Journal of Al-Quds Open University for Educational & Psychological Research & Studies

Volume 11 | Number 31 Article 15

2020

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

Rihab Aref Al-Sadi
Al-Istiqlal university/Palestine, rihab_alsadi@yahoo.com

Recommended Citation

Al-Sadi, Rihab Aref (2020) "Perceived Social Support and Its Relationship to the Quality of Life Among Patients with Renal Failure in Palestine: An Applied Study in Jenin Governorate," *Journal of Al-Quds Open University for Educational & Psychological Research & Studies*: Vol. 11 : No. 31 , Article 15.
Available at: https://digitalcommons.aaru.edu.jo/jaqou_edpsych/vol11/iss31/15

Journal of Al-Quds Open University for Educational & Psychological Research & Studies مجلة جامعة القدس المفتوحة للأبحاث والدراسات التربوية والنفسية
Vol. (11) - No. (31) - August 2020 المجلد (11) - العدد (31) - آب 2020م

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

الدعم الاجتماعي المدرك وعلاقته بنوعية الحياة لدى مرضى الفشل الكلوي في فلسطين (دراسة تطبيقية في محافظة جنين)

Rihab Aref Al-Sadi
Assistant Professor/ Al-Istiqlal University/ Palestine
Rihab_alsadi@yahoo.com

رحاب عارف السعدي
أستاذ مساعد/ جامعة الاستقلال/ فلسطين

Received: 5/ 8/ 2019, **Accepted:** 23/ 12/ 2019.
DOI: 10.33977/1182-011-031-015
https: //journals.qou.edu/index.php/nafsia

تاريخ الاستلام: 5/ 8/ 2019م، تاريخ القبول: 23/ 12/ 2019م.
E-ISSN: 2307-4655
P-ISSN: 2307-4647

الملخص:

هدفت الدراسة إلى الكشف عن العلاقة بين الدعم الاجتماعي المدرك ونوعية الحياة لدى مرضى الفشل الكلوي، إذ تكونت عينة الدراسة من (123) مريضاً ومريضةً في محافظة جنين. أظهرت نتائج الدراسة عدم وجود فروق دالة إحصائياً عند مستوى الدلالة ($\alpha \leq 0.05$) في متوسطات استجابات أفراد العينة في مستوى الدعم الاجتماعي المدرك بحسب متغيري الجنس ومدة الإصابة بالمرض، وتبين عدم وجود فروق دالة إحصائياً عند مستوى الدلالة ($\alpha \leq 0.05$)، في متوسطات استجابات أفراد العينة في مستوى نوعية الحياة بحسب متغير الجنس، في حين تبين وجود فروق بحسب متغير مدة الإصابة بالمرض على مستوى نوعية الحياة (الأداة الكلية) وبُعدِ الصحة النفسية لصالح المريض أقل من سنة.

كما أظهرت النتائج أيضاً وجود علاقة خطية موجبة دالة إحصائياً بين مستوى الدعم الاجتماعي المدرك ومستوى نوعية الحياة لدى مرضى الفشل الكلوي.

الكلمات المفتاحية: الدعم الاجتماعي المدرك، نوعية الحياة، الفشل الكلوي.

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 difference also at $\alpha \leq 0.05$ 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 geo-political 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, Amayasu, 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, Karakoç, Çağlayan, Akdeniz, Oktayoğlu, 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 is an important and multi-faceted concept. It covers all areas of an individual's life, and can be examined in all ages (Ghotra, McIsaac, Kirk & Kuhle, 2016;Krinitcyna, Mikhailova & German 2016). The concept refers to the well-being of individuals and societies in general, including the economic, development, social, health aspects, in addition to living standards, income, education and housing. It is closely linked to ideals of freedom, human rights, the pursuit of happiness, and the transition of society to a state where all citizens are satisfied (Streimikiene, 2015; Kahneman & Krueger, 2006; Ismail, Jabar, Janipha & Razali 2014; Ramya, Aruna & Mangala, 2017). Life satisfaction includes the individual's awareness and expectations of their life, which may vary depending on the individual culture, such as the incidence of chronic diseases. (Yodmai, Phummarak, Sirisuth, Kumar& Somrongthong, 2015; Datta, Datta & Majumdar 2015). The Quality of Life Assessment Group of the World Health Organization defined the concept of quality of life, based on self-indicators, such as human, ideas, behavior, culture, values, and feelings, as well as objective indicators, such as physical and environmental surroundings (Ismail, Jabar, Janipha & Razali, 2014; Aggarwal, Jain, Pawar & Yadav, 2016). All medical, social, economic, psychological, and political interventions generally aim to increase the quality of people's life (Refahi, Bahmani, Nayeric& Nayeri, 2015). The quality of life has been assessed historically on several levels (physical, psychological, economic, spiritual, and social). Some have suggested that the quality of life refers to the individual's satisfaction in general with life and a general sense of personal well-being (Lavdaniti & Tsitsis, 2015; Aggarwal, Jain, Pawar & Yadav, 2016). The concept of quality of life, however, refers to a patient's assessment and satisfaction of their current level of performance compared with their potentials. The larger the gap between the actual and the ideal reality, the lesser the degree of perception of the quality of life for them (Bottomley, 2002).

