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LIVING WITH PERITONEAL DIALYSIS: A PHENOMENOLOGICAL EXPLORATION OF PATIENTS' EXPERIENCES IN CARAGA REGIONAL HOSPITAL, PHILIPPINES

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Abstract

Background. Peritoneal dialysis (PD) provides home-based renal replacement therapy but reshapes patients' daily routines, mobility, relationships, emotional well-being, and financial circumstances. This study explored the lived experiences of adults undergoing PD at Caraga Regional Hospital in Surigao City, Philippines, across physical, emotional, social, spiritual, and economic dimensions.

Methods. A qualitative descriptive phenomenological design grounded in Husserlian transcendental phenomenology was used, incorporating *epoché* (bracketing) and Colaizzi's seven-step analysis. Eight adult PD patients participated in semi-structured interviews lasting approximately 10–30 minutes. Data were collected from November 2025 to January 2026. The final two interviews were reviewed against the established coding structure as a thematic-stability check, and synthesized findings were returned to participants for validation and clarification through member checking. Analysis included significant statements, formulated meanings, clustered themes, an exhaustive description, and the fundamental structure.

Results. Five interrelated themes emerged: living with restricted movements; becoming independent with PD care; holding onto hope and acceptance; surviving through the support of others; and bearing the weight of treatment. Each theme was supported by participant quotations presented in the original languages with literal English translations. The findings reflected physical restrictions, self-care learning, hope and acceptance, relational support, and continuing financial, emotional, and psychosocial burdens.

Conclusion. In this single-site study, participants described living with PD as an ongoing process of adapting to treatment while continuing to experience physical, emotional, social, and financial demands. "Treatment-bound adaptation" is presented as a context-specific descriptive synthesis of these accounts rather than a definitive phenomenological essence.

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Nursing Implications and Recommendations. Nurses should strengthen individualized PD education, refresher training, and family-inclusive demonstrations to promote safe self-management and confidence. Routine assessment should address physical, psychosocial, spiritual, and financial needs.

Keywords: *Chronic kidney disease; coping; lived experience; patient adaptation; peritoneal dialysis; phenomenology; Philippines*

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Research Highlights

What is the current knowledge?

- PD is an effective home-based treatment that may support greater patient independence but requires substantial self-management and ongoing care.
- People receiving PD may experience physical, emotional, lifestyle, and financial challenges that affect everyday life.
- Family support, healthcare-provider guidance, and spirituality are described in the literature as resources for coping and adjustment among dialysis patients
- Qualitative research provides important insight into how patients experience the everyday demands of PD within their social and cultural contexts.

What is new in this study?

- This study provides a qualitative account of the lived experiences of adults receiving PD in a regional hospital setting in the Philippines.
- Five interconnected themes emerged: living with restricted movements; becoming independent with PD care; holding onto hope and acceptance; surviving through the support of others; and bearing the weight of treatment.
- The findings characterize living with PD as treatment-bound adaptation, in which self-care learning, physical restrictions, hope and acceptance, social support, and continuing treatment-related burdens coexist.
- The findings provide context-specific insights that may inform nursing education, psychosocial support, and PD program development in similar settings, without implying national generalizability or establishing intervention effectiveness.

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INTRODUCTION

Chronic kidney disease (CKD) is a progressive and irreversible condition characterized by the gradual loss of kidney function, resulting in impaired regulation and elimination of waste products and disturbances in electrolyte, fluid, and acid–base balance. Its increasing prevalence and substantial contribution to morbidity, mortality, and healthcare-system burden have established CKD as a major global health concern (Shlipak et al., 2021).

In the Philippines, kidney failure and kidney replacement therapy are associated with substantial treatment, financing, and health-system considerations (Bayani et al., 2021). These challenges may be particularly pronounced in geographically isolated and resource-limited communities, where access to renal services, adequately trained healthcare personnel, and sustained treatment and support may be constrained.

Peritoneal dialysis (PD) is a home-based renal replacement therapy that uses the peritoneal membrane as a semipermeable membrane to remove metabolic waste products and excess fluid from the body. Compared with facility-based hemodialysis, PD may provide greater flexibility, autonomy, and continuity in daily life because treatment can be integrated into patients' home routines (Corbett, 2023; Jacquet & Trinh, 2019). However, this relative flexibility does not eliminate the demands of treatment; rather, it requires patients to develop and maintain self-care skills, adapt daily activities, and incorporate treatment responsibilities into everyday life.

The home-based approach to PD, however, also shifts a significant portion of the treatment burden to patients and their families. Patients need to practice aseptic technique, manage their diet and fluid intake, plan their treatment schedules, monitor for potential complications, and maintain adherence to treatment while facing fatigue, increased risk of infection, lifestyle limitations, and financial difficulties (Jacquet & Trinh, 2019; Li et al., 2022; Oveyssi et al., 2021; Sluiter et al., 2024). This may create a tension between autonomy and the restrictions that can arise in the home environment with regard to daily movement, work, travel, and social participation, as treatment schedules may become central to daily routines.

This study has a rationale that extends beyond clinical adequacy and treatment compliance. Patients' descriptions can illuminate how dialysis may alter movement, work, relationships, hope, self-concept, and daily decision-making. In the Philippine context, these experiences may also be influenced by family relationships, spiritual beliefs, and economic circumstances (Ahmadi et al., 2024; Cura, 2015; Fuertes et al., 2021). Rather than assuming that these factors have the same meaning for all Filipino patients, the present study examines how they are described and experienced by patients receiving PD within the local setting.

The Caraga context is important because Caraga Regional Hospital is a government referral hospital serving patients from varied socioeconomic and cultural backgrounds and operating a Peritoneal Dialysis Unit that provides education, training, and continuing monitoring for home dialysis. The setting therefore provides a regional context in which the practical demands of PD intersect with patients' everyday experiences.

The regional service context further underscores the importance of examining patient experiences within Caraga. Philippine evidence has documented important financing and policy considerations in the provision of kidney replacement therapy, supporting the need for context-specific inquiry into renal replacement care (Bayani et al., 2021). This context strengthens the rationale for examining how patients receiving PD experience treatment within a regional public-hospital setting.

