Quality of life and glycemic control in adolescents with type 1 diabetes and the impact of an education intervention

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Objective: To assess quality of life (QoL) and glycemic control in adolescents with type 1 diabetes and to investigate the impact of an educational program.

Methods: A quasiexperimental study with nonrandomized experimental and control groups was conducted in which a total of 503 adolescents with type 1 diabetes completed a questionnaire using the Diabetes Quality of Life Instrument for Youth. Adolescents were then assigned to experimental and control groups. The experimental group was subjected to four 120-minute sessions of an educational program over a period of 4 months. Extracted medical chart data included the duration of diabetes, insulin dosage, and most recent hemoglobin A1c levels. Analysis of covariance was used to detect the impact of intervention.

Results: The overall mean QoL score (%) was 76.51 ± 9.79, with good QoL in 38% of all adolescents. Poorer QoL was significantly associated with older age (P < 0.001), more hospital admissions in the last 6 months (P = 0.006), higher levels of depression (P < 0.001), poor self-esteem (P < 0.001), and poor self-efficacy (P < 0.001). There was significant deterioration in all domains of QoL in the experimental group after intervention. However, this deterioration was significantly less severe than in the control group. Between-group effects on total knowledge, adherence to exercise, glucose monitoring, treatment, self-efficacy, family contribution to management, glycemic control, and satisfaction with life were significantly in favor of the experimental group.

Conclusion: Education intervention for adolescents with type 1 diabetes could be a safeguard against possible deterioration in QoL and glycemic control over time.

Keywords: adolescents, diabetes, QoL, glycemic, intervention

Introduction

Adolescents with type 1 diabetes are challenged to adapt to a lifestyle that requires the self-management of dietary practices, exercise behaviors, and insulin adjustment in addition to developing autonomy and self-identity. The rapid biological changes that occur during adolescence and the need to learn to manage a chronic illness can place adolescents at risk for poor metabolic control and life adjustment difficulties.1,2 These considerable demands may interfere with adolescents’ ability to negotiate important developmental tasks, including the ability to achieve good psychological adjustment2 and improve overall quality of life (QoL).3,4 Lower QoL scores were associated with older age, poor glycemic control, increasing hypoglycemic episodes, complications, lower levels of education and outcome, self-reported depression, and female gender.5
The goal of diabetes education is to help patients acquire the knowledge, information, self-care practices, coping skills, and attitudes required for the effective self-management of their diabetes. The literature shows that educational and counseling interventions designed to facilitate the development of diabetes self-management skills can improve QoL in people with diabetes.

The effect of educational programs on glycemic control differs among studies. Some studies have reported improvement in glycemic control. Matam et al stated that their behavioral intervention led to an improvement in glycemic control, which was maintained at a 3-month follow-up period. Tang et al reported that glycosylated hemoglobin (HbA1c) decreased from a baseline level of 9.2% to 8.6% after implementing their self-management intervention. Ellis et al found that in adolescents who underwent an intervention program, HbA1c was found to have declined by an average of 0.8%.

The purpose of this study was to assess QoL and glycemic control and the impact of an educational program on adolescents with type 1 diabetes in Alexandria City, Egypt. This knowledge can provide direction for the establishment of individualized interventions to assist in lifelong adaptation to a chronic illness.

Patients and methods
Study setting
In this study, we included diabetic students in the city of Alexandria who had received follow-up care in one of two main diabetes outpatient clinics: the El-Shatby Pediatric Hospital and the Sporting Student’s Insurance Hospital. The Sporting Student’s Hospital is affiliated with Egypt’s health insurance organization, and the El-Shatby Pediatric Hospital is affiliated with the Egyptian Ministry of Health. In both hospitals, children or students can be hospitalized and treated with outpatient care in the specialized clinics. Diabetes clinics in these two hospitals are responsible for managing all diabetic children and adolescents in Alexandria and the West Delta in terms of diagnosis, treatment, hospitalization, the provision of drugs, and health education. The type of care provided in the two facilities was similar, with no special formal educational training being given to the diabetic students.