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, 20152015; 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, Rascle, 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, K im, 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, Amirshekari, 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 1.

Distribution of Respondents by Gender and Duration of the Disease.

Variable	Variable levels	Number	Percentage
Gender	Male	61	49.6%
	Female	62	50.4%
The duration of the disease	Below one year	41	%33.3
	1-5 years	45	36.6%
	More than 5 years	37	%30.1

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.

Table 2.

Vocabulary Correlation Coefficients for the Total Degree of Perceived Social Support Dimension.

No	Correlation Coefficient.	No.	Correlation Coefficient
1	.633**	4	.707**
2	.684**	5	.621**
3	.589**	6	.622**
7	.654**	10	.573**
8	.596**	11	.750**
9	.735**	12	.585**

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.

No	Perceived Social Support Dimension	Number of Paragraphs	The Alpha Value
1.	Family	4	0.846
2.	Friends	4	0.856
3.	Others	4	0.929
Total Perceived Social Support		12	0.837

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.

Correlation Coefficient	No.	Correlation Coefficient	No.	Correlation Coefficient	No.
.708**	1	.672**	7	.657**	13
.736**	2	.747**	8	.757**	14
.651**	3	.690**	9	.680**	15
.764**	4	.709**	10	.711**	16
.662**	5	.775**	11	.721**	17
.737**	6	.664**	12	.801**	18
.691**	25	.800**	22	.684**	19
.703**	26	.683**	23	.790**	20
		.741**	24	.719**	21

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.

No	The Dimensions of The Quality of Life	Number of Paragraphs	The Value of Alpha
.1	Physical Health	8	0.831
.2	Psychological Health	7	0.782
.3	Social Relationships	3	0.769
.4	Environment	Environment	0.795
The combined dimensions of the quality of life		26	0.911

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 $a \leq 0.05$ 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.

Table 6.

Test Results for Independent Samples to Test the Level of Significance of Differences According to the Gender Variable.

The Dimension	Gender	Average	Standard Deviation	Degree of Freedom	The Value of "T" Calculated	Statistical Significance
Family	Male	4.34	.722	121	0.279	1.088
	Female	4.16	1.066			
Friends	Male	3.39	.934	121	0.555	.593
	Female	3.27	1.270			
Others	Male	4.57	.909	121	0.818	-.231-
	Female	4.61	.769			
Perceived Social Support (Total tool)	Male	4.10	.717	121	.717	0.475
	Female	4.02	.777			

As seen from Table 6, there are no statistically significant differences at the level of significance α≤ 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 a≤ 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.

Table 7.

Results of the Mono Variance Analysis Test for the Level of Significance of the Duration Variable.

The Dimension	Source of Variation	Sum of Squares	Degrees of Freedom	Average Squares	Value of Alpha	The Level of Significance
Family	Between groups	.454	2	.227	0.764	.269
	Inside groups	101.046	120	.842		
Friends	Between groups	1.717	2	0.504	.690	0.504
	Inside groups	149.366	120	1.245		
Others	Between groups	.915	2	0.525	.647	0.525
	Inside groups	84.775	120	.706		
Perceived Social Support (total tool)	Between groups	.270	2	.135	.291	0.748
	Inside groups	55.654	120	.464		

As seen from the Table 7, there are no statistically significant differences at the level of α≤ 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, Braido, 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 a≤ 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.

Test Results for Independent Samples to Test the Level of Significance of Differences According to the Gender Variable.

