


Muslim caregivers' experiences in caring for patients receiving peritoneal dialysis

Sunisa Seephom (Ph.D candidate)¹  | Piyanuch Jittanoon PhD, RN² | Karnsunaphat Balthip PhD, RN²

¹Division of Adult and Gerontological Nursing, The Srisavarindhira Thai Red Cross Institute of Nursing, Pathumwan, Bangkok, Thailand

²Division of Community Nurse Practitioner, Faculty of Nursing, Prince of Songkla University, Hat Yai, Thailand

Correspondence

Sunisa Seephom, Division of Adult and Gerontological Nursing, The Srisavarindhira Thai Red Cross Institute of Nursing, Rama 4 Road, Pathumwan 10330, Thailand.
Email: sunisa.s@stin.ac.th

Abstract

Background: Fulfilling the role of a family caregiver has a substantial effect on the lives of those involved. However, existing information on family caregivers of patients receiving peritoneal dialysis is insufficient—especially Muslim caregivers, whose practice is unique.

Objectives: The aim of this study was to understand the experiences of Muslim family caregivers looking after patients receiving peritoneal dialysis in an Islamic context.

Design: A descriptive qualitative approach was employed.

Participants: Thirteen Muslim family caregivers who have cared for patients undergoing peritoneal dialysis for at least 1 month.

Approach: Data were collected through face-to-face in-depth interviews and a focus group discussion. Content analysis was used to analyse the data with initial codes grouped into sub-categories, generic categories, and main categories.

Findings: The experiences of Muslim family caregivers looking after patients receiving peritoneal dialysis generated two main categories: overwhelmed with suffering and learning to live as a caregiver.

Conclusions: Caregiving has a substantial impact on Muslim family caregivers. They need to be cared for holistically. The recognition of Islamic beliefs, doctrine of Allah, and religious practices are clear spiritual anchors for caregiving. The findings provide a deeper understanding of the experiences of Muslim family caregivers looking after patients receiving peritoneal dialysis. These findings could serve as the basis for developing a specific nursing intervention for such caregivers.

KEYWORDS

Islamic beliefs, Islamic practices, Muslim family caregivers, peritoneal dialysis

INTRODUCTION

The incidence of patients with kidney failure requiring renal replacement therapy is increasing, which is having a major impact on healthcare costs and outcomes. From 2005 to 2015, the mortality

rate for people with chronic kidney disease increased by 31.7% globally (Wang et al., 2016). Likewise, the number of patients receiving dialysis worldwide was estimated to be 2.6 million in 2010 and is projected to increase to 5.4 million by 2030 (Liyanage et al., 2015). In Thailand, the incidence of new patients receiving peritoneal

dialysis (PD) increased from 2069 in 2018 to 4799 in 2019 (Chuasuwat & Lumpaopong, 2019).

Family caregivers play a key role in successfully managing the health of patients receiving PD, particularly those who lack the ability to self-care at home (Ng et al., 2020). In the context of being a Muslim, they normally spend their entire lives following Islamic beliefs and practices based on the Qur'an, the Hadith, and Sunnah (Alsharif et al., 2011). They are therefore required to take care of their parents as instructed by the Qur'an and the Prophet Muhammad of Islam (Begum & Seppänen, 2017), which states that caregiving is a primary responsibility of a Muslim.

However, fulfilling this role has a substantial effect on caregivers' lives and places a great burden upon them. In Thailand, PD has been successfully implemented since 2008; however, existing information on family caregivers of patients receiving PD is insufficient, especially among Muslims. Although they take care of others as means of repaying gratitude, as instructed by the Qur'an and the Hadith, they can experience undesirable feelings such as stress, anxiety, and exhaustion (Hemman et al., 2017). Focusing on the perspective of a human being in an Islamic context, this study aimed to understand the experiences of Muslim family caregivers looking after patients receiving PD in an Islamic context. The findings will be beneficial for healthcare providers, especially PD nurses, as it will enable them to tailor healthcare to Muslim family members.

LITERATURE REVIEW

A family caregiver plays a key role in managing patients' health. Most perceive the continued use of home dialysis to be a burden of care (Sauvé et al., 2016). Alongside dialysis-related activities, they also have other responsibilities that become a frequent burden (Griva et al., 2016). Longer overall duration of caregiving as well as hours per day spent giving care have been found to correlate with caregiver burden. This is because caregiving tasks have a holistic impact on caregivers' lives in the long term (Nagarathnam et al., 2020; Shah et al., 2017).

