

Resilience And Illness Behaviour Among Hemodialysis Patients At A Tertiary Care Centre

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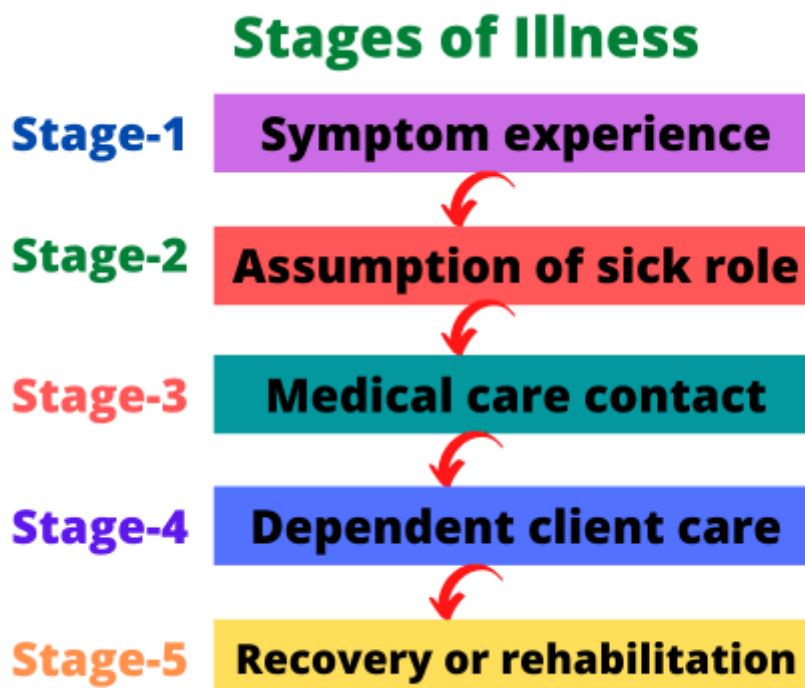
I. INTRODUCTION

Resilience refers to the ability to cope with difficult, stressful and traumatic situations while maintaining or restoring normal functioning. Resilience is a positive adaptation after stressful situations and it represents mechanisms of coping and rising above difficult experiences. Resilience is the psychological quality that allows some people to be knocked down by the adversities of life and come back at least as strong as before rather than letting difficulties, traumatic events, or failure overcome them, highly resilient people find a way to change course, emotionally heal, and continue moving toward their goals. It represents a complex set of various protective and salutogenic factors and process important for understanding health and illness, and treatment and healing processes. The higher the resilience, the lower the vulnerability and risk of illness.

Chronic kidney disease caused 1.4 million deaths in 2019(WHO) . Chronic kidney disease (CKD) is associated with a decrease in renal function due to age that is aggravated by factors such as high blood pressure, diabetes, obesity or primary renal disorders. This decline in kidney function is progressive and irreversible, so for prevention of severe complications such as uremia, patients must undergo renal replacement therapies such as hemodialysis and renal transplantation. It is estimated that more than two million people in the world are undergoing maintenance hemodialysis , these complex therapeutic regimens impose a heavy burden on patients and severely affects all aspects of individual, family and social life of them. Success in controlling CKD depends on compliance with the treatment. The results of studies show that when the complexity and length of the therapeutic regimen are greater, the likelihood of its nonadherence also increases. Various studies have focused on identifying the predictors of therapeutic regimen compliance in patients with chronic kidney disease. The results of the studies show that motivation by the staff, the level of knowledge and social support is associated with the compliance of the therapeutic regimen.

The term illness behavior was introduced by Mechanic and Volkart to describe the individuals' different ways to respond to their own health status. The concept of illness behaviour, in contrast, describes the ways persons respond to bodily indications and the conditions under which they come to view them as abnormal. Illness behaviour thus involves the manner in which persons monitor their bodies, define and interpret their symptoms, take remedial action, and utilize various sources of help as well as the more formal health-care system. It also is concerned with how people monitor and respond to symptoms and symptom change over the course of an illness and how this affects behaviour, remedial actions taken, and response to treatment. The different perceptions, evaluations and responses to illness have, at times, dramatic impact on the extent to which symptoms interfere with usual life routines, chronicity, attainment of appropriate care and co-operation of the patient in treatment.