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

As seen in Table 8, there are no statistically significant differences at the level of α≤ 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, Poínhos, 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 a≤ 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 9.

Analysis of Mono Variance Test Results to Test the Level of Significance of Differences Due to the Duration of the Disease Variable.

The Dimension	Source of Variation	Sum of Squares	Degrees of Freedom	Average Squares	Value of Alpha	The Level of Significance
Physical Health	Between groups	3.683	2	1.841	2.557	0.082
	Inside groups	86.411	120	.720		
Psychological Health	Between groups	4.789	2	2.394	4.062	0.020
	Inside groups	70.737	120	.589		
Social Relationships	Between groups	.260	2	.130	.213	0.808
	Inside groups	73.279	120	.611		
Environment	Between groups	2.868	2	1.434	2.530	0.084
	Inside groups	68.023	120	.567		
Quality Of Life (Total Tool)	Between groups	2.908	2	1.454	3.404	0.036
	Inside groups	51.251	120	.427		

It is seen from Table 9 that there are no statistically significant differences at the level of significance α≤ 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 α≤ 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.

The Duration of the Disease	Less than one year average (3.70)	1-5 years average (3.41)	More than 5 years average (3.34)
Less than one year average (3.70)	--------	.29383*	35574*
1-5 years average (3.41)		--------	.06191
More than 5 years average (3.34)			-------

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, Poínhos, Constante, Pais-Ribeiro, Freitas, and Carvalho's study (2015).

- **The fifth hypothesis:**

There is no statistically significant relationship at the level a≤ 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.

The Level of Quality of Life		
.280**	Correlation Coefficient	The level of Perceived Social Support
0.002	The Level of Significance	
123	Number	

** 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, Rascle, Rayner, Mapes & Lopes, 2011). This finding has been confirmed by the study of Silva, Braido, Ottavian, 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:

- Abdel-Kader, K., Unruh, M., & Weisbord, S.(2009). Symptom Burden, Depression, and Quality of Life in Chronic and End-Stage Kidney Disease. Clinical Journal of the American Society of Nephrology,(4), 1057–1064.Doi: 10.2215/.00430109.
- Aggarwal, D., Jain, S., Pawar, R., & Yadav, K. (2016). Health-related quality of life in different stages of chronic kidney disease. QJM: An International Journal of Medicine, 109(11),711 -716, Doi.org/10.1093
- Ahrari, SH., Moshki, M., & Bahrami, M.(2014)The Relationship Between Social Support and Adherence of Dietary and Fluids Restrictions among Hemodialysis Patients in Iran. Journal of Caring Sciences, 3(1):11-19, Doi:10.5681/jcs.2014.002.
- Akkari, K. (2013). Projecting requirements for end stage renal disease services in Libya 2014-2024. Ibnosina Journal of Medicine and Biomedical Sciences,5(6): 354-362. Doi: 10.4103/1947-489X.210570.
- Akyüz, A., Sayın, CB., Erdal, R., Özcan, C., & Haberal, M.(2018). Influence of Social, Economic, Familial, Marital Status, and Disease Adaptation on the Physical and Mental Health Dimensions of Patients Who Are Candidates for Renal Transplant. Journal of Experimental and Clinical Transplantation, Mar(16), (Suppl 1),112-116. Doi: 10.6002/ect.
- Alexopoulou,M., Giannakopoulou, N., Komna, E., Alikari,V., Toulia, G., & Polikandrioti, M. (2016). The Effect of Perceived Social Support on Hemodialysis Patients' Quality of Life. Mater Sociomed, Oct;28(5):338–342. Doi: 10.5455/.2016.28.

