

Health Needs and Self Efficacy for Rheumatoid Arthritis Patients

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ABSTRACT

Background: Rheumatoid arthritis (RA) is a chronic inflammatory autoimmune disease that greatly impacts all aspects of health-related quality of life, including physical, emotional, social and spiritual. **Aim:** This study aimed at assessing health needs and self efficacy for rheumatoid arthritis patients. A **descriptive research design** was conducted. **Setting:** At rheumatology outpatient clinics at Port-Said general hospital and Port-Fouad general hospital which are affiliated to the Ministry of Health in Port-Said governorate. A **convenient sample** of 50 adult rheumatoid arthritis patients was included in the study. **Tools of data collection:** Tool (1) A Structured Interview consisted of two parts- a) Socio-demographic characteristics and medical history-b) Health Needs Questionnaire. Tool (2) Arthritis Self-Efficacy Scale (ASES). **Results:** More than half of study patients have health needs. The highest needs are in relation to psychological needs; then physical needs; then educational needs. The lowest needs are in relation to social and spiritual needs. Also, most of patients have high self-efficacy and there is statistically significant negative relation between health needs of RA patients and their self-efficacy. **Conclusion:** More than half of RA patients have health needs, although most of them have high self-efficacy. The highest needs are in relation to psychological needs, then physical needs, then educational needs, while the lowest needs are in relation to social and spiritual needs. **Recommendations:** Further study for assessment of factors influencing health needs and self-efficacy of RA patients.

Key Words: Health Needs, Patients, Rheumatoid arthritis, Self-Efficacy.

INTRODUCTION

Rheumatoid arthritis is a chronic autoimmune systemic inflammatory disease of unknown cause affecting many tissues and organs but principally targets the synovial lining of the joints leading to peripheral symmetrical inflammatory polyarthritis (*Ferri, 2017*). RA attacks approximately 0.5% to 1% of the world population, with predominance of 2-3 times more in females. It affects all age groups, but is more prevalent among 40-60-year people. In rural Egypt, a prevalence of up to 0.3% was found in the adult population (*Smolen et al., 2016 & Usenbo et al., 2015*).

Clinical onset of RA may be variable; it generally begins with symmetrical involvement of the small joints, pain, morning stiffness, and limitation of movement for more than 1 hour. Although the meta-carpophalangeal (MCP) joints, the proximal interphalangeal (PIP) joints, the wrists, the metatarsophalangeal (MTP) joints and the knee joints are the most frequently involved joints, RA may also involve other ones (*Almeida et al., 2014*).

Rheumatoid arthritis patients face an increased mortality risk, largely as a result of cardiovascular disease. Specifically, rheumatoid arthritis patients have a higher incidence of myocardial infarctions and congestive heart failure because of the chronic inflammatory nature of RA and the increased prevalence of atherosclerosis in this population. Rheumatoid arthritis is associated with other serious co morbidities, including infection, osteoporosis, lymphoma, Felty syndrome, vasculitis, and peptic ulcer disease (often as a result of nonsteroidal anti-inflammatory drug (NSAID) treatment). In addition to physical limitations, patients with RA can experience social and emotional impairments and disabilities. Many RA patients report impaired psychological and social functioning, depression and reduced ability to participate in gainful employment. Individuals with RA also experience diminished quality of life relative to those without RA (*Lesko et al., 2010*).

Health needs are defined as “the requirements of individuals to enable them to achieve, maintain, or restore an acceptable level of social independence or quality of life (*Carlsson et al., 2010*). Assessment of RA patients’ needs is crucial to enable the development of better healthcare services and contribute towards a more holistic care

of RA patients, which will ultimately improve the QoL of these patients (*Zuidema et al., 2015*).

Self-efficacy (SE) refers to the belief in one's capabilities to organize and execute the courses of action required to manage prospective situations. More simply, it is what an individual believes he or she can accomplish using his or her skills under certain circumstances. Self-efficacy is predictive of motivation levels, thought patterns, moods, emotional reactions, and attitudes that can mediate the capacity and willingness to elicit behaviors that promote health (*Sperber et al., 2014*). Because it is fundamental to many health-related behaviors and practices, self-efficacy is likely to be of immense importance in the context of influencing health outcomes among RA patients. This is not only because self-efficacy predicts the amount of effort and perseverance expended in reaching a goal, but it specifically influences the selection of goal-directed behaviors, in addition to the development of realistic goals (*Larkin & Kennedy, 2014*).

