

Relationship Between Adherence to Speech Therapy in Patients With Dysphonia and Quality of Life

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Summary: Objective. The present study analyzed if aspects of voice-related quality of life (VRQOL) were associated with adherence to voice therapy in teachers.

Study Design. Retrospective survey in which the medical records of 179 dysphonic teachers (62, abandonment group and 114, discharge group) who underwent speech therapy at the Speech Therapy Clinic at the Hospital das Clínicas of the Universidade Federal de Minas Gerais (AV-HCUFGM) were analyzed.

Methods. Female teachers with dysphonia referred by Gerência de Saúde e Perícia Médica (Department of Health and Medical Analysis) of Belo Horizonte City Hall were included. The variables of interest were: age, number of voice therapy sessions attended (attendance), number of sessions missed (absence), type of dysphonia, and Vocal Activity and Protocol Profile (VAPP) scores administered during the first therapy session as a component of voice assessment. The chi-square test was used to assess categorical variables. For continuous variables, the Mann-Whitney test, a nonparametric test for independent samples, was used.

Results. The groups differed with regard to the type of dysphonia as well as the several parameters of the VAPP: vocal self-perception, effects at work, effects on daily communication, effects on emotion, and the total VAPP score.

Conclusions. Individuals with less favorable VRQOL scores were less adherent to voice therapy compared with subjects with more favorable VRQOL.

Key Words: Voice–Quality of life–Dysphonia–Speech therapy.

INTRODUCTION

Over the last several decades, the concept of health has changed greatly and has incorporated patient perceptions of both the disease and its impact on their lives. The World Health Organization (WHO) extended the concept of health to formally include quality of life in its definition.¹ According to the WHO,¹ “the concept of quality of life is very broad, and it is affected in a complex way by the individual’s physical health, psychological state, level of independence, social relations, cultural context in which he or she is inserted, and the value systems in which the person lives.” The effects of a vocal change on quality of life have been extensively studied recently.^{2–5} The impact of aberrant vocal function on quality of life has been correlated to various factors including the necessity for occupational voice use, yet not related to the severity of dysphonia.²

Insight regarding the patient opinion of their health issues should be evaluated during the diagnostic and therapeutic processes by health professionals. Self-assessment is essential, particularly regarding dysphonia, as this perception and the overall impact of dysphonia may alter both motivation and treatment adherence.⁶ The literature suggests that decreased motivation and poor adherence to treatment are often related to patient misconceptions about treatment and concerns regarding potential adverse effects.^{7,8}

Adherence to therapy has been widely discussed and studied by health professionals because the success of behavioral treatment is related to patient adherence. Often, in the voice therapy, treatment adherence plays a more critical role in the rehabilitation process than the actual therapeutic approach used.^{9,10}

Adherence is defined as an active collaboration between patient and health professional, developed through cooperative work to achieve therapeutic success and the completion of the treatment.¹¹ Adherence is related to personal behaviors, such as taking medication, following a diet, and/or change of lifestyle and corresponds with recommendations from a health professional. Adherence is a multifactorial phenomenon, determined by the cumulative effect of five factors: (1) social and economic factors, (2) health teams and factors related to the health system, (3) factors related to disease, (4) factors related to the therapy, and (5) patient-related factors.¹²

Quality of life and treatment adherence are important aspects of the therapeutic process. Previous studies have attempted to quantify the relationship between the outcomes of various treatments and their subsequent impact on quality of life; therapeutic success is associated with improved quality of life.^{13–16}

However, relatively little is known regarding the relationship regarding quality of life and adherence to treatment. Self-perception of illness by the patient and the relationship with the adherence has been previously described with the ultimate goal of increased insight regarding patient perception of disease and how this subjective point of view may alter adherence.^{17,18} According to Mannheim,¹⁹ quality of life may influence treatment adherence because patients with higher quality of life tend to exhibit increased adherence to the therapy.

Previous research suggests that teachers have increased risk for voice disorders compared with the general population.^{6,20} This occupational label is more likely to present with multiple vocal signals/symptoms, such as hoarseness, fatigue,

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discomfort and vocal effort, and alterations in overall voice quality among others.²⁰

Given the opportunity to assess the relationship between voice-related quality of life (VRQOL) and adherence to voice therapy, the present study aims to determine if the aspects of VRQOL are related to the process of adherence to therapy in teachers with voice disorders.