- Al-shagran,H., & Al-karaki,Y.(2016). Perceived Social Support among Breast Cancer Patients in the light of some Variabels. Jordanian Journal of Educational Sciences, 12(1): 100-85.
- Al-Sheerawi, A.(2015).Differences in the Quality of Life and Academic Achievement According to the Level of Life Skills Among University Students in the Kingdom of Bahrain. Journal of Educational and Psychological Sciences, 16 (4):16-49.
- Al-Suwaidaa', A. (2010). The Comprehensive Guide for the Patients of Renal Failure. 1st edition, Wahj Al-Hayat for Publishing and Distributing: The Kingdom of Saudi Arabia.
- Azab, A., & Al-Basha, M.(2015). Physiological Changes which Accompany Renal Failure Among Patients of Chronic Renal Failure at Al-Zahraa' Hospital for the Treatment and Surgery of the Kidneys. Journal of the Faculty of Education, (3): 159-173.
- Brissette, I., Cohen, S., & Seeman, TE. (2000). Measuring Social Integration and Social Networks. In: Measuring and Intervening in Social Support. edited by Cohen S, Underwood L, Gottlieb B, New York, Oxford University Press: 53–85.
- Bottomley, A. (2002). The cancer patient and quality of life, Oncologist,(7):120-125. Doi: 10.1634.
- Cruz, M., Andrade, C., Urrutia, M., Draibe, S., Martins, La. & Sesso, R. (2011). Quality of life in patients with chronic kidney disease. Clinics(Sao Paulo), 66(6): 991–995. Doi: 10.1590/S18075932201100062
- Cohen, S., Sharma, T., Acquaviva, K., Peterson, R., Patel, SS., & Kimmel, PL. (2007) Social support and chronic kidney disease: An update. Advances in Chronic Kidney Disease., 14(4): 335–344. Doi:10.1053/j.ackd.2007.04.007.
- Datta, D., Datta, P., & Majumdar, K.(2015). Association of quality of life of urban elderly with socio-demographic factors. International Journal of Medicine and Public Health, 5(4):274-278. Doi: 10.4103/2230-8598.165944.
- Eom, CS., Shin, DW., Kim , SY., Yang, HK., Jo, HS., Kweon, SS., Kang, YS., Kim, JH., Cho, BL., & Park, JH.(.2013). Impact of perceived social support on the mental health and health-related quality of life in cancer patients: results from a nationwide, multicenter survey in South Korea. Psychooncology. 22(6):1283-90.Doi: 10.1002/pon.3133.
- Farahani, S., Amiri, P., Karimi, M., Notash, G., Amirshekari, G., & Azizi, F. (2018). Perceived social support and health-related quality of life (HRQoL) in Tehranian adults: Tehran lipid and glucose study, Health Qual Life Outcomes,16(90),Doi: 10.1186/s12955-018-0914-y.
- Gerogianni, KG.(2003). Stressors of patients undergoing chronic hemodialysis. Nursing. 42 (2): 228-246.
- Gerogianni, S., Babatsikou, F., Gerogianni, G., Koutis, CH., Panagiotou, M., & Psimenou, E.(216). Social Life of Patients Undergoing Haemodialysis. International Journal of Caring Sciences, 9 (1): 122-134.
- Gerogianni, S., & Babatsikou, F.(2014). Psychological Aspects in Chronic Renal Failure. Health Science Journal,8(2):205-214.
- Ghotra,S., McIsaac, J., Kirk, S., & Kuhle, S.(2016). Validation of the "Quality of Life in School" instrument in Canadian elementary school students. Journal of Life and Environmental Sciences(PeerJ),12(4) :e1567: 2-17. Doi 10.7717/peerj.1567
- Ismail,F., Jabar, I., Janipha, N., & Razali, R. (2014) Measuring the Quality of Life in Low Cost Residential Environment, Asia Pacific International Conference on Environment-Behaviour Studies Sirius Business, Park Berlin-yard field. Berlin, 24-26 February 2014, Procedia -Social and Behavioral Sciences, (168) : 270 – 279. Doi:10.1016.2014.10.232

