Patient-related attitudinal barriers to cancer pain management among adult Jordanian patients

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目的：评价成年约旦患者癌症疼痛管理中的态度障碍，并探讨态度障碍、疼痛、以及人口统计学变量之间的关系。

方法：这项描述性相关性研究，从约旦地区综合癌症中心的 outpatient cancer clinic 招募了 150 名患有癌症疼痛的约旦成人。患者完成阿拉伯版的 Barriers Questionnaire (ABQ-II)，阿拉伯版的 Brief-Pain-Inventory (ABPI)，以及人口统计学问题。

结果：超过一半的参与者为男性（61%），平均年龄为 44 岁，受教育年限平均为 14.5 年。ABQ-II 总分平均（SD）为 2.3（0.8），范围为 0–5，得分越高表示障碍越强烈。年龄较大的患者有显著更多的障碍，并在对危害效果和沟通方面的得分为高。受教育程度较高的患者有显著较低的宿命论信念。有更高障碍的患者有显著更高的最严重疼痛水平。疼痛影响日常生活活动与宿命论子维度呈正相关。

结论：研究提供了有用的基线数据，这些数据尚未在约旦之前出现。这些数据可以用于规划和测试干预措施，以了解和改善患者的癌症疼痛管理态度，并允许对跨文化进行比较。

1. 介绍

全球范围内对癌症疼痛的统计结果表明，50%的患者在所有阶段的疾病中，70%的患者在患有高级别癌症时报告有疼痛（Portenoy et al., 2013；Parás-Bravo et al., 2017）。为了达到最佳的癌症疼痛管理，障碍存在于患者、临床医生，以及医疗系统中（Kwon, 2014）。障碍在疼痛管理中存在于患者是国籍态度障碍基于对疼痛和疼痛管理的误解或信息混淆，以及其管理（Kwon et al., 2013；Lin et al., 2015）。

据估计，30–50%的患者在早期和中期癌症期间经历的疼痛程度为严重，以及许多涉及 75% 的患者在高级别癌症期间经历的疼痛，25–30% 的患者经历严重疼痛（Miller et al., 2016）。同样，大约 95% 的癌症患者可能因疼痛而被错误地管理（Dowell et al., 2016）。但是，来自世界各地的支持表明，许多患有癌症的患者仍然收到不适当的麻醉剂和与不可接受的疼痛水平生活（Cleary et al., 2013；Liang et al., 2013；Blaney et al., 2016）。此外，患者可能选择不使用可用的资源来管理疼痛，因为他们有错误的信念。BQII 识别了八种态度障碍（对成瘾的担忧、宿命论、耐受性、监控、抱怨、分心、免疫功能和副作用），这些障碍对使用麻醉剂、疼痛严重性以及生活质量有负面影响。

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life (Gunnarsdottir et al., 2005; Greco et al., 2014). These barriers were identified by patients’ self-report on the Barriers Questionnaire-II (BQ-II) (Gunnarsdottir et al., 2017).

In Jordan, however, only a few research studies were found concerning pain or pain management in general, and even fewer research studies were conducted to describe the prevalence of attitudinal barriers to cancer pain management. Instruments to conduct such research have been lacking. The Barriers Questionnaire (BQ-II) is an instrument developed to measure barriers to cancer pain management (Gunnarsdottir et al., 2005). In order to use the BQ II in Jordan, the instrument was translated to the Arabic language, its psychometric properties examined, and a feasibility study using the questionnaire in its Arabic translation was conducted. The results proved the Barriers Questionnaire (BQ II), Arabic version (ABQ-II) to be a reliable measure of barriers to cancer pain management. The purposes of the present study were to evaluate the attitudinal barriers to cancer pain management among adult Jordanian patients and to explore relationships between attitudinal barriers, pain, and demographic variables. Understanding attitudinal barriers to pain management can enable nurses and other health care providers to design and offer appropriate health education programs for cancer pain management.

2. Methods

2.1. Sample

A convenience sample of 150 Jordanian patients with cancer was recruited from the outpatient cancer clinic at a regional comprehensive cancer center in Jordan. Inclusion criteria were a) age 18 years and older, b) ability to read and write Arabic, c) receiving treatment at the regional comprehensive cancer center in Jordan, and d) had experienced cancer-related pain in the past week.

2.2. Instruments

2.2.1. Demographic characteristics

Participants answered questions regarding gender, age, marital status, education, employment and income.

2.2.2. Attitudinal barriers

The Barriers Questionnaire-II (BQ-II) is a 27-item self report instrument developed by Gunnarsdottir and her colleagues designed to measure the extent to which people endorse eight beliefs about reporting cancer pain and using analgesics that can act as barriers to pain management (Gunnarsdottir et al., 2002). The eight beliefs are 1) fear of addiction; 2) concerns about tolerance; 3) concerns about side effects; 4) fatalistic beliefs; 5) desire to be a ‘good’ patient; 6) fear of distracting one’s physician from treating the disease; 7) concerns about ability to monitor changes in one’s body; and 8) fear that opioids impair immune function. The BQ-II consists of 4 subscales: a) Physiological effects, which consists of 12 items about the physical effects of cancer pain and the side effects of analgesics; b) Fatalism, which consists of 3 items reflecting cancer pain is inevitable; c) Communication, which consists of 6 items regarding communication with the physician; and d) Harmful effects, which consists of 6 items about potential harmful effects of analgesics (Gunnarsdottir et al., 2002). Participants rate the extent to which they agree with each item on a numeric scale, ranging from 0 (Do not