Stages of illness behaviour: Edward A. Suchman formulated illness behaviour consists of five stages like symptom experience, assumption of the sick role, medical care contact, dependant patient and recovery or rehabilitation.



Stage-1: Symptom experience-At first, the person could not identify what is wrong with him, why he is feeling differently. Gradually he realises from his perception and some symptoms like pain, rashes that he is having a health problem. The emotional response includes in the stage like fear concern and anxiety.

Stage-2: Assumption of sick role-Assumption of sick role starts when an individual accepts that he or she is sick. After that individual seeks information from others, because an individual could not sufficiently confident to decide on their own that they are sick. All most all cases individual follows advice given by with whom he or she has discussed.

Stage-3: Medical care contact-At this stage, individually take the help from medical professionals. He or she takes advice and permission to be sick from a “scientific” source rather than a lay source. If a medical professional denied, he may return to normal activities. Sometimes an individual could not satisfy himself by consulting one professional, in this stage individual go for many called “doctors shop”.Most common treatment in this stage is one or more medication prescribed by the physician.

Stage-4: Dependent client care-Dependant client care starts when an individual makes the decision to give full control to the physician and follow the treatment. At this stage sick individual becomes patient. Most individual believe and adhere to physicians treatment and they also become dependent on family. Some individual could not believe that they are ill and deny taking the help. At last, they understand and realise that this the only way to health and render autonomy to the physician.

Stage-5: Recovery and rehabilitation-This is the final stage, in which both medical professional and lay caregivers agree that patient is fit to return to his normal duties. This stage holds special significance with chronic conditions. An ill person can do everything to return to his normal conditions but the person with chronic condition losses hope to become cure and return to his normal duties. This put pressure on both patients and lay caregivers.

OBJECTIVES OF THE STUDY

- To assess the illness behavior among hemodialysis patients.
- To assess the resilience among hemodialysis patients.
- To find the association between resilience and illness behavior

II. REVIEW OF LITERATURE:

A correlational and cross sectional study on relationships between resilience and illness behaviour among hemodialysis patients by Zinat goldanminogham et al. (2019) conducted among 78 participants in Iran revealed

a negative relationship between resilience and illness behaviour which concluded that psychological aspects of patients should be focused in the treatment of disease.

Hamid Ravaghi et al (2017) conducted a systematic review on prevalence of depression among hemodialysis patient in Iran from electronic literature data of 27 studies on 2822 patients . The review indicated that overall prevalence of depressive symptoms in dialysis patient was 62% [95% confidence interval,0.54 to 0.71] based on random model using BDI test for detection of patient with depression.

A cross sectional study on relationship between quality of life and self care ability among 115 hemodialysis patient by Mehdi Heidarzadeh et al [2008] performed showed that 60% of patients had undesirable quality of life and there was a direct and significant relationship between quality of life and self care ability [$p < 0.05$].

A qualitative study conducted by Rasheed K.Hall et al (2019) on quality of life in older adults receiving hemodialysis in Durham , North Carolina identified two major quality of life themes which are having physical well-being and having social support for quality of life and maintaining their health.

Mahsa Sabet Ghadam , Farzad Poorgholami , Zohreh Jaoromi et al (2014-2015) in their quasi experimental , study among 50 hemodialysis patients found that the mean of quality of life has improved after educating patients and providing psychological counseling.

The Dept. of Renal Medicine, Indiana University School, Indianapolis conducted a study on intensive hemodialysis and health related quality of life in the year 2016. The characteristics assessed in the study were quality of life and clinical outcome, physical, sleep quality , depression ,caregiver burden and mental health, by randomized clinical trial. It was found that 17% says after hemodialysis . then physical functioning was improved ,19% they were feeling better, 17% improved over all quality of life . The ratio between positive and negative response were 3:1. Thus concluded that intensivr hemodialysis can address both physical and mental aspects of poor health related quality of life related to conventional hemodialysis. Hence it is important to understand the psychological process in CKD patients to build up resilience and facilitate the illness behaviour positively.

Research methodology:A quantitative research approach was used in the study for a systemic and objective method of collecting empirical evidences, the design adopted for the study is a non-experimental descriptive research design. The researcher identified this design as the most suitable in achieving the objectives of the study. This study was conducted at the dialysis centre of a tertiary care centre in Lucknow among 50 hemodialysis patients selected using puposive sampling who were available at the time of data collection.

