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Perceived Social Support and Its Relationship to the Quality of Life Among Patients with Renal Failure in Palestine: An Applied Study in Jenin Governorate

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Abstract:

The study sought to demonstrate the relationship between perceived social support and quality of life among patients with renal failure. The study sample consisted of 123 patients from Jenin Governorate. The study results indicated a lack of statistically significant differences at the level of $\alpha \leq 0.05$ in the average levels of perceived support due to the variables of gender and duration of disease. There were no statistically significant differences in the responses related to quality of life due to gender. There were however statistically significant differences in quality of life due to the duration of the disease and mental health, in favor of the patients who had the disease for less than one year.

Results also showed a positive linear relationship, statistically significant, between the level of perceived social support and the quality of life among patients with renal failure.

Keywords: Perceived Social Support, Quality of Life, Renal Failure.

Introduction:

At the present time, society reaps the benefits of science, progress, and technology in all aspects of daily life. However, this does not prevent psychological and health pressures, as well as the spread of diseases, especially among developing nations with limited economic stability and geopolitical conflict. This would, in turn, increase the potential for poverty, ignorance, and disease. These factors lead to the inability to provide necessary health care for citizens, especially in the case of chronic diseases (renal failure), which require stable health care systems.

There are two types of renal failure:

- Acute renal failure: This occurs during a short period of time, ranging from hours to days, after which the kidneys recover their functions after the treatment (al-Suwaidaa’, 2010:25).

- Chronic renal failure: This failure is a public health problem affecting 5-10% of the world’s population with adverse consequences (Aggarwal, Jain, Pawar & Yadav, 2016). Chronic Renal failure is a comprehensive term that describes a group of disorders that affect the structure and function of the kidney (Ibrahim, TeoNormah, Che Din, Abdul Gafor & Ismail, 2015). Kidneys lose their functions gradually over time (Weiner, 2007), leading to the inability of the body to release metabolic waste and toxins (Gerogianni & Babatsikou, 2014), after which the use of blood purification system is required to remove toxins. When kidney function is reduced to less than 15 mm/min, it is called hemodialysis and kidney transplant becomes a therapeutic alternative for kidney failure (al-Suwaidaa’, 2010; Miqdad, 2015). At this stage, the kidneys lose their functions completely, and it is considered the final stages of the disease, and life becomes unsustainable (Tzanakaki, Boudouri, Stavropoulou, Stylianou, Rovithis & Zidianakis, 2014; Gerogianni & Babatsikou, 2014).

Primary causes of chronic renal failure
include: Diabetes, high blood pressure, blockage in the course of the urinary tract, infections, disorders of the blood vessels, toxic substances, and heavy metals such as lead and mercury (Akkari, 2013; Itai, Amayas, Kuribayashi, Kawamura, Okada, Momose, Tateyama, Narumi, Uematsu & Kaneko, 2000). Renal failure is treated by maintaining the internal balance of fluids and ions in the body by dialysis or kidney transplantation (Meyer & Hastetler, 2007). The treatment seeks to prevent premature death and the progress of renal failure while maintaining the quality of life (Weiner, 2007). The quality of patient’s lives is affected dramatically during dialysis treatment, as many changes happen to the habits and daily lifestyle among both patients and their families, which greatly affect physical health, job status, personal relationships, social activities, and economic status (Joshi, 2014; Gerogianni & Babatsikou, 2014). Leung (2003) and Pereira, Fernandes, Melo, Abrita, Grincenkov & Fernandes (2017) indicated that the most common pressures among patients with renal failure are financial difficulties and changes in social and marital relations.

