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Eşleşme Grupları

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Investigating the Effect of Hemodialysis on Family Dynamics: A Qualitative Study

Abstract

Objective: This study sought to conduct a qualitative analysis of the changes caused by hemodialysis in families and their effects on family dynamics.

7

Method: A qualitative research design was employed. From May to July 2025, face-to-face semi-structured interviews were conducted with 15 patients receiving hemodialysis treatment at a hospital in the Central Anatolian region of Türkiye to collect data. Purposeful sampling was used. A thematic analysis was conducted that used a hybrid analytic framework, comprising deductive codes taken from the family systems literature, combined with inductive codes from the field.

Results: Six main themes were identified. These were: T1, intra-family solidarity and closeness; T2, redistribution of roles and caregiving burden; T3, fatigue–rest cycle; T4, dialysis-centered routine; T5, threshold between emotional continuity and practical/material support; T6, faith- and submission-based acceptance, long-term adaptation, and "normalization." These themes suggested increased household coordination, yet also pointed to the need for reorganizing timing and logistical routines. The T3 theme was more dominant among new hemodialysis patients, while T6 was more prominent among long-term hemodialysis patients.

Conclusion: Through the formation of solidarity, redistribution of roles, and management of time around dialysis, hemodialysis restructures family functioning. The discourse of faith and acceptance helps to regulate emotions. The results emphasize the need for family-centered planning and the integration of periods of rest in everyday life, and for strengthening arrangements for transportation and logistics.

Keywords: Hemodialysis; Family dynamics; Qualitative research; Thematic analysis; Social support; Care burden.

Introduction

Chronic kidney disease is a global health problem characterized by a severe impairment of renal function and many systemic effects. In such cases, artificial methods must be used to support the kidney's role in filtering blood and removing excess fluid. Hemodialysis is the most commonly used renal replacement therapy for patients with CKD (Mallamaci & Tripepi, 2024; Murdeshwar et al., 2025).

Although hemodialysis can treat the symptoms and stabilize the clinical indicators, the long duration of treatment and dependence on the machine can cause problems. Patients have to go to the centers designated on the days of the week and for multi-hour sessions (Demirel & Sükut, 2024; Tuna et al., 2018; Yavuz & Var Çalık, 2023).

The impact of hemodialysis is not only on the patient but also on all the family members. It causes social and economic disruption. It also disturbs the daily activities of the family members. As patients usually live with family members, the family gets involved directly through witnessing disease- and dialysis-related changes and complications and taking on caregiving responsibilities (Ebadi et al., 2021; Hejazi et al., 2021; Nimah et al., 2024). Caregivers of patients on hemodialysis face more issues than caregivers of people with other chronic illnesses, such as frequent hospitalizations and complex drug regimens (Rajkhowa, 2019).

In the qualitative study of DePasquale et al. 2019, family members of people on hemodialysis reported unexpected obligations, sleep disturbances, anxiety, and depression. Likewise, Abebe et al. (2022) recognized sentiments, ways people react, and their transformations in life as a result.

There has been considerable research on the psychosocial burdens of HD on patients and caregivers, including depression, anxiety, caregiving burden, and quality of life. However, qualitative studies focusing on the evolution of intra-family processes are limited (Adejumo et al.; Demir Dikmen et al.; Farzi et al.; Meriç and Oflaz). It is still important to explore these internal family processes to curb caregiver overload and family wellness (Faridah et al., 2024).

Hence, this qualitative research study aims to explore how hemodialysis treatment affects the family unit as well as its impact on family dynamics.

Materials and Methods

Study Design

A qualitative semi-structured interview study design was employed with thematic analysis as the main analytic approach (Braun & Clarke, 2006; 2019).

Setting and Sample

The study was conducted in Karaman, a city in the Central Anatolia region of Türkiye. Purposeful sampling was used to recruit participants. The criteria for inclusion were being a hemodialysis patient and being ≥18 years. Following due ethical and institutional approvals and informing participants about the study, written and oral consent were obtained from the participants before participating in the study. The researcher included participants unless they refused to participate or withdrew from the interview. No participant did so. Interviews were completed with 15 participants in total.

Data Collection and Instruments

A set of open-ended questions helped the researcher conduct face-to-face interviews. To ensure that the questions drew rich data relevant to the study and its objectives (Table 1), the interview guide was pretested on two pilot interviews.