Family caregivers experience numerous adverse effects on their health. For instance, they are at greater risk of mental health concerns (Cantekin et al., 2016) such as stress (Shah et al., 2017), anxiety, worry, and uncertainty (Rabiei et al., 2015). Thai-Muslim family caregivers in particular experience anxiety and stress as a result of providing care for a long period of time (Hemman et al., 2017). The physical problems reported include little time for self-care, frustration, and fatigue (Alnazly & Samara, 2014; Rabiei et al., 2015; Shah et al., 2017). Social problems have also been reported, such as limited social lives (Nagarathnam et al., 2019) and social isolation (Pourghaznein et al., 2018). Furthermore, caregivers have less time for spiritual activities (Kiyancicek & Caydam, 2017) and are affected financially (Wightman et al., 2019).

In Thailand, PD has been promoted as the first treatment option for patients with kidney failure requiring renal replacement therapy (Sirivongs, 2015) and is included under three healthcare coverage schemes: Civil Servant Medical Benefit Scheme, Social Security Scheme,

and the Universal Coverage scheme. The PD costs can be fully reimbursed, even if a patient then needs to change to haemodialysis because of problems with the treatment. These costs cover an outpatient visit, a home visit, and 24-h trouble-shooting calls, Tenckhoff catheter implantation, and a training programme in the first month (Chuengsamran & Kasemsup, 2017). Over time, researchers have analysed the impacts of PD on either patients or family caregivers and explored strategies to improve the quality of PD care. However, existing literature in this field is scarce, especially on Muslim family caregivers, who are the second largest religious group in Thailand. Therefore, the aim of this study was to understand the experiences of Muslim family caregivers looking after patients receiving PD in an Islamic context.

METHODS

Design

To obtain an understanding of the experiences of Muslim family caregivers in caring for patients receiving PD, a descriptive qualitative study was conducted comprising face-to-face in-depth interviews, followed by a focus group discussion.

Participants

In the initial stage of data collection, purposive sampling was used to recruit the participants (Polit & Beck, 2010). The inclusion criteria were as follows: (i) Muslim family caregivers of patients receiving PD for at least a month, (ii) aged at least 18, (iii) able to speak and understand Thai, (iv) willing to participate in this study and (v) with no cognitive impairment that may affect the interpretation of information.

Data collection

The 12 potential participants were first approached by the head nurse of the PD unit. Muslim family caregivers who were willing to take part were then approached by the researcher when they came to the dialysis unit with their care-receivers on the date of follow-up. Two participants were excluded because they were not able to understand the questions and could not recall their experiences. All data were collected in a private room by the nursing instructor, who is a healthcare worker practising outside the setting. Data were collected from October 2019 to January 2020.

In the first stage, face-to-face in-depth interviews were conducted with participants in the Thai language. All interviews were digitally recorded (with their permission). To establish trust and rapport, the researcher introduced herself and expressed respect and support during the interviews. Participants were encouraged to speak freely. The interview guide was examined by three experts for content validity. The guide included broad open-ended questions followed by probing questions,

all of which were related to experiences in caring: for example, How do you feel about being a caregiver? What have you experienced as a caregiver? What situations affected your experiences of being a caregiver? The in-depth interviews generally lasted from 40 to 60 min. Field notes were taken by the researcher during each interview.

In the second stage, a focus group was conducted to obtain a more in-depth understanding of Muslim family caregivers' experiences. All Muslim caregivers who met the inclusion criteria were eligible to attend, including those who were interviewed. Seven of the Muslim caregivers were approached by the head nurse of the PD unit: although three were unable to participate due to time constraints, four were willing to attend the discussion.

When conducting the focus group, the researcher acted as a moderator and the PD nurse acted as a facilitator responsible for observing, taking field notes, and audio recording. An interview guide that had been successfully tested in a pilot focus group was used to conduct the focus group discussion. An example question from the interview guide is 'How does being caregiver affect your normal life?' The follow-up probes then addressed the 'physical, psychological, social, and spiritual or belief dimensions' of caregiving. All participants were encouraged to describe and discuss their experiences as fully as possible. The data were elicited without any intervention from the researcher. The focus group discussion lasted 60 min.

