



## Effect of motivational interviewing on quality of life in patients with epilepsy



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### ABSTRACT

**Objective:** In this study, the effect of motivational interviewing on quality of life was evaluated in patients with epilepsy.

**Methods:** Fifty-six patients with epilepsy in a clinical trial were randomly assigned to intervention and control groups. Motivational interviewing during 5 sessions was applied for the intervention group, and the control group received health-care services. Quality-of-life questionnaire in epilepsy (QOLIE-89) was applied as pre- and posttest for both groups. Before and two months after intervention, both groups were assessed. Data were analyzed by independent t-test, Chi-square test, and paired t-test.

**Results:** The data analysis showed that mean score of the QOLIE-89 was  $38.94 \pm 8.55$  and  $70.90 \pm 7.99$  in the intervention group before and after the intervention, respectively, and  $44.59 \pm 12.27$  and  $36.52 \pm 7.16$  in the control group sequentially. The intervention group showed a significant score increase in their quality of life ( $p < 0.001$ ), whereas the control group had a score decrease ( $p < 0.001$ ).

**Conclusion:** Motivational interviewing approach could be used as an effective intervention method for improving patients' quality of life.

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### 1. Introduction

Because of unpredictable seizures, patients with epilepsy experience economic, social, physical, and psychological consequences in all life dimensions [1,2]. Global prevalence of epilepsy has been estimated from 0.5% to 0.9% [3]. An Iranian study showed an estimated 1.8% epilepsy prevalence in the rural and urban areas of Iran. Some studies from Iran, Africa [4], the United States [5], and the United Kingdom [6] have shown that patients with epilepsy experience social stigma and are labeled as psychotic, insane, and demonic. Numerous worldwide studies have reported misunderstanding and negative attitudes in the general public [4]. People with epilepsy are doubly vulnerable to the pervasive stigma in most societies. The studies in Ethiopia, Iran, Vietnam, Zambia, China, and USA, as well as several European and Middle Eastern countries, have found that stigma related to epilepsy is a major concern in the world [5]. The research in Europe showed that fifty-one percent reported feeling stigmatized, with 18% reporting feeling highly stigmatized [6], and in another study, 17% reported feeling highly stigmatized [4]. But felt stigma is greater in developing countries than in developed countries. The study of Forsgren reported that felt stigma in Iran is

greater than in Sweden [7]. Moreover, negative public attitude toward epilepsy has led to unemployment, demotion, disruption in family life, and social discrimination [8]. Therefore, patients with epilepsy often experience low quality of life because they feel insecure and live in the fear of having a seizure in public [9]. Psychosocial factors and mental health issues associated with epilepsy include feeling hopeless due to prolonged or ineffective treatment, slow improvement, and continued sense of embarrassment [10,11].

Quality of life is a multifactorial entity, defined by patients, since they objectively and subjectively evaluate their disease and treatment outcomes based on their daily functions and social relationships [12]. Epilepsy is not only a clinical diagnosis, but also a social stigma [13]. These patients are susceptible to social isolation and low self-esteem [14]. The study of Baker et al. in some of the Middle Eastern countries showed quality-of-life scores of patients with epilepsy at 46% in Qatar, 43% in Kuwait, 43% in Jordan, 42% in Bahrain, 41% in Lebanon, 38% in Iran, and 25% in Syria using the SF-36 questionnaire [15].

Studies have demonstrated that long-term adherence to multidrug medical treatment can be difficult, especially when multiple drugs at various doses produce side effects [16]. Antiseizure medicine nonadherence leads to a decrease in seizure control which may result in injury and an increase in office visits, trips to the emergency room, and need for hospitalization [17]. However, patients with better

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adherence to medical management are more likely to experience satisfactory outcomes. Adherence to treatment helps to decrease the feeling of being stigmatized and ultimately helps to improve the quality of life in patients with epilepsy [17]. The positive effects of lifestyle modification represent an important aspect of disease management for patients with epilepsy [18]. Interventional studies aiming to enhance the quality of life for patients with epilepsy have used cognitive behavioral group therapy [12], education based on Precede–Proceed model [19], and muscle relaxation [20]. Also, patient education programs which help improve adherence to treatment [21] are designed to support, protect, and enhance competencies for self-care and self-efficacy [22]. Others have used motivational interviewing to modify behavior and improve patients' quality of life [23].

Motivational interviewing is a current and effective method for motivating patients to engage in a behavior modification process [24]. Studies on effective motivational interviewing for marital discourse [25], adherence to asthma treatment [26], and fear of a hypoglycemic crisis among diabetic patients [27] have demonstrated significant improvement in patients' quality of life. Motivational interviewing is an intervention approach not only to promote patients' quality of life, but also to reduce psychological, social, and even physical effects of the disease to a greater extent.

We were unable to find published studies of motivational interviewing on the quality of life of patients with epilepsy. Therefore, considering the low quality of life in patients with epilepsy, the present study aimed to determine the effect of motivational interviewing on quality of life in patients with epilepsy.