- Ibrahim, N., TeoNormah, S., Che Din, N., Abdul Gafor, A., & Ismail, R. (2015). The Role of Personality and Social Support in Health-Related Quality of Life in Chronic Kidney Disease Patients. PLoS One. , 10(7): 1-11,Doi: 10.1371/.012901
- Itai, T., Amayasu, H., Kuribayashi, M., Kawamura, N., Okada, M., Momose, A., Tateyama, T.,Narumi, K., Uematsu, W., & Kaneko,S. (2000). Psychological effects of aromatherapy on chronic hemodialysis patients. Psychiatry and Clinical Neurosciences, (54): 393–397. Doi:10.1046 .
- Joshi, V.(2014). Quality of life in end stage renal disease patients. World Journal Nephrol, Nov 6, 3(4): 308–316. Doi: 10.5527/wjn.v3.i4.308.
- Kahneman, D., & Krueger, A.(2006). Developments in the measurement of subjective well-being. Journal of Economic Perspectives, 20(1): 3-24. Doi: 10.1257/089533006776526030.
- Karadag, E., Kilic, S., & Metni, O. (2013). Relationship between fatigue and social support in hemodialysis patients. Nursing & Health Sciences. 15(2):164-71.Doi: 10.1111.12008.
- Kimmel, PL. & Patel, SS. (2006). Quality of life in patients with chronic kidney disease. Focus on end-stage renal disease treated with hemodialysis. Seminars in Nephrology, 26(1):68–79. Doi:10.1016/j.semnephrol.2005.06.01
- Krinitcyna, Z., Mikhailova, T., & German, M. (2016). Quality of life as the basis for achieving social welfare of the Population. SHS Web of Conferences 28, 01060 (2016) , Doi: 10.1051/shsconf/20162801060.
- Kumar, P., Agarwal, N., Singh, C., Pandey, S. Ranjan, A., & Kumar, D. (2015) Diabetes and quality of life—a pilot study. International Journal of Medical Science and Public Health, 5(6):1143-1147, Doi: 10.5455.2016.18092015155.
- Laird, B., Fallon, M., Hjermstad, M., Tuck, S., Kaasa, S., Klepstad, P., & McMillan, D.(2016). Quality of Life in Patients with Advanced Cancer: Differential Association With Performance Status and Systemic Inflammatory Response. Journal of Clinical Oncology, 34(23): 2769-2775. American Society of Clinical Oncology. Doi: 10.1200/JCO.2015.65.7742.
- Lavdaniti, M. & Tsitsis, N. (2015). Definitions and Conceptual Models of Quality of Life in Cancer Patients. Health Science Journal,9(2:6):1-5.
- Leung, DK.(2003). Psychosocial aspects in renal patients. Peritoneal Dialysis International , 23(S2): S90-S94. PMID: 17986567.
- Meyer,T., & Hastetler,T. (2007). Uremia. The New England Journal of Medicine,357(13):1316-1325. Doi: 10.1056 071313.
- Mistik, S., Ünalan, D., & TokgÖz, D. (2017).The Effect of Depression and Perceived Social Support Systems on Quality of Life in Dialysis Patients. Turkish Nephrology, Dialysis and Transplantation Journal, 26(1): 23-28, Doi: 10.5262/tndt.2017.1001.04.
- Miqdad,G.(2015).Future Anxiety and its Relationship With Some Variables. an unpublished Master’s thesis, The Islamic University, Gaza.
- Palestinian Center for Health Information(2017).Palestinian Ministry of Health/Ramallah. https:/www.site.moh.ps
- Pereira, B., Fernandes, N., Melo, N., Abrita, R., Grincenkov, F., & Fernandes, N. (2017). Beyond quality of life: a cross sectional study on the mental health of patients with chronic kidney disease undergoing dialysis and their caregivers. Health and Quality of Life Outcomes,15(74): 1-10, Doi 10.1186/s12955-017-0646-4.
- Rambod, M., & Rafii, F. (2010). Perceived social support and quality of life in Iranian hemodialysis patients. Journal of Nursing Scholarship. 2010 Sep 1,42(3):242-9. Doi: 10.1111/j.1547-5069.2010.01353.x.