Existing qualitative and patient-perspective studies have examined selected dimensions of dialysis experience, including psychological difficulties, social support, catheter-related concerns, and social isolation (Avdal et al., 2020; Fissell et al., 2023; Sitjar-Suñer et al., 2020; Sluiter et al., 2024). However, these studies generally emphasize particular domains or broader dialysis populations rather than the interconnected everyday experience of living with PD in a regional Philippine setting. The present study therefore extends this literature by examining how physical restriction, self-care learning, hope and acceptance, relational support, and continuing treatment burden are experienced together within the Caraga context.

Within the Philippine context, sustaining peritoneal dialysis (PD) may be influenced by geographic access to renal services, household financial resources, family involvement, and continuity of care. These considerations are particularly relevant in regional and geographically dispersed settings, where patients may need to travel for follow-up care while managing treatment-related expenses and responsibilities within available household resources. Such circumstances may shape how patients incorporate PD into their daily routines and how they experience its physical, emotional, social, and practical demands.

Although Philippine research has examined clinical outcomes, treatment adherence, quality of life, and coping among patients with kidney disease, qualitative studies describing the everyday lived experiences of patients receiving PD remain less represented, particularly in regional settings such as Caraga and Mindanao. A phenomenological perspective can provide a more detailed understanding of how physical restrictions, self-care demands, family and healthcare support, hope and acceptance, and continuing treatment burdens are experienced as interconnected aspects of everyday life. Examining these experiences within the local context may therefore contribute context-specific insights that complement existing clinical and quantitative evidence.

Because quantitative indicators alone may not fully capture the meaning and essential structure of living with a long-term treatment regimen, a descriptive phenomenological approach was used to explore how patients receiving PD at Caraga Regional Hospital experience, describe, and adapt to the interconnected physical, emotional, social, spiritual, and economic dimensions of treatment.

LITERATURE REVIEW

CKD and the Burden of Long-Term Renal Care

The literature establishes chronic kidney disease (CKD) as both a biomedical condition and a long-term disruption to everyday life. Globally, CKD is associated with substantial morbidity, mortality, and increasing healthcare needs (Shlipak et al., 2021). In the Philippine context, kidney failure and kidney replacement therapy are associated with considerable treatment and financing challenges for patients and the healthcare system (Bayani et al., 2021). These broader CKD and renal-care findings provide the health-system context for understanding the demands associated with renal replacement therapy.

However, evidence concerning the general burden of CKD does not necessarily describe the specific experience of living with peritoneal dialysis (PD). The transition from advanced CKD to dialysis introduces treatment routines, self-care responsibilities, and physical and social adjustments that may differ according

to dialysis modality. Consequently, broader CKD literature is useful for establishing the context of long-term renal care but should not be assumed to represent the lived experience of patients receiving PD.

Peritoneal Dialysis, Mobility, and Daily Life

PD-specific literature describes home dialysis as a treatment modality that can provide patients with greater flexibility and opportunities for autonomy because treatment can be performed within the home environment. At the same time, patients assume substantial responsibility for treatment-related tasks, including performing exchanges, maintaining infection-prevention practices, protecting the catheter, managing diet and fluid intake, and organizing daily activities around treatment schedules (Bennett et al., 2022; Li et al., 2022). Thus, the potential flexibility of PD exists alongside continuing treatment obligations.

This distinction is important when interpreting evidence from other dialysis populations. Findings concerning dialysis-related physical limitations may be relevant to PD patients, but experiences reported by patients receiving hemodialysis cannot automatically be considered equivalent to those receiving home-based PD. The treatment setting, frequency and organization of treatment, degree of self-management, and involvement of family members may differ between modalities. PD-specific evidence therefore provides the more direct basis for understanding how patients incorporate treatment into everyday life, whereas broader dialysis literature provides complementary context.

Physical functioning is also reported as an important concern among patients receiving dialysis. Fatigue, abdominal discomfort, drain pain, reduced stamina, and catheter-related concerns may interfere with routine activities and physical participation among patients receiving PD (Aga et al., 2023; Lightfoot et al., 2021; Tian et al., 2020). These studies provide evidence that physical effects can extend beyond individual symptoms and may affect work, family responsibilities, and valued activities.

Nevertheless, much of the existing evidence examines physical functioning, symptoms, or quality of life as discrete outcomes. Such approaches can identify the presence and extent of particular difficulties but may provide less insight into how patients themselves understand the relationship between physical restrictions and other aspects of daily living. A phenomenological approach can therefore add a different level of understanding by examining how physical changes are experienced as part of the patient's broader everyday world.

Self-Management, Autonomy, and Relational Support

Studies involving patients with CKD and dialysis have associated self-efficacy with treatment adherence and self-management (Curtin et al., 2008; Griva et al., 2018; Jaelani et al., 2023; Karadag, 2019). A systematic review of qualitative studies further identified multiple barriers and facilitators influencing self-care and disease management among patients receiving dialysis, emphasizing that self-management is shaped by individual capabilities, treatment demands, and supportive contexts (Escudero-Lopez et al., 2024). These findings support the importance of strengthening patients' skills and confidence while recognizing that self-management extends beyond technical competence.

Although these studies support the importance of self-efficacy and education, evidence from broader CKD and dialysis populations should be interpreted cautiously when applied specifically to PD. Technical competence in PD is only one component of adapting to treatment. Patients must also integrate treatment

knowledge into household routines, physical capabilities, emotional responses, and changing social circumstances. The home setting may consequently make self-management both a source of autonomy and an ongoing responsibility.

Autonomy in chronic illness should likewise not be equated with complete independence. Family members may contribute to treatment routines, transportation, financial arrangements, decision-making, and emotional support. Philippine studies have highlighted the importance of family relationships and social context in patients' experiences of illness and healthcare decision-making (Torres et al., 2021; Cura, 2015; Fuertes et al., 2021). These studies provide important contextual information, but evidence concerning Filipino family relationships should not be treated as evidence specific to PD unless the study population and treatment context are comparable.

This distinction is particularly relevant to the present study. The ability to perform PD independently may coexist with dependence on family members for transportation, financial assistance, household activities, or emotional support. Rather than treating autonomy and dependence as opposing conditions, the present study considers how both may be experienced simultaneously within the patient's everyday life.