The tool consisted of three sections :-

Section -A : Socio- demographic data

Section -B: Connor-Davidson resilience scale .

Section-C: Pilowsky Spencer illness behaviour scale.

Connor-Davidson resilience scale : This scale was developed by Katherine M Connor and Jonathan R T Davidson as a means of assessing resilience. The CD-RISC scale consists of 25 items, which are evaluated on a five point Likert scale ranging from 0 to 4: not at all true (0), rarely true (1), sometimes true (2), often true (3), true nearly all of the time (4)- these ratings result in a number between 0-100 and higher scores indicate higher resilience.

Pilowsky Spencer illness behaviour scale: The illness behavior questionnaire (IBQ) is a 62 item self report instrument that provides information relevant to the delineation of a patient's attitudes, ideas, affects and attributions in relation to illness. The scores generated are described and seven factorial derived scales: A. general hypochondriasis, B. disease conviction, C. psychological vs somatic focusing, D. affective inhibition, E. affective disturbance, F. denial, G. irritability. The IBQ contains 62 items with a dichotomous response format(yes/ no).

A pilot study was conducted over 10 subjects after seeking Administrative permission was obtained from Head of the hospital and IEC. Keeping all the ethical considerations in place data was collected over a period of one month duration. Tool was administered to the participants. The investigator personally approached the study subjects and obtained a written consent after assuring the subjects about the confidentiality of the data. The selected patients were given the questionnaire. The average time taken by the participants to complete the questionnaire was 20 mins. The data collected from the sample are grouped and analysed with the help of statistical measures on the basis of the objectives and hypothesis.

III. RESULTS

TABLE1. SOCIODEMOGRAPHIC DISTRIBUTION OF SAMPLE

S NO.	ENTITIY		FREQUENCY	PERCENTAGE	MEAN	SD
1	AGE	20-40	10	20	16.6	3.81
		40-60	21	42		2.52
		>60	19	38		1.38
2	GENDER	MALE	34	68	25	6.3
		FEMALE	16	32		6.3
3	DIALYSIS FREQUENCY	ONCE	3	6	16.6	7.8
		TWICW	21	42		2.53
		THRICE	26	52		4.94
4	DIALYSIS FROM	1-3YRS	28	56	16.6	6.63
		3-5YRS	18	36		0.77
		>5YRS	4	8		7.27
5	COMORBIDITIES	NO	16	32	25	6.36
		YES	34	68		6.36
6	DM	NO	32	64	25	4.89
		YES	18	36		4.89
7	HTN	NO	28	56	25	2.12
		YES	22	44		2.12
8	HEP B +VE	NO	48	96	25	16.26
		YES	2	4		16.26
9	INTESTINAL CANCER	NO	49	98	25	16.97
		YES	1	2		16.97
10	RENAL TRANSPLANT	NO	45	90	25	14.14
		YES	5	10		14.14

TABLE2: CONNOR – DAVIDSON RESILIENCE SCALE

VARIABLE	SUB GROUPS	p-VALUE
AGE	20-40	0.564
	40-60	
	>60	
GENDER	MALE	0.166
	FEMALE	
DIALYSIS FREQUENCY	ONCE	0.642
	TWICE	
	THRICE	
DIALYSIS FROM	1-3YRS	0.055
	3-5 YRS	
	>5 YRS	
COMORBIDITIES	YES	0.048
	NO	
DM	YES	0.448
	NO	
HTN	YES	0.217
	NO	
HEP B+VE	YES	0.286
	NO	
INTESTINAL CANCER	YES	0.972
	NO	
RENAL TRANSPLANT	DONE	0.046

	NOT DONE	
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Table 2 table shows that none of the variables like age, gender, dialysis frequency, comorbidities except renal transplant done status was found associated with resilience that shows the importance of renal transplant in boosting the morale of the CKD patients and giving a positive hope for future. The p value was found to be 0.046 at 0.05 level of significance.

Table 3. Illness behaviour score.

Illness Behaviour	Mean	Median	Standard Deviation
Affective Disturbance	3.66	4	1.10
General Hypochondriasis	5.56	6	1.77
Denial Of Problems	3.18	3	1.72
Affective Inhibition	1.98	2	1.08

The table shows the mean score (5.56+1.77) is highest for general hypochondriasis followed by affective disturbance, denial of problem and affective inhibition. Hence its clear that CKD patients have higher tendency to go into hypochondriacal features followed by emotional problems .

