



Opioid-taking self-efficacy as influencing emotional status in patients with cancer pain



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ABSTRACT

Purpose: The purpose of this study was to evaluate how much of the variance in emotional status amongst Taiwanese cancer patients could be accounted for by opioid-taking self-efficacy.

Methods: This cross-sectional study included 109 cancer patients who had taken prescribed opioid analgesics for cancer related pain in the past week and completed the Opioid-Taking Self-Efficacy Scale-CA (OTSES-CA) and Hospital Anxiety and Depression Scale.

Results: There was a significant and negative correlation between scores on anxiety and self-efficacy total scale ($r = -0.29, p < 0.01$), self-efficacy communication subscale ($r = -0.37, p < 0.01$), self-efficacy acquiring help subscale ($r = -0.22, p < 0.05$) and self-efficacy managing treatment related concerns subscale ($r = -0.32, p < 0.01$). However, the correlation between scores on depression and the self-efficacy total scale was not significant ($r = -0.18, p > 0.05$); only the self-efficacy communication subscale was significantly and negatively associated with depression ($r = -0.27, p < 0.01$). The opioid-taking self-efficacy total scale accounted for 8% of predicting the patients' anxiety. Opioid-taking self-efficacy subscales accounted for 20% ($R^2 = 0.20, p = 0.000$) of the variance in predicting anxiety and 10% ($R^2 = 0.10, p = 0.02$) of the variance in predicting depression.

Conclusions: This study highlights the potential importance of a patient's opioid-taking self-efficacy beliefs in their emotional status, which is relevant to cancer pain.

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1. Introduction

Pain is a common symptom for many patients experiencing an advanced cancer stage. Research has revealed that approximately 43%–63% of cancer patients, and 58%–73% of those undergoing a progressing stage of cancer, experience chronic pain during aggressive cancer treatment (van den Beuken-van Everdingen et al., 2007). Given that unrelieved pain not only affects the patients' quality of life (Eyigor et al., 2010; Holtan et al., 2007), it may motivate the patient within a cancer population to commit suicide (Holtan et al., 2007). Thus, issues related to pain management are of a high priority.

Pain management faces many challenges, mainly in its involvement of a multidimensional nature of pain experiences,

such as physical, psychological and cognitive encounters (Kwon, 2014). Specifically, pain can cause apparent beliefs of uncertainty and hopelessness and feelings of loss of control (Fortier et al., 2012; Mystakidou et al., 2007; Vallerand et al., 2007), with emotional distress being a highly consistent psychological variable that is associated with pain reported among cancer patients (Lehto et al., 2006; Mantyh, 2006). Researchers have suggested that such psychological distress is significantly correlated with shorter survival periods in cancer patients, outside of biomedical prognostic factors (Lehto et al., 2006; Mantyh, 2006). Thus, the psychological dimension of pain is an important component in the process of assessment and management of cancer pain.

Depression and anxiety are prevalent and highly comorbid in cancer populations (Cardoso et al., 2016; Iconomou et al., 2004), particularly among patients with cancer pain (Badr and Shen, 2014; Kyranou et al., 2013). Studies have shown that as high as 49% (Kroenke et al., 2010; Laird et al., 2009) and as high as 70% (Kyranou et al., 2013; Ozalp et al., 2003; Parker et al., 2007) of patients with cancer pain are at risk of developing depressive and anxious disorders, respectively. Prior research has shown that, in addition to

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cancer-related pain, additional factors affecting depression (Cardoso et al., 2016; Mystakidou et al., 2006; Smith et al., 2015) and anxiety (Cardoso et al., 2016; Lee and Lee, 2015) include age, gender, level of education, religion, the support of family/friends, metastasis, and duration of opioid medications use.

Importantly, the cognitive dimension of pain experience, such as self-efficacy, plays a central role in the psychological well-being of patients with cancer, particularly in the control of psychological distress. A significant correlation was found between cancer patients' perceived self-efficacy and their anxiety and depression (Chang et al., 2014; Offerman et al., 2010; Zhang et al., 2014) and quality of life, such as emotional well-being (Rottmann et al., 2010). For example, newly diagnosed colorectal cancer patients with higher self-efficacy have less depression and anxiety compared to patients with less self-efficacy (Zhang et al., 2014). A recent study on breast cancer patients also revealed that self-efficacy was associated with emotional well-being and had a direct effect on emotional functioning (Namkoong et al., 2010).

Self-efficacy refers to an individual's beliefs of how well a person believes that the individual can perform a specific behavior in a particular situation (Bandura, 2006). Particularly, self-efficacy affects the persistence and effort level for an individual to overcome difficult circumstances. Pharmacological agents are considered to be a keystone of cancer pain control; however, many difficulties that can affect patients' behaviors are relevant to their opioid use.

