

The Effectiveness of Self-care Program on the Life Quality of Patients with Multiple Sclerosis in 2015

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Abstract: This study aimed to investigate the effectiveness of self-care plan on the life quality of patients with Multiple sclerosis (MS). The samples in this study included all the patients with MS under medical coverage of Iranian Association of supporting patients with MS in Tehran in 2015 who were studied as Convenience sampling and based on the inclusion and exclusion criteria. In this study, Dr. Madani's self-care program as an intervention and The World Health Organization Quality of Life (WHOQOL)-BREF for assessment of consequences were used. Spss software using Wilcoxon and ANOVA tests were used to analyze the data. Values are significant at P value less than 0.05. Before the intervention, the quality of life was 59.91 ± 13.39 and after the intervention, it was 69.37 ± 11.73 and there was a significant difference between them (P value < 0.001). Also, there was a significant difference between the items of life quality-including the physical, psychological and social relationships and living environment items-before and after the interventions. Self-care program has an effect on the quality of life and physical, psychological and social relationships and living environment items.

Keywords: Self-care program ■ Quality of life ■ Multiple sclerosis

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INTRODUCTION

Multiple sclerosis (MS) is a chronic, progressive and common disease of Demyelination in central nervous system in young adults. It's broken out at young ages and comes along with decreasing in individual and social function.^{1,2} Almost 500,000 people in America have MS and every year, 8000 new cases are recognized. This disease occurs at the ages of 20–40 and is the third reason of inability in America.³

In Iran, according to the Association of MS, there are almost 50,000 patients with MS and it's broken out in Isfahan more than other cities (about 15–20 patients per 100,000).⁴ The patients with MS face with problems relating to their disease and these problems restrict the presence of patients in health promotion activities and increase the side effects and limitations in independent life and finally have negative effects on their quality of life.⁵ In 1993, World Health Organization (WHO) defined quality of life as “The quality of life includes imaginations of

people from their position in life regarding the cultural contents and value of system they live relating to aims, standards and their concerns”.⁶

The quality of life included four areas: physical health, psychological, social relationship, living environment and condition areas. Training patients the proper program and treatment method and the items they must consider, can cause the physical function, public health, emotional-mental and social condition to improve (WHOQOL-BREF). As chronic diseases, like Multiple sclerosis, effect on all of the economic, financial, social and emotional dimensions of the individual, family and society, so pharmaceutical treatment and controlling periods of diseases in these patients are only not enough.⁷ Lack of knowledge in patients with chronic disease about the self-care method is one of the reasons of their re-hospitalization in hospitals.⁸ So, the aim of training patients is helping them to get more responsibility for their self-care and to adapt them for changes in their physical and functional conditions which finally leads to improvement in their life quality.⁹

The self-care programs, means conscious, acquired and targeted actions and activities which the individual uses them for survival and health promotion of his family or him. Self-care is a part of daily life and includes the cares applied for children, family, friends, neighbors and local associations. In fact, self-care includes the activities which people do in order to be healthy, preserve their physical health, provide for their social and mental needs, prevent from diseases or events, modify the illness and chronic states and sustain their health following severe illness or discharging from hospital.¹⁰ A rising trend to increase MS patients makes consideration of treatment issues and problems in patients necessary.⁵ With regard to the fact that the necessity of recognizing and adopting measurements to control disabling problems of these patients and promote their quality of life by treatment team is felt and pharmaceutical treatments do not effect on physical dimensions of quality life in these patients,¹¹ inciting the self-care power in these patients and planning based on this potential power is important. There are a few studies about self-care in these patients and just the quality and

quantity of self-care behaviors were investigated, while self-care power in these patients was not so considered.¹²

In this study, the researcher sought to determine the effectiveness of self-care programs on quality of life in four areas of quality of life (such as physical health, psychological area, social relationships, living environment and status) in patients with MS.