Table 1. Semi-Structured Interview Guide

No	Questions
1	What has changed in your daily flow before and after starting dialysis?
	• How are fatigue–rest periods planned on session days? • What becomes possible or postponed on non-dialysis days? • How do you arrange activities such as vacations, outings, or going to the seaside according to dialysis schedules?
2	How are domestic chores and caregiving tasks currently shared in your household?
	• Which of your previous roles have changed? (e.g., shopping, cooking, childcare) • How do you balance between protective discourse (e.g., “sit down/rest”) and your autonomy? • If single or living alone, how do you organize these responsibilities? • Is there household help or support from relatives? How frequent?
3	Who makes decisions regarding session times, transportation, diet, or medication, and how?
	• Do you make these decisions jointly or individually? • How do you resolve disagreements? (Can you describe an example?) • Have you experienced a crisis or turning point? How was it managed? • How do the healthcare team’s recommendations influence your decisions?
4	How do you talk about difficult topics (fatigue, finances, anxiety about the future) within the family?
	• Are you able to express your emotions openly? Which issues remain unspoken? • How are moments of tension that you consider “normal in every family” repaired?

	• How and to what extent do you talk with your children?
5	What emotional impact does dialysis have on you and your family?
	• How often do you experience emotions such as hope, anxiety, anger, or guilt? • Do you ever feel lonely or like a burden? • How has acceptance or adaptation developed over time (first days vs. today)? • What factors facilitate or hinder emotional expression within the family?
6	How have your spousal relationship/intimacy and parenting roles been affected?
	• Has there been any change in closeness or sexuality? How have you managed it? • How have boundaries and responsibilities in parenting been adjusted? • What does "acting together" look like in daily life?
7	What challenges do you experience concerning work/income, transportation/service, social life, and finances?
	• How does your income situation affect planning (adequate/insufficient/comfortable)? • How do transportation, vehicle, or accompaniment arrangements function, and where do they fail? • What kind of support do neighbors/relatives provide: emotional or practical/material? Which is lacking? • Is there flexibility from your employer or institution (e.g., leave, work hours)?
8	How do you cope with this process, and what kinds of support help you most?
	• How does faith or submission (e.g., "It comes from God / Thanks be to God") give you strength? • Among the available sources — family/relatives/neighbors, healthcare staff, or social services — which are most helpful? • What strategies have you tried that did not work? • What advice would you give to others in similar situations, and what are your expectations from healthcare professionals?
9	Is there anything else you would like to add that I have not asked but you consider important?

Pilot and Interview Procedure

Pilot interviews confirmed that the questions generated sufficient depth of data. This pilot data is excluded from the final analysis. Each interview was conducted once, in person, by the researcher. They were held between May and July 2025 in the dialysis unit of the hospital. Each interview took about 25-35 minutes, was audiotaped, and transcribed word-for-word. After each session, the interviewer (D.Ç.) wrote descriptive reflections and preliminary analytical impressions as fieldnotes.

Data Saturation

Data collection finished after the point at which the participants' narratives started to become repetitive, and no new themes were being presented.

Interview Guide

The guide consisted of eight core questions and contextual probes addressing themes such as daily routine and time use, family roles, decision-making, communication, emotional climate, spousal and parental relationships, socio-economic and logistical factors, and coping or support mechanisms (see Table 1).

Data Analysis

Quantitative data were analyzed descriptively using SPSS v27.0 (mean, frequency, and percentage). Qualitative data were examined through thematic analysis, proceeding through the phases of familiarization, initial coding (hybrid: deductive + inductive), theme development, refinement, and naming – reporting. Coding was managed using the MAXQDA software.

Trustworthiness

To ensure rigor, a decision log and codebook were maintained; peer debriefing was used to test the consistency of theme boundaries; and thick description strengthened transferability. Thematic saturation was observed around the twelfth interview, while interviews 13–15 further consolidated emerging motifs.

Ethical Approval

2 The study received approval from the Karamanoğlu Mehmetbey University Faculty of Medicine Ethics Committee (No. 05-2024/13) and institutional permission from the Education and Research Hospital (No. 277289996-26.05.2025). 8 Written and verbal informed consent was obtained from all participants.

1

Results

A total of fifteen participants took part in the study. The mean age was 58.6 ± 11.34 years; 33.3% (n = 5) were female, 60.0% (n = 9) were married, and 73.3% (n = 11) had children. Eight participants (53.3%) were retired, and twelve (80.0%) had completed primary education. Almost three-quarters (73.3%, n = 11) stated that their income was “enough for basic necessities,” and 46.7% (n = 7) reported no other comorbidities. The average time that the participants had experienced chronic kidney disease was 7.99 ± 5.54 years, and the average time spent on hemodialysis treatment was 6.37 ± 4.94 years.