DATA ANALYSIS

All data were organised and transcribed into Thai from an audio recorder (in-dept interview and focus group data) and were integrated by moving back and forth to discover data merging, distinction, and complementarity following the guidelines on inductive content analysis described by Elo and Kyngäs (2008). Field notes also were reviewed to gain further insights into the phenomenon. An analysis of the meanings of words or sentences from the manifest content was performed in accordance with the research questions and objectives.

First, open coding was conducted; this involved using a computer to highlight the codes in each line to identify and describe the phenomenon in the text. The names of codes came directly from the text. Second, inductive reasoning was employed to group the codes into sub-categories, taking into consideration the relationships between codes. Third, each subcategory was then grouped into generic categories by identifying similarities or differences. Finally, generic categories were grouped into main categories (Table 1).

TABLE 1 Examples of a condensed meaning unit, code, subcategory, generic category, and main categories derived from content analysis of interviews and focus group discussion

Condensed meaning unit	Code	Subcategory	Generic category	Main category
I'm stressed out, and I'm tired... I have worked like everyone else... but it's still not improved. I'm discouraged	Discouragement in caregiving	Hopelessness	Feeling discouraged	Overwhelmed with suffering
I think... I want to see my friends. I want to live like my friends. But I can't.	Less socialisation with others	Losing time for social interaction	Loss of freedom in living	

TRUSTWORTHINESS

Based on Lincoln and Guba (1999), four criteria for establishing trustworthiness were employed. Credibility was obtained through peer debriefing and triangulation of methods (in-depth interview and focus group discussion). Dependability was achieved through researcher triangulation (peer debriefing). Confirmability was established by the inquiry audit of the process and the findings of the research. All activities and any summaries or ideas that occurred to the researcher during the study also were noted. Code-recode procedures were then performed. Quotations from the participants were selected to illustrate each emerging main category. Transferability was ensured by offering a detailed description of the context, location and characteristics of the participants.

FINDINGS

A total of 13 Muslim family caregivers participated in this study (in-depth interview, $n = 10$; focus group discussion, $n = 4$). One participant participated in both an in-depth interview and the focus group discussion. The average age of participants was 38.58 years. Twelve Muslim family caregivers were female. Their relationship with care-receivers was that of children, spouses, and relatives, respectively. Almost half had a high school diploma. Ten were married. Most were farmers whose incomes were below 10,000 Baht. Their average caring time was 12 h a day and the average duration of caregiving was 23.2 months.

Muslim family caregivers' experiences in caring for patients receiving PD were divided into two main categories: overwhelmed with suffering and learning to live as a caregiver (Table 2).

OVERWHELMED WITH SUFFERING

Overwhelmed with suffering means that being a family caregiver negatively affects multiple dimensions of the lives of Muslim family caregivers. The participants said that when they became caregivers, their lives changed. They felt that their lives were completely full of suffering. This was described through five generic categories: (i) feeling discouraged, (ii) loss of freedom in living, (iii) facing an economic crisis, (iv) experiencing family conflict and (v) physical disturbance.

TABLE 2 Main categories derived from the experiences of Muslim family caregivers

Generic category	Main category
Feeling discouraged	Overwhelmed with suffering
Loss of freedom in living	
Facing an economic crisis	
Experiencing family conflict	
Physical disturbance	
Adherence to religious doctrine and religious practices	Learning to live as a caregiver
Valuing being a caregiver as a child's responsibility	
Seeking support and searching for information	
Balancing roles	

Feeling discouraged

Feeling discouraged refers to the negative feelings that result from being a caregiver. It was expressed through feelings of uncertainty, fear, hopelessness, and helplessness. The most common causes of discouragement were the increase in workload and lack of improvement in patients' health.