Hope, Spirituality, and Psychosocial Burden

Hope, spirituality, and meaning-making have also been described as important resources in coping with chronic illness. A qualitative study involving Filipino patients reported spirituality, prayer, gratitude, and family relationships as resources in coping with illness (Ahmadi et al., 2024). Broader chronic kidney disease literature has likewise highlighted the relevance of social support and caregiver relationships to patients' experiences of illness (Fuertes et al., 2021). These findings provide cultural and psychosocial context for interpreting the present participants' accounts; however, they should not be generalized to all Filipino patients or assumed to have the same meaning for individuals receiving PD.

PD and broader dialysis literature also identifies psychological distress, financial hardship, and social isolation as continuing concerns (Avdal et al., 2020; Ng et al., 2021; Sluiter et al., 2024; Yang et al., 2024). These studies demonstrate that coping resources do not necessarily eliminate treatment-related difficulties. Rather, patients may simultaneously experience hope, acceptance, uncertainty, distress, and treatment burden.

The coexistence of positive coping resources and continuing difficulties is therefore important for a phenomenological examination of PD. Instead of viewing hope or spirituality simply as protective factors, the present study examines how patients themselves describe hope, acceptance, and meaning while continuing to live with the demands and uncertainties of treatment.

Critical Synthesis of the Literature

Taken together, the literature suggests that living with PD involves interacting physical, behavioral, relational, psychosocial, and economic dimensions. However, these dimensions are not equally represented across the evidence base. PD-specific studies provide the most direct evidence concerning home-based treatment, self-management, catheter-related concerns, and the integration of dialysis into daily routines. Broader dialysis and CKD studies contribute evidence concerning fatigue, psychological burden, coping, quality of life, and chronic illness adaptation but may involve treatment contexts that differ from PD.

Philippine and Filipino-context studies add information concerning family relationships, spirituality, and social circumstances but should likewise be interpreted according to their populations and specific research contexts.

The literature consequently supports a more nuanced understanding of autonomy and burden. PD may increase patients' control over where treatment is performed and may promote self-care competence, yet the same home-based arrangement can transfer substantial responsibility to patients and families. Similarly, family and spiritual support may facilitate coping without necessarily removing financial, physical, or emotional difficulties. These apparent tensions are not contradictions but may represent different dimensions of the same lived experience.

The present study adds to this body of evidence by examining these dimensions as they are experienced together rather than treating them as separate outcomes. In particular, the Caraga findings provide a regional account of how patients negotiate restricted movement, learning and performing self-care, hope and acceptance, support from others, and the continuing weight of treatment. These findings can be considered alongside previous literature to identify areas of convergence as well as aspects that provide additional context to existing knowledge.

Importantly, the present phenomenological inquiry does not seek to test whether previous theoretical or empirical propositions are correct. Instead, previous literature serves as contextual and comparative evidence against which the meanings emerging from participants' accounts can be considered. This approach allows the study to identify experiences that converge with previous findings while also recognizing experiences that may extend, qualify, or differ from existing accounts.

Synthesis and Qualitative Gap

A review of the available literature identified qualitative and patient-perspective studies addressing important aspects of dialysis experience, including psychological difficulties, social support, social isolation, and treatment-related concerns (Avdal et al., 2020; Fissell et al., 2023; Sitjar-Suñer et al., 2020; Sluiter et al., 2024). Other Philippine studies provide perspectives on CKD, family experiences, coping, and treatment-related circumstances (Torres et al., 2021; Cura, 2015; Fuertes et al., 2021). Collectively, these studies provide valuable evidence, but they differ in dialysis modality, population, setting, and the particular dimension of experience examined.

Within the literature reviewed for the present study, relatively limited attention was identified to the interconnected everyday experience of patients receiving PD in a regional Philippine setting such as Caraga. Existing studies commonly address specific experiences or outcomes, whereas the present study brings together physical restriction, self-care learning, hope and acceptance, relational support, and continuing treatment burden within a single phenomenological inquiry. This represents a search-informed qualitative gap rather than a claim of an exhaustive absence of Philippine PD research.

The present study therefore uses Husserlian descriptive phenomenology to explore how patients receiving PD at Caraga Regional Hospital experience and give meaning to their everyday lives. Rather than testing the effectiveness of an intervention or examining a single outcome such as adherence, quality of life, or psychological distress, the study seeks to describe the structure and meanings of the experience as represented in participants' accounts.

The regional setting further contributes contextual value. Patients receiving PD in Caraga may experience treatment within particular geographic, socioeconomic, family, and healthcare circumstances. Examining these experiences within the local setting may therefore provide context-specific insights that complement findings from studies conducted in other populations, healthcare systems, and dialysis modalities.

This synthesis provided the basis for examining the lived experience of PD without using external theoretical frameworks to organize or force the final themes. The semi-structured interview guide included study-relevant domains such as physical, emotional, social, spiritual, economic, coping, support, and adjustment experiences. These domains guided the interviews, while the final themes were developed through participants' accounts and Colaizzi's analytic process.

Aim of the Study

This study aimed to describe the lived experiences of patients undergoing peritoneal dialysis at Caraga Regional Hospital in the Philippines.

Specifically, the study was guided by the following objectives:

1. To describe the physical, emotional, social, spiritual, and economic experiences of patients undergoing peritoneal dialysis;
2. To describe how patients experience and adjust to the routines, restrictions, and self-management demands of peritoneal dialysis;
3. To describe the coping responses and sources of support that patients experience as helping them sustain treatment;
4. To describe the essential structure and meanings of living with peritoneal dialysis; and
5. To formulate implications for nursing practice, hospital support systems, patient education, policy, and future research.

METHODOLOGY

Design

This qualitative study employed a descriptive phenomenological design grounded in Husserlian transcendental phenomenology to describe the lived experiences and descriptive structure of living with peritoneal dialysis as perceived by the participants (Al-Sheikh Hassan, 2023; Shorey & Ng, 2022). The approach emphasized participants' descriptions while minimizing the influence of the researcher's pre-existing assumptions through *epoché* (bracketing) and reflexive practice (Ash, 2025).

Environment

This study was conducted in the Peritoneal Dialysis Unit of Caraga Regional Hospital, a government referral hospital serving patients from Surigao City and surrounding areas in the Caraga Region of

Mindanao, Philippines. The unit provides PD education, home-based PD, and continuing monitoring. Participant recruitment and interviews were conducted from November 2025 to January 2026. All participants were receiving continuous ambulatory peritoneal dialysis (CAPD), with PD duration ranging from 5 to 18 months. The setting was relevant because patients experienced home-based PD within a regional public-hospital context shaped by family support, financial circumstances, mobility, and access to continuing care.