SIGNIFICANCE OF THE STUDY:

Rheumatoid arthritis is a chronic often disabling form of inflammatory arthritis. The impact of RA is reduction of patients' daily activities. As RA follows patients for their entire lives, a severe condition leads to disability and eventually affects patients' education, work, family life and social activity. Thus, the disease is not only affects patients' quality of life, but also increases the cost of care, resulting in a financial burden for society and the patient's family. Management of RA involves treatment from a range of healthcare providers over many years as well as self-management by the person affected (*Brand et al., 2010 & Lee et al., 2010*). Because of the far-reaching impacts of RA on the physical, psychological, social, and spiritual aspects of patients' lives, it is important for nurses to have insight in RA patients' health needs with considering the perspectives of these patients to deliver effective interventions tailored to these needs (*Zuidema et al., 2015*).

There is an increasing awareness that RA symptoms are influenced by psychosocial factors such as self- efficacy (SE), which is thought to be associated with self-management behavior and thus to affect the course of the disease (*Primdahl et al., 2011*) , therefore assessment of self efficacy of RA patients will help identify

specific problem areas that need special attention. So, there is a necessary need to conduct this study to assess health needs and self-efficacy of rheumatoid arthritis patients.

AIM OF THE STUDY:

This study aimed at assessing health needs and self-efficacy for rheumatoid arthritis patients.

it will be achieved through the following:

- Assess health needs for rheumatoid arthritis patients.
- Assess self efficacy for rheumatoid arthritis patients.

SUBJECTS AND METHOD:

A descriptive research design was utilized in this study.

Study setting:

This study was conducted at rheumatology outpatient clinics at two hospitals affiliated to the Ministry of Health in Port-Said governorate (Port-Said General Hospital and Port -Fouad General Hospital).

Study subjects:

A convenient sample, which consisted of 50 adult patients diagnosed with rheumatoid arthritis, was included in the study.

Tools of data collection:

Two tools were used in data collection:

Tool I: Structured Interview

This tool was adapted from (Hurlbert, 2002 & Mohamed, 2012) to assess health needs of rheumatoid arthritis patients. Some modifications were done based on the reviewing literature and translated into Arabic language.

It consisted of two parts:

Part (1): Socio-demographic characteristics and medical history

This part composed of 21 items as the following:

- I. **Socio-demographic characteristics:** included gender, age, job, level of education, marital status, residence area, family income and treatment payment system.
- II. **Medical history:** included patient's history, family history of rheumatoid arthritis, signs and symptoms of disease.

Part (2): Health Needs Questionnaire

This part included five dimensions:

- I. **Physical needs:** included 49 items related to rest and sleep, eating, mobility, body care "personal hygiene", wearing clothes "dressing", household chores for female patients, holding and gripping "hand activities", work outside home for employed patients, exercise, sexual relation, and prescribed medications.
- II. **Psychological needs:** included five items to assess (mood swings "anxiety / fear / sadness", feeling of distress without reason...etc).
- III. **Social needs:** included six items (decreased visits to friends and relatives, decreased participation in social activities...etc).
- IV. **Spiritual needs:** included three items (disease is a punishment from god, an expiation of sins or a test from god).
- V. **Educational needs:** included four items (does your rheumatologist answer all your questions?, if yes; what do you need to ask for the following "causes of disease, clinical manifestations, medications, treatment options and cost, follow up...etc"?, you have other sources for meeting your educational needs?, and if yes; which of the following "internist, nurse, rheumatology books, mass media...etc"?)

Scoring system of tools:

A) Scoring system of Health Needs Questionnaire

The respondent was asked for each item to explore if there was a health need requiring to be met. Items are scored on a three-point likert scale dividing in: 0 (never or low need), 1 (sometimes or moderate need), and 2 (always or high need). The higher scores indicated higher needs. The total score percentage was classified as the

following: > 66.7% (high needs), from 33.3% to 66.7% (moderate needs), and < 33.3% (low needs) (Mohamed, 2012).

