medical Association*, 284(20), 2622–2624.

- Welch, J., & Austin, J. (1999). **Factors associated with treatment related stressors in hemodialysis patients.** *ANNA Journal*, 26,318-326.
- Welch, J.,& Austin, J. (2001). **Stressors, coping and depression in haemodialysis patients.** *Journal of Advanced Nursing*, 33,200-207.
- Yeh, S., & Chou, H. (2007). **Coping strategies and stressors in patients with hemodialysis.** *Psychosomatic Medicine*, 69, 182–190.
- Yen, C., Huang, H., Chou, C., & Wan, H. (2009). **Gender differences in stress and coping among elderly patients on hemodialysis.** *Sex Roles*, 60(1), 44–56.

ANNEX (1)

Information and Details

مقدمة

أخي/ أختي المشارك/ة:

أنا الباحثة دينا تحسين طالبة ماجستير صحة نفسية مجتمعية في جامعة النجاح الوطنية يسرني أن ادعوك إلى المشاركة في بحثي المتعلق (بقياس مستوى القلق والعصبية وطرق التكيف عند مرضى غسيل الكلى في شمال مستشفيات الضفة الغربية).

لك/ي كامل الحرية والإرادة في المشاركة في هذا البحث ولك/ي الحق في اخذ الوقت الكافي للتفكير في المشاركة من عدمها وسؤال الباحث عما تراه مناسباً والتحدث لأي شخص أو جهة عن هذا البحث. كما يمكنك الاستفسار عن أي جزء يتعلق في البحث الآن أو فيما بعد وإذا كانت هناك كلمات أو أجزاء غير مفهومة بإمكانك سؤال الباحثة وستجد/ين الوقت والإجابة الكافيتين. يضمن البحث سرية المعلومات المتعلقة بالمشارك/ة.

الهدف من البحث

تهدف هذه الدراسة إلى التعرف على الأسباب المحتملة ، ومستوى التوتر الذي يعيشه مرضى غسيل الكلى في فلسطين، وأكثر الطرق التي يستخدمونها للتعامل مع هذه التوترات ، وتحقيقاً لهذه الغاية نرجو منك تعبئة الاستبانة التالية التي لن تأخذ من وقتك أكثر من خمسة عشر دقيقة، حيث تتكون هذه الاستبانة من قسمين، القسم الأول ويتكون من استبانة تقيس مستوى التوتر واسبابه حسب الاستبانة ،والقسم الثاني استبانة عن الطرق التي استخدمتها للتحكم بالتوتر عند مواجهتك إحدى المشاكل حسب الاستبانة، لذا يرجى عدم إدخال اسمك على الاستبانة، شاكرًا لك مشاركتك في هذه الدراسة.

كما أن مشاركتك ودعمك لهذا البحث سيساهمان في تطوير وتعزيز الواقع الصحي في فلسطين ،عن طريق زيادة إدراك الممرضات والطاقم الطبي المختص الذي يعتني بمرضى غسيل الكلى، بأهم الأسباب التي تؤدي إلى التوتر عندهم ،والعمل على تخفيفها قدر المستطاع عن طريق وضع استراتيجيات في كيفية استخدام طرق التأقلم السليمة،الذي بدوره سيؤدي إلى تعزيز الالتزام بالعلاج من أجل حياة أفضل.

طبيعة المشاركة في البحث

بعد الموافقة على المشاركة في البحث سنطلب من المشاركون الإجابة على استبيان يتكون من مجموعة أسئلة تتعلق بالتوتر والعصبية وطرق التكيف.

اختيار المشاركين

سيتم اختيار المشاركين من المرضى في المستشفيات الحكومية (مستشفى قلقلية والوطني و جنين وطولكرم الحكوميين) . المشاركة طوعية واختيارية وبإمكان المشاركون الانسحاب من البحث في أي وقت ودون الحاجة لإبداء الأسباب وبدون أي تبعات.

المدة المتوقعة لإنهاء إجراءات البحث

عشرون دقيقة لكل مشارك .