Participants

Eight adult patients receiving peritoneal dialysis (PD) were purposively selected to provide information-rich descriptions of their lived experiences. An information-rich sample was appropriate for the phenomenological design because the study sought depth and meaning in participants' experiences rather than statistical representation. Eligibility criteria included age ≥18 years, current PD treatment for at least 1 month, ability to articulate experiences, and provision of informed consent; patients unable to provide informed consent or with severe cognitive impairment or psychological instability were excluded.

Recruitment documentation was limited to the eligible patients approached for participation, and no separate screening log was maintained to document the broader eligible population or non-participation; therefore, the potential for self-selection could not be fully assessed. Participation was voluntary, and the decision to participate or decline had no effect on medical care. All participants were receiving continuous ambulatory peritoneal dialysis (CAPD), with PD duration ranging from 5 to 18 months. Sample adequacy was based on the richness of participants' descriptions and thematic stability rather than statistical power. The final two interviews were reviewed against the established coding structure, and no substantially new experiential dimensions emerged.

Table 1 summarizes the demographic and contextual characteristics of the eight participants, including age, sex, PD duration, employment or educational context, documented support, and PD modality.

Instruments

The researcher served as the primary instrument and was a registered nurse with clinical experience in peritoneal dialysis. This clinical familiarity was recognized as potential pre-understanding; therefore, reflexive notes were maintained throughout data collection and analysis to document assumptions, reactions, and analytic decisions and to support *epoché*.

A semi-structured, researcher-developed interview guide was used, beginning with the grand-tour question, "Can you describe to me your experience as a patient undergoing peritoneal dialysis?" Follow-up prompts explored participants' physical, emotional, social, spiritual, and economic experiences, including self-care, support, coping, and adjustment. The guide was reviewed by the research adviser for clarity, relevance, and alignment with the study objectives. This review was not considered formal instrument validation, and no formal pilot-testing record was available. The complete guide is provided.

Table 1.

Participant Characteristics and Context

Participant	Age	Sex	PD Duration	Employment or Education Context	Support Or Contextual Information Documented	PD Modality
P1	44	Male	6 months	Worked 6 days/week, 8 hours/day	Family and nurses identified as important supports.	CAPD
P2	42	Female	5 months	Described loss of work opportunities and breadwinner role	Family and friends were identified as supports; anxiety/depression were described.	CAPD
P3	18	Female	11 months	Not systematically reported	Sought help from parents; family assistance was described.	CAPD
P4	52	Male	7 months	Not systematically reported	Managed PD schedule and treatment routine independently.	CAPD
P5	38	Female	5 months	Described breadwinner role and financial strain	Family support was important in coping with burden.	CAPD
P6	52	Male	8 months	Not systematically reported	Family was identified as a central support; responses were brief and generally positive.	CAPD
P7	39	Female	18 months	No longer working; reduced ability to care for child	Husband was described as supportive; hope was linked to family.	CAPD
P8	20	Male	8 months	No longer in school	Siblings provided emotional support; participant described early emotional difficulty and social restriction.	CAPD

Note. Participant characteristics are presented using participant codes to protect confidentiality. Employment or education and support information are reported only where they were documented in the study records.

Interviews were conducted in the participants' preferred language (Surigaonon, Bisaya, Filipino, or English) and were audio-recorded with permission. Prompts were adapted using meaning-equivalent wording while maintaining the same underlying questions and domains across languages. Clarification was sought when necessary. Detailed records of interviewer–participant prior relationships, participants' knowledge of the interviewer, and non-participant presence were not systematically documented and are acknowledged as limitations. Any direct clinical-care relationship with individual participants was likewise not systematically documented. Reflexive practice, *bracketing*, and open-ended questioning were used to minimize the influence of the researcher's prior clinical assumptions.

