

HOW DO THAI PATIENTS RECEIVING HAEMODIALYSIS COPE WITH PAIN?

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SUMMARY

Background: Pain affects peoples' well-being and quality of life and is one of the most common symptoms experienced by people receiving haemodialysis (HD).

Objectives: To explore how Thai people receiving HD perceive pain, the effect of pain on their lives, and how they cope with and manage pain.

Methods: Purposive sampling was used to recruit participants from two Thai outpatient haemodialysis facilities in Songkhla province. Face-to-face, in-depth individual interviews using open-ended questions were conducted during January and February 2012. The interviews were audio-recorded and transcribed verbatim. Data were analysed using Ritchie and Spencer's Framework method.

Findings: Twenty people receiving HD participated in the study: age range 23–77 years; 10 were females. Three main types of pain emerged: physical pain, which occurred when needles were inserted during HD treatment and vascular access operations; psychological pain due to unfulfilled hopes and dreams and changes in family roles; and social pain. Perception of pain was influenced by the general populations' perceptions of chronic kidney disease. Participants used two main coping styles to manage pain: health-adjustment and health-behaviour styles. These two coping styles encompassed four specific coping strategies: religion, spirituality, accepting pain associated with HD treatment, and social support. Coping styles and strategies were influenced by Thai culture.

Conclusion: The study elicited information that could help nursing staff understand how Thai people manage pain and the importance of cultural beliefs to their pain experience and coping strategies, which in turn can help nurses plan appropriate pain management.

KEY WORDS Chronic kidney disease • Coping • Culture • Haemodialysis • Pain

INTRODUCTION

People with chronic kidney disease (CKD) receiving haemodialysis (HD) suffer pain from various sources such as the complications of HD. Pain has a significant effect on well-being

and impairs quality of life (Antoniazzi *et al.* 2003; Williams & Manias 2008). Pain and suffering are different but inter-related concepts. Pain is defined as '*an unpleasant sensory experience that can affect patients' quality of life if not addressed*

BIO DATA

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adequately' (Walker 2003, p. 494). Suffering refers to 'the perception of serious threat or damage to the self, and it emerges when a discrepancy develops between what one expected of one's self and what one does or is' (Chapman & Gavrin 1999, p. 2233). People experience suffering in the mind as spiritual pain.

Studies show people receiving HD experience various types of pain such as physical, psychological and social pain (Williams & Manias 2007; Moulton 2008; Ramirez et al. 2012; Wachholtz & Makowski 2012). Social pain is an emotional experience associated with the general populations' perceptions of chronic kidney disease and its treatment (Yodchai et al. 2011) that threaten people with CKD's integrity and lead to spiritual pain.

Spiritual pain refers to an individual's experience of loss of meaning and purpose in their life (Millspaugh 2005). Spiritual pain can occur when an individual perceives the burden of managing CKD to be uncomfortable, unpleasant or overwhelming, feels they are not in control of their life, and are unable find meaning and purpose in life with CKD (Suet-Ching 2001). Physical pain and psychological pain often occur simultaneously and exacerbate each other.

People receiving HD experience physical pain associated with CKD and HD, including needle pain, muscle cramps, chest pain and headaches during HD treatment (Davison 2007; Murtagh et al. 2007; Williams & Manias 2007). Renal osteodystrophy-related physical pain is common in people with advanced CKD receiving dialysis (Davison 2007). Renal osteodystrophy includes various types of bone disease such as osteitis fibrosa due to faster bone desorption and deposition of calcium phosphate in arteries, joints, soft tissues and the viscera (Tanenbaum & Quarler 2005; Davison 2007). People with CKD who develop bone disease tend to present with bone pain and/or fractures.

Psychological pain refers to 'the introspective experience of negative emotions such as anger, despair, fear, grief, shame, guilt, hopelessness, loneliness and loss' (Shneidman 1999, p. 287). Previous research shows people receiving HD treatment experience psychological pain associated with adhering to treatment such as medicines, treatment regimens and food and fluid restrictions. For example, anxiety stress and depression (Hyre et al. 2008; Weisbord et al. 2008)

that inhibit their willingness and ability to socialise (Horigan 2012).