2 **Table 2. Sociodemographic Characteristics of Participants**

Variable	Mean ± SD	Min-Max

Age (years)	58.6±11.34	35-75
Duration of Chronic Kidney Disease (years)	7.99±5.54	0.25-16
Duration of Hemodialysis (years)	6.37±4.94	0.25-16
Gender	n	%
Female	5	33.3
Male	10	66.7
Marital Status		
Single	6	40.0
Married	9	60.0
Parental Status		
No children	4	26.7
Has children	11	73.3
Occupation		
Retired	8	53.3
Worker–Retired	2	13.3
Housewife	2	13.3
Worker	1	6.7
Hairdresser	1	6.7
Unemployed	1	6.7
Educational Level		
Primary school	12	80.0
Middle school	1	6.7
High school	2	13.3
Perceived Income Level		
“Enough for basic necessities”	11	73.3
“Not sufficient”	3	20.0
“Comfortably sufficient”	1	6.7
Chronic Disease Status		
None	7	46.7
Hypertension only	2	13.3
Diabetes mellitus	3	20.0
Hypertension + Stroke	1	6.7
Hypertension + Cancer + Hepatitis	1	6.7
Diabetes mellitus + Hypertension	1	6.7

Six main themes were revealed through thematic analysis. Each of those is summarized below with quotes from the participants.

T1 – Intra-Family Solidarity and Closeness

Subthemes: (a) emotional closeness, (b) practical and logistical solidarity

In most households, dialysis seemed to strengthen the emotional ties and practical cooperation. The schedules for appointments, transport, and care were arranged together.

“We are closer now… we haven’t drifted apart, we’ve grown even closer.” (P1)

“No, it didn’t distance us; it brought us together.” (P3)

“My daughter drives me to Konya; we plan everything together.” (P12)

“My father takes me and brings me back—he never leaves me alone.” (P11)

Solidarity was often expressed through the sharing of responsibilities and the provision of transport support, which helped to lessen fatigue and limited functionality.

T2 – Redistribution of Roles and Caregiving Burden

Subthemes: (a) domestic role changes, (b) caregiving and logistical responsibilities

Domestic roles were flexible and often balanced an attitude of protection or authority (“sit, rest”) against the autonomy of the patient.

“My mom does everything… she chops, and I cook.” (P1)

“A house helper comes once a week; for the rest, my husband helps a lot.” (P8)

“They tell me, you’re sick, just sit down—they won’t let me do anything.” (P10)

The reduction in caregiving load because of protective attitudes limits autonomy. As a result, a quiet negotiation between these two ends sustained family functionality.

T3 – Fatigue, Functional Limitation, and Dialysis-Centered Routine

Subthemes: (a) fatigue–rest cycle, (b) dialysis-based scheduling, (c) transportation and service solutions

After treatment, fatigue consumed the rest of the day, so one had to rest and recover. The logistics of transporting patients were managed by family members and the hospital transport service.

“After leaving here, we’re exhausted; when I get home, I just lie down.” (P2)

“If we plan to go to the seaside, we do it around the dialysis schedule.” (P10)

“I use the hospital shuttle; I signed up for it.” (P5)

“My brother drives me; we arrange everything accordingly.” (P1)

“Dialysis-centered time” structures the functioning of families. Support in the form of transport by either a family member or hospital service lessened their workload and stress.

T4 – The Dual Face of Social Capital: Emotional Continuity vs. Material Gaps

Subthemes: (a) emotional interest and attentiveness, (b) threshold of practical/material support, (c) fragmentation in kinship ties

On the whole, relations with neighbors and kin maintained emotional continuity, although real or financial support was often limited.

“I have good relations with my neighbors; they ask how I’m doing.” (P2)

“I’ve never received help from neighbors; they just call to ask.” (P5)

“I have many relatives, but… they’re there and not there—we’re not really close.” (P1)

The concern remained emotional, while the material help was more situational and sporadic. This gap increased vulnerability, especially for participants living alone.

T5 – Faith, Submission, and Acceptance

Subthemes: (a) initial resistance followed by acceptance, (b) “It comes from God/thanks be to God” discourse, (c) emotional regulation

A faith-based perspective served as a key regulator to the transition from denial to acceptance and meaning-making.

“Illness comes from the Almighty; I’m grateful.” (P7)

“At first, I couldn’t accept it… but later I had to—it came from God.” (P9)

“I pray for patience; God gives me strength.” (P11)

Expressions of submission reframed the sense of lost control, they softened feelings of guilt and fear, and allowed for more open family communication.