B) Scoring system of Arthritis Self-Efficacy Scale

Items were rated on a 1 (very uncertain) to 10 (very certain) rating scale. The score for each item was the number circled. The score for the scale was the mean of the eight items. The higher scores indicated a higher degree of self-efficacy. The total score percentage was classified as the following: $\geq 50\%$ (high self-efficacy) and < 50% (low self-efficacy).

Tool II: Arthritis Self-Efficacy Scale (ASES)

This tool was adapted from (Lorig et al., 1989), to assess self-efficacy for rheumatoid arthritis patients or patients' belief that they could perform specific tasks or behaviors to cope with the consequences of rheumatoid arthritis. It consisted of eight items in three subscales: self-efficacy for managing pain, two items; self-efficacy for controlling other symptoms, four items; and self-efficacy for preventing pain and fatigue from interfering with daily activities, two items. ASES was translated into Arabic language and then retranslated to English language to ensure the right or accurate translation.

Content validity & Reliability:

Content validity of both tools was tested by nine experts from Faculty of Nursing in the field of medical-surgical nursing (5) and community health nursing (1), as well as rheumatologists from Faculty of Medicine (3). The tools were modified according to the experts' comments and recommendations. Also, both tools were tested for reliability using Cronbach's alpha that was for Health Needs Questionnaire = 0.920 and for Arthritis Self-Efficacy Scale = 0.995.

Pilot study:

A pilot study was carried out on 10% of the study sample (five patients) who were then excluded from the sample to test the feasibility and applicability of tools and estimate the time required to fill in them. It was conducted over a period of one month before embarking on the field work of the study.

Field work:

Data were collected by the researcher using the study tools through an individualized interview with each patient that lasted between 20 and 30 minutes. The researcher visited the selected settings for the purpose of collecting data in the morning

shift for three days per week in a period of six months from October 1st 2015 to March 31st 2016.

Ethical consideration:

An approval to conduct the study at the study settings was taken from directors, rheumatologists, and nurses after the researcher explained the aim of this study. Verbal consent was obtained from each patient to be included in the study after explaining the aim of this study and the importance of his / her participation, as well stressing on confidentiality of the collected information. The researcher emphasized that the participations are absolutely voluntary and each patient has the right to withdraw from the study at anytime without explaining any reasons. The process of data collection did not disturb the harmony of the work, in other words, all collected data from the study subjects were only used for the purpose of the study and were processed in a total confidentiality.

Statistical analysis:

Data entry and statistical analysis were done using statistical package for social sciences (SPSS) version 20.0. Data were presented using descriptive statistics in the form of frequency, percentages, means, and standard deviations. Categorical variables were compared using Chi-square test; Fisher's Exact, and Monte Carlo correction for chi-square when more than 20% of cells have expected count less than 5. In addition, Pearson coefficient test was used to correlate between health needs and self-efficacy for rheumatoid arthritis patients at Port-Said governmental hospitals.

RESULTS:

Table (1): clarifies that 90% of study patients were females, 28% of them were at age group 40 – < 50, 64% of them were housewives, 36% of them got secondary education, 82% were married, all of them (100%) were from urban area, 66% of them had not enough family income and 40% of them were patient expense as treatment payment system.

Table (2a): illustrates that 48% of study patients had > 5 years duration of disease, 96% of them detected the disease by suffering from symptoms, 64% of them suffer from other chronic diseases whereas 68.8% of them suffer from hypertension, 18.8% suffer from cardiovascular diseases, and 15.6% suffer from diabetes mellitus and liver

diseases; for rheumatoid treatment, 86% of patients took medications, 90% of patients were adherent to medications, and 78% of patients had not family history of disease; for patients with family history of disease, 36.4% of them had second degree relatives with the same disease and 81.1% of them reported "improved" as disease prognosis in family.

Table (2b): illustrates that, for articular manifestations, all patients (100%) reported joints pain; for extra – articular manifestations, 84% of them reported difficulty in performing activities of daily living; and for medications' side effects, 50% of them reported heart burn, 34% reported weight gain, and 22% reported constipation.

Table (3): illustrates that the study patients have high psychological needs (48%); moderate physical and educational needs (54% and 58%, respectively); and low social and spiritual needs (58% and 100%, respectively). Briefly, 58% of patients have moderate health needs.