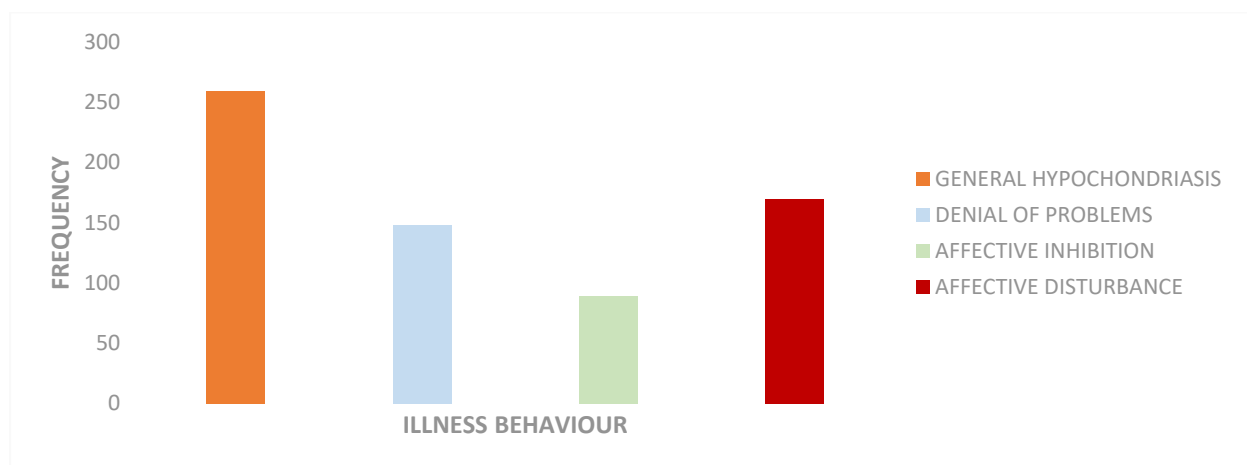


Fig1. This figure shows that majority of the patients suffered general hypochondriasis symptoms followed by denial of any problem, affective disturbance and affective inhibition. This clears that CKD patients have multiple psychological issues as a part of their chronic illness and emotional turmoil from time to time.

IV. DISCUSSION:

When illness behaviour was compared under different sociodemographic variables. The people who belonged to the age group of 20-40, females, frequently undergoing dialysis or underwent transplant were found to be significant in expression of more illness behaviour. However General hypochondriasis or health anxiety with morbid preoccupations of physical symptoms was the most significant parameter (50%) observed. Regarding denial of problem the people with high expression of illness behaviour shown more denial towards illness & affective inhibition the people with higher resilience were found to be more emotionally stable and shows less inhibition of spontaneous action, feeling or communication. They usually accept disapproval by others, has less feeling of guilt or shame and has control over their impulses. Which is same as explained in study by Liu et al (2016) and Kimmel P L (2019). The people with higher scores found to have higher resilience when compared with those of lower scores. In a similar study conducted by Mary et al showed an increase in resilience after a four week resilience course. The nutrition, self actualisation, and stress management subjects of health promotion behaviour were found to predict resilience however in this study the resilience in males was higher than in females, similar to the findings of similar study conducted by Ross and Wu (2020) & Jomomn Joy et al (2015).

The study was limited by time and several research factors since it was a cross sectional study. There was no long term follow up or continuity to assess patients for resilience at each stage after kidney disease. Also the study was conducted only on patients who utilised outpatient facilities in this tertiary care hospital hence findings regarding illness behaviour and resilience cannot be generalised to in patient or outpatient settings of other hospitals.

IMPLICATIONS: Educating the patient and caregivers on importance of social groups and support systems and about various coping strategies is always important. Effective training of health care workers in promotion of resilience in each patient considering their individuality is required to develop a positive attitude while communicating with chronically ill patients. Further research in nurse's role in all three levels of health care settings is to promote resilience.

Improved training for nurses in promotion of resilience among chronically ill patients. Special training for nurses who work in renal care settings in identifying the illness behaviours and improving resilience in chronic CKD and ESRD patients can really change the game.

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