As these challenges accumulate, the quality of life of patients with renal failure decreases significantly over time with the disease (Serda, Bozkurt, Karakoc, Caglayan, Akdeniz, Oktayoglu, Varol, & Nas 2015; Kumar, Agarwal, Singh, Pandey, Ranjan & Kumar, 2015). Some studies (Kalender et al., 2007; Perlman et al., 2004) have found that the quality of life decreased among kidney patients in all stages of the disease, where there was a decrease in physical performance (Cruz, Andrade, Urrutia, Draibe, Martins, La. & Sesso, 2011). Challenges in participating in social, recreational, and sports activities, affect the self-esteem of the patient and reduce life satisfaction (Gerogianni & Babatsikou, 2014).

The concept of quality of life varies between individuals as well. Those who have variable expectations will perceive quality, even if they have the same health status (Datta, Datta & Majumdar, 2015; Lavdaniti & Tsitsis, 2015). The individual’s sense of dissatisfaction with the quality of life affects his/her psychological ability to adapt with the social environment, as well as the feelings of happiness and well-being (al-Sheerawi, 2015). Clinical experiments
have shown that improving the quality of life of patients is becoming increasingly important for survival (Laird, Fallon, Hjermstad, Tuck, Kaasa, Klepstad & McMillan, 2016). It can be said that the quality of life is a state of well-being, which includes the individual’s ability to perform daily activities and reflects the physical and psychological requirements for social well-being and satisfaction within the performance levels and control of the disease symptoms (Lavdaniti & Tsitsis, 2015; Krinitcyna, Mikhailova & German, 2016).

One important factor in the quality of life equation is the level of social support available to the patient, in terms of providing assistance and appropriate opportunities for socialization (Silva, Braido, Ottavian, Gesualdo, Zazzetta & Orlandi, 2016). Social support includes an integrated social network covering the deficit in the physical and psychological abilities of the patient and should contribute to improving the level of health, regardless of geography, economy, and location (Gerogianni & Babatsikou, 2014; Yilmaz, Piyal & Akdur, 2017). Social support includes three types: Economic support (provision of resources and material assistance), information support (guidance and information), and emotional support (emotional expression and empathy). It also involves social integration, which includes the active participation of patients in a wide range of activities and social relations (Brissette, Cohen & Seeman., 2000).

Providing social support for patients contributes to lowering symptoms of depression and increases the positive perception of their disease, which shapes the degree of their general satisfaction with life (Kimmel & Patel, 2006). Social support contributes to improving the mood of patients and reducing symptoms of anxiety, especially when receiving the treatment (Gerogianni & Babatsikou, 2014; Untas, Thumma, Rascal, Rayner, Mapes & Lopes, 2011). This finding was confirmed by Sadeghi, Saeedi, Rahzani, and Esfandiary’s study (2015), who demonstrated that patients who have weak levels of social support had increased anxiety of death, compared to their peers who have strong social support systems.

It can be said that social support by family, friends, and caregivers to patients with renal failure plays an important role in helping patients to comply with treatment instructions (Gerogianni & Babatsikou, 2014; Ahrari, Moshki, & Bahrami, 2014). It was indicated through self-report that patients are interested in psychological, social, and spiritual support. The need for support is related to age, level of education, place of residence, difficulties in the family relationships, and anxious personality (Xhulia, Gerta, Dajana, Koutelekos, Vasilopoulou & Skopelitou, 2015). External support is one of the most effective ways to increase the success of long-term treatment and adjust patients’ attitudes towards the disease (Theodoritsi, Aravantiou, Gravani, Bourtsi, Vasilopoulou, Theofilou & Polikandrioti, 2016). Eom, Shin, Kim, Yang, Jo, Kweon, Kang, Kim, Cho, and Park’s study (2013) showed that social support is linked to positive mental health and quality of life due to the direct influence of interventions of social support. However, Ibrahim, TeoNormah, Che Din, Abdul Gafor, and Ismail’s study (2015), and Silva, Braido, Ottavian, Gesualdo, Zazzetta and Orlandi’s study (2016), in addition to Tchape, Tchapoga, Atuhaire, Priebe, and Cumber’s study (2018) indicated that social support contributes to the planning of interventions for patients with renal failure, which would improve the medical outcomes. Karadag, Kilic, and Metni’s study (2013) demonstrated that there is a negative correlation between fatigue and social support for renal failure patients, as people who received support reported less fatigue.