المعلومات الديموغرافية:

العمر:

الجنس :

مدة فترة العلاج:

قياس مستوى التوتر الذي يسببه غسيل الكلى

تختلف آراء الناس فيما يتعلق بعلاج غسيل الكلى، فالبعض يجده مزعجا بينما يتقبله البعض الآخر. سأعرض في هذا الاستبيان قائمة بالأمر التي تزعج مرضى غسيل الكلى، والمطلوب منك توضيح إلى أي مدى كانت هذه الأمور مزعجة لك خلال الأسبوعين المنصرمين. تجد في هذا الاستبيان أربعة أجوبة ممكنة: (أبدا، قليلا، بشكل معتدل، إلى حد كبير). ليس هناك أجوبة صائبة أو خاطئة، لذلك قم باختيار الإجابة التي تصف تجربتك، سأقوم بذكر الأمر وانتظر إجاباتكم.

4 إلى حد كبير	3 بشكل معتدل	2 قليلا	1 أبدا	الأمر المسببة للتوتر عند غسيل الكلى
				1. الأنبوب الشرياني والوريدي
				2. الغثيان والتقيؤ
				3. تشنجات وألم العضلات
				4. الحكة
				5. طول فترة العلاج
				6. تشنج المفاصل
				7. الشعور بالتعب
				8. فقدان الجسم لوظائفه الحيوية
				9. تراجع في الحياة الاجتماعية
				10. الحد من الأكل
				11. الحد من السوائل
				12. التضارب مع أوقات العمل
				13. تراجع الحياة الجنسية
				14. انخفاض مستوى النشاط الجسدي
				15. صعوبات النوم
				16. تغييرات في المسؤوليات العائلية
				17. تغير في الأدوار العائلية مع الشريك
				18. تغير في الدور العائلي مع الأبناء
				19. عدم التيقن من المستقبل
				20. تغييرات في المظهر الجسدي
				21. تقييد في نمط اللباس
				22. تكلفة العلاج/ المواصلات لمراكز العلاج/ عوامل تكلفة أخرى
				23. المواصلات لمركز العلاج ذهابا وإيابا
				24. تقييد زمان ومكان الإجازات
				25. الإدخال المتكرر للمستشفى
				26. آلات ومعدات غسيل الكلى
				27. الاعتماد على الممرضين/ات

				والفنيين انت
				28. الاعتماد على الطاقم الطبي
				29. الخوف من الوحدة
				30. شعور متعلق بالعلاج كالشعور بالبرد مثلا
				31. الملل
				32. انخفاض القدرة على الإنجاب

قياس مستوى التأقلم (JCS)

يقدم هذا الاستبيان طرق عدة للتعامل والتأقلم مع التوتر الذي يسببه علاج غسيل الكلى، حيث أن هناك تفاوت بين الأشخاص في إتباعهم لأساليب التأقلم المختلفة والمتعددة. والمطلوب منك ذكر مدى إتباعك لكل أسلوب من أساليب التأقلم المذكورة وكم كان ذلك مجدياً.

تجد في هذا الاستبيان العديد من ردود الأفعال والخيارات المقدمة لكل أسلوب من أساليب التأقلم (فيما يتعلق بمدى إتباعك له) زهي: (أبدأ، نادراً، أحياناً، عادة).

نجد أيضاً أن الخيارات المتعلقة بمدى نجاعة الأسلوب هي: (ضعيفاً، قليلاً، إلى حد ما، كثيراً).

وكما ذكر سابقاً، ليس هناك أجوبة صائبة وخاطئة، قم باختيار الجواب الذي يصف تجربتك.

سأقوم بذكر أسلوب التأقلم وانتظار أجوبتكم.

الجزء (ب) في حال استخدمت ذلك الأسلوب، إلى أي مدى كان ذلك مفيداً؟				الجزء (أ) مدى استخدامك لأسلوب التأقلم				أسلوب التأقلم
كثيراً 4	إلى حد ما 3	قليلاً 2	ضعيفاً 1	عادة 4	أحياناً 3	نادراً 2	أبدأ 1	
								1. قلق بشأن المشكلة
								2. آملاً أن تتحسن الأمور
								3. زيادة في نسبة الأكل أو التدخين عن الحد المألوف
								4. فكرت في طرق عدة لمعالجة المشكلة
								5. أقنعت نفسك أنه كان بإمكان أن يكون الأمر أسوأ
								6. قمت بالتمارين الرياضية أو أي نشاط جسدي
								7. حاولت تجاهل المشكلة لفترة من الزمن
								8. أطلقت العنان لأي تفكير جنوني
								9. توقعت أسوأ النتائج
								10. حاولت تجاهل المشكلة والتفكير في أمور أخرى
								11. تحدثت مع الأهل والأصدقاء عن الأمر
								12. تقبلت الأمر لأنه ليس لديك حول ولا قوة
								13. حاولت التعامل مع المشكلة بشكل موضوعي وتحليلها
								14. أطلقت العنان لأحلام اليقظة بحياة أفضل
								15. تحدثت عن الأمر مع شخص مختص كالطبيب أو الممرض أو الوزير أو المدرس أو المستشار، الخ
								16. حاولت إبقاء الوضع تحت السيطرة