METHODS

A retrospective, observational, and analytical survey, in which the medical records of 249 dysphonic teachers of Rede Municipal de Ensino (Municipal Schools) from Belo Horizonte who underwent speech therapy at the Speech Therapy Clinic of the Hospital das Clínicas of the Universidade Federal de Minas Gerais (AV-HCUFG) was performed. The total number of analyzed reports was determined by the number of patients attended in AV-HCUFG from August 2007 to December 2009.

Inclusion criteria included female teachers with dysphonia referred by Gerência de Saúde e Perícia Médica (Department of Health and Medical Analysis) of Belo Horizonte City Hall with complete clinical documentation including speech therapy and ear, nose, and throat (ENT) assessments. Exclusion criteria were: attendance only at the clinical assessment or to the vocal health workshops. Male teachers were excluded because of the relatively small number of men in teaching.

Adherence to treatment was obtained through the review of medical records and was categorized in either “discharge” or “abandonment” groups. Criteria from the AV-HCUFG was used to classify speech therapy discharge and included no complaints of vocal fatigue and vocal quality adapted to the anatomical and functional conditions of the larynx evaluated via auditory-perceptive analyses and ENT examination. Criteria for abandonment of treatment were three consecutive unexcused absences or patient-mediated discontinuation of treatment.

Other variables, also collected from medical reports, were age, number of sessions attended (attendance), number of sessions missed (absence), type of dysphonia, and values obtained on the Vocal Activity and Protocol Profile (VAPP) administered during the first session as a component of a voice assessment.

Translated and validated for Brazilian Portuguese,²¹ the VAPP is a self-assessment voice questionnaire consisting of 28 questions divided into five categories: self-perception of voice quality alteration, the effects of this alteration on work, on daily and social communication, and on emotional well-being. For each item, responses are represented on a 10 cm visual analog scale. The left of the line represents not affected

and conversely the right represents significant affect of voice. Each section of the questionnaire yields a section score; five section scores were obtained.

1. Self-perceived voice problem score (one question, maximum score = 10, score in individuals with normal voice = 0,1²¹)
2. Job section score (four questions, maximum score = 40, score in individuals with normal voice = 0,2²¹)
3. Daily communication section score (12 questions, maximum score = 120, score in individuals with normal voice = 0,9²¹)
4. Social communication section score (four questions, maximum score = 40, score in individuals with normal voice = 0,2²¹)
5. Emotion section score (seven questions, maximum score = 70, score in individuals with normal voice = 0,4²¹)

The sum of the five section scores gave rise to the total score (maximum score = 280, score in individuals with normal voice = 1,8²¹).

Statistical analyses were performed using *Statistical Package for Social Sciences (SPSS, version 17.0)* (IBM, Chicago, IL). First, descriptive analysis of the data with measures of central and dispersal tendency was performed. Subsequently, the chi-square test was performed for categorical variables. For continuous variables, nonparametric tests for independent samples were used, specifically, the Mann-Whitney test. Significance was set at $P < 0.05$.

Data collection was performed at the Voice Clinic of the Speech Therapy Service of HC/UFG; the present study was approved by the Research Ethics Committee of UFG, Protocol ETIC 482/08.

RESULTS

Of 249 total medical records identified, 176 (70.68%) met inclusion criteria; 62 (35.2%) were assigned to the abandonment group and 114 (64.8) qualified for the discharge group. Excluded cases included 14 (5.62%) male teachers; 11 (4.41%) insufficient medical records, 7 (2.81%) in the abandonment group and 4 (1.60%) in the discharge group; 24 (9.63%) teachers who participated only in vocal health workshops and no speech therapy; and 24 (9.63%) teachers who underwent only the assessment and not the subsequent sessions. A total of 73 (29.31%) records were excluded from the study.

TABLE 1.
Distribution According to Types of Dysphonia for Both Groups

	Situation		Total, N (%)	Chi-Square Test	P
	Abandonment, n (%)	Discharge, n (%)			
Types of dysphonia					
Functional	14 (21.2)	52 (78.8)	66 (100)	10.779	0.003
Organic	48 (43.6)	62 (56.4)	110 (100)		
Total	62 (64.8)	114 (35.2)	176 (100)		

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