Alexopoulou, Giannakopoulou, Komna, Alikari, Toulia, and Polikandrioti’s study (2016) and Rambod and Rafii’s study (2010) found that there is a positive correlation between social support and quality of life. The more social support patients receive from family and friends, the higher their quality of life. The study of Farahani, Amiri, Karimi, Notash, Amirshahkari, and Azizi (2018) recommended designing interventions aimed at helping individuals to enhance their social network and achieve better social relationships, especially with family members.
Study Problem and Questions

Renal failure in Palestine is one of the chronic diseases that require consistent and stable medical care. The current prevalence of renal failure in Palestine is 1739 patients (West Bank 1119, Gaza Strip 620). There are 11 dialysis units in the West Bank, sponsored by the Ministry of Health (Palestinian Health Information Center, 2017).

Patients with chronic renal failure frequently constitute a significant economic burden, both directly in terms of the use of resources and indirectly in terms of lost productivity and quality of life (Aggarwal, Jain, Pawar & Yadav, 2016). Patients with renal failure suffer renal related mental disorders, including anxiety, depression, pain, fatigue, difficulty in sleeping and reduced sexual function, and an increased risk of death as a result of dialysis, that may last for years (Itai, Amayasu, Kuribayashi, Kawamura, Okada, Momose, Tateyama, Narumi, Uematsu, & Kaneko, 2000; Abdel-Kader, Unruh, & Weisbord, 2009; Gerogianni, 2003). Social support for the patient may affect the patient’s acceptance and adaptation to their medical condition and impacted functions (Spiridi, Iakovakis & Kaprinis, 2008; Cohen, Sharma, Acquaviva, Peterson, Patel, & Kimmel, 2007; Akyüz, Sayın, Erdal, Özcan, & Haberal, 2018).

Therefore, the study problem is determined by answering the main question: Is there a statistically significant correlation at the level of significance $\alpha \leq 0.05$ between social support and quality of life among renal failure patients?

From the main question emanate the following four sub-questions:

- Are there statistically significant differences in perceived social support among patients with renal failure due to the gender variable in the study sample?
- Are there statistically significant differences in perceived social support among patients with renal failure due to the variable of the duration of the disease in the study sample?
- Are there statistically significant differences in the quality of life among patients with renal failure due to the gender variable in the study sample?
- Are there statistically significant differences in the quality of life among patients with renal failure due to the variable of the duration of disease in the study sample?

Objectives of the Study

The study seeks to achieve the following objectives:

1. Verify the existence of a relationship between quality of life and social support among patients with renal failure.
2. Identify differences in perceived social support and quality of life among patients with renal failure due to the variables of gender and duration of disease.

The Study Hypotheses

The study states the following assumptions:

1. There are no statistically significant differences at the level $\alpha \leq 0.05$ in perceived social support among patients with renal failure due to the variables of gender and duration of disease.
2. There are no statistically significant differences at the level $\alpha \leq 0.05$ in the quality of life among renal failure patients due to the variables of gender and duration of disease.
3. There is no statistically significant correlation at the significance level $\alpha \leq 0.05$ between the quality of life and social support among patients with renal failure.

Study Limitations:

This study was limited to patients with renal failure attending Khalil Suleiman Hospital in Jenin, in the period between May-June, 2019.

Terms of the Study

Social support: The feeling of the presence of some people close to the patient, whether family, a
group of friends or co-workers, who provide him/her with love, respect, and moral and emotional support (Tashtoush, 2015).

It is defined procedurally by the degree of which the respondent receives on the social support measure used in this study.

Quality of life: The individual’s sense of happiness and satisfaction with life, through balancing the health, psychological, social, study, environmental, and economic aspects, as well as the degree of compatibility with oneself and others (Tashtoush & al-Qashar, 2017:134).