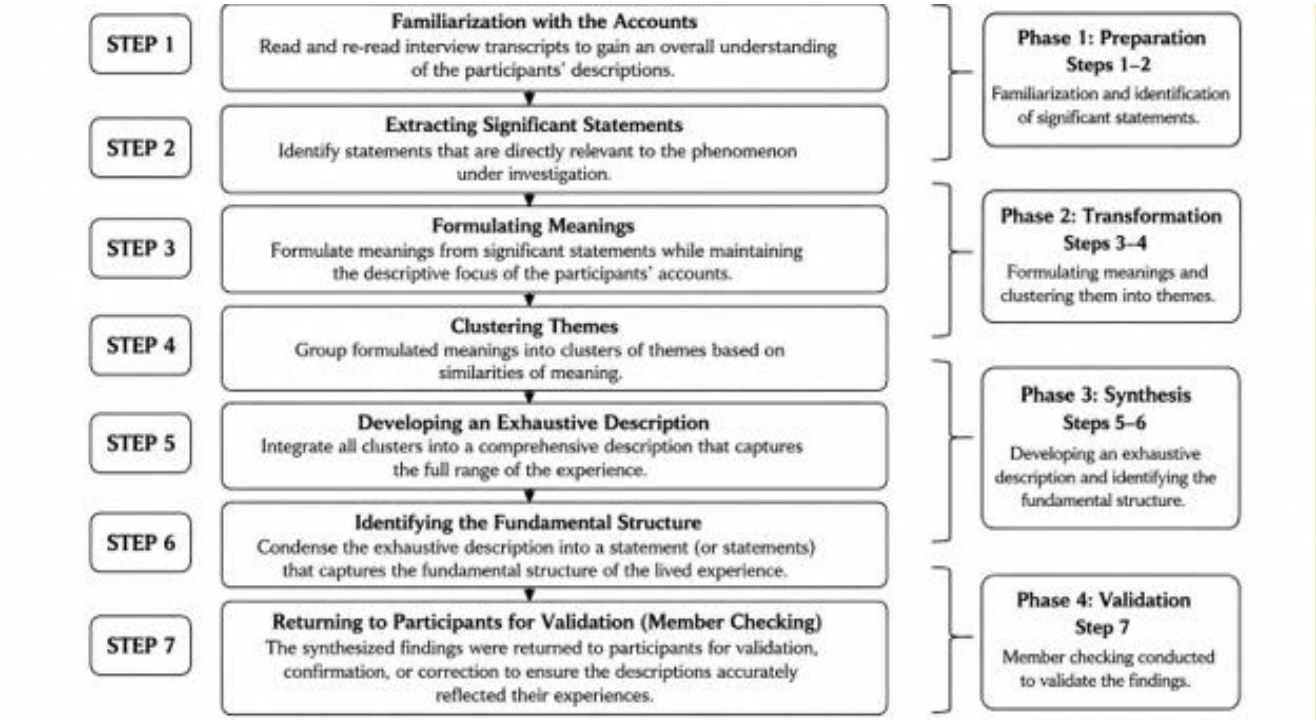
Data Collection and Analysis Procedure

After ethical approval and institutional permission were obtained, eligible patients were identified through the PD Unit and invited to participate. Participation was voluntary, and written informed consent was obtained before the interviews. Semi-structured interviews were conducted during monthly PD follow-up visits from November 2025 to January 2026. Each interview lasted approximately 10–30 minutes and was conducted in Surigaonon, Bisaya, Filipino, or English according to participant preference. Interviews were audio-recorded with permission, and field notes

documented relevant observations and nonverbal cues. The interviews began with the grand-tour question, "Can you tell me about your experience as a patient undergoing peritoneal dialysis?" Open follow-up prompts explored participants' physical, emotional, social, spiritual, and treatment-related experiences.

Figure 1.

Colaizzi's Seven-Step Phenomenological Analytic Sequence



Interviews conducted in Surigaonon, Bisaya, and Filipino were transcribed in the original language. Original-language accounts were retained during analysis and presented with literal English translations. Translations were checked against the audio recordings and source-language transcripts to preserve participants' intended meanings. No independent back-translation was documented.

Data were analyzed using Colaizzi's seven-step phenomenological method (Edward & Welch, 2011; Tavakol et al., 2026), involving the identification of significant statements, formulation of meanings, clustering of themes, development of an exhaustive description, and identification of the fundamental structure. Findings were returned to participants for *member checking* to validate and clarify the synthesized descriptions.

First, the researcher read and re-read the transcripts to become familiar with the participants' accounts. Significant statements directly related to the phenomenon were then extracted, and formulated meanings were developed from these statements. Related meanings were clustered into themes, followed by

development of an exhaustive description of the phenomenon and identification of its fundamental structure.

The final two interviews were reviewed against the established coding structure to assess thematic stability. No substantially new experiential dimensions requiring modification of the five emergent themes were identified. This review was considered a stability check and was not treated as evidence of data saturation.

The synthesized findings were returned to participants for validation and clarification through *member checking*. Participants were invited to identify inaccurate, incomplete, or unclear descriptions, and their feedback was considered when reviewing the final themes and overall description of the phenomenon. However, participant-level dates, modes of feedback, and detailed responses were not systematically documented. Therefore, *member checking* is reported as a validation and clarification procedure rather than as evidence of specific participant-level changes to the analysis.
As shown in Figure 1, the Colaizzi phenomenological analytic sequence progressed through familiarization with participants' accounts, extraction of significant statements, formulation of meanings, clustering of themes, development of the exhaustive description, identification of the fundamental structure, and participant validation through *member checking*.

Trustworthiness was supported through credibility, dependability, confirmability, and transferability strategies, including participant validation, reflexive *bracketing*, source-transcript verification, verbatim quotations, audit-trail documentation, and detailed contextual description.

Ethical Considerations

Ethical approval was granted by the Caraga Regional Hospital Ethics Committee (HREC Code: 2025–0018 [REV 1]) on November 7, 2025. Written informed consent was obtained from all participants before data collection and explained the study purpose, procedures, potential risks and benefits, confidentiality measures, voluntary participation, and the right to withdraw at any time without effect on their medical care. Recruitment was facilitated through the PD Unit, but participation was clearly separated from clinical care. Eligible patients were informed that participation was voluntary, that declining or withdrawing would not affect their treatment or relationship with healthcare providers, and that they could decline to answer any question or discontinue the interview without consequences. These measures were intended to minimize potential undue influence arising from the clinical setting.

No formal distress-response protocol was systematically documented; therefore, no additional procedures are reported beyond allowing participants to decline questions or withdraw from the interview if they experienced discomfort. Recordings were made only with participants' permission, pseudonyms were used in the transcripts and manuscript, and access to research data was restricted to the research team. Data were securely stored; however, a specific data-retention and destruction period was not systematically documented. Any use of artificial intelligence (AI) in preparing the manuscript was disclosed in accordance with applicable publication requirements.

RESULTS AND DISCUSSION

Five emergent themes were identified through Colaizzi's analysis. Table 2 presents the emergent themes and their cluster meanings, while Table 3 traces participant accounts to formulated meanings, cluster themes, and emergent themes. The discussion below presents the findings in narrative form, drawing on these cluster meanings and participant accounts, and then relates each theme to existing literature. This approach preserves the structure of the original analysis while making the relationship between participants' experiences, the descriptive findings, and previous research more explicit.

As shown in Table 2, the five themes describe interconnected changes in movement, daily routines, self-care, emotional adjustment, relationships, and the ability to plan for the future. Together, they portray living with PD as an ongoing process of adapting to treatment while managing limitations that remain present in everyday life.

Table 2.

Emergent Themes on the Lived Experience of Patients Undergoing Peritoneal Dialysis

Theme	Brief Description	Cluster Meanings
Living with restricted movements	Patients reorganized bodily movement, activity, diet, and daily pacing to protect the catheter and prevent complications.	Limited mobility; strict diet; activity restriction; treatment routine; reduced physical activity
Becoming independent with PD care	Training and repeated practice helped patients develop confidence and self-management competence.	Gradual skill acquisition; self-efficacy; functional independence; time management; empowerment through self-care
Holding onto hope and acceptance	Spirituality, gratitude, and acceptance provided sources of emotional resilience while living with ongoing treatment demands.	Faith; gratitude; positive outlook; acceptance of treatment
Surviving through the support of others	Family, nurses, friends, and faith communities served as stabilizing systems in the PD journey.	Healthcare support; emotional support; financial support; spiritual support; social support
Bearing the weight of treatment	Patients continued to experience financial strain, role loss, limited opportunities, and future uncertainty despite adaptation.	Economic burden; restricted opportunities; lifestyle disruption; functional dependence; uncertain future

Table 3.