Study design
A cross-sectional, interview-based study design was used to study the QoL and its determinants in diabetic adolescents. A quasiexperimental study using a longitudinal approach to compare two nonrandomized groups (experimental and control groups) with pre- and post-tests was conducted to evaluate the impact of an intervention program on QoL and glycemic control in a subset of adolescents who completed the preliminary interview. The experimental group received the group intervention monthly for 4 consecutive months, whereas the control group did not receive any intervention. Both groups were post-tested 6 months after completion of the intervention.

Target population and sampling technique
The target population was diabetic adolescents of both sexes (between the ages of 12 and 20 years) who were attending the diabetes outpatient clinics in the El-Shatby Pediatric Hospital and the Sporting Student’s Insurance Hospital. Using EPI Info™ Version 6.4 (Centers for Disease Control and Prevention, Atlanta, GA, USA), we determined the sample size needed to assess the QoL of adolescents based on the prevalence of poor QoL of 5% of adolescents with type 1 diabetes with 1.8% precision and a 95% confidence limit. The sample size required was 563 adolescents. A total of 503 diabetic adolescents who attended the previously mentioned two outpatient clinics during the period of the cross-sectional study (4 months) and agreed to participate were allocated (89.3% response rate).

For the intervention program, to calculate the sample size, we used published recommendations to detect differences in psychosocial measures. A sample size of 286 adolescents (143 in each group) was required to detect an increase of 10% in the percentage mean score of total QoL after intervention more than the control group, considering a β error of 20% and an α error of 5% using a two-sided analysis with a Chi-squared (χ²) test. The number of patients who attended the previously mentioned two hospitals during the period of intervention (4 months) and agreed to participate in the program was 243 (85% response rate). The experimental group comprised 121 adolescents who were the first to come to the clinics for follow-up. All of the remaining adolescents (n = 122) comprised the control group. Both groups were subjected to the pre- and post-tests. No statistical differences were detected between the intervention and nonintervention groups based on age (χ² = 2.311, P = 0.43), gender (χ² = 0.47, P = 0.85), or socioeconomic status (χ² = 1.11, P = 0.76).

Measures
An interview questionnaire
A predesigned structured interview questionnaire was used to collect all data. It was divided into 10 parts.
Personal and sociodemographic characteristics
The following data were collected: i) personal data, including the student’s name, sex, adolescence stage, and age (early adolescent: <14 years, mid-adolescent: 14–16 years, and late adolescent: 16 years) and ii) sociodemographic data, including the number of family members, crowding index, father’s education, father’s employment, mother’s education, mother’s employment, and family income. These data were summed in a total socioeconomic score following the methods used by Fahmy and El Sherbini13 with some modifications. The socioeconomic class was classified as “high”, “middle”, or “low”.

Social family environment
The following data were collected: the people the adolescent was living with, the social status of the parents, the relationship between the parents, and the relationship between the patient and his or her parents and siblings. This was divided into three categories: “poor”, “moderate”, and “good” social family environment.4

Medical history of diabetes
The following data were collected: age of onset of diabetes, duration of disease, place of diagnosis, number of insulin injections/day, number of glucose monitorings/month, number of appointments/month, type of medication, number of hypoglycemic attacks within the last 3 months, number of hospital admissions in the last 6 months, and causes of dissatisfaction in diabetics care (eg, waiting time, shortage of medications).

The DQoL measure for youth
The DQoL Measure for Youth is a modification of the DQoL Instrument developed for the Diabetes Control and Complications Trial.14 The questionnaire consists of three parts: impact of diabetes, worry about diabetes, and satisfaction with life.

The worry about diabetes part consists of 11 items assessing worry about marriage, having children, death, job, education, body shape, complications of diabetes, and social relations. The adolescent was asked to answer each item on a 5-point scale ranging from 1 to 5. A higher score reflects lower worry (better QoL). Total score was obtained by summing the scores for the 11 items and then a percentage total score was calculated.

The impact of diabetes part consists of 23 items assessing the impact of diabetes on physical (4 items), social (13 items), family (4 items), and school (2 items) aspects of the life of diabetics. The adolescent was asked to answer each item on a 5-point scale from 1 to 5. A higher score reflects a lower impact of diabetes on the adolescent’s life (better QoL). A total score was obtained by summing the scores for the 23 items and then a percentage total score was calculated.