It is defined procedurally by the degree of which the respondent receives on the quality of life scale used in this study.

Renal Failure is the inability of the kidneys to dispense toxins and maintain the internal balance of water and minerals in the body (Azab & al-Basha, 2015).

Methods:

The researcher used the descriptive analytical correlational method to achieve the objectives of the study, using appropriate and statistical methods.

Study Population:

The study population consisted of 136 patients with renal failure who are attending Khalil Suleiman Governmental Hospital in Jenin city.

Sample Study:

The study sample consisted of 123 male and female patients with renal failure who were selected by the simple random sampling method, according to two variables, gender and duration of the disease. The following table shows the distribution of the sample

<table>
<thead>
<tr>
<th>Variable</th>
<th>Variable levels</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male</td>
<td>61</td>
<td>49.6%</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>62</td>
<td>50.4%</td>
</tr>
</tbody>
</table>

| study measures: |

Perceived social support scale:

The researcher used the Perceived Social Support Scale (Tashtoush, 2015), consisting of 12 items distributed over three dimensions: Family, friends, and others. The answers followed a five-point Likert scale: Always: 5, Often: 4, Sometimes: 3, Rarely: 2, and Never: 1.

The researcher verified the validity of the perceived social support scale using construct validity.

| study measures: |

<table>
<thead>
<tr>
<th>Table 2. Vocabulary Correlation Coefficients for the Total Degree of Perceived Social Support Dimension.</th>
</tr>
</thead>
<tbody>
<tr>
<td>-----</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>9</td>
</tr>
</tbody>
</table>

It is clear from Table 2 that all correlation coefficients of the items of the perceived social support measure with the total score were statistically significant at $\alpha \leq 0.05$ and ranged between 0.57-0.75, which means that the perceived social support measure has an appropriate degree of internal consistency.

The researcher also verified the degree of stability of perceived social support through the measure. Internal consistency was calculated using the Cronbach alpha formula for internal consistency. The values reached reliability coefficients in this way to measure overall perceived social support. Its dimensions are shown in Table 3.
Table 3.
The Values of Stability for the Dimensions of Perceived Social Support Coefficient.

<table>
<thead>
<tr>
<th>No</th>
<th>Perceived Social Support Dimension</th>
<th>Number of Paragraphs</th>
<th>The Alpha Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Family</td>
<td>4</td>
<td>0.846</td>
</tr>
<tr>
<td>2.</td>
<td>Friends</td>
<td>4</td>
<td>0.856</td>
</tr>
<tr>
<td>3.</td>
<td>Others</td>
<td>4</td>
<td>0.929</td>
</tr>
<tr>
<td></td>
<td>Total Perceived Social Support</td>
<td>12</td>
<td>0.837</td>
</tr>
</tbody>
</table>

Table 3 shows the values of the reliability coefficient of the dimensions of perceived support. Combined or separate, dimensions were higher than 84%, which is an accepted stability ratio.

**Quality of Life Scale:**

The researcher used the quality of life scale prepared by Tashtoush and Kechar (2017), consisting of 26 items distributed over four dimensions: Physical health, mental health, social relationships, and environment. The scale is answered by a five-point Likert scale: Always: 5, Often: 4, Sometimes: 3, Rarely: 2, and Never: 1.

To verify the quality of life scale, we used the construct validity method. The researcher calculated the coefficients of the degree of correlation of each of the dimension paragraphs and the overall degree of the dimension. The following table is extracted:

Table 4.
Vocabulary Correlation Coefficients to the Overall Degree of Quality of Life.