- Ramya, S., Aruna, S., & Mangala, P. (2017) Quality of life and chronic renal failure, International Journal of Development Research, 7(9): 15524-15526.
- Refahi, Z., Bahmani, B., Nayeric, A. & Nayeri, R. (2015). The relationship between attachment to God and identity styles with Psychological well-being in married teachers. Social and Behavioral Sciences, 174 (2015): 1922 – 1927. 856.
- Sadeghi, H., Saeedi, M., Rahzani, K., & Esfandiary, A. (2015). The relationship between social support and death anxiety in hemodialysis Patients. Iranian Journal of Psychiatric Nursing (IJPN), 2(4), Issue 8 : 36-48.
- Sepúlveda, E., Poínhos, R., Constante, M., Pais-Ribeiro, J., Freitas, P., & Carvalho, D. (2015). Health-related quality of life in type 1 and type 2 diabetic patients in a Portuguese central public hospital. Diabetes, Metabolic Syndrome and Obesity. 2015, 8: 219–226., Doi: 10.2147 80472 .
- Serda, EM., Bozkurt, M., Karakoç, M., Çağlayan, M., Akdeniz, D., Oktayoğlu, P., Sefer Varol, S., & Nas,K.(2015). Determining Quality of Life and Associated Factors in Patients with Stroke. Turkish Journal Physical Medicine and Rehabilitation,(61):148-54. Doi: 10.5152/tftrd.2015.80090.
- Silva, S., Braido, N., Ottavian, A., Gesualdo, G., Zazzetta, M., & Orlandi, F. (2016). Social support of adults and elderly with chronic kidney disease on dialysis. Revista latino-americana de enfermagem, (24): 1-7, Doi: 10.1590/1518-8345.0411.2752.
- Spasic, A., Velickovic, R. , Dordevic, A., Nikola, S., & Tatjana, C. (2014). Quality of Life in type 2 diabetic patients. Scientific Journal of the Faculty of Medicine in Niš, 31(3):193–200. Doi: 10.2478/afmnai-2014-0024.
- Spiridi, S., Iakovakis, A. & Kaprinis, G. (2008). Renal insufficiency: Biological and psychosocial consequences In. Psychiatriki, (19): 28-34.
- Streimikiene, D.(2015). Quality of Life and Housing. International Journal of Information and Education Technology, 5(2):140-145. Doi: 10.7763/IJIET.2015.V5.491.
- Tashtoush, R.(2015). Life Satisfaction and Perceived Social Support and the
- Relationship Between them among a Sample of Breast Cancer Patients. Jordanian Journal of Educational Sciences,11(4): 467 -449.
- Tashtoush, R., & Kechar.M.(2017). Quality of Life and Self-Esteem Among Diabetic Patients in Jordan. Jordanian Journal of Educational Sciences, 13(2): 133-151.
- Tchape, ODM., Tchapoga, YB., Atuhaire, C., Priebe, G., & Cumber, SN.(2018). Physiological and psychosocial stressors among hemodialysis patients in the Buea Regional Hospital, CameroonThe Pan African Medical Journal, May(18),30-49. Doi:10.11604/pamj.2018.30.49.180
- Theodoritsi, A., Aravantiou, M., Gravani, V., Bourtsi, E., Vasilopoulou, C., Theofilou, P., & Polikandrioti, M. (2016). Factors Associated with the Social Support of Hemodialysis Patients. Iran Journal Public Health. Oct, 45(10): 1261–1269.
- Thong, MS., Kaptein, AA., Krediet, RT., Boeschoten, EW., & Dekker, FW.(2007) Social support predicts survival in dialysis patients. Nephrol Dial Transplant, 22(3): 845–850. Doi: 10.1093/ndt/gfl700
- Tzanakaki, E., Boudouri, V., Stavropoulou, A., Stylianou, K., Rovithis, M., & Zidianakis, Z. (2014) Causes and complications of chronic kidney disease in patients on dialysis. Health Science Journal, 8(3):343-349.
- Untas, A., Thumma, J., Rascle, N., Rayner, H., Mapes, D., & Lopes, A. (2011).The associations of social support and other psychosocial factors with mortality and quality of lie in the Dialysis outcomes and Practice Patterns Study. Clinical Journal of the American Society of Nephrology , 6(1):142–152 Doi: 10.2215.02340310
- Weiner, D.(2007).Causes and Consequences of Chronic Kidney Disease: Implications for Managed Health Care. Journal of Managed Care Pharmacy,13(3): 1-9.
- Xhulia, D., Gerta, J., Dajana, Z., Koutelekos,

I. , Vasilopoulou, C. & Skopelitou, M. (2015). Needs of hemodialysis patients and factors affecting them. Global Journal of Health Science, 2015,8(6):109-120. Doi: 10.5539/gjhs.v8n6p109.

- Yilmaz, M., Piyal, B., & Akdur, R.(2017). Social support and quality of life in a group of cancer patients (Ankara, Turkey). Turkish Journal of Medical Sciences, (47): 732-737. Doi:10.3906/sag-1508-42.
- Yodmai, K., Phummarak, S., Sirisuth, J., Kumar, R., & Somrongthong, R. (2015) Quality of Life and Fear of Falling among an Aging Population in Semirural, Thailand. Journal of Ayub Medical College, Abbottabad ,27(4):771-774.