Sample Analytical Matrix Linking Significant Statements, Formulated Meanings, Cluster Themes, and Emergent Themes

Participant	Significant Statements (Dialect)	English Translations	Formulated Meaning	Cluster Theme	Emergent Theme
P2	*"Dili na ako puwede maglihok-lihok og paspas kay mahadlok ako nga maigo o mabira ang catheter."*	"I can no longer move around quickly because I am afraid the catheter might be hit or pulled."	Movement was deliberately slowed or limited because of concern about pulling or striking the catheter.	Limited mobility	Living with Restricted Movements
P4	*"Sa una, mahadlok gyud ako mohimo sa dialysis nga ako ra. Pero sige ko og tudloi sa nurse hangtod nakat-on ako."*	"At first, I was really afraid to perform dialysis by myself. But the nurse kept teaching me until I learned."	Repeated nursing instruction reduced fear and supported learning to perform PD independently.	Gradual skill acquisition	Becoming Independent with PD Care
P6	*"Karon, kaya na nako mag-exchange bisan walay motabang, basta kompleto ang gamit ug limpyo ang lugar."*	"Now, I can perform the exchange even without anyone helping, as long as the supplies are complete and the area is clean."	Repeated practice enabled the participant to perform exchanges without assistance under appropriate conditions.	Self-efficacy / functional independence	Becoming Independent with PD Care
P5	*"Mag-ampo lang gyud ako nga hatagan pa ako og kusog kada adlaw. Ang Ginoo ra gyud akong gisaligan."*	"I simply pray that I will be given strength every day. The Lord is truly the one I trust."	Prayer and trust in God were used to sustain strength while living with PD.	Faith	Holding Onto Hope and Acceptance
P2	*"Kon mahuyang akong buot, akong pamilya ang magdasig nga dili ako mohunong ug magpadayon lang."*	"When I feel emotionally weak, my family encourages me not to stop and to just keep going."	Family encouragement helped the participant continue during emotional difficulty.	Emotional support	Surviving Through the Support of Others
P5	*"Bisan naa ang tabang sa PhilHealth, naa gihapoy gasto sa tambal, pagkaon, plete, ug uban pang kinahanglanon."*	"Even with PhilHealth assistance, there are still expenses for medicine, food, transportation, and other necessities."	Treatment-related expenses remained despite financial assistance, creating continuing economic burden.	Economic burden	Bearing the Weight of Treatment
P8	*"Lisod magplano para sa umaabot kay wala ako kabalo kon unsa pa kadugay akong lawas makaya."*	"It is difficult to plan for the future because I do not know how much longer my body can endure."	Uncertainty about physical endurance made future planning difficult.	Uncertain future	Bearing the Weight of Treatment

Note. English translations are literal translations of the original participant statements and were checked against the audio recordings and source-language transcripts. Statements originally expressed in English are retained as stated. Participant codes are used to protect confidentiality.

As shown, Table 3 demonstrates how participants' original statements were translated and linked to formulated meanings, clustered into related concepts, and developed into the five emergent themes. The statements show that participants experienced PD simultaneously as a source of restriction, a learned self-care responsibility, a context for hope and acceptance, a condition requiring interpersonal support, and an ongoing economic and future burden. The matrix also demonstrates that the themes were grounded in specific participant accounts rather than imposed as predetermined categories.

Theme One: Living with Restricted Movements

Living with PD required participants to make changes in how they moved, performed physical activities, managed their diet, and organized their daily routines. Concerns about the catheter and physical strain influenced how participants approached activities that were previously part of everyday life. These adjustments reflected an ongoing effort to maintain safety while continuing necessary activities. The experience of restriction therefore became part of participants' everyday management of PD.

> **Participants' voices**
> *"Dili na ko pwede molihok ug paspas o mo-alsa ug bug-at kay basin masamdan ang PD catheter." (P1)*
> Word-for-word English translation: "I can no longer move quickly or lift heavy things because I might injure the PD catheter."
>
> *"Discomfort lang sa bug-at sa tiyan, limited ako movement." (P2)*
> Word-for-word English translation: "There is discomfort because of the heaviness in my abdomen, and my movement is limited."
>
> *"Dili ka alsa ug bug-at, di kaayo makalaag." (P8)*
> Word-for-word English translation: "You cannot lift heavy things, and you cannot go out much."

Participants described deliberately slowing their movements, avoiding heavy lifting, and reducing physical activity because of concern about the catheter and physical strain. These restrictions extended beyond movement to dietary control and organizing daily activities around treatment routines. Participants therefore experienced PD as requiring continuous adjustment of ordinary activities to maintain safety and treatment adherence.

This finding is consistent with literature describing physical activity limitations, catheter-related concerns, and treatment-related physical difficulties among people receiving dialysis, including those receiving PD (Aga et al., 2023; Lightfoot et al., 2021; Tian et al., 2020). However, participants in the present study described restriction not only as a physical symptom but as a continuing reorganization of ordinary movement, diet, and daily routines.

Theme Two: Becoming Independent with PD Care

Participants described developing greater independence in PD care through training, repeated practice, and increasing confidence. Learning to perform exchanges required time and continued guidance before participants felt capable of assuming greater responsibility for their treatment. As their skills developed,

participants became more confident in managing PD within appropriate conditions. Independence was therefore experienced as a gradual process of learning and adjustment.

Participant voices

"Sa una, mahadlok gyud ako mohimo sa dialysis nga ako ra. Pero sige ko og tudloi sa nurse hangtod nakat-on ako." (P4)
Word-for-word English translation: "At first, I was really afraid to perform dialysis by myself. But the nurse kept teaching me until I learned."

"Karon, kaya na nako mag-exchange bisan walay motabang, basta kompleto ang gamit ug limpyo ang lugar." (P6)
Word-for-word English translation: "Now, I can perform the exchange even without assistance, as long as the materials are complete and the area is clean."

"Naka-adjust na ako lawas sa peritoneal dialysis." (P1)
Word-for-word English translation: "My body has already adjusted to peritoneal dialysis."