<table>
<thead>
<tr>
<th>Correlation Coefficient</th>
<th>No.</th>
<th>Correlation Coefficient</th>
<th>No.</th>
<th>Correlation Coefficient</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>.708**</td>
<td>1</td>
<td>.672**</td>
<td>7</td>
<td>.657**</td>
<td>13</td>
</tr>
<tr>
<td>.736**</td>
<td>2</td>
<td>.747**</td>
<td>8</td>
<td>.757**</td>
<td>14</td>
</tr>
<tr>
<td>.651**</td>
<td>3</td>
<td>.690**</td>
<td>9</td>
<td>.680**</td>
<td>15</td>
</tr>
<tr>
<td>.764**</td>
<td>4</td>
<td>.709**</td>
<td>10</td>
<td>.711**</td>
<td>16</td>
</tr>
<tr>
<td>.662**</td>
<td>5</td>
<td>.775**</td>
<td>11</td>
<td>.721**</td>
<td>17</td>
</tr>
<tr>
<td>.737**</td>
<td>6</td>
<td>.664**</td>
<td>12</td>
<td>.801**</td>
<td>18</td>
</tr>
<tr>
<td>.691**</td>
<td>25</td>
<td>.800**</td>
<td>22</td>
<td>.684**</td>
<td>19</td>
</tr>
<tr>
<td>.703**</td>
<td>26</td>
<td>.683**</td>
<td>23</td>
<td>.790**</td>
<td>20</td>
</tr>
</tbody>
</table>

It is clear from Table 4 that all correlation coefficients for the quality-of-life scale paragraphs and its overall grade were statistically significant at $\alpha \leq 0.05$, ranging from 0.65 to 0.80, meaning that the quality-of-life scale had an appropriate degree of internal consistency.

In order to verify the degree of stability of the quality of life scale, a measure of internal consistency was calculated using the stability equation alpha Cronbach (Cronbach's alpha). The values of reliability coefficients measure the overall quality of life and its dimensions are shown in Table 5.

Table 5.
The Values of Reliability Coefficient of the Dimensions of the Quality of Life.

<table>
<thead>
<tr>
<th>No</th>
<th>The Dimensions of the Quality of Life</th>
<th>Number of Paragraphs</th>
<th>The Value of Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Physical Health</td>
<td>8</td>
<td>0.831</td>
</tr>
<tr>
<td>2</td>
<td>Psychological Health</td>
<td>7</td>
<td>0.782</td>
</tr>
<tr>
<td>3</td>
<td>Social Relationships</td>
<td>3</td>
<td>0.769</td>
</tr>
<tr>
<td>4</td>
<td>Environment</td>
<td>Environment</td>
<td>0.795</td>
</tr>
<tr>
<td></td>
<td>The combined dimensions of the quality of life</td>
<td>26</td>
<td>0.911</td>
</tr>
</tbody>
</table>

Table 5 illustrates that the combined values of the reliability coefficient of the dimensions of the quality of life and each dimension were higher than 76%, which is an acceptable stability ratio.

**Results and Discussion:**

● The first hypothesis:

There are no statistically significant differences at the level $\alpha \leq 0.05$ in the mean of the sample responses for the perceived level of social support due to gender.

To examine this hypothesis, a T-test for two independent samples was conducted, and the results are shown in Table 6.
As seen from Table 6, there are no statistically significant differences at the level of significance \( \alpha \leq 0.05 \), in the averages of the sample responses in the level of perceived social support according to gender, and at the level of perceived social support in total. Each dimension is represented through family, friends, and others. The level of significance reached 0.475, 0.279, 0.555, 0.818. These values are greater than 0.05, which means acceptance of the null hypothesis; the perceived social support level is not different among patients with renal failure due to gender. It appears that all patients, regardless of gender, are receiving social support commensurate with their sickness. Friends, family, and others provide support because patients are in need of support, and they do not differentiate between males and females. This shows a humane aspect and that the goal is to help and encourage the patient.

- **The second hypothesis:**

There are no statistically significant differences at the level of \( \alpha \leq 0.05 \) in the mean of the sample responses to the level of perceived social support due to the duration of the disease.

To examine this hypothesis a mono variance analysis test was conducted. The results obtained are shown in Table 7.