T6 – Long-Term Adaptation and ‘Normalization’

Subthemes: (a) narratives of adjustment, (b) workplace or institutional flexibility, (c) coordinated family action

As the years of dialysis increased, there was a strong narrative of “we’ve gotten used to it/it’s normal now”. This adaptation was made easier by employer support and coordinated household routines.

“We’ve gotten used to it, professor; it’s been years now.” (P9)

“I’m working, and the factory makes things easier for me.” (P3)

“We move together, organize things accordingly.” (P12)

“I continue my normal life; I’ve established my routine.” (P8)

Over time, routinization, institutional flexibility, and collaboration among households have all made “living with illness” more sustainable.

Thematic Saturation and Scope

From the 10th to the 12th interviews, saturation occurred for Themes T1 – T3. Themes T4 and T5 were consolidated in interviews 13–15, particularly highlighting the threshold of practical support among participants living alone. Long-term dialysis patients (e.g., P9) showed the strongest effect for theme T6.

Contextual Analysis by Sociodemographic Characteristics

1) Participants Living Alone – Thresholds of Practical Support and Faith-Based Coping

P11 said: “I live alone.” When asked about their neighbors, they mentioned a warm relationship, but no material help (e.g., “We get along, but no one helps materially”). In the same way, P6 (75-year-old) lived alone and said she only occasionally got help from her children. The old and lonely tended to have only episodic forms of support. There was emotional and moral support in the case of P6 and P11. However, systematic practical aid did not take place in both cases. Thus, the linking pattern makes one think of “emotional continuity vs. practical gap,” which has already been defined under T4.

2) Transportation and Shuttle Services – The Invisible Backbone of Care

Participants P8, P12, and P15 mentioned using the shuttle service at the hospital, but P10, who relied on family, did not. An organizational axis of care access was represented by these arrangements. Transportation was a key contributor to the “dialysis-centered routine” (T3) and reduced logistical difficulties exacerbated by post-treatment fatigue.

3) Duration of Dialysis (Vintage) – Reinforcing the Narrative of Normalization

Participants with long-term treatment histories of P9 for 16 years, involved in 10-year treatment with P10 and P13, more often said “we got used to it”. In contrast, newer participants like P8 (4 months) viewed family and transport assistance as the core of their daily functioning. Accordingly, the T6 theme of long-term adaptation gained strength as the duration of treatment increased. In contrast, the fatigue-rest cycle (T3) was more pronounced in patients at early stages of the disease.

4) Marital Status and Care Organization

The married participants (e.g., P10, P14, P15) showed clear changes with domestic roles and shared care. A single participant, P13 (35 years), relied on his parents. His father managed the transport, and his mother, who was also sick, helped at home. Married households presented a negotiation between protection ("rest, don't do that") and autonomy, while unmarried participants relied to a greater extent on parental or kin-based care.

5) Education, Occupation, and Perceived Income

Participants such as P9 (high-school graduate, retired police officer) said that financial adequacy is "barely sufficient but manageable," while P10 (primary-school, retired) stated that "it is sufficient." P14, who only receives the social security pension, stated that he does not receive anything else. Such variations affected T4 and T6 resource balance and adaptation.

Contextual Patterns by Participant Group

New Hemodialysis (≤ 1 year) – P3, P4, P12, P13

The group stressed fatigue–rest cycles and T3 (dialysis-based planning) for P12 and P13. Transport and accompaniment arrangements constituted the backbone of household functioning for these patients.

Long-Term Hemodialysis (≥ 10 years) – P2, P9, P10, P11

This group showed a pronounced "adaptation/normalization" narrative (T6). P9 (≈ 16 years) and P10 (≈ 15 years) frequently described structured routines and institutional flexibility, while P2 and P11 consistently expressed acceptance and reliance on faith (T5).

Financial Fragility – P10, P14, P15

Participants reporting inadequate income articulated stronger needs for logistical and material assistance (T3, T4), and displayed a clearer divide between sustained emotional support and limited practical help (T4).

Education and Routine Management – P7, P9 (high school); P10 (middle school)

Participants with ≥ secondary education or higher exhibited more systematic narratives of organized routine management (T6). In contrast, the primarily primary-educated group (12 of 15) displayed a greater need for health-literacy-sensitive counseling and practical care support.

Comorbidity Clusters – Hypertension: P2, P4, P11, P14, P15; Diabetes: P8, P12, P13, P15

There were often discussions of energy management (T3) and routinization strategies (T6) in the presence of comorbidities like hypertension or diabetes. For example, P4 had contact with the healthcare system because he had hypertension, cancer, and hepatitis. Similarly, P11 with hypertension and stroke increased concerns related to accompaniment and safety.