Previous studies have revealed that capability beliefs in relation to pharmacological use, for example, opioid-taking self-efficacy, can affect an individual's behavior to adhere to a therapeutic prescription for cancer pain and thus can trigger a pain relief (Liang et al., 2008b). Opioid-taking self-efficacy refers to the patients' capability beliefs in relation to prescribed opioid analgesic taking to managing cancer pain. Self-efficacy is a potentially modifiable variable and by itself, it can provide the basis for effective interventions to improve health outcomes. Thus the purpose of the present study was to evaluate how much of the variance in emotional status amongst Taiwanese cancer patients with pain could be accounted for by opioid-taking self-efficacy.

2. Methods

2.1. Sample and procedure

The sampling frame included all cancer outpatients with pain who had been admitted to the oncology units of one teaching hospital in the Taipei area of Taiwan. Eligible participants were invited for enrollment if they met the following inclusion criteria: (1) had a cancer diagnosis, (2) had been prescribed opioid analgesics for cancer-related pain on an around the clock (ATC) ± as needed (PRN) basis and had consumed the medication for at least the previous week, (3) were over 18 years of age and (4) were conscious and able to sign a consent form. The exclusion criteria included patients with: (1) prescribed opioid analgesics that were administered by caregivers (2) impaired cognition. The study was approved by the ethics committee of the institution where the teaching hospital is located.

Data collection for the present study was between February 2012 and July 2012 and used a convenience sample. Information of participants who had been prescribed opioid analgesics for cancer-related pain and their diagnosis and cancer metastases were identified using hospital medical charts. Eligible patients were invited to participate by the research investigator. Patients who showed an interest were provided with additional verbal information. When verbal consent was obtained, the patient information sheet, consent form, and self-administered questionnaire were presented such that the potential patient could decide whether to

participate in this study. After the patients had completed the questionnaire, the investigator confirmed any omitted information on the document. The participants were invited to complete the items that they had missed. The investigator collected information relevant to medical characteristics from the participants' medical records. A total of 37 patients refused to participate, with most (33 patients) indicating being unwell or as being inconvenient as their reason for refusal and four patients refusing to participate after providing verbal consent due to the "excessive" length of the questionnaires (See Fig. 1).

2.2. Demographic and medical variables

Demographic variables included gender, age, education level, married status, living status, religious affiliation, work status, financial means, and household income. In addition, medical variables including location of the cancer, metastases status, duration that the patient had experienced pain, frequency of pain, opioids taken, opioid side effects, and opioid adjuncts were examined.

2.3. Hospital Anxiety and Depression Scale (HADS)

Emotional status was measured using the Hospital Anxiety and Depression Scale (HADS) (Zigmond and Snaith, 1983). The HADS is a 14-item questionnaire consisting of two seven-item subscales, 7 items assessing anxiety and 7 items assessing depression. Each item was scored on a four point (0–3) scale, which generated scores for generalized anxiety (0–21) and depression (0–21). Scores was categorized as follows: normal 0–7, mild 8–10, moderate 11–14, and severe 15–21. Scores for the entire scale range from 0 to 42, with higher scores indicating more emotional distress. The coefficient alphas for the two subscales were 0.74 for anxiety and 0.70 for depression (Zigmond and Snaith, 1983). The coefficient alphas for the Chinese version in a cancer population for the two subscales were 0.84 for anxiety and 0.76 for depression (Chen et al., 2000).

2.4. Opioid-taking self-efficacy

The Opioid-Taking Self-Efficacy Scale–Cancer (OTSES-CA) is a 30-item questionnaire used to measure the multiple property of self-efficacy in relation to opioid analgesic use. Items were graded using a scale ranging from 0 to 10, with 0 signifying "not at all confident" and 10 signifying "completely confident." Given the subjects' responses on the 11-point scale, a summarized total score and a variety of subscores for the subscales were obtained. A higher score indicated greater perceived opioid-taking self-efficacy.

The construct validity of the OTSES-CA was developed by Liang, Yates, Edwards, and Tsay (Liang et al., 2008a). Factor analysis

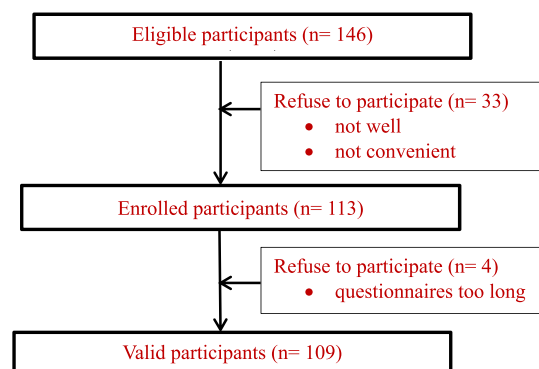


Fig. 1. Diagram of participant enrolment and participation.

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