The satisfaction with life part consists of 17 items assessing satisfaction with management (8 items), social life (6 items), and school life (3 items). The adolescent was asked to answer each item on a 5-point scale from 1 to 5. The higher score reflects higher satisfaction with life (better QoL). Total score was obtained by summing the scores for the 17 items and then a percentage total score was calculated.

The total QoL was obtained by summing i) the total impact of diabetes, ii) worry about diabetes, and iii) satisfaction with life. The total sum of QoL range was divided into poor QoL (<60%), moderate QoL (60%–80%), and good QoL (>80%).

Knowledge about diabetes
The data collected included 16 items assessing the knowledge of diabetics about the appropriate glucose level for diabetics; symptoms of hyper- and hypoglycemia; complications; the effect of exercise, infections, and food on glucose level; sites of insulin injection; and glucose analysis in blood and urine. The answers were summed and then a percentage total score was calculated. The total sum of the knowledge score was graded as “poor knowledge” (≤60%), “fair knowledge” (60%–80%), and “good knowledge” (>80%).9

Self-efficacy
This questionnaire was designed to be similar to that developed by McCaul et al15 with some modifications. It consisted of 11 items to assess the adolescents’ self-efficacy to medication (insulin intake), diet, and exercise. A percentage
total score for self-efficacy was calculated. The total sum of self-efficacy was graded as “low” (≤60%), “moderate” (60%–80%), and “high” (≥80%).

Adherence to self-management
A questionnaire composed of 10 items that covered adherence to different domains of self-management during the previous month was used. These domains were adherence to medication, adherence to a diabetic diet, adherence to glucose monitoring, adherence to medical appointments, and adherence to exercise. Each item was scored on a 3-point scale (never, sometimes, and always) with 1, 2, and 3 points assigned, respectively. A total score for adherence was obtained by summing the scores of these 10 items. The maximum total sum was 30 points and then the percentage total score was calculated and categorized as follows: “poor” (≤50%), “moderate” (>50%–75%), and “good” (>75%) adherence to self-management.9,15

Family contribution to diabetes self-care4
A questionnaire composed of 11 items was used to assess the family’s contribution to diabetes self-care. The answers were scored on a 3-point scale (never = 1, sometimes = 2, and always = 3) and then a percentage total score for family contribution was calculated. The total sum of family contribution was categorized as follows: “poor” (≤60%), “moderate” (60%–80%), and “good” (>80%) family contribution.

Self-esteem of diabetics
An Arabic version of the 25-item Coppersmith’s Self-esteem Inventory21 adopted by Mossa and Al-Dosokki16 was administered to the adolescents to measure their self-esteem. The responses of the items were scored as 0 (for unfavorable response) or 1 (for favorable response). The range of total scores was from 0 to 25 and was divided into “high self-esteem” (more than $X \pm$ standard deviation [SD] or $>19.62$), “moderate self-esteem” (between $X \pm$ SD or 12.12–19.62), and “low self-esteem” (less than $X - $ SD or $<12.12$) and then the percentage score for total self-esteem was calculated for each patient.

Depression
The Arabic version of the Children’s Depression Inventory (CDI)17 was used, which included 27 multiple-choice items that covered an array of overt symptoms of depression, such as sadness, suicidal ideation, and sleep and appetite disturbances. Each CDI item assessed one symptom by presenting three choices that were graded from 0 to 2 in the direction of increasing psychopathology. Thus, the highest CDI total score was 54. The calculated cut-off score was 25, and the categories were “not depressed” (<25 points) and “depressed” (≥25 points). The percentage score of total depression was then calculated for each patient.

Record review
Data were collected on the age, type of medication, glycemic control as measured by HbA1c (controlled diabetes ≤7.5 and uncontrolled diabetes >7.5) based on International Society for Pediatric and Adolescent Diabetes Guidelines,18 and complications.

Intervention phase
General objective and contents of the program
The main goal of the education program was to fill the gap between adolescents’ knowledge about diabetes and their adherence to diabetes management through a behavioral education program. The cognitive objective of the intervention was to describe the details of self-management while stressing the drawbacks of poor adherence. The affective objective was to help adolescents accept living with diabetes, increase their confidence in managing it, and improve their QoL. The behavioral objective of the program was to improve the self-management of patients.