Renal disease affects people's ability to function in the workplace, family relationships and often causes social pain (Suet-Ching 2001). Yodchai et al. (2011) found people with CKD receiving HD experienced difficulty in maintaining employment because they tired easily and as a result were unable to fulfil their duties. Several other studies show HD causes significant financial difficulties because it affects people's ability to maintain their jobs (Mok & Tam 2001; Tong et al. 2008). Adaptation is an essential part of learning and understanding how to live with and cope with pain.

Adaptation is being used to conceptually frame the study; adaptation refers to an individual's capacity to respond to physical, psychological, social and spiritual pain. Coping is an important part of the adaptation process when individuals have to deal with a life threatening situation. Coping strategies are the cognitive and/or behavioural efforts an individual makes to reduce or tolerate the demands of life challenges (Logan et al. 2006). People with CKD receiving HD use various coping strategies to manage life events depending on a combination of factors such as religion, education, perception of stress, gender, age, experiences, race, nationality and social support (Hubbard & Workman 1998).

Pain is known to be a significant problem for people with CKD receiving HD in Western countries (Davison 2003; Strang et al. 2004; Williams & Manias 2007, 2008; Claxton et al. 2010; Davison & Jhangri 2010; Kafka et al. 2011; Green et al. 2012) but little is known about Thai people's experience of CKD-related pain. Previous Thai studies involving people receiving HD investigated a range of individual factors: stressors (Meephol 2000), fatigue (Haemwean 2008), self-care (Chokephichit 2003), self-efficacy (Sa-ngakul 2006), spirituality (Prekbunjun 2004) and uncertainty (Langnak 2008) but not pain. Thus, there is a gap in nursing knowledge about how Thai people receiving HD perceive and cope with pain. To help bridge this gap, we undertook a study to explore how Thai people receiving HD perceived pain and to investigate the effect of HD on Thai peoples' experiences of pain and how they cope with and manage pain.

METHODS

DESIGN

A qualitative study was undertaken using semi-structured individual interviews.

ETHICAL CONSIDERATIONS

The study was approved by the ethics committee of two public hospitals in Thailand. Informed consent was obtained from all participants. Participants had the right to refuse to participate or to withdraw from the study at any time until data were analysed without affecting their relationship with the researchers or the hospital.

SAMPLING POPULATION

The research was undertaken in Thailand. People with CKD receiving haemodialysis treatment were recruited from two tertiary care hospital haemodialysis units located in Songkhla Province in Southern Thailand during January and February 2012.

SAMPLING PROCEDURE

Purposive sampling was used to recruit participants. Using the respective hospital HD databases, nursing staff helped the researcher identify potential participants who met the inclusion criteria. Both genders were eligible to participate in the study if they met the inclusion criteria: started dialysis six months or more before the interview, aged 18 years or older, were medically stable and had no acute medical problems such as shortness of breath, nausea and vomiting and cardiac arrhythmias, were mentally competent to give informed consent to participate in the study, and were Thai nationals.

DATA COLLECTION QUESTIONNAIRE

A questionnaire was used to collect demographic data from participants; the questionnaire consisted of two parts. Part one asked about general demographic data including age, gender, marital status, religion, education level and socioeconomic status. Part two encompassed health information data including current treatment, co-morbidities and complications associated with HD treatment. The general demographic and health information data were collected before the interview.

INTERVIEW PROCESS INTERVIEW GUIDE

An interview guide was developed using adaptation as the conceptual basis to frame the research questions. Data from a pilot study (Yodchai *et al.* 2011) and a review of relevant literature related to people receiving HD and the methods they used to cope with the resulting pain, informed the content of the interview questions. The questions concerned pain experiences, the effects of pain on peoples' lives and how they coped with pain.

Example interview questions were:

1. Can you tell me how haemodialysis affected your life?
2. Have you experienced any pain since you started haemodialysis?
3. If yes, can you tell me more about the pain?
4. Please describe how you manage pain-related to haemodialysis?