								17. قمت بالصلاة والتوكل على الله
								18. حاولت الخروج من هذا الوضع
								19. لم تشارك أحدا مشاعرك
								20. قمت بإلقاء اللوم على شخص آخر
								21. انتظرت لترى ماذا سيحصل
								22. أردت أو تبقى وحيدا للتفكير في الأمر
								23. استسلمت للوضع لأنه أمر ميؤوس منه
								24. أفرغت توترك على شخص آخر
								25. حاولت تغيير الوضع
								26. اتبعت أساليب الاسترخاء
								27. حاولت معرفة المزيد عن المشكلة
								28. استسلمت للنوم أكثر من قبل
								29. حاولت معالجة الأمور شيئا فشيئا
								30. حاولت العيش بشكل طبيعي وعدم السماح للأمر بإعاقة ذلك
								31. حاولت التفكير في كيفية معالجتك لمشاكل أخرى في السابق
								32. أقنعت نفسك بعدم القلق وأن الأمور ستنتهي على خير
								33. حاولت إيجاد حل وسط
								34. شربت الخمر للتحسين من شعورك
								35. تركت الأمر للزمن
								36. حاولت تسلية نفسك والقيام بأمر تحبه
								37. أقنعت نفسك بقدرتك على معالجة أي أمر مهما كان
								38. وضعت خطة عمل
								39. حاولت الحفاظ على الروح الايجابية
								40. تجنبت مواجهة المشكلة
								41. حاولت إبقاء مشاعرك تحت السيطرة
								42. تحدثت عن المشكلة مع شخص عايشها
								43. دربت تفكيرك على كيفية المعالجة
								44. حاولت إبقاء نفسك مشغولا
								45. تعلمت شيئا جديدا يساعدك على معالجة المشكلة
								46. قمت بعمل متهور لم تعهد عمله من قبل
								47. تذكرت الأشياء الجيدة في حياتك
								48. قارنت نفسك بأشخاص آخرين كانوا بنفس

								المحنة
								49. حاولت تجاهل أو تجنب المشكلة
								50. حاولت التفكير بإيجابية
								51. قمت بإلقاء اللوم على نفسك بسبب هذه المحنة
								52. تفضل معالجة الأمور بنفسك
								53. تناولت الأدوية للتقليل من حالة التوتر
								54. حاولت إيجاد الجانب الجيد من المحنة
								55. أقنعت نفسك أن هذا الأمر ليس ذات أهمية
								56. تجنبنا الاختلاط بالناس
								57. حاولت تطوير نفسك بشكل يساعدك على معالجة الأمر بشكل أفضل
								58. تمنيت أن تنتهي هذه المحنة
								59. اعتمدت على الغير لمساعدتك
								60. أقنعت نفسك أن الأمر مجرد حظ عاثر

ANNEX (2)

Hemodialysis Stress Scale

People view dialysis treatment in many ways, some people find parts of the treatment, and bothersome other does not. In this questionnaire, I will list things that some hemodialysis patients are bothered by. I want you tell me what extent you have bothered by each of these during the last two weeks, as you can see from this piece of paper that I have given you, there are four possible answers; Not at all, Slightly, Moderately, or A great deal. There are no rights or wrong answers, for this give the response that best describe your experience. I will read each thing and wait for your answer

Hemodialyses stressors	1 Not at all	2 slightly	3 moderately	4 A great deal
1.Arterial & venous stick				
2.Nausea and vomiting				
3.Muscle cramps/soreness				
4.Itching				
5.Length of treatment				
6.Stiffening of joints				
7. Feeling tired.				
8.Loss of body function				
9.Decrease in social life				
10.Limitation of food				
11.Limitation of fluid				
12.Interference with job				
13.Decrease in sexual derive				
14.Limitation of physical activity				
15.Sleep disturbances				
16.Changes in family responsibilities				
17.Reversal in family role with spouse				
18.Reversal in family roles with the children				
19.Uncertainty about the future				
20.Changes in body appearance				
21.Limited in style of clothing				
22.Cost of treatment /transportation to treatment /or other cost factors				
23.Transportation to and from the unit				
24.Limits on time and place for vacation				
25.Frequent hospital admission				
26.Dialysis machine and /or equipment				
27.Dependency on nurses and technicians				
28.Dependency on physicians				
29.Fear of being alone				
30. Feelings related to treatments example;(feeling cold)				
31.Boredom				
32.Decreased ability to have children				