Selection of participants
All targeted adolescents for intervention who agreed to participate were identified (n = 243). For logistic reasons, to complete the intervention before the end of the academic year (when the students are busy with their final examinations), and to avoid dropout of adolescents, the researchers implemented the program first for the 121 patients who attended the clinics for follow-up within a period of 4 months. The other 122 adolescents who did not receive the intervention were considered to be the control group. Both groups were tested 6 months after completion of the program.

Selection of methods
The intervention group (n = 121) was divided into smaller groups containing about 15 adolescents each. Every group attended four 120-minute sessions over a period of 4 months, with one session every month (at their normal appointment at the clinic to get their medication). The program covered the following components: i) short- and long-term complications of diabetes, ii) medication and glucose monitoring, iii) nutrition and diabetes, and iv) exercise and foot care.
The framework for the sessions was based on a multi-component framework, including education and mutual support. Several teaching methods were used in the teaching settings, including group discussion, to allow the researcher to explore the main ideas that needed to be discussed. Group discussions also helped adolescents share information, gave them confidence, and motivated them to comply with the contents of the intervention. Counseling was used to individualize the behavioral objectives when needed. In addition, certain demonstrations helped the participants to understand some aspects of self-management such as insulin injection. Visual aids in the form of a white board and colored posters were used. The posters provided information about insulin injection sites, signs of hypoglycemia, signs of hyperglycemia, the diabetes food pyramid, and foot care. Demonstrations were used to explain insulin injection techniques and sites. The program was run by the investigators to ensure consistency, with the help of the health providers in the clinics to minimize logistic problems.

Statistical analysis
Data were collected, coded, analyzed, and tabulated using the Statistical Package for Social Sciences (SPSS Inc., Chicago, IL, USA) Version 17.1. The Pearson Chi-square test, Chi-square test for linear trends, and Fisher’s exact test were used to compare the categorical data. The Mann–Whitney U test, Kruskal–Wallis test, and Wilcoxon test were used to compare the quantitative data. Multiple linear regression was used to find the predictors of QoL score. Analysis of covariance was used to evaluate the impact of the program after adjusting for the results of the experimental and control groups before the intervention as covariates. Between-group effects (the intervention group minus the control group) were corrected for the baseline scores. A desirable effect of the intervention was determined by the positive difference between the experimental and the control groups.

Ethical considerations
A letter was sent by the school to the parents of each diabetic adolescent, describing the aim of the study. It asked for their agreement for their children to participate in an interview at the time the children attended the diabetes clinics. The parents who received information about the questionnaire could interact with the research team and learn about the study, its objectives, the possible benefits and risks of participating, and the child’s rights and responsibilities. In this way, they could make a fully informed decision about whether or not to give permission for their child’s participation in the intervention. The Research Committee of the High Institute of Public Health of Alexandria University approved the research after ensuring that it was in the minimal-risk category.

Results
The sample included 503 adolescents, of whom 218 (43.3%) were males and 285 (56.6%) were females. About half of the adolescents (49.5%) were early adolescents (ages 12 to less than 14 years old), 39.6% mid-adolescents (ages 14–16 years old), and 10.9% late adolescents (ages 17 years or more). Overall, the mean age of the patients was 14.63 ± 2.23 years. There was no statistically significant difference between the sexes regarding age ($\chi^2 = 0.49$, $P = 0.91$).

QoL of adolescents with diabetes and glycemic control
Table 1 shows the QoL of adolescents with diabetes by sex and QoL domain. The percentage mean score of total QoL for all adolescents was 76.51 ± 9.79. This percentage mean score was the lowest in the impact domain (75.25 ± 10.23) and the highest in the worry domain (77.92 ± 13.26). Patients with a good total QoL constituted 38% of all children. This percentage was higher for the satisfaction and worry domains (46.7% and 49.1%, respectively), whereas the percentage dropped to 33.2% in the impact domain. Male diabetic adolescents showed significantly better QoL in all domains ($P < 0.001$).

Table 2 shows the glycemic control of adolescents with diabetes by sex. About three-quarters (74.8%) of adolescents had uncontrolled glucose levels according to the HbA1c level, and only 25.2% were controlled, with no statistically significant difference between the sexes regarding age ($\chi^2 = 0.046$, $P = 0.64$). The mean score of HbA1c for all adolescents was 10.53 ± 1.90.