## 2. Material and methods

### 2.1. Design and sample

The present randomized clinical trial study using convenience sampling was conducted on patients diagnosed with epilepsy from Nour and Kashani Hospitals in Isfahan, Iran. Eligible subjects were those who had been referred to the epilepsy clinic, met the inclusion and exclusion criteria, and provided informed consent. The inclusion criteria were age of 18 years and above, willingness to participate, epilepsy diagnosis for at least 1 year, patients with primary generalized tonic-clonic epilepsy and uncontrolled seizures that were diagnosed by a neurologist, no other chronic illness, and not being enrolled in any other research. The exclusion criteria included being an immigrant, missing more than one intervention session, and having recent tragic life events (influencing the quality of life such as loss of life, divorce, etc.). The convenience samples were randomly and equally assigned to an intervention (28 patients) group or a control (28 patients) group by simple random assignment. Using the list of names and drawing lots, the first person was placed in the experimental group, and the second in the control group. This process was continued to the end.

### 2.2. Data collection

A demographic survey questionnaire and the Quality of Life in Epilepsy-89 (QOLIE-89) were used to collect data. The QOLIE-89 is a self-report questionnaire with 89 specific items about personal life experiences. This instrument consists of 17 multidimensional subscale items, which covers subjects related to health such as emotional well-being, overall quality of life, role limitations due to emotional problems, social support, health perception, energy/fatigue, seizure worry, medication effects, health discouragement, work/driving/social function, attention/concentration, language, memory, physical function, pain, role limitation due to physical problems, and social isolation. The participants also responded to an item asking about changes in health over the preceding year, and two items were added after field testing to ask about the overall health and satisfaction with sexual relations [28].

Validity and reliability of this questionnaire were previously confirmed in Iran by Ebrahimi et al. in a study of 75 patients with epilepsy. Instrument reliability for internal consistency (Cronbach's alpha) ranged between 0.78 and 0.92. The overall score had internal consistency reliability of 0.97 and test–retest reliability of 0.88. To calculate the scores, numerical values were assigned and coded for each question and converted to a score from 0 to 100. High scores indicate a better quality of life. Total score for QOLIE-89 was obtained with weighted mean of scale scores [29]. The demographic questionnaire identified each participant's age, gender, education, job, marital status, and disease duration. Data were gathered and coded by a nursing student not part of the researchers' team. Data were gathered and coded by a nursing student who was blind to allocation of patients to study groups. Therefore, researchers who analyzed the data were also blind to study group assignment.

### 2.3. Procedure

A detailed research protocol was described to all the participants, and they were informed about being randomly assigned to the intervention or control groups. An informed written consent was obtained from all the participants, and they were assured that the information would be kept confidential and they could be excluded from the study at any time. Before group assignment, general information for all the patients in each group was recorded, and all the patients filled out QOLIE-89 questionnaires.

After they were presented with a detailed description of the research protocol, patients randomized to motivational interviewing participated in 5 sessions each separated by 4 days. Sessions took place in the epilepsy clinic [30]. The researcher who conducted the motivational interview had a nursing background and was experienced in motivational interviewing. The nurse, who delivered the intervention, had previously completed a course and workshop for “Intensive Training in Motivational Interviewing (MI)”. The control group received standard health-care services. A clinical psychologist observed and evaluated motivational interviewing sessions to comment on improvement, if needed.

The structure of the motivational interviewing sessions was extracted from the book “Motivational Interviewing Group Intervention” for each session [31]. Motivational interview is a referral-oriented method, a strategy for fortification and enhancement of internal motivation for changing through exploration, identification, and overcoming doubts and dualism. This method helps explore and solve the duality and doubt of individuals. The conceptual model of motivational interview is based on concepts of stages of change by Prochaska and DiClemente, hygienic beliefs, Roger's maintenance theory, Janis and Mann's parallelism of decision-making, Brehm's balancing theory, Bem's self-perception theory, and Rokeach's value theory. The basis of this method is the participation of the clients (patients), motivating their desires, and respecting their independence. Four fundamental processes in motivational interviewing are Engaging (the relational foundation), Focusing (guiding client to a target behavior that is important to them), Evoking: (drawing out client's intrinsic motivation (reasons/importance for change) and their own ideas for change), and Planning (the bridge to change). This method was based on the effective fundamental and technical principles supported in the literature by different techniques such as open-ended questions, reflective listening, and verification, as well as summarizing and concluding through multiple change-oriented sessions in order to modify health behaviors among the participants [30,31].

Some aspects of the group intervention such as being hopeful for overcoming the issue, decreasing social isolation, helping others in solving their problems, and learning that others may have to grapple with the same issue just like them can lead to a change in behavior. Working or practicing with a peer group and receiving feedback make this experience different than individual therapy and help change behavior. Both

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