"I'm stressed out, and I'm tired...I have worked all my life... I have worked like everyone else...but it's still not improved. I'm discouraged...sometimes I cried." (Daughter, P05)

"I'm stressed, I take care of him (husband) until I'm exhausted...so much...I'm exhausted...I'm discouraged." (Wife, P09)

During the focus group discussion, two participants who had to take care of their parents shared the same experience of discouragement, as illustrated in the following quotes:

"I'm willing to take care of her (mother)...I have to do everything...I'm a fisher...I changed to go fishing at night...and I had to come to take care of my mother in the morning...sometime, I'm discouraged...and I cried..." (Daughter, FG1)

"For me...I had to take care of both my father and mother...nobody helps me...sometimes, my parents were admitted in different hospitals...I have to hire a caregiver...I also have two children...It's really difficult to manage...sometimes I'm discouraged...I have to do everything." (Daughter, FG4)

Loss of freedom in living

Loss of freedom in living arose when Muslim family caregivers experienced no longer having the ability to go anywhere they wished. They were concerned about leaving the patient alone and felt a high level of responsibility when caring for them. Their lifestyle changed after becoming a caregiver, especially as a sole Muslim family caregiver. They spent most of their time providing

care, which resulted in losing time for social interaction with others and travel. This situation made them feel they were living with limitations.

"Before the dialysis started, I used to see my friends. Now, there's no one... I want to see my friends...I want to live like my friends. But I can't." (Daughter, P03)

"I am not social anymore...I don't go anywhere... anywhere. Before becoming a caregiver, I used to hang out with others. But this illness (dialysis) made me...for example, I have to go to my wife's home and return on the same day. I can't travel...When I leave, I have to hurry home." (Son, P01)

Facing an economic crisis

Facing an economic crisis refers to the financial strain that results from taking a caregiver role. Nearly all participants mentioned a lower income and the higher cost of care. Most Muslim family caregivers were farmers. Changing the role of the farmer to that of the caregiver resulted in a lack of income. Some quit their jobs. Their income was generally low, and some lost their income entirely, especially those who have no savings.

"I quit my job because I had to be a caregiver. That affected my income...I hope to have more income. Now I'm a farmer...It's enough to survive but I don't have any savings." (Granddaughter, P10)

"It's difficult to manage...I'm living hand to mouth...medication money...When we go to the hospital...we spend about 400-500 baht each time...And then transportation expenses...daily life expenses...And if he's admitted...at least 300 baht a day...I am the only one who earns...It's not enough." (Wife, P02)

Experiencing family conflict

Experiencing family conflict refers to conflict between a family caregiver and their family members, and between a caregiver and the patient. This was strongly evident, especially in Muslim family caregivers who performed caregiving tasks without family support. As one participant who was responsible for taking care of her mother alone mentioned:

"Sometimes, I felt irritability...why...they [her brother] push all responsibility to me...I thought...She's our mother... Sometimes, I am angry...why...our mother, why don't they help me to take care of her... I sometimes argue with my brothers." (Daughter, P03)

Physical disturbance

Physical disturbance refers to changes in Muslim family caregivers' physical health during caregiving tasks. Although most participants seemed to ignore their physical changes, once they focused on their physical health, they realised that it had changed. They noticed that caregiving affected their health in terms of weight loss caused by

decreased appetite and delayed eating, loss of leisure, and sleep deprivation caused by their workload and the patient's illness.

"I lost weight. I couldn't swallow anything, like my throat was obstructed, I couldn't sleep, I had no appetite for about 2-3 months. When he was ill, it seemed like I was ill too." (Wife, P09)

LEARNING TO LIVE AS A CAREGIVER

Learning to live as a caregiver refers to the strategies that Muslim family caregivers employed to deal with the changes created to attain greater harmony in life whilst acting as a caregiver. This was described through four generic categories: (i) adherence to religious doctrine and religious practices, (ii) valuing being a caregiver as a child's responsibility, (iii) seeking support and searching for information and (iv) balancing roles.

Adherence to religious doctrine and religious practices

The participants stated that, according to the Qur'an, they are required to take care of their family members. They have been taught that caregiving is an act of kindness or a good deed performed for their loved ones and that caregiving was a chance to demonstrate faith in Allah, gratitude, and love for family. In addition, the value of religious practices was significant, especially prayers and reading the Qu'ran. Feeling closer to God, receiving a blessing from Allah (Dua), and asking God to forgive their sins and bad deeds (Taubah) were performed during prayers. Once they had aligned their behaviour with their religious doctrine, they were more willing to accept their role and obtain harmony in life.