Face-to-face, in-depth, individual interviews using open-ended questions were conducted in Thai language. All interviews were audio-recorded and transcribed verbatim by K.Y. After approximately 16 interviews were completed and analysed very little new information emerged. However, four more interviews were conducted to ensure the data were complete, indicating data saturation was reached. Thus, data saturation was deemed to be reached after 20 interviews. After one or two weeks, the researcher distributed the transcript to individual participants in a sealed envelope when they attended the hospital for a dialysis treatment. Participants were asked to check the transcript to ensure the information accurately reflected the conversation and captured their experiences.

K.Y. was careful to preserve the real meaning of participant's words when she translated information from the Southern Thai dialect and Thai formal language into English to enable the other researchers to read and analyse the transcripts. K.Y. also received advice from a Thai English teacher from the Language Institute in Thailand and an English teacher in Australia to ensure the interviews were translated as accurately as possible in order to preserve the integrity of the data.

DATA ANALYSIS

Data analysis was conducted using Ritchie and Spencer's Framework method of qualitative data analysis (Ritchie & Spencer 1994). NVivo software 9 (QSR International) was used to manage the data efficiently. The Framework method consists of five main stages: familiarisation, identifying a thematic framework, indexing, charting and mapping and, interpretation (Ritchie & Spencer 1994). In the familiarisation stage, the researcher read and reread the transcripts to become familiar with the data; then identified the key issues by writing memos or short phrases, ideas or concepts in the NVivo software computer program to identify a thematic framework. The researcher made judgments about the meaning and importance of the data and comparisons within and between the individual transcripts in

the indexing stage before charting the information by transferring quotes from their original context and re-arranging them under the appropriate newly developed themes. Finally, the findings were mapped and interpreted as a whole to answer the a priori research questions and explain the emergent themes.

FINDINGS

Twenty people participated in the study: 10 from Songklanagarind Hospital and 10 from Hat Yai hospital. Fifteen interviews were undertaken in hospitals, participants' homes ($n = 4$) and a participant's workplace ($n = 1$). All interviews were undertaken in private rooms. The duration of the interviews varied from 40 to 120 minutes: mean 68.30 minutes (± 20.61 SD).

DEMOGRAPHIC DATA

Participants were aged between 23 and 77 years: mean 53.7 (± 16.38 SD). Ten were females. Seventeen were Buddhist and three were Muslim. Duration of CKD ranged from 3 to 21 years: mean 9.75 (± 5.21 SD). Duration of HD ranged from 2 to 13 years: mean 6.20 (± 3.40 SD). Sixteen participants had HD treatment twice a week and four had HD three times a week. Participants were using between 5 and 20 medicines per day: mean 10.75 (± 3.77 SD). Nineteen participants used western medicines and one participant used a combination of western medicines and traditional Thai medicine. Other demographic data are shown in Table 1.

TYPES OF PAIN

The interview findings suggest people undergoing HD experience three main types of pain: physical, psychological and social pain. Physical pain was caused by tissue damage, which occurred when needles were inserted during HD treatments and vascular access operations and when secretions were suctioned from the endotracheal tube. Participants also suffered cramps and joint and muscle pain. In addition, many

Demographic variable	Number of participants
Marital status	
Married	13
Never married	4
Widowed	3
Education	
Primary school	5
High school	3
College/university	10
Other	2
Employment status	
Not employed	10
Government employee	5
Farmer	4
Business person	1
Treatment payment options	
Government reimbursement	14
National health security office	5
Social security fund	1
Income (baht/month)	
No income	5
<5,000	1
5,001–10,000	1
10,001–15,000	2
15,001–20,000	2
>20,001	9
Comorbidities	
Hypertension	14
Heart disease	5
Diabetes	3
Breast cancer	1

Table 1: Demographic data of the 20 people receiving HD who participated in the study.

participants experienced psychological pain due to unfulfilled hopes and dreams and changed family roles. Social pain was influenced by the general populations' perceptions of CKD. Participants used various coping strategies to manage pain depending on the type of pain they experienced. The themes and sub-themes are shown in Table 2.