As seen from the Table 7, there are no statistically significant differences at the level of \( \alpha \leq 0.05 \), in the averages of the sample responses to the level of perceived social support due to the variable of the duration of the disease, and at the level of perceived social support in total. All dimensions
of family, friends, and others reached the level of significance 0.748, 0.764, 0.504, 0.525. These values are greater than 0.05, which means the null hypothesis is accepted; the level of perceived social support among patients with renal failure is not different due to the duration of their disease.

Patients need social support at all stages of the disease. At diagnosis, the patient endures a psychological shock due to health deterioration and starting dialysis. They are in urgent need of support from friends, family, and the medical staff so that they can accept the disease and positively comply with treatment regimes. When the disease worsens, the patient may need more support and assistance to overcome feelings of anxiety, fear, and fear of death. The patient may become more dependent on others to fulfill his/her physical needs and carry out daily functions. This may generate a sense of guilt, where the patient feels that they are a burden on the family (Thong, Kaptein, Krediet, Boeschoten & Dekker, 2007). This was confirmed by Silva, Braid, Ottavian, Gesualdo, Zazzetta, and Orlandi (2016), who focused on the importance of social support during treatment and adaptation to the disease process. The result of this study differs from the study of al-Shagran & al-Karaki (2016), which showed that social support was beneficial only for female cancer patients, whose duration of the disease was 8 months or less. It also differs from Tashtoush’s study (2015), which showed that the level of social support for female breast cancer patients was beneficial for patients whose duration of the disease was three years and above.

- **The third hypothesis:**

There are no statistically significant differences at the level of \( \alpha \leq 0.05 \) in the mean of the sample responses to the level of quality of life due to the variable of gender.

To examine this hypothesis, a T-test for independent samples was conducted, and the results are shown in Table 8:

### Table 8.

<table>
<thead>
<tr>
<th>The Dimension</th>
<th>Gender</th>
<th>Average</th>
<th>Standard Deviation</th>
<th>Degree of Freedom</th>
<th>Calculated Value of “T”</th>
<th>Statistical Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health</td>
<td>Male</td>
<td>3.13</td>
<td>.833</td>
<td>121</td>
<td>.143</td>
<td>0.887</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>3.10</td>
<td>.891</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological Health</td>
<td>Male</td>
<td>3.59</td>
<td>.791</td>
<td>121</td>
<td>.520</td>
<td>0.604</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>3.51</td>
<td>.787</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Relationships</td>
<td>Male</td>
<td>4.30</td>
<td>.643</td>
<td>121</td>
<td>1.501</td>
<td>0.136</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>4.09</td>
<td>.881</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment</td>
<td>Male</td>
<td>3.52</td>
<td>.709</td>
<td>121</td>
<td>-.187</td>
<td>0.852</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>3.55</td>
<td>.819</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of Life (total tool)</td>
<td>Male</td>
<td>3.51</td>
<td>.622</td>
<td>121</td>
<td>.356</td>
<td>0.723</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>3.47</td>
<td>.712</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As seen in Table 8, there are no statistically significant differences at the level of \( \alpha \leq 0.05 \) in the averages of the sample responses to the level of quality of life due to gender, and on the level of quality of life in total. Each of its dimensions is represented by physical health, mental health, social relations, and the environment, which reached the level of significance 0.723, 0.887, 0.604, 0.136, 0.852, which is greater than 0.05. This means that the null hypothesis is accepted; the level of the quality of life does not differ among patients with renal failure due to gender. Patients with renal failure, both male and female, live in a society of similar living, health, and cultural conditions. Patients also have feelings of general satisfaction about their lives, illness, and the services provided to them. They are able to perform everyday activities that meet their physical and
psychological needs, promote social welfare, and control the disease (Lavdaniti & Tsitsis, 2015; Krinitcyna, Mikhailova & German, 2016). These patients assess their current level of performance compared with their potentials in a positive way (Bottomley, 2002). This result differs from the study of Spasic, Velickovic, Dordevic, Nikola and Tatjana, 2014; Sepúlveda, Poinhos, Constante, Pais-Ribeiro, Freitas and Carvalho (2015), and from the study of Tashtoush and Kechar (2017), which showed differences in favor of males.