"Taking care of my parents is one of the highest merits in Islam. Our life is so hard today, but our life after death will be in heaven. Although our life is now so hard, it will be happy in the future...My difficulties are God's test of my faith... I sometimes feel stress, but after prayer I feel better. It means that I can get closer to God." (Daughter, P05)

"Love...love (cry)...a new job can be found anytime, but...the parents I can't find anywhere. I lost my job. I lost my money. I have now become a merchant, I get more income than before, this is the reward that he (God) gives to me...I have taken care of my parents, and he (God) returns the reward to me." (Daughter, P06)

"About the bad thing, I think... Allah gives it to me...it comes from Allah. Belief...I really believe even though I cannot see it. I appreciate that...faith...I have faith that if I ask anything, I will get it...I pray for my father. I pray for him to be better and do his duty at Masjid...could pray five times like others. I pray...pray from Allah...Taubah (repentance)...like a forgiveness." (Wife, P09)

Valuing being a caregiver as a child's responsibility

The value of being a caregiver was mostly found among the sole Muslim family members. In Muslim culture, caregiving is valued as the

responsibility of a person living with a care-recipient. The youngest children are automatically required to become a caregiver. When they meaningfully recognised their culture, they became more aware of their roles.

"I'm the youngest daughter. My brother and sister are married. I am the only one who lives with him (father). It's my responsibility. Taking care of our parents is our duty." (Daughter, P08)

During the focus group discussion, two participants perceived that being a caregiver was the most valuable role in Muslim culture, as illustrated in the following quotes:

"In Islam...the religion requires the son to take care of his parents...It has been described in the Qur'an...The son has responsibility in taking care of the parents." (Son, FG3)

"I don't think so...my mother has two sons and two daughters...my two brothers refused to take care of her (mother)...but I didn't blame them...I can do...taking care of the parents is the duty of children...it's my responsibility." (Daughter, FG1)

Seeking support and searching for information

Seeking support and searching for information refers to the strategies employed to ensure stability in the management of care. The caregivers sought support from other family members, relatives, healthcare providers, and peers. Of these, family members and relatives were mentioned most often when Muslim family caregivers needed help in managing caregiving and financial support. Peers and healthcare providers were mentioned most often when they needed more information about caregiving.

"I have more things to do...spend less time to care for him (husband). Someone has other people to help them...I have no one...if I had someone, they would help me...reduce my workload...I would spend more time with the patient." (Wife, P02)

"They came for a follow-up on the same day. The patients can meet each other. There are caregivers who are the role models. They gave me courage. It's not bad at all." (Son, P01)

During the focus group discussion, two participants explained that healthcare providers were consulted when they needed more information about caregiving, as demonstrated in the following quotes:

"When my mother got sick...sometimes I had to manage her medicines... I didn't know...I consulted them (PD nurses) by calling...they told me everything." (Son, FG3)

"I had ever called to consult them...I didn't know...how to manage abnormal signs at home...they told me how to solve them." (Daughter, FG4)

Balancing roles

Balancing roles refers to the way in which the new Muslim family caregivers strived to balance their multiple roles of caregiving. Most participants are adults who have multiple burdens of responsibility.

They tried to balance the multiple roles associated with caregiving by revising schedules and managing a new lifestyle. Rearrangement priorities were identified so that they could adjust to caregiving. Working-family caregivers, for instance, had to change their work schedules to continuously perform caregiving. Similarly, changing an educational plan or school schedule was reported by one school-age caregiver.

"After my mom became bedridden, I changed my work shifts to night shifts. I can take care of her during the day. Before I go to work, I do dialysis activities at about 7.30 p.m. because my sister can't do it. The dialysate is drained out the next morning when I come back. It's a little too late, but I have to do it like this because my sister can't do it." (Daughter, P05)

"My school schedule was formal at first, then, after my mother got sick, it was changed to nonformal. I would like to take care of my mom." (Daughter, P03)

"I tried to participate in Muslim merit-making, I came back for peritoneal dialysis, then I went back there again." (Daughter, P06)

DISCUSSION

The findings of this study provide an in-depth understanding into the experiences of Muslim family members in caregiving roles in terms of the difficulties experienced, their feelings, and adaptation strategies. PD affects family caregivers in a holistic sense as it impacts all aspects of being a human. Most participants in this study were middle-aged caregivers who have multiple roles. Caregiving indirectly affects these other roles, which has numerous impacts on a caregiver.