Themes	Sub-themes
Spiritual and religious coping	<ul style="list-style-type: none"> – Sin transformed into pain – Making merit to relieve pain – Diverting pain by praying and chanting – Praying to Allah to relieve pain
Accepting pain associated with haemodialysis treatment	<ul style="list-style-type: none"> – Using local anaesthetic to relieve needle pain – Pain is necessary to save life – Becoming used to pain
Obtaining support	<ul style="list-style-type: none"> – Obtaining spiritual support – Obtaining physical and financial support
Emotional coping	<ul style="list-style-type: none"> – Ignoring and avoiding pain

Table 2: Table outlines the themes and sub-themes that emerged in the study.

COPING STRATEGIES

Participants used two main coping styles to manage pain: health-adjustment and health-behaviour styles. Health-adjustment coping styles refer to the decisions an individual makes to control and manage pain. Health-behaviour coping styles describe the individual's ability to manage pain. These two coping styles encompassed four specific coping strategies: religion and spirituality, accepting pain associated with HD treatments, and social support.

RELIGIOUS AND SPIRITUAL COPING

All participants used various religious and spiritual coping strategies to manage HD-related pain. During the interview participants were medically stable; however, some participants developed fluid overload and were hospitalised with pulmonary oedema. In most cases an endotracheal tube was needed to support participants' airway: the endotracheal tube caused participants great suffering. Most participants tried to come to terms with physical pain, often by asking 'why me?' For example, one female participant coping with suction pain said:

... When the nurse came in to suction me, I exclaimed to myself why did it [pain] have to be me? [P2F]

Most participants tried to come to terms with their pain and believed pain was a consequence of their sins in the past or present life.

SIN TRANSFORMED INTO PAIN

Participants followed two main religions: Buddhism and Islam. Both Buddhist and Muslim participants felt their pain resulted from their 'sins', or 'bad karma', either in a past or their present life. Karma refers to previous volitional acts (a conscious choice or decision), which can be physical, spoken or thought and are either good or bad. Buddhist participants believed the law of cause and effect influences karma: doing a good deed begets good karma while a bad act results in bad karma. Karma in the current life affects future lives. The future life can be positive or negative depending on the merit people accrue and sins committed in the past. Most Buddhist participants felt their 'bad karma' or 'bad deeds' transformed into 'bad luck', 'fate' and 'destiny' in the form of pain, which participants regarded as a punishment for previously committed sins in earlier lives. One elderly participant said:

Right now my arm still hurts. My joints were stiff. I couldn't even lift a piece of tissue. I did all kinds of exercise but it was

not better... I reflected on the old times when I committed sins. Things usually got worse near Chinese New Year because a lot of chickens were slaughtered during that festive season [when she was teenager, she helped her parents to kill chickens to sell for food]. My reflection is that I am in pain because of the sin I committed and I am now paying for that sin [Killing chickens]. [P16F]

Participants who believed pain was due to their past sins searched for ways to mitigate their sins to relieve their pain. Although participants believed they could not cancel out their sins, they knew good deeds could help mitigate their effects. Consequently, they tried to accumulate good deeds in the hope their life path could be altered for the better. Hence, another coping strategy was using religious and spiritual beliefs and practices such as making merit.

MAKING MERIT TO RELIEVE PAIN

Making merit has long been the most important way Buddhists accumulate 'good deeds' to positively influence their current and future lives. Several participants attempted to balance their sins or bad deeds and reduce their pain by making merit. For example, one elderly participant who suffered needle pain said:

After giving alms to the monks, I pour water to announce to all creatures to come and share the merit so I can live without pain. [P18F]

Participants also prayed and chanted to manage their physical and spiritual pain.

DIVERTING PAIN BY PRAYING AND CHANTING

The *Shinabunshorn prayer* and the *Burapharatsaming prayer* are common Buddhist prayers people chant to Buddha; in this case asking him to allow them to live without pain. Praying and chanting relieved pain by diverting people's attention elsewhere. Participants used the '*Shinnabanshorn prayer*' because it is a long prayer and takes a while to chant. Thus, participants believed it is likely to control their pain for a longer period of time.

For example, a participant who used the *Shinnabanshorn prayer* during vascular access surgery said:

Shinabanshorn is a very long prayer and it is very good because we will not be thinking of other things [fear or pain]. If the prayer is very long, it will take a long time to finish and

one can pray for a long time. During the vascular surgery, the doctor would give me a shot or not. I wasn't concerned. I was going to get operated on. I prayed and I felt I had concentration. I didn't think about the fact that I was having an operation. [P9F]

The second most common religion was Islam. Most Muslim participants also used religious beliefs and practices to cope with pain by praying to Allah (God).