The finding is consistent with evidence that self-efficacy and structured training are important to self-management among people with CKD and PD (Curtin et al., 2008; Jaelani et al., 2023; Karadag, 2019). However, these studies do not by themselves demonstrate that training produces independence in the present setting. The participants' accounts instead suggest that independence was conditional rather than absolute, developing through repeated instruction, practice, confidence, and access to appropriate supplies and a suitable environment. Thus, the present study adds a relational understanding of PD independence: self-management was experienced not as complete self-sufficiency but as competence supported by continuing nursing guidance and environmental conditions.

Theme Three: Holding Onto Hope and Acceptance

Participants described hope and acceptance as important aspects of living with the continuing demands of PD. Prayer, trust in God, gratitude, and a positive outlook provided ways of sustaining strength while facing treatment difficulties. Participants could recognize the challenges of dialysis while also expressing appreciation for the opportunity to continue living. Hope and acceptance therefore formed part of their ongoing adjustment to life with PD.

Participant voices

"Mag-ampo lang gyud ako nga hatagan pa ako og kusog kada adlaw. Ang Ginoo ra gyud akong gisaligan." (P5)
Word-for-word English translation: "I simply pray that I will continue to be given strength every day. It is truly the Lord whom I trust."

"Lisod ang dialysis, pero nagpasalamat gihapon ako kay tungod niini, nadugangan pa ang akong kinabuhi." (P1)
Word-for-word English translation: "Dialysis is difficult, but I am still grateful because, through it, my life has been extended."

"Naguol ko pero nadawat ra kay naay family support." (P5)
Word-for-word English translation: "I feel sad, but I have accepted it because I have family support."

This finding is consistent with literature identifying spirituality and hope as coping resources among people living with chronic illness and renal failure (Ahmadi et al., 2024; Billington et al., 2008). However, the present accounts also complicate a purely positive interpretation of coping. Participants expressed gratitude and acceptance while simultaneously describing sadness and treatment difficulty. Rather than demonstrating that spirituality leads to better adjustment, the findings suggest that faith and acceptance provided personally meaningful ways of living alongside an ongoing treatment burden. This coexistence of acceptance and difficulty adds nuance to previous accounts of coping in chronic illness.

Theme Four: Surviving Through the Support of Others

Participants described support from family, healthcare providers, friends, and faith communities as an important part of their experience with PD. Support included emotional encouragement, practical assistance, financial help, healthcare guidance, and spiritual support. These relationships helped participants manage difficulties associated with treatment and sustain their daily care. The experience of PD was therefore situated within a broader network of interpersonal and professional support.

Participant voices

"Kon mahuyang akong buot, akong pamilya ang magdasig nga dili ako mohunong ug magpadayon lang." (P2)
Word-for-word English translation: "When I feel emotionally weak, my family encourages me not to give up and simply to continue."

"Dili gyud nako makaya ang tanang gasto kon wala ang tabang sa akong mga anak ug mga paryente." (P3)
Word-for-word English translation: "I really could not manage all the expenses without the help of my children and relatives."

"ako Bana , mga amigo, ug ang amo mga silingan." (P7)
Word-for-word English translation: "My husband, friends, and community."

Participants described family encouragement as a source of strength during emotional difficulty. Assistance from children and relatives also helped with treatment expenses, while nurses provided instruction, reassurance, and practical guidance. Support was therefore both emotional and practical, forming part of the conditions that helped participants continue living with PD. Support was not experienced as a single source of assistance but as a network addressing different aspects of treatment. Family members provided emotional and financial assistance, while nurses contributed instruction, reassurance, and practical guidance. Thus, independence in PD did not represent complete self-sufficiency; rather, it was supported by continuing interpersonal and professional relationships.

This pattern is consistent with literature emphasizing social support and caregiver relationships in chronic kidney disease and dialysis, including the importance of family and home-care contexts (Fissell et al., 2023; Fuertes et al., 2021; Sitjar-Suñer et al., 2020; Torres et al., 2021). However, participants in the present study

described support not merely as an emotional coping resource but also as practical infrastructure for treatment continuation, including financial assistance, treatment guidance, and everyday encouragement.

Theme Five: Bearing the Weight of Treatment

Despite developing ways to manage PD, participants continued to experience burdens associated with treatment. These included financial expenses, changes in previous roles and opportunities, functional limitations, and uncertainty about the future. The continuing nature of these difficulties showed that adaptation did not remove all the challenges of living with PD. Participants therefore experienced treatment as both something they learned to manage and a continuing weight carried in everyday life.

Participant voices

"Bisan naa ang tabang sa PhilHealth, naa gihapoy gasto sa tambal, pagkaon, plete, ug uban pang kinahanglanon." (P5)
Word-for-word English translation: "Even with assistance from PhilHealth, there are still expenses for medicine, food, transportation, and other necessities."

"Lisod magplano para sa umaabot kay wala ako kabalo kon unsa pa kadugay akong lawas makaya." (P8)
Word-for-word English translation: "It is difficult to plan for the future because I do not know how long my body will continue to endure."

"Mabalaka ko sa akong kaugmaon ug sa gasto sa akong tambal." (P3)
Word-for-word English translation: "I worry about my future and the expenses of my treatment."

The findings are consistent with literature describing financial hardship, treatment burden, and burnout among patients and caregivers receiving dialysis (Ng et al., 2021; Oveyssi et al., 2021), as well as documented financing and policy considerations surrounding renal replacement care in the Philippine context (Bayani et al., 2021). However, the present study does not treat treatment burden as an isolated outcome. Instead, participants described burden as coexisting with increasing self-care competence, social support, acceptance, and uncertainty.

Variation across participants was also evident. P6 described PD as manageable, whereas P2 reported anxiety, depression, work loss, and breadwinner strain. P7 expressed gratitude while also describing employment and caregiving loss, and P8 described disrupted schooling, restricted mobility, social limitation, and crying. These contrasting accounts indicate that the experience of PD was not uniform. Adaptation could coexist with distress, role loss, and uncertainty, while gratitude and acceptance could coexist with continuing burden. Individual circumstances therefore shaped how restriction, competence, support, and treatment burden were experienced.