The findings from this study indicated that being a family caregiver affected their entire lives. There is ample evidence to show that caregivers of dialysis patients perform multiple activities every day. Those activities have simultaneous, negative impacts on caregivers' lives (Hoang et al., 2018). Feeling discouraged in relation to caregiving and the patients' illness were mentioned by Muslim family caregivers in this study. The increase in workload and a lack of improvement in patients' health were considered the main determinants of suffering.

Feelings of uncertainty and fear in relation to caregiving and the patients' illness were common, especially during the first 3 months. These may arise because caregiving is a new task. Even though they were trained by the PD nurses approximately three times before patients' discharge to home, this may not be sufficient for learning and training caregiving activities. Moreover, they had to begin by themselves without the help of the PD nurses. Due to their conditions when initially receiving dialysis, patients heavily depend on their caregivers which increases the burden felt by the latter (Tao et al., 2020). The findings support those of previous research which found that family caregivers can experience negative feelings such as uncertainty, fear, and an increased burden in the earlier phase (McDonald et al., 2016; Rabiei et al., 2015).

Once caregiving has been continuously performed for more than 3 months, hopelessness and helplessness were experienced among Muslim family caregivers who did not have sufficient family support. These findings are consistent with a previous study which found that Thai Muslim family caregivers of patients with kidney failure requiring renal replacement therapy felt tired (Hemman et al., 2017). This suggests that emotional resilience in Muslim family caregiver wanes over time. Healthcare providers should not overlook such psychological effects. Even though family caregivers are better at performing caregiving tasks, they may eventually experience burnout (Kang et al., 2019).

Another impact on their normal life is a loss of freedom in living. Reduced social interaction and travelling were experienced as they spent an average of 13 h a day on caregiving which meant they had less time available for interacting with others and travelling. All these factors may increase the risk of social isolation (Sun et al., 2019). Indeed, eight out of ten Muslim family caregivers in this study reported that they felt socially isolated while being family caregivers.

Facing an economic crisis was prioritised as the third most common negative effect. Even though all coverage healthcare schemes provide full reimbursement for PD, numerous expenses paid by the patient or their family are incurred in each follow-up, such as transportation and daily living expenses. This means caregivers have to shoulder the financial burden. This finding is consistent with previous research. Out-of-pocket costs in each follow-up include transportation, fees paid to hospital, food, and accommodation, all of which affects the financial status of families (Chuengsamran & Kasemsup, 2017). However, while expenses have been rising, their incomes have been travelling in the opposite direction. A falling income was reported by several Muslim family caregivers in this study. This may correlate with their occupation and income levels as most were farmers and workers. Once they became a caregiver, they focused on caregiving tasks rather than on other roles, which may have affected their income.

Family conflicts were also evident. Muslims generally believe that caregiving is the responsibility of the children. When other family members cannot take the actions expected of them, conflicts may arise within the family. These findings are consistent with a previous study which reported that caregiving also affects families and friends (Manera et al., 2019).

Physical disturbance was expressed less often by Muslim family caregivers in this study. These findings support previous research which found that family caregivers focused mainly on providing care for the patients and consequently neglected themselves (Amankwaa, 2017; Liu et al., 2017). The physical problems cited by Muslim family caregivers in this study include body weight loss, loss of leisure, and sleep deprivation, all of which are consistent with previous studies (Hemman et al., 2017; Rabiei et al., 2015).

To fulfil the role of a caregiver, they need to find positive ways to adjust with their new roles. In general, family caregivers mainly dealt with suffering by resorting to religion. Muslims usually spend their lives adhering to Islamic beliefs and practices

based on the Qur'an, the Hadith, and Sunnah (Alsharif et al., 2011). The findings in this study indicate that Muslim family caregivers adhered to the doctrine of Allah. For them, caregiving was the highest merit. It represented an opportunity to display true love towards their loved ones. This is the core religious principle in relation to caring (Nashif et al., 2020). Expressing gratitude was reported as their primary mental anchor while caregiving. Muslim family caregivers viewed caregiving as an expression of gratitude to their parents and spouses. This is grounded in their belief that Muslims who exhibit gratitude and kindness towards their parents or family also express gratitude towards Allah and will be rewarded (Nemati et al., 2017). Once caregivers valued their gratitude, they developed their caregiving and did their best to achieve wellbeing (Balthip et al., 2021).