PRAYING TO ALLAH TO RELIEVE PAIN

Most Muslim participants viewed health, illnesses, suffering, and dying as a natural part of life and felt illness and suffering were a test set by God. Although they accepted physical pain patiently, they prayed to God to relieve their pain. Muslim participants believed prayer was a powerful coping strategy, which they used when they had serious pain. For example, a Muslim participant said:

...I asked him [God] not to let me be in pain. It enhanced my inner-strength when I prayed to God to help get rid of the pain. [P8F]

Participants eventually accepted pain associated with HD treatment.

ACCEPTING PAIN ASSOCIATED WITH HD TREATMENT

Although inserting the needle does not take long, participants regarded it as a negative experience for various reasons, including the associated pain. In addition, most participants who reported pain when needles were inserted said the insertion technique was the main cause of the pain because staff were 'heavy handed', especially when they pierced the access vessel and the skin several times to gain access. Novice staff members were most likely to be 'heavy handed' and have difficulty inserting needles because they were less experienced. Participants managed the needle pain in various ways, for example using local anaesthetic.

USING LOCAL ANAESTHETIC TO RELIEVE NEEDLE PAIN

Most nursing staff did not use local anaesthetic before they inserted needles. Some nurses encouraged patients to buy their own local anaesthetic cream to apply to the skin at the insertion site before the needle was inserted. However, when participants did apply anaesthetic cream, nursing staff did not always insert

the needle into the area where the anaesthetic had been applied. For example:

...It [needle insertion] was exceedingly painful. The needle was a number 16, only a bit smaller than a nail, right? The nurse pierced the flesh, right? Why wouldn't it hurt? It does every single time. But when the nurse used it [local anaesthetic], it still hurt because the nurse pierced the needle in the wrong spot. I bought a tube and used it once and not again. I have lost interest now. I will bear the pain. [P16F]

The local anaesthetic might have relieved the pain, but nursing staff did not place the needle into the anaesthetised area. Therefore, participants who applied local anaesthetic eventually abandoned the practice and learned to cope with needle pain because it was part of the HD treatment that saved their lives.

PAIN IS NECESSARY TO SAVE LIFE

Some participants used positive thinking, telling themselves they 'have pain to save their life'.

One male participant said:

...I was very scared the first time, but now I can take it [needle insertion]. Otherwise I cannot be treated. It [needle insertion] saved my life; so I don't feel anything now. Well, it extends my life... If I don't do it [needle insertion] I get oedema and can be shocked. Pulling out water from my body is saving my life. [P6M]

Over time, participants became accustomed to their pain and accepted it as part of life with CKD and its treatment.

BECOMING USED TO PAIN

People eventually became more tolerant and accepting of pain. For example, one female participant with needle phobia said:

I'm getting used to pain now. For the first time, when they placed the needle in this area [pointing at the double lumen catheter in her neck] I cried a lot because it hurt badly. They used a very big needle. I'm afraid of needles even when I have normal injections... But it's quite okay now. [P5F]

Participants coped with psychological pain by obtaining various types of support.

OBTAINING SUPPORT

Despite the change in family roles, most participants tried to come to terms with their changed role, accept the changes, and learned to live with HD by obtaining spiritual, physical and financial support from their family members, friends and health care professionals.

OBTAINING SPIRITUAL SUPPORT

Spiritual support involved understanding, sympathising with and encouraging participants. Participants indicated family members such as wives, children and siblings understood and encouraged them to deal with the changes in their role, which helped them develop inner strength. One woman said:

... Spiritual support from my family made me feeling a lot better. It makes me stronger to fight the disease. [P4]

OBTAINING PHYSICAL AND FINANCIAL SUPPORT

As indicated, many participants felt tired and unable to engage in their usual activities after HD treatments, which affected their family roles. Men regarded themselves as the head of the family, believing that 'the man is an elephant's front legs' and takes responsibility for the family as a whole. Participants' ability to perform usual activities in daily life was affected by CKD and its treatment. Family members and friends helped by providing physical support; for example, preparing food, assisting with personal hygiene, taking participants to hospital and other places such as the temple to pray. The following comment clearly demonstrates one man's distress at his changed role.