Table (4): shows that most of study patients (84%) have high self-efficacy $\geq 50\%$ with (Mean \pm SD, 74.80 ± 26.95).

Table (5): shows that there is highly statistically significant negative correlation between health needs of the study patients and their self efficacy.

Table (1): Distribution of the study patients according to their socio-demographic characteristics (n=50)

Socio-demographic characteristics	No.	%
Gender		
Male	5	10.0
Female	45	90.0
Age		
20 - <30	5	10.0
30 -<40	8	16.0
40 -< 50	14	28.0
50 -< 60	12	24.0
≥60	11	22.0
Mean ± SD	47.96 ± 11.31	
Job		
Officer	8	16.0
Laborer	6	12.0
Retired	4	8.0
Housewife	32	64.0
Education		
Don't read & don't write	9	18.0
Read & write	10	20.0
Primary education	9	18.0
Secondary education	18	36.0
Institute	1	2.0
University	2	4.0
Post graduate	1	2.0
Marital status		
Single	1	2.0
Married	41	82.0
Widowed	7	14.0
Divorced	1	2.0
Residence area		
Urban	50	100.0
Rural	0	0.0
Family income		
Enough	17	34.0
Not enough	33	66.0
Treatment payment system		
Health insurance	14	28.0
Patient expense	20	40.0
Government expense	16	32.0

Table (2a): Distribution of the study patients according to their medical history

(n=50)

Medical history	No.	%
Disease duration		
6months - 1 year	8	16.0
1 year > 3 years	2	4.0
3 years - 5 years	16	32.0
> 5 years	24	48.0
Detection of disease by		
periodic checkup	2	4.0
suffering from symptoms	48	96.0
Suffering from other chronic diseases		
No	18	36.0
Yes	32	64.0
If yes		
Hypertension	22	68.8
Cardiovascular diseases	6	18.8
Diabetes mellitus	5	15.6
Thyroid diseases	1	3.1
Renal diseases	0	0.0
Liver diseases	5	15.6
Respiratory diseases	3	9.4
Rheumatic diseases	1	3.1
Osteoporosis	1	3.1
Lumbar disc prolapse	4	12.6
Glaucoma	1	3.1
Anemia	1	3.1
Hypotension	1	3.1
Rheumatoid treatment		
Medications & physiotherapy	6	12.0
Medications	43	86.0
Not comply treatment	1	2.0
Are you adherent to medications		
No	5	10.0
Yes	45	90.0
If no why: n= 5		
Neglect doses of medications	2	40.0
Need money	2	40.0
Lack of knowledge about importance of medications	1	20.0
Family history of disease		
No	39	78.0
Yes	11	22.0
If yes who: n=11		
First degree	3	27.3
Second degree	4	36.4
Third degree	3	27.3
Fourth degree	1	9.1
Disease prognosis in family: n=11		

Improved	9	81.8
Complicated	1	9.1
Death	1	9.1

Table (2b): Distribution of the study patients according to their medical history (n=50)

Medical history 2	No.	%
Articular manifestations		
Joints pain	50	100.0
Early morning stiffness	34	68.0
Joints tender, warm and swollen	45	90.0
Joints movement limitation	48	96.0
Joints deformity	13	26.0
Extra – articular manifestations		
Chronic muscle ache	26	52.0
Difficulty in performing activities of daily living	42	84.0
Fatigue with minimum effort	26	52.0
Dyspnea	33	66.0
Medications side effects		
Nausea	3	6.0
Vomiting	2	4.0
Heart burn	25	50.0
Anorexia	7	14.0
Weight gain	17	34.0
Constipation	11	22.0
Diarrhea	2	4.0
Dysuria	10	20.0
Hematuria	0	0.0
Urinary retention	1	2.0
Increased liver enzymes	1	2.0
Leucopenia	1	2.0
Itching	1	2.0

Table (3): Distribution of the study patients according to their health needs (n=50)