METHODS

Statistical population and sample volume

The statistical population of the present study included all of the patients with MS under medical coverage of “Association of supporting MS patients” that were 11,000 patients in Tehran in 2015. All patients were informed about the study and signed a written constant. The ethical issue was considered according to the ethical principles of Helsinki. In the present study, the volume of samples was obtained using the formula of comparing two means (Mohammad 2013) for 4 social, psychological, physical and living environment areas. The required parameters for calculating the volume of samples from a primary descriptive study on 10 patients, were obtained (SD were 10.35, 7.40, 6.94 and 11.24, respectively). Thus, with regard to this formula, with type 1 error of 5% and statistical power of 80%, and difference with 10 units, the lowest sample volume was offered to be 21 subjects and with regard to the probable decline of samples being tested, 28 subjects were considered.

Sampling method

The samples of this study who were 11,000 subjects were selected via Convenience sampling method from “Iranian Association of supporting MS patients” in Tehran. After coordinating with this Association, the researcher referred to this place and after reviewing the file of available patients, he selected the qualified patients.

The inclusion criteria included: having at least guidance school degree, not having severe physical illness and patients who are not under other self-care training plans.

The exclusion criteria: having other diseases history such as mental disorders including fundamental depression (with regard to the patient’s file and physician’s comments), addiction to drug, other neurological disorders, having the history of Corticosteroid abuse or relapse of illness during 8 weeks, not taking part in meetings.

The World Health Organization Quality of Life (WHOQOL)-BREF

In this study, The World Health Organization Quality of Life (WHOQOL)-BREF was used in order to assess the individual’s quality of life.

This short form includes 26 items taken from a 100-version questionnaire. This questionnaire measures 4 wide areas such as: physical health, psychological health, social relationships and the environment. Besides, the items of this questionnaire can assess the public health. The items of the questionnaire were assessed based on a 5-choice scale. Higher score suggested better quality of life. In an investigation of items of WHOQOL-BREF, it was shown that score 4 is very similar. This similarity has been reported to be 95%.¹³ In reported results by scale creators of WHOQOL-BREF performed in 15 international centers, Cronbach’s alpha coefficient was reported to be 0.73 to 0.89 for fourfold subscales and the whole scale, and in Iran, Nasiri¹⁴ used three methods of retest with a three week interval, split half and Cronbach’s alpha methods which were 0.67, 0.87 and 0.84, respectively, to assess the reliability of scale. Also, the reliability of quality of life scale was evaluated by Rahimi¹⁵ and Cronbach’s alpha coefficient for whole scale was reported to be 0.88, for physical health 0.70, for mental health 0.77, for social relationship 0.65 and for quality of living environment 0.77. In order to determine the validity of scale, Nasiri¹⁴ used concurrent validity method and evaluated the relationship between the total score of test and its subscales and the total score and subscales of public health questionnaire by correlation coefficient. In present study, in order to determine the validity, the correlation of total score of each dimension with each questions consisting that dimension was applied. The range of correlation coefficient was from 0.45 to 0.83 and all of the coefficients were significant ($P = 0.01$). Every item had the highest correlation with its related dimension. In a study by Yusefi and Safari,¹⁶ in order to determine the validity, the correlation of total score of each dimension with each questions consisting that dimension was used. The range of correlation coefficient was from 0.45 to 0.83 and all of the coefficients were significant ($P = 0.01$). Every item, based on the aims relating to MS, had the highest correlation with its related dimension. In this clinical trial, the patients with MS were selected by convenience sampling. First, before training the self-care program, the form of required information (personal information and side effects of disease) and a 26-item (WHOQOL)-BREF were filled out. Then, in order to make these patients familiar with the disease, reasons, diagnostic methods, treatments and self-care programs about problems and side effects of MS, training classes were held within two sessions in a group; following that, self-care programs — including training required self-care skills such as urination and defecation disorders, constipation, sensory dysfunction, memory loss, chronic fatigue and also coordinating and balancing exercises both theoretically and practically—were performed

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