I suffered from kidney disease... She [his wife] has to bear a large burden. I feel upset sometimes that I can't help her. Instead of me helping her, she has to help me. She has to be a leader. In fact, the family leader should be me, but she has to do my duty...I think that it's very nice that she never says anything that makes me sad. I feel very lucky that I married her. [P12M]

Women also reported CKD and HD led to changes in their roles and self-perception. According to Thai cultural beliefs, the ideal Thai woman is a virtuous caregiver in the family. Some women

participants described how HD affected their ability to be the 'ideal Thai woman', that is, a homemaker, respectful, obedient and helpful to their husbands and who provides her husband with children. Thus, having CKD and receiving HD often made female participants feel regretful and guilty. One woman stated:

Deep in my heart I'm sorry for him [her husband]. I can't do things for him. I can't give him children. He has a very kind heart, he helps me with everything. [P2F]

Most female participants obtained physical and spiritual support from their husbands, which helped relieve their psychological and spiritual pain about being unable to fulfil their role as a wife. However, some participants felt their family members and friends were sometimes 'overly helpful', which made participants feel they were not 'allowed' to do anything for themselves; one participant said:

I felt useless... I feel they [friends] think I am not capable of doing anything. They just won't let me do anything because they think that I am disabled. [P1M]

If participants perceived support from their families and friends as unnecessary, inappropriate or unwanted, 'support' could affect relationships between participants and their family and friends. In addition to the consequences of unwanted support, some participants developed stress and depression, which compromised the participant's ability to adapt to life with CKD. Emotional coping was an essential type of coping to help participants overcome social pain.

EMOTIONAL COPING

Emotional coping approaches that participants used to deal with social pain included two main strategies: ignoring and avoiding pain.

IGNORING AND AVOIDING PAIN

Participants ignored and avoided pain where possible; especially when managing social pain. Participants found it very painful when people commented about their misfortune at having CKD. Consequently, they stopped socialising and attending ceremonies and festivals to avoid placing themselves in a position where other people would notice their 'big ugly scar' and comment about their misfortune at having CKD. For example:

...Other people made comments about my misfortune at getting kidney disease. If I go out, there are many people who make this comment again and again. So I decided not to go out. Still some people came to visit me at my place and made this comment...and that hurts me. [P4F]

Ignoring and avoiding social situations to manage pain could be regarded as passive behaviour, but these are Thai cultural traits. Thai people tend to avoid conflict to maintain harmony in interpersonal relationships and show they are 'good neighbours'.

DISCUSSION

The interviews of 20 participants receiving HD treatment revealed participants suffered three types of pain: physical, psychological and social. These findings are similar to those of previous studies that show people receiving HD treatment experience numerous types of pain such as physical, psychological and social pain that impaired their quality of life (Antoniazzi et al. 2003; Sadala & Lorençon 2006; Davison 2007; Williams & Manias 2008; Davison & Jhangri 2010). Both the literature and the current study show people often ask 'Why me?' when they face a life crisis such as pain or the diagnosis of cancer or a chronic disease such as diabetes (Bury 1982; Parsian & Dunning 2009). Bury (1991) indicated people asked 'why me?' when they contemplated the misfortune of having a chronic incurable disease by comparing perceived causes of their diseases with their past actions. Individuals try to answer 'why me' in different ways. For example, the current participants mainly relied on religious and spiritual beliefs and practices to help them understand why they developed CKD and the associated pain. Both Buddhists and Muslims believed their past sins contributed to their current pain and illness.

Several previous studies reported Thai people with chronic illness such as cancer (Junda 2004), diabetes (Sowattanagoon et al. 2009) and stroke (Thongbaiprasath et al. 2007; Ting & Ng 2012) believed bad karma from sins committed in a present or previous life caused illness and pain. Likewise, American Buddhists believed their stress or suffering resulted from their bad karma (Phillips et al. 2009). Thus, religious beliefs appear to help people with different chronic illnesses or crises explain their situations, find meaning and purpose in life and eventually accept the reality that their lives include pain and illness.