Health needs	Low need <33.3%		Moderate 33.3 - 66.6%		High need ≥66.7	
	No.	%	No.	%	No.	%
Physical needs	13	26.0	27	54.0	10	20.0
Rest and Sleep	20	40.0	17	34.0	13	26.0
Eating	26	52.0	13	26.0	11	22.0
Mobility	21	42.0	20	40.0	9	18.0
Body Care "Personal hygiene"	19	38.0	15	30.0	16	32.0
Wearing clothes "Dressing"	17	34.0	15	30.0	18	36.0
Household chores "for females" (n =45)	12	26.7	19	42.2	14	31.1
Holding and Gripping "Hand Activities	8	16.0	15	30.0	27	54.0
Work "for employed patients(n =14)	8	57.1	6	42.9	0	0.0
Exercise	6	12.0	16	32.0	28	56.0
Medications	22	44.0	23	46.0	5	10.0
Sexual Relation(n =41)	12	29.3	21	51.2	8	19.5
Psychological needs	5	10.0	21	42.0	24	48.0
Social needs	29	58.0	14	28.0	7	14.0
Spiritual needs	50	100.0	0	0.0	0	0.0
Educational needs	10	20.0	40	80.0	0	0.0
Overall needs	14	28.0	29	58.0	7	14.0

Table (4): Distribution of the study patients according to their self-efficacy (n=50)

Self-efficacy	No.	%
Low self-efficacy < 50%	8	16.0
High self-efficacy ≥50%	42	84.0
Min – Max	0.0 – 100.0	
Mean ± SD	74.80 ± 26.95	

Table (5): Pearson coefficient correlation between health needs of the study patients and their self-efficacy.

Items	Total self-efficacy	
	R	p
Total health needs	-0.763*	<0.001*

r: Pearson coefficient

*: Statistically significant at $p \leq 0.05$

DISCUSSION:

The current study portrays that more than half of patients have physical needs. The highest physical needs in this study are in relation to holding and gripping "hand activities", as well as exercise. This concurs with (Poole, 2011) who mentioned that RA results in pain, deformities, weakness, and other impairments that affect the hands. Also, this supports the view of (Cooney et al., 2011) who demonstrated that RA patients do less exercise than their healthy counterparts, and that uncertainty about the benefits of exercise and appropriate type of it, deters many patients from exercising at all, which also prove the same in this study.

Almost half of patients have high psychological needs whereas they always experience mood swings which appear as anxiety, fear, sadness and the latter is considered an indicator for depression, as well as they sometimes feel distress without reason. From the viewpoint of the researcher, increased pain, fatigue, reduced health-related quality of life, increased physical disability and health care costs are considered as stress factors that may lead to psychological distress and in turn, a higher need for emotional support. An additional explanation is that physicians tend to objectify patients and focus only on the physical symptoms, hence negligence of psychological support. This suggests reinforcing the role of nurse in the provision of emotional support for RA patients.

This result coincides with (Kostova et al., 2014; Ahlstrand et al., 2012; Lack et al., 2011) who concluded that RA may have a powerful psychological impact, evoking a variety of negative thoughts and emotions that adversely affect wellbeing.

Similarly, **Cho et al. (2013)**; **Mostafa & Radwan. (2013)**; and **Ho et al. (2011)** demonstrated that depression and anxiety frequently occur in RA, and are significantly associated with poorer health-related quality of life and subsequently higher psychological needs.

The findings of this study show that more than half of patients have low social needs. This indicates that RA had less effect on patients' social life. A possible explanation is that RA patients adapt to balance their social roles, relationships and activities while contending with pain, fatigue and disability imposed by RA. This is broadly consistent with **(Poh et al., 2015)** who mentioned that social relationships and role balance are unaffected by RA and most patients still enjoy an active social life. On the contrary, **Zuidema et al. (2015)** and **Feldthusen et al. (2013)** found that the illness has a significant negative impact on role balance and social functioning.

Also, all of patients have low spiritual needs in the present study. This result disagrees with **(Lin et al., 2011)** who concluded that RA patients have a strong need for spiritual support.

The current study reveals that most of patients have educational needs, especially in areas of disease follow up, medications, treatment options, clinical manifestations and complications of disease. Similarly, **Poh et al. (2015)** mentioned that patients have inadequate information in these areas. As well, this result agrees with **(Zuidema et al., 2015)** who showed that RA patients have informational needs for various topics e.g. medications.