Predictors of QoL (Table 3)
In the bivariate analysis, QoL was significantly associated with age ($P < 0.001$), levels of depression ($P < 0.001$), self-esteem ($P < 0.001$), the number of insulin injections/day ($\chi^2 = 6.73$, $P < 0.001$), the number of hospital admissions per 6 months ($\chi^2 = 19.07$, $P < 0.001$), glycemic control ($\chi^2 = 47.72$, $P < 0.001$), satisfaction with health care services ($\chi^2 = 12.92$, $P < 0.001$), adherence ($\chi^2 = 33.19$, $P < 0.001$), self-efficacy ($\chi^2 = 38.34$, $P < 0.001$), and family contribution ($\chi^2 = 14.77$, $P < 0.001$). However, after adjustment for all
these significant variables, poorer QoL was significantly associated with older age ($P < 0.001$), more hospital admissions in the last 6 months ($P = 0.006$), higher levels of depression ($P < 0.001$), poor self-esteem ($P < 0.001$), and poor self-efficacy ($P < 0.001$).

Impact of the educational intervention program on diabetes QoL (Table 4)
There was significant deterioration in all domains of QoL in the experimental group after intervention. However, this deterioration was significantly less so than in the control group. The between-group effects were in favor of the intervention group in the physical impact ($P = 0.006$), social impact ($P < 0.001$), school impact ($P = 0.03$), satisfaction with social life ($P < 0.001$), satisfaction with school life ($P < 0.001$), and total satisfaction ($P = 0.002$) domains.

Impact of educational intervention program on possible determinants of diabetes QoL and glycemic control (Table 5)
Table 4 shows the percentage mean difference of QoL determinants in the experimental and control groups before and after intervention. The positive effect of educational intervention was supported by the significance of the between-group effect on total knowledge ($P < 0.001$), total adherence ($P < 0.001$), self-efficacy ($P < 0.001$), family contribution ($P < 0.001$), and HbA1c ($P < 0.001$).