- **The fourth hypothesis:**

There are no statistically significant differences at the level $\alpha \leq 0.05$ in the mean of the sample responses to the level of quality of life due to the duration of the disease.

To examine this hypothesis, the mono variance analysis test was conducted. The results obtained are shown in Table 9.

<table>
<thead>
<tr>
<th>Table 9. Analysis of Mono Variance Test Results to Test the Level of Significance of Differences Due to the Duration of the Disease Variable.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Dimension</strong></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Physical Health</td>
</tr>
<tr>
<td>Inside groups</td>
</tr>
<tr>
<td>Psychological Health</td>
</tr>
<tr>
<td>Inside groups</td>
</tr>
<tr>
<td>Social Relationships</td>
</tr>
<tr>
<td>Inside groups</td>
</tr>
<tr>
<td>Environment</td>
</tr>
<tr>
<td>Inside groups</td>
</tr>
<tr>
<td>Quality Of Life (Total Tool)</td>
</tr>
<tr>
<td>Inside groups</td>
</tr>
</tbody>
</table>

It is seen from Table 9 that there are no statistically significant differences at the level of significance $\alpha \leq 0.05$, in the averages of the sample responses to the level of quality of life due to duration of disease, including the dimensions of physical health, social relations, and environment, which have significance level at 0.082, 0.808, 0.084. These values are greater than 0.05, which means the null hypothesis is not accepted. The level of quality of life does not differ among patients with renal failure due to the duration of their disease, in the dimensions of physical health, social relations, and the environment.

There are statistically significant differences at the level of $\alpha \leq 0.05$, in the averages of the sample responses to the level of quality of life due to the duration of the disease, and the level of quality of life in total, including the dimension of mental health, which have significance level of 0.036, 0.020 respectively, which is smaller than 0.05. This means that the null hypothesis is not accepted in terms of these two dimensions. Quality of life is different among patients with renal failure due to the duration of their disease and the level of quality of life in total related to mental health symptoms.

To identify the differences in the quality of life in total due to the duration of the disease and to determine its destination, the less statistically significant test (LSD) was conducted for the dimensional comparisons. The results are shown in Table 10.
Table 10.
Less Statistically Significant Difference Test (LSD) for Comparisons of the Posteriori of the Level of Quality of Life (total tool) Due to the Duration of the Disease.

<table>
<thead>
<tr>
<th>The Duration of the Disease</th>
<th>Less than one year average (3.70)</th>
<th>1-5 years average (3.41)</th>
<th>More than 5 years average (3.34)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than one year</td>
<td>----</td>
<td>.29383*</td>
<td>3.5574*</td>
</tr>
<tr>
<td>average (3.70)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5 years</td>
<td>----</td>
<td>----</td>
<td>.06191</td>
</tr>
<tr>
<td>average (3.41)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More than 5 years</td>
<td>----</td>
<td></td>
<td></td>
</tr>
<tr>
<td>average (3.34)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 10 indicates the differences between the responses regarding the quality of life in total due to the duration of the disease. Differences were noted among the patients who had the disease for less than one year, and who had it for 1-5 years, and who had it for more than 5 years. A positive indication was for patients of less than a year, with answers average 3.70, compared to the averages of the patient who had it for 1-5 years and more than 5 consecutive years, 3.41, 3.34, respectively.