Strong faith in Allah was thus demonstrated through caregiving, which is consistent with the findings of previous studies (Nashif et al., 2020; Nemati et al., 2017). Prayers and reading the Qu'ran commonly were used to cope with negative feelings. These religious practices are beneficial in managing stress (Shaw et al., 2019), leading to a positive caregiving experience (Pearce et al., 2016).

The value of being a caregiver was mostly found among sole Muslim family members. This enabled these caregivers to accept their new role. In the Islamic context, children are raised to take care of their parents or spouses. The duties of a Muslim, family responsibilities, and living with a care-recipient encouraged them to accept their caregiving roles, as determined by culture and religious values.

Seeking support and searching for more information was considered problem-focused coping strategies aimed at balancing multiple roles. Support from family members and relatives is required to reduce the workload and financial burden. Peers were also important in providing social and emotional support. For instance, Noohi et al. (2016) reported that peers can act as facilitators and offer emotional support.

To successfully balance multiple roles with caregiving, revising schedules and managing a new lifestyle was achieved through the rearrangement of priorities. Changing a work or educational plan and modifying the schedule were some of the actions undertaken depending on the caregivers' status. These strategies were beneficial in reducing the caregiver burden (Gaugler et al., 2018).

STUDY LIMITATIONS

This study was conducted in one PD unit in the south of Thailand. The findings may therefore not be transferable to other settings. The interviews on the date of patient's appointment might have been interrupted by other people and the environment might have affected the response. The interview may have focused more of the adverse effects of caregiving, as a result of which positive experiences were slightly underreported by the participants. In addition, the interview about religion suggests that the experiences of caregiving differ according to how strictly

participants adhere to the religion. Therefore, the findings may not completely explain the experiences of Muslim family caregivers looking after patients receiving PD in an Islamic context. Future studies should therefore be conducted in other settings to explore similar and different experiences of caregiving. The researcher should also carefully prepare the interview questions to ensure participants express the full range of caregiving experiences.

IMPLICATIONS AND CONCLUSION

The experiences of Muslim family caregivers in their roles are complex. Being a family caregiver exerts multiple effects that change over time. Religion was valuable in enabling them to perform caregiving and deal with negative experiences.

These conclusions will be useful for healthcare providers as well as nurse educators responsible for Muslim family caregivers of patients receiving PD. The suffering of family caregivers and strategies in dealing with life's changes should be a central concern in assessing and caring by PD nurses. Finally, religion should be involved in the development of specific interventions and its effectiveness should be evaluated further in future research.

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CONFLICT OF INTERESTS

The authors state that there is no conflict of interests.

ETHICS STATEMENT

The research proposal was approved by the Institutional Review Board on Research Involving Human Subjects of Prince of Songkhla University (PSU IRB 2019-NSt 009) and the hospital in which data were collected (ETA004/62). All participants were informed about the objectives, processes, disadvantages, and benefits of the study. The ethical information was presented to them both orally and in writing before them giving signed consent. Participants could withdraw from this study at any time, and the data were anonymised to ensure confidentiality.

AUTHOR CONTRIBUTIONS

Sunisa Seephom, principle leader, is a PhD candidate at the Faculty of Nursing, Prince of Songkla University. She graduated a master's degrees in nursing (adult). She conceived the idea, design, data collection and analysis, drafted and revised the manuscript and approved the final manuscript. Assoc. Prof. Dr. Piyanuch Jittanoon is the major advisor; she participated in the study in all processes, supervised the design, data collection and analysis, guided draft

the manuscript and approved the final version. Assoc. Prof. Dr. Karnsunaphat Balhthip is the co-advisor; she supervised the study design and data analysis, helped draft the manuscript and approved the final version.

ORCID

Sunisa Seephom  <https://orcid.org/0000-0002-8615-3926>

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AUTHOR BIOGRAPHY



Sunisa Seephom, Principle leader, is a PhD candidate at the Faculty of Nursing, Prince of Songkla University. She graduated a master's degrees in nursing (adult).

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