The experimental group showed a significant increase in the mean score of adherence, whereas the control group showed a significant reduction. With regard to knowledge, although both groups showed a significant increase in the mean score, this increase was significantly higher among
Table 3 Distribution of adolescents with type 1 diabetes according to personal, disease, and health care characteristics and the percentage mean quality of life score. *P* values were adjusted only for significant variables in the univariate analyses. Higher scores denote lower worry, lower impact, higher satisfaction, and better total quality of life.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Total No.</th>
<th>%</th>
<th>% mean score</th>
<th>Adjusted P value</th>
</tr>
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<tbody>
<tr>
<td><strong>A. Personal characteristics</strong></td>
<td></td>
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<tr>
<td>Sex</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Male</td>
<td>218</td>
<td>43.3</td>
<td>78.77 ± 8.92</td>
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<tr>
<td>Female</td>
<td>285</td>
<td>56.7</td>
<td>74.51 ± 10.03</td>
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<tr>
<td>Stage of adolescence</td>
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<tr>
<td>Early (12 to &lt;14 years)</td>
<td>249</td>
<td>49.5</td>
<td>78.80 ± 8.85</td>
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<td>Mid (14–16 years)</td>
<td>199</td>
<td>39.6</td>
<td>74.09 ± 10.22</td>
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<tr>
<td>Late (&gt;16 years)</td>
<td>55</td>
<td>10.9</td>
<td>73.49 ± 9.68</td>
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<td>Socioeconomic level</td>
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<tr>
<td>Low</td>
<td>191</td>
<td>38.0</td>
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<tr>
<td>Moderate</td>
<td>197</td>
<td>39.1</td>
<td>76.02 ± 9.41</td>
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<tr>
<td>High</td>
<td>115</td>
<td>22.9</td>
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<td>Social family environment</td>
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<td>Poor</td>
<td>92</td>
<td>18.3</td>
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<tr>
<td>Moderate</td>
<td>221</td>
<td>43.9</td>
<td>75.74 ± 9.74</td>
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<tr>
<td>Good</td>
<td>190</td>
<td>37.8</td>
<td>79.34 ± 9.40</td>
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<tr>
<td>Self-esteem</td>
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<tr>
<td>Low</td>
<td>90</td>
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<td>Moderate</td>
<td>328</td>
<td>65.2</td>
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<td>High</td>
<td>85</td>
<td>19.9</td>
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<td>Depression</td>
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<td>13.3</td>
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<td>Not depressed</td>
<td>436</td>
<td>86.7</td>
<td>78.04 ± 9.04</td>
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<td><strong>B. Disease characteristics</strong></td>
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<td>Age of onset</td>
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<td>&lt;6 years</td>
<td>79</td>
<td>15.7</td>
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<td>6–10 years</td>
<td>158</td>
<td>31.4</td>
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<tr>
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<td>266</td>
<td>52.9</td>
<td>75.00 ± 9.61</td>
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<tr>
<td>Duration of disease</td>
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<td></td>
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<tr>
<td>&lt;1 year</td>
<td>105</td>
<td>20.9</td>
<td>76.10 ± 11.21</td>
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<td>1–5 years</td>
<td>233</td>
<td>46.3</td>
<td>77.23 ± 8.87</td>
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<tr>
<td>&gt;5 years</td>
<td>165</td>
<td>32.8</td>
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<tr>
<td>Number of insulin injections/day</td>
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<tr>
<td>Once or twice/day</td>
<td>322</td>
<td>64.5</td>
<td>75.67 ± 9.63</td>
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<tr>
<td>Three +/day</td>
<td>177</td>
<td>35.5</td>
<td>77.67 ± 10.01</td>
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<tr>
<td>Number of hypoglycemic attacks/3 months</td>
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<td></td>
<td></td>
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<tr>
<td>Never</td>
<td>168</td>
<td>33.4</td>
<td>77.67 ± 9.38</td>
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<tr>
<td>Once</td>
<td>68</td>
<td>13.5</td>
<td>77.28 ± 9.91</td>
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<tr>
<td>Twice</td>
<td>84</td>
<td>16.7</td>
<td>75.01 ± 9.78</td>
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<tr>
<td>Three or more</td>
<td>183</td>
<td>36.4</td>
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</table>

(Continued)
the experimental group. Mean scores of both self-efficacy and family contribution showed no significant change in the experimental group, whereas significant reductions were detected in the control group. Although HbA1c showed no significant improvement from the baseline by the experimental group (0.18% reduction), a significant adverse increase in the mean figure was detected in the control group (0.25% increase).

### Discussion

In this study of the QoL and its determinants in diabetic adolescents in Alexandria, we found that the mean total QoL score was 76.36% ± 9.79%. This figure is similar to that from a study conducted by Cara11 (73%) in Europe, less than that from a study by Lafel et al19 (81.3% ± 4.57%) in the US, and higher than that reported by Sawyer et al20 (61.4% ± 15.4%) in the US. Generally, lower QoL scores were associated with different factors, including number of hospital admissions, glycemic control, complications, type of care, satisfaction with health care service, adherence, knowledge, self-efficacy, and family contribution.
### Table 4 Percentage (%) mean scores of quality of life (QoL) domains before and after intervention among experimental and control groups. Higher scores denote lower worry, lower impact, higher satisfaction, and better total QoL.

<table>
<thead>
<tr>
<th>Group (QoL domains)</th>
<th>Experimental group</th>
<th>Control group</th>
<th>Between-group effecta</th>
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<tbody>
<tr>
<td></td>
<td>Pre-test</td>
<td>Post-test</td>
<td>Within groupb</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
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<tr>
<td>Total worry</td>
<td>77.74</td>
<td>11.90</td>
<td>71.84</td>
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<tr>
<td>Physical impact</td>
<td>70.50</td>
<td>16.36</td>
<td>69.03</td>
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<tr>
<td>Social impact</td>
<td>80.99</td>
<td>8.59</td>
<td>75.70</td>
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<td>School impact</td>
<td>80.55</td>
<td>19.35</td>
<td>78.34</td>
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<tr>
<td>Family impact</td>
<td>56.94</td>
<td>17.94</td>
<td>58.38</td>
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<tr>
<td>Total impact</td>
<td>74.95</td>
<td>8.93</td>
<td>69.21</td>
</tr>
<tr>
<td>Satisfaction with management</td>
<td>71.73</td>
<td>13.35</td>
<td>70.34</td>
</tr>
<tr>
<td>Satisfaction with social life</td>
<td>76.20</td>
<td>19.43</td>
<td>70.44</td>
</tr>
<tr>
<td>Satisfaction with school life</td>
<td>76.55</td>
<td>19.43</td>
<td>79.64</td>
</tr>
<tr>
<td>Total satisfaction</td>
<td>75.45</td>
<td>10.77</td>
<td>69.92</td>
</tr>
<tr>
<td>Total QoL</td>
<td>75.66</td>
<td>8.32</td>
<td>71.28</td>
</tr>
</tbody>
</table>