Based on the participants' profiles, the theme constellation became clearer. The new hemodialysis group has fatigue-rest stories and transport dependence (T3), while long-term patients have normalization stories (T6). Households with financial fragility show the greatest dissonance between T4 emotional continuity and support thresholds. Individuals with higher education were able to voice structured management of routines (T6); individuals with lesser schooling expressed greater reliance on families. Comorbidities, including hypertension and diabetes, strengthened the relationship between T3-T6 time-energy and transport/caregiver arrangements.

Discussion

The study showed that hemodialysis modifies family dynamics primarily through three intersecting dimensions, namely, solidarity, redistribution of roles, and dialysis-centered time management.

Both the hemodialysis process and the patient's dependence on the dialysis machine to sustain life give rise to numerous psychosocial and physical challenges. Emotional burden, diminished functional ability, change in self-identity or body image, perceived stigma, and loss of social participation or status are some of them. In addition, patients are often partially dependent on daily life activities (Tuna et al., 2018; Ölmez et al., 2023).

Our results reveal that patients starting hemodialysis have fatigue and difficulties organizing their lives around dialysis.

Individuals undergoing hemodialysis often struggle with depressive feelings, logistical issues, and fatigue, according to a qualitative study by DePasquale et al. (2019). According to a review performed by Zhang et al. (2025), participants experienced financial hardships and disruption in daily life patterns due to the long-term nature of hemodialysis, often leading to seeking other assistance. A different study also found that hemodialysis patients require assistance in the physical and psychological domains (Albayrak Okçin & Usta Yeşilbalkan, 2020).

The results indicated that over years of hemodialysis, individuals adapted to and normalized their treatment. In line with our observations, Keskin Yıldırım and Özpulat (2019) point out that although hemodialysis negatively affected patients' lives at first, later their acceptance developed along with treatment compliance.

In our research, we noted a definite change in the respective roles undertaken by married participants (e.g., P10, P14, P15). In line with our findings, Meriç and Oflaz's (2013) qualitative study showed that a constant ebb and flow was the main theme portraying the spouses' lived experience, which reflected in their emotions, routines, and mutual expectations.

Based on our evidence, dual-axis fluctuations appear in the household via renegotiations of role distribution and autonomy. Patients' family members are implicated in the illness trajectory and witness the changes, difficulties, and complications in hemodialysis directly (Hejazi et al., 2021). Sajadi et al. (2017) found that often the quality of life of the caregivers of hemodialysis patients decreases. In a similar vein, Solaimanimoghaddam et al. (2024) stated that the problems faced during the hemodialysis process can destabilize the family. According to the findings of Yıldız et al. (2023), the impact was not limited to patients themselves; family members also expressed a strong need for psychological and social support.

The results from our study are consistent with this wider body of evidence, as family members attempt to give the patient emotional, logistical, and physical support, which inevitably results in a redistribution of housework and a direct increase in care burden. Hemodialysis represents a family-wide process of adaptation rather than an individual experience.

Participants' narratives were also different, as per their sociodemographic features. Particularly, educational level and marital status seem to shape the coping styles and the articulation of family roles. Likewise, Xhulia et al. (2015) found that the responses to chronic illness and caregiving role were based on factors such as age, education, and place of residence.

Collectively, these findings indicate that hemodialysis is more than a medical treatment; it also modifies the family's everyday rhythms, emotional climate, and role organization. The sustainability of this adaptation depends on emotional solidarity, flexible role sharing, and access to practical support.

Conclusion and Recommendations

Undergoing hemodialysis entails a progressive transformation in the role distribution and organization of time and logistics, as well as solidarity in the home environment. The idea of faith and submission ("trust in God's will") is vital for emotional balance and acceptance for patients and their families.

Recommendations

- Family-centered planning: All households should incorporate rest into their daily schedules as well as promote the sharing of roles.
- Transportation and service coordination: It enhances the capability of social service and transportation networks that allow for access to routine dialysis.
- Emotional support: Patients and families may find a space to express their feelings and receive faith-sensitive counseling or psychoeducational support.

We must evaluate patients' social support systems and raise awareness of who can help care for the patient. Patients should receive counseling and psychoeducation according to their social context as well. Furthermore, it is necessary to aid the effort to express one's emotions in order to provide an opportunity to express feelings concerning illness and treatment (Duran & Güngör, 2015).

Hemodialysis is a family-wide experience characterized by mutual adaptation and cooperation sustained through emotional solidarity, spiritual strength, practical organization, and structured daily coordination.