Taken together, the five themes show that living with PD was not a simple progression from dependence to independence, nor did adaptation eliminate suffering. Participants developed competence in treatment management while continuing to experience restrictions, financial strain, role disruption, and uncertainty. Hope and acceptance provided meaning, while family and healthcare support helped sustain care. These

findings are broadly consistent with literature describing PD as a multidimensional experience involving self-management, psychosocial coping, social support, and treatment burden (Bennett et al., 2022; Fuertes et al., 2021; Jacquet & Trinh, 2019; Ng et al., 2021). However, the present study adds a context-specific phenomenological perspective by showing how these dimensions were experienced simultaneously rather than as separate stages of adaptation. Within this single-site Caraga setting, adaptation was experienced as an ongoing process of living with both capability and limitation. The findings provide contextual depth rather than a basis for broader population claims.

Across the five themes, participants described peritoneal dialysis as an ongoing experience of reorganizing everyday life around treatment. Physical restrictions, dietary changes, and concerns about catheter safety altered ordinary activities, while repeated instruction and practice supported increasing competence in PD self-care. At the same time, participants described hope, acceptance, family and healthcare support, financial assistance, and continuing concerns related to work, family roles, mobility, and uncertainty about the future. These experiences were not mutually exclusive; participants could experience greater competence while continuing to carry physical, emotional, social, and economic burdens.

The participants' accounts suggest a lived experience characterized by learning to live within the continuing demands and limitations of PD while drawing on personal, relational, and spiritual resources. Adaptation was therefore experienced not as the disappearance of burden but as an ongoing process of negotiating capability and limitation within everyday life.

Strengths and Limitations

The study's strengths include its Husserlian descriptive approach, use of *epoché* and Colaizzi's systematic analysis, participant quotations in the original language with literal English translations, and a traceable participant-to-theme analytic process. The regional referral-hospital setting also provides context-specific insight into living with PD. Limitations include the purposive single-site sample of eight participants, brief 10–30-minute interviews, possible loss of nuance during multilingual translation, and limited documentation of researcher positionality. The brief interviews may have restricted opportunities for deeper exploration of some experiences, while single-site sampling limits transferability to settings with different patient populations or service contexts. Findings should therefore be considered context-specific rather than universally generalizable.

CONCLUSION

Living with PD was described by participants as an embodied and relational experience involving physical restriction, developing self-care competence, emotional and spiritual adjustment, support from others, and continuing financial and lifestyle burdens. Across the five themes, treatment routines, catheter care, dietary and activity changes, training, faith, family support, and acceptance shaped participants' daily experiences. Taken together, these accounts support the study's context-specific descriptive synthesis of "treatment-bound adaptation," referring to how participants learned to live with the capabilities, limitations, and ongoing demands of PD.

IMPLICATIONS AND RECOMMENDATIONS

Nursing Practice. Nurses caring for patients receiving PD should incorporate routine assessment of physical, psychosocial, spiritual, and financial concerns into continuing PD follow-up. Individualized education and refresher training should reinforce safe self-management, catheter care, treatment routines, and confidence in performing exchanges. Family involvement may also be incorporated when patients require practical, emotional, or financial support. These recommendations are consistent with literature emphasizing patient perspectives, self-management, and social support in PD and CKD care (Fissell et al., 2023; Fuertes et al., 2021; Jaelani et al., 2023).

Nursing Policy. PD programs should consider context-specific mechanisms that address treatment-related transportation costs, medication and supply expenses, and disruptions to employment or household roles. Institutional policies may also strengthen coordination between PD services, social-support mechanisms, financial assistance, and referral systems. These recommendations arise from participant-described burdens and should be regarded as service considerations rather than tested policy interventions (Ng et al., 2021; Bayani et al., 2021).

Nursing Theory. The findings suggest that adaptation to PD may be understood as a multidimensional and relational process in which self-care competence, physical restriction, support, hope, and continuing treatment burden coexist. The study's concept of "treatment-bound adaptation" should therefore remain a context-specific descriptive synthesis rather than a definitive phenomenological essence or a formally established theory. Future studies may examine whether this descriptive synthesis is applicable in other PD populations and settings.

Nursing Education. PD education should extend beyond initial competency training and include refresher instruction, family-inclusive demonstrations, infection-prevention reinforcement, problem-solving, and assessment of patients' confidence in performing treatment-related tasks. Repeated training and self-management support may be particularly relevant because participants described independence as developing progressively through instruction and practice (Curtin et al., 2008; Jaelani et al., 2023; Karadag, 2019).

Future Research Directions. Future studies should examine PD experiences across multiple Philippine settings using larger qualitative samples, longitudinal designs, or mixed-methods approaches. Further research may explore psychological distress, financial burden, family involvement, social participation, quality of life, and longer-term adaptation. Comparative studies across urban and regional or geographically dispersed settings may also help determine which findings are context-specific and which may recur across populations.

List of Abbreviations

CAPD – Continuous Ambulatory Peritoneal Dialysis
CKD – Chronic Kidney Disease
ESRD – End-Stage Renal Disease
HREC – Hospital Research Ethics Committee
PD – Peritoneal Dialysis
PhilHealth – Philippine Health Insurance Corporation

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Declarations

Ethics Approval and Consent to Participate

Prior to data collection, ethical approval was granted by the Caraga Regional Hospital Ethics Committee (HREC Code: 2025–0018 [REV 1]) approval date: November 7, 2025. Participants provided voluntary, informed written consent; anonymity was protected through participant codes and secure data handling; and participants retained the right to withdraw at any time without penalty or effect on medical treatment.

Consent for Publication

The author confirms that the manuscript contains anonymized findings and does not disclose identifying information of participants. Consent for use of anonymized interview data for academic reporting was obtained.

Availability of Data and Materials

The full qualitative dataset is not publicly available because of participant confidentiality and ethical restrictions. De-identified excerpts may be made available from the author upon reasonable request and subject to institutional and ethical approval. Data access was restricted to authorized research personnel, and handling of personal information followed institutional safeguards and the principles of Republic Act No. 10173, the Data Privacy Act of 2012.

Competing Interests

The author declares no competing interests.

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Authors' Contributions

Ray-An Diowell Bacolod Conejos conceptualized the study, conducted the research process, analyzed the data, and prepared the manuscript.

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Use of Artificial Intelligence

Artificial intelligence tools were used for language refinement, organization, formatting, and manuscript preparation support. The author reviewed, verified, and approved the final content and remains responsible for the accuracy, integrity, and originality of the manuscript.

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