Notes: aBetween-group effect sizes (experimental minus control groups) were adjusted for the results of the experimental and the control groups before the program using analysis of covariance; bWilcoxon test was applied to test the significance of the difference between pre- and post-test percentage mean scores.

Abbreviations: M, mean; SD, standard deviation.

### Table 5 Percentage (%) mean scores of quality of life (QoL) determinants, depression scores, and levels of glycosylated hemoglobin before and after intervention among experimental and control groups. Higher scores denote higher levels of knowledge, adherence, self-efficacy, self-esteem, family contribution, more depression, and worse glycosylated hemoglobin.

<table>
<thead>
<tr>
<th>Group (QoL determinants)</th>
<th>Intervention group</th>
<th>Control group</th>
<th>Between-group effecta</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-test</td>
<td>Post-test</td>
<td>Within groupb</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Total knowledge</td>
<td>89.66</td>
<td>7.87</td>
<td>94.40</td>
</tr>
<tr>
<td>Total adherence</td>
<td>63.86</td>
<td>10.26</td>
<td>69.23</td>
</tr>
<tr>
<td>Total self-efficacy</td>
<td>74.18</td>
<td>15.47</td>
<td>74.06</td>
</tr>
<tr>
<td>Family contribution</td>
<td>58.22</td>
<td>11.68</td>
<td>61.25</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>58.40</td>
<td>18.12</td>
<td>59.36</td>
</tr>
<tr>
<td>Depression</td>
<td>27.46</td>
<td>16.64</td>
<td>37.42</td>
</tr>
<tr>
<td>Glycosylated hemoglobin</td>
<td>10.62</td>
<td>1.89</td>
<td>10.44</td>
</tr>
</tbody>
</table>

Notes: aBetween-group effect sizes (experimental minus control groups) were adjusted for the results of the experimental and the control groups before the program using analysis of covariance; bWilcoxon test was applied to test the significance of the difference between pre- and post-test percentage mean scores.

Abbreviations: M, mean; SD, standard deviation.
old age, poor glycemic control, an increasing number of hypo-
glycemic episodes, complications, low levels of education
and outcome, self-reported depression, and female gender.5
The present study showed that significant predictors of poor
QoL were older age, more hospital admissions in the last
6 months, higher levels of depression, poor self-esteem, and
poor self-efficacy.

The results of the current work demonstrate that there was
a significant reduction in the total QoL and its four domains
following the intervention in the experimental group as well
as in the control group. These findings contradicted those
of other studies.21,22 The inability to detect improvements
in adolescent QoL in the experimental group might have
resulted from an insufficient number of participants or
inadequate time to observe such changes. However, the
between-group differences were in favor of the experimental
group in the impact and satisfaction QoL domains. The
promise of a short intervention of minimal cost providing
immediate health benefits by preventing deterioration of QoL
and possibly preventing long-term diabetes complications is
worthy of longer-term investigation.23

The program in the present study had a nonsignificant
effect on self-esteem. This was also true for depression. These
results may reflect the need to combine psychoeducational
techniques (eg, coping skills or adjustment techniques)
with behavioral education to improve psychological
aspects in adolescents.24 Moreover, decreased self-esteem
and an increased rate of depression in adolescents may
pose a question about using the fear–appeal technique with
adolescents.

The importance of knowledge in health education
must not be ignored, because increased knowledge is the
first step toward health behavior modification; thus, many
studies have incorporated knowledge building into their
intervention programs.9,22,25,26 However, a systematic review
reported that the effect of educational intervention on diabetes
knowledge was unclear, with 12 of 30 studies reporting a
significant impact.27 The present study had a positive effect
on knowledge.