The current study suggests participants believed they could not escape from their bad karma; consequently, they used various

practices such as prayers, chants, making merit, and believing in karma to mitigate past sins and manage their pain. Chinese Buddhists in Malaysia believed bad karma caused their health issues and relived their pain and suffering by performing meritorious behaviours such as meditation and asking for blessings from Buddhist monks and nuns (Ting & Ng 2012). In contrast, Lin et al. (2005) found Taiwanese Buddhists with CKD believed that they could cancel out their past evil deeds by accepting dialysis treatment; otherwise, they believed they would suffer with CKD again in the next life. Consequently, religious beliefs helped participants accept dialysis treatment.

Muslim participants in the current study viewed illness and suffering as a test set by God (Allah) and prayed to God for relief. Previous studies (Abdoli et al. 2011; Padela et al. 2012) found Muslims had a God-centric perspective wherein God's will was paramount, and God could grant health or illness. When a Muslim person believed God willed CKD and HD on them, they accepted it because they believed their life was in God's hands (Ramirez et al. 2012). Muslims also sought a cure by praying to God, supplication and reciting the Quran, and consulting Imams (Muslim leaders) who gave them spiritual support and motivated them to take care of their bodies (Padela et al. 2012). Abdoli et al. (2011) found Muslims with diabetes in Iran did undertake self-care because their body was a gift from God and they had a responsibility to take good care of it.

Bauer-Wu et al. (2007) stated that God did not create any disease or suffering without creating a cure. Muslims believed that Allah (God) provided a balance between health and illness and that belief helped them control and manage pain. Religious and spiritual beliefs and practices appear to be positive, powerful coping strategies that help people reorient their lives and manage and accept pain. Thus, health professionals should ask about coping and help people develop relevant coping strategies that enable them to accept the changes in their lives and usual roles and come to terms with their pain.

Participants in the current study and other studies indicated social support was generally provided by family caregivers such as spouses and children. Although they appreciated the help these caregivers provided, they also felt guilty about being a burden to the family (Fan et al. 2008; Lai et al. 2012). Not surprisingly, while support is generally regarded as beneficial, some participants in the current study felt stressed when they felt overly supported. Linnarsson et al. (2010) indicated that

caregivers want to protect and guard loved ones, which can have positive or negative effects on the receivers. Positive support from family members, friends and health care professionals helps people with CKD cope including with pain, whereas stress and suffering occur if the receivers find the support unhelpful (Manne & Zautra 1989). The current study suggests support should focus on the receiver's needs and the quality of the support rather than on quantity. In the current study participants highlighted the importance of nurses reducing needle pain. The researchers suggest nurses need to be aware of HD related needle pain in order to help people with CKD participate in pain management and to set goals for relief.

LIMITATIONS OF THE STUDY

The sample was limited to people with CKD who received HD in two public hospitals in Southern Thailand. This could limit the transferability of the findings to other hospitals in Thailand and other countries. Therefore, a larger study is needed to explore how people receiving HD who are from other religions, cultural settings and diverse socioeconomic groups adapt to HD related pain to help nephrology nurses provide effective pain management. Translation is a complex process and there is often no exact equivalent words between two languages; thus, some distortion of the meaning could have occurred unintentionally.

IMPLICATIONS FOR PRACTICE

The study elicited information that could help nurses and other health professional disciplines understand how Thai people manage pain and the importance of cultural beliefs to their pain

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experience and coping strategies, which in turn can help nurses improve their pain assessment and management skills.

CONCLUSION

Thai people receiving HD reported that significant levels of pain affected their physical and spiritual well-being. They used two main coping styles: health-adjustment and health-behaviours. These two coping styles encompassed four specific coping strategies: religion, spirituality, accepting pain associated with HD treatment, and social support, which were all strongly influenced by Thai culture.

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CONFLICT OF INTEREST

No conflict of interest has been declared by the author(s).

AUTHOR CONTRIBUTIONS

Study design: KY, TD, SS and AH Data collection: KY Data Analysis: KY and TD Preparation of Manuscript: KY, TD, SS, AH and AO.

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