ANNEX (3)

JCS (Jalowiec Coping Scale)

Now I am going to ask you about what you do to cope with the stress of dialysis. This questionnaire lists many different ways of coping with stress. Some people use a lot of different coping methods, some people use only a few. For each coping method I want you to tell me first how often you have used it in the last two weeks and then, if you have used it how helpful it was.

Once again, if you look at this piece of paper, the various responses are listed, the choices for how often you use a coping method are: never used, seldom used, sometimes used and often used. The choices for how helpful are: not helpful, slightly helpful, fairly helpful and very helpful. Once again there no right or wrong answers, simply pick the response that best describes what you do.

I will read each coping method and wait for your answer.

COPING METHODS	Part A How often you used each coping method?				Part B If you have used that coping method, how helpful was it ?			
	Never Used	Seldom Used	Sometimes used	Often	Not helpful	Slightly helpful	Fairly helpful	Very helpful
1. Worried about the problem								
2. Hoped that things would get better								
3. Ate or smoked more than usual								
4. Thought out different ways to handle the situation								
5. Told yourself that things could be much worse								
6. Exercised or did some physical activity								
7. Tried to get away from the problem for awhile								
8. Got mad let off steam								
9. Expected the worst that could happen								
10. Tried to put the problem out of your mind and think of something else								
11. Talked the problem over with family or friends								
12. Accepted the situation because very little could be done								




13. Tried to look at the problem objectively and see all sides								
14. Daydreamed about a better life								
15. Talked the problem over with a professional person (such as a doctor, nurse, minister, teacher, counsellor)								
16. Tried to keep the situation under control								
17. Prayed or put your trust in God								
18. Tried to get out of the situation								
19. Kept your feelings to yourself								
20. Told yourself that the problem was someone else's fault								
21. Waited to see what would happen								
22. Wanted to be alone to think things out								
23. Resigned yourself to the situation because things looked hopeless								
24. Took out your tensions on someone else								
25. Tried to change the situation								
26. Used relaxation techniques								
27. Tried to find out more about the problem								
28. Slept more than usual								
29. Tried to handle things one step at a time								
30. Tried to keep your life as normal as possible and not let the problem interfere								
31. Thought about how you had handled other problems in the past								
32. Told yourself not to worry because everything would work out fine								

33.Tried to work out a compromise								
34.Took drink to make yourself feel better								
35.Let time take care of the problem								
36.Tried to distract yourself by doing something that you enjoy								
37.Told yourself that you could handle anything no matter how hard								
38.Set up a plan of action								
39.Tried to keep a sense of humour								
40.Put off facing up to the problem								
41.Tried to keep your feelings under control								
42.Talked the problem over with someone who had been in similar situation								
43.Practiced in your mind what had to be done								
44.Tried to keep busy								
45.Learned something new in order to deal with the problem								
46.Did something impulsive or risky that you would not usually do								
47.Thought about the good things in your life								
48.Tried to ignore or avoid the problem								
49.Compared yourself with other people who were in the same situation								
50.Tried to think positively								
51.Blamed yourself for getting into such a situation								

52.Preferred to work things out yourself								
53.Took medication to reduce tension								
54.Tried to see the good side of the situation								
55.Told yourself that this problem was really not that important								
56. Avoided being with people.								
57.Tried to improve yourself in some way so you could handle the situation better								
58.Wished that the problem would go away								
59.Dependded on others to help you out								
60.Told yourself that you were just having some bad luck								

ANNEX (4)

Permission Letter: Use of Hemodialysis Streeor Scale

الرجاءات
 05/11/34
 إيفانغ إبي جيت الاتصال (cferrans@uic.edu) Ferrans, Carol
 إبي دينا إيسا
 RE: permission
 ,Dear Dina
 I am pleased to grant you permission to use the scale, as requested in your email below
 .Good luck with your work
 Sincerely
 Carol Estwing Ferrans, PhD, RN, FAAN
 Professor and Associate Dean for Research

ANNEX (5)

permission letter: Use of Hemodialysis Stressor Scale

Anne Jalowiec
29/01/35

إلى: dina issa



12-1-2013

Permission granted to Dina Issa to use the Jalowiec Coping Scale for thesis research.