According to the previously mentioned systemic
review,27 10 of 21 studies reported improvement in the
area of management/regimen adherence. The current
findings demonstrated a significant impact of the program
on adherence. There was improvement in adherence in
both groups, with significantly more improvement in the
experimental group than in the control group. The program
helped to maintain optimal self-efficacy in the experimental

Research had found that family contribution decreased
with increased duration of diabetes4 as parents started to
transfer responsibility of disease management to their
children. This was evidenced in the present study where a
significant reduction in family contribution mean score was
detected among the control group, although this score was
preserved in the experimental group, resulting in a significant
between-group effect. This finding was in agreement with
the finding of a family-focused teamwork intervention where
more families in the teamwork group increased or maintained
family involvement than in the standard care group.23

Deterioration of glycemic control is a common problem
in adolescents with diabetes.29 The effect of educational
programs on glycemic control differs among studies.8–10
In the present study, there was a nonsignificant improvement
in the level of HbA1c from the baseline in the experimental
group compared with a significant adverse increase in the
control group. Although HbA1c showed no significant
improvement from the baseline by the experimental group
(0.18% reduction), a significant adverse increase in the
mean figure was detected in the control group (0.25%
increase), leading to a significant desirable between-effect
size (−0.43%).

Although a positive relation between adherence and
glycemic control has long been assumed, there is some
evidence to the contrary.30 In the present study, there was
no improvement in HbA1c in the experimental group, yet
there was an improvement in total adherence. This may be
explained by the fact that some aspects of adherence (such
as diet) may have deteriorated, whereas other aspects (such
as exercise and glucose monitoring) may have improved.
In addition, hormonal effects in adolescence may play a role
in this lack of improvement. However, further investigation
of the adherence–glycemia relationship is warranted.

This study has some limitations. First, there was a lack
of a true control group. This may lessen the validity of the
conclusions as to the intervention actually being beneficial.
Second, an inability to detect within- or between-group
differences in adolescent QoL and/or glycemic control might
have resulted from an insufficient number of participants
or inadequate time to observe such changes. Third, process
evaluation was not conducted. Fourth, the missing data in
the survey and the intervention phases may affect the validity of the conclusion.

**Conclusion**

Aside from these limitations, the present study showed that the level of QoL among Egyptian adolescents with type 1 diabetes is comparable with figures from many Western countries. Significant predictors of poor QoL were older age, more hospital admissions in the last 6 months, higher levels of depression, poor self-esteem, and poor self-efficacy.

The program was found to have a positive effect on total knowledge, total adherence, self-efficacy, and family contribution. Although significant deteriorations were detected in all domains of QoL after intervention, the intervention could be considered a safeguard against the increased deterioration that could have occurred with no intervention. This was also the case for glycemic control. This study is particularly relevant to health professionals who work with adolescents and their families. The finding that deterioration of QoL and/or glycemic control can be prevented by using a short intervention at a minimal cost is encouraging.

The following approaches are recommended. First, health education must be an integral part of diabetes management in all diabetic clinics and hospitals rather than a set of instructions given once at the beginning of the follow-up. Education of children and adolescents with type 1 diabetes and their families needs to be supported by psychosocial and possibly family therapy interventions. Second, continuous training of health staff (doctors, nurses, and lab workers) is needed for the implementation of educational interventions to raise awareness about the importance of health education among adolescents and to train them in how to communicate with patients so they can keep adolescents motivated for self-management and detect early psychological stresses. Third, further research is needed to test efficacious interventions in terms of their effectiveness in clinical practice, prior to widespread implementation in practice settings.

**Acknowledgements**

This study was approved by the Research Committee of the High Institute of Public Health, Alexandria University, Alexandria, Egypt. We thank the editing service office at King Abdullah International Medical Research Center (KAIMRC), King Saud Bin-Abdulaziz University for Health Sciences, Riyadh, Saudi Arabia, for the English language editing of the manuscript via a specialist English language copy editor (American Journal Experts).

**Disclosure**

The authors declare that they have no competing interests.

**References**