In the present study, most of patients have high self-efficacy. A possible explanation is that the chronic nature of RA and its related pain require patients to learn novel health behaviors to manage and adapt to their disease and as means of enhancing their self-efficacy.

The current study elicits that patients' self-efficacy is negatively correlated with their health needs. This finding coincides with **(Barlow, 2013)** who mentioned that greater levels of self-efficacy are typically associated with less psychological distress "less anxiety and depression", greater tolerance of pain and other symptoms,

increased ability to cope, greater use of self-care activities, better physical functioning and hence lower health needs. This is also in accordance with (Sinikallio et al., 2014; Ahmed et al., 2012) who demonstrated that high self-efficacy consistently correlates with patients' functional ability and therefore, their health needs. Ahmed et al. 2012 added that strengthening self-efficacy results in improving functioning of RA patients and subsequently lowering health needs of these patients.

CONCLUSION :-

Based on the results of the present study, more than half of rheumatoid arthritis patients have health needs, although most of them have high self-efficacy. The highest needs are in relation to psychological needs, then physical needs, then educational needs, while the lowest needs are in relation to social and spiritual needs. Also, there is highly statistically significant negative correlation between health needs of rheumatoid arthritis patients and their self-efficacy.

RECOMMENDATIONS:

Based on the findings of the current study, the following recommendations are suggested: nurses should enhance health education programs provided to rheumatoid arthritis patients, including proper pain management strategies and techniques for overcoming physical limitations to help patients feel more in control of their pain and improve their physical functions, thereby reducing psychosocial distress. Family involvement in patient education should be strongly encouraged so that family members can better empathize and provide active support for the patients throughout their illness experience. Also, patient education materials should be redesigned to present more comprehensive information, including causes of rheumatoid arthritis, triggers of flare-ups, medication use and their side effects, as well self-management strategies.

Furthermore, nurses need to actively screen for patients at risk of psychological distress or depression and providing appropriate support for these patients such as empathic listening and validating their suffering, instead of focusing only on physical symptoms, to maintain their psychological health. Nurses can also conduct support groups for rheumatoid arthritis patients so that the latter can share

their experiences and coping strategies, and gain confidence and self-efficacy from meeting other rheumatoid arthritis patients who are successfully coping with everyday life.

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الاحتياجات الصحية والكفاءة الذاتية لمرضى التهاب المفاصل الروماتويدي

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الخلاصة

مرض التهاب المفاصل الروماتويدي هو مرض مناعي مزمن يؤثر بشكل كبير علي صحة المرضى الجسدية والنفسية والاجتماعية والروحية. صممت هذه الدراسة الوصفية لتقييم الاحتياجات الصحية والكفاءة الذاتية لمرضى التهاب المفاصل الروماتويدي، وقد أجريت هذه الدراسة على 50 مريض من العيادات الخارجية لأمراض الروماتيزم بالمستشفيات التابعة لوزارة الصحة بمحافظة بورسعيد (مستشفى بورسعيد العام ومستشفى بور فؤاد العام). تم استخدام أداتين لجمع البيانات: الأداة الأولى عبارة عن استمارة المقابلة الشخصية وتتكون من جزأين: الجزء الأول يتضمن الخصائص الديموغرافية والتاريخ الطبي للمريض والجزء الثاني لتقييم الاحتياجات الصحية لمرضى التهاب المفاصل الروماتويدي أما الأداة الثانية عبارة عن مقياس لتقييم الكفاءة الذاتية لهؤلاء المرضى. أظهرت نتائج الدراسة أن أكثر من نصف المرضى لديهم احتياجات صحية بالرغم من أن معظمهم ذو كفاءة ذاتية عالية للمرض. تتمثل الاحتياجات الأعلى للمرضى في الاحتياجات النفسية ثم الجسدية ثم التعليمية بينما تتمثل الاحتياجات الأقل في الاحتياجات الاجتماعية والروحية. أوصت نتائج الدراسة الحالية بتقييم العوامل التي تؤثر على الاحتياجات الصحية والكفاءة الذاتية لمرضى التهاب المفاصل الروماتويدي.

الكلمات المرشدة: الاحتياجات الصحية، المرضى، التهاب المفاصل الروماتويدي، الكفاءة الذاتية.