It appears that the duration of the disease plays a major role in the degree of quality of life among patients with renal failure. When the disease impact patients, they continue to maintain physical and psychological health to some extent. The side effects accompanying the disease evolve over time and with the frequency of the dialysis process. The patient at the beginning of the illness receives a lot of support and help from parents, friends, or the medical staff, but with time the side effects of the disease worsen and the patient loses much of his/her daily functions and responsibilities. Social life, family functioning, and professional performance are influenced significantly. With the progress of the disease, the patient becomes unable to perform many daily duties, affecting his mental situation and leading to a feeling of helplessness, anxiety, and fear of death. This leads to the inability to meet the patient own needs. He/she becomes increasingly dependent on others, especially when commuting between the house and the hospital (Abdel-Kader, Unruh & Weisbord, 2009; Gerogianni, 2003).

This result is consistent with Tashtoush and Kechar’s study (2017) and Sepúlveda, Poinhos, Constante, Pais-Ribeiro, Freitas, and Carvalho’s study (2015).

- The fifth hypothesis:

There is no statistically significant relationship at the level \( a \leq 0.05 \) in the level of perceived social support and the quality of life among patients with renal failure.

To examine the existence of a correlation between the level of perceived social support and the quality of life, the Pearson correlation coefficient test was calculated. Results are presented in Table 11.

Table 11.
Results of the Pearson Correlation Coefficient Test between the Level of Perceived Social Support and the Level of the Quality of Life.

<table>
<thead>
<tr>
<th>The Level of Quality of Life</th>
<th>Correlation Coefficient</th>
<th>The Level of Significance</th>
<th>The Level of Perceived Social Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>.280**</td>
<td>Correlation Coefficient</td>
<td>0.002</td>
<td>123 Number</td>
</tr>
</tbody>
</table>

** The value of Pearson’s correlation coefficient function at the level of statistical significance \( (\alpha \leq 0.01) \).

It is evident from Table 11 that there is a positive relationship between perceived social support and the quality of life among patients with renal failure, where the level of significance reached 0.002. The null hypothesis is rejected because higher levels of perceived social support among patients with renal failure were correlated with a higher quality of life. The researcher explains that patients always need social support from family, friends, or medical staff. These are the individuals closest to patients while receiving the treatment. Patients need sympathy and social participation to relieve their pain in order to improve their psychological state, acceptance of the disease, compliance with the instructions of the treatment, their sense of importance, and their sense of belonging to a group. This would enhance their self-confidence (Kimmel & Patel, 2006). This support eases loneliness, anxiety,
and depression and improves mood (Gerogianni & Babatsikou, 2014; Untas, Thumma, Rasele, Rayner, Mapes & Lopes, 2011). This finding has been confirmed by the study of Silva, Braidó, Ottavan, Gesualdo, Zazzetta and Orlandi (2016) who showed that there is a significant correlation between the level of perceived social support and aspects of the quality of life, such as health, and social, economic and spiritual performance, as well as family relations.

This finding is also consistent with the studies of Alexopoulou, Giannakopoulou, Komna, Alikari, Toulia, and Polikandrioti (2016) and Rambod and Rafii (2010), in addition to Mistik, Ünalan, and TokgÖz (2017), which showed that there is a positive relationship between the social support given to the patients and their quality of life.

**Recommendations:**

This research reinforces the critical role of social support in the perception of the quality of life among renal patients. The following recommendations stem from the findings:

1. Increasing the interest of the community institutions in providing social and psychological programs and activities for patients with renal failure, which contribute to increasing their social effectiveness and improving their mental health.

2. The Palestinian Ministry of Health needs to adopt, in its annual programs, psychological support for patients in order to overcome psychological distress during the treatment. This would reinforce the positive psychological health.

3. Health institutions should take appropriate measures to help patients with renal failure improve their quality of life.

4. Further studies and research should be conducted on the patients of renal failure with other variables, such as anxiety, depression, optimism, and spiritual well-being.

**Conclusion**

The study concluded that renal failure patients need to improve their quality of life, while the Palestinian Ministry of Health and institutions need to continue providing social support for them, especially institutions dealing with renal failure patients. This would greatly improve patients’ mental health, especially those at the early stages of the disease.

**References:**


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