Dr Anne Jalowiec, RN, PhD
ajalowiec@yahoo.com

ANNEX (6)

I P R Permission

**An - Najah
National University**

Faculty of Medicine & Health Sciences
Department of Graduate Studies

بسم الله الرحمن الرحيم



جامعة النجاح
الوطنية
كلية الطب وعلوم الصحة
دائرة الدراسات العليا

IRB Approval letter

Study title:

STRESSORS AND COPING STRATEGIES AMONGST PATIENTS
WITH HEMODIALYSIS IN NORTH OF WEST BANK

Submitted by:

Dina Tahsin Nimer Issa

Date Reviewed:

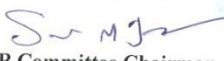
June 23, 2013

Date approved:

Sep 19, 2013

Your study titled " STRESSORS AND COPING STRATEGIES AMONGST
PATIENTS WITH HEMODIALYSIS IN NORTH OF WEST BANK " Was
reviewed by An-Najah National University IRB committee & approved on Sep 19, 2013 .

Samar Musmar, MD, FAAFP


IRB Committee Chairman,
An-Najah National University



101
ANNEX (7)

M O H Permission

State of Palestine
Ministry of Health - Nablus
General Directorate of Higher & Continuing
Education



دولة فلسطين
وزارة الصحة - نابلس
الإدارة العامة للتعليم الصحي

Ref.:
Date:.....

الرقم: ٢٠١٢/١٥٠٥/٦٤٠
التاريخ: ٢٠١٢/١٠/٢٨

الأخ مدير عام الرعاية الصحية الأولية والصحة العامة المحترم،،،

تحية واحترام،،،

الموضوع: تسهيل مهمة طلاب - جامعة النجاح

تماشياً مع سياسة وزارة الصحة المتعلقة بتعزيز التعاون مع الجامعات والمؤسسات الأكاديمية
بإتاحة فرص التدريب أمام الطلبة والخريجين والباحثين في المؤسسات الوطنية وإسهاماً في تنمية
قدراتهم.

يرجى تسهيل مهمة الطالبة دينا-تحسين نمر عيسى-ماجستير تريض الصحة النفسية المجتمعية

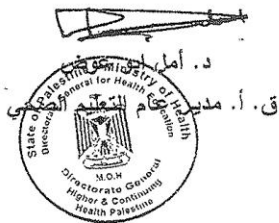
جامعة النجاح الوطنية ، في عمل بحث بعنوان " Stressors and Coping Strategies

among Haemodialysis Patients in North of West Bank" وذلك من خلال

السماح للطالبة في جمع معلومات تتعلق ببحثها في مديريات صحة: نابلس، قلقيلية، جنين

وطولكرم، علماً بأنه سيتم الالتزام بمعايير البحث العلمي والحفاظ على سرية المعلومات.

مع الاحترام،،،



نسخة: مساعد العميد للدراسات العليا المحترمة/ جامعة النجاح

Consent Form

جامعة النجاح الوطنية

كلية الدراسات العليا

نموذج موافقة على المشاركة في بحث

الباحثة: دينا تحسين نمر عيسى طالبة في كلية الدراسات العليا / ماجستير صحة نفسية مجتمعية،

جامعة النجاح الوطنية

المشرفة: الدكتورة مريم الطل في كلية التمريض جامعة النجاح الوطنية.

الجهة المشرفة: جامعة النجاح الوطنية / كلية الدراسات العليا / قسم التمريض / الصحة النفسية

المجتمعية.

عنوان البحث:

مستوى القلق والعصبية وطرق التكيف عند مرضى غسيل الكلى في شمال مستشفيات الضفة

الغربية .

STRESSORS AND COPING STRATEGIES AMONGST
HEMODIALYSIS PATIENTS IN NORTH OF WEST BANK.

يحتوي هذا الملف على :

1. معلومات وتفاصيل البحث

2. شهادة الموافقة على المشاركة في البحث

(سيقدم لكل مشارك نسخة كاملة عن ورقة الموافقة على المشاركة في البحث)

شهادة الموافقة على المشاركة في البحث

إقرار من المشارك في البحث:

قمت بقراءة المعلومات الواردة في ورقة معلومات البحث وأتيحت لي الفرصة ان اسال اي سؤال وقد تمت الإجابة على كافة أسئلتي بشكل كاف، وبناءا على ذلك أوقع طوعيا على المشاركة في هذا البحث.

اسم المشارك.....

توقيع المشارك.....

التاريخ.....\.....\.....

إقرار من الباحث:

قمت بقراءة المعلومات الواردة في ورقة معلومات البحث بطريقة صحيحة وواضحة، وبذلت جهدي أن يعي المشارك أن البحث سيتضمن:

1. الإجابة على استبيان يتعلق بمستوى التوتر والعصبية وطرق التكيف .

أؤكد على أن المشارك اخذ الفرصة الكافية للإجابة على استفساراته بشكل واضح وصحيح وبذلت ما بوسعي لتحقيق ذلك.

أؤكد أن المشارك لم يجبر على التوقيع على الورقة وان مشاركته كانت بمحض ارادته وكامل اختياره.

الباحثة دينا تحسين عيسى

توقيع الباحثة.....

التاريخ.....\.....\.....

جامعة النجاح الوطنية

كلية الدراسات العليا

مستوى الضغوطات، وطرق التكيف لدى مرضى غسيل الكلى في
شمال مستشفيات الضفة الغربية

إعداد

دينا تحسين نمر عيسى

إشراف

د. مريم الطل

د. جمال القدومي

قدمت هذه الأطروحة استكمالاً لمتطلبات درجة الماجستير لتخصص تمريض الصحة النفسية
المجتمعية بكلية التمريض في جامعة النجاح الوطنية في نابلس - فلسطين .

2015

ب

مستوى الضغوطات وطرق التكيف عند مرضى غسيل الكلى في شمال مستشفيات الضفة

الغربية

إعداد

دينا تحسين نمر عيسى

بإشراف

د. مريم الطل

د. جمال القدومي

الملخص

يتعرض مرضى غسيل الكلى بصفة خاصة إلى قلق وضغوطات نفسية كبيرة نتيجة طبيعة المرض وطول علاجه، مما له من آثار مدمرة على صحة وحياة المريض، حيث أن في السنوات القليلة الماضية ازداد انتشار مرضى غسيل الكلى بسرعة بين السكان الفلسطينيين ولا يوجد إلا القليل من الأبحاث حول الضغوطات والتكيف عند مرضى غسيل الكلى في فلسطين. ولذلك فمن المهم دراسة مستوى الضغوطات والتوتر التي تعاني منها هذه الفئة وطرق التكيف الأكثر استخداما في فلسطين.

الهدف من الدراسة: تهدف هذه الدراسة لتحديد عوامل الضغوطات التي يعاني منها مرضى غسيل الكلى وطرق التكيف عندهم.

طريقه إجراء البحث: أجريت دراسة مقطعية في أربعة مراكز لغسيل الكلى في شمال الضفة الغربية، ثلاثة مراكز في مستشفيات حكومية ومركز في مستشفى خاص، وذلك باستخدام الاستبيان الذي يحتوي على مقياس التوتر ومقياس آخر للتأقلم وطرق التكيف عند مرضى غسيل الكلى، والمقابلات المباشرة مع مرضى الفشل الكلوي النهائي.

نتائج الدراسة: أظهرت البيانات أن مرضى غسيل الكلى يعانون من ضغوطات، حيث أنا أكبر مصدر للضغوطات حسب البيانات هو "تقييد زمان ومكان الإجازات" بمتوسط (3.366)، يليه "تراجع الحياة الجنسية" بمتوسط (3.290)، وفقا لمقياس الضغوطات بين مرضى غسيل الكلى.

ج

بالنسبة إلى طرق التكيف يبدو أن مرضى غسيل الكلى يلجئون إلى أسلوب "قمت بالصلاة والتوكل على الله" بمتوسط (3.791) يليها "حاولت العيش بشكل طبيعي وعدم السماح للأمر بإعاقة ذلك" بمتوسط (3.600) وفقا لاستبيان طرق التكيف عند مرضى غسيل الكلى.

الاستنتاج والتوصية: إن وتيرة التوتر بين مرضى غسيل الكلى كانت تقريبا متوسطة بما يكفي لاعتبارها خطرا يشلك على صحة المريض وعلاجه مما يتطلب من المؤسسات الصحية العمل على وضع استراتيجيات تساهم في الحد والتقليل من التوتر والآثار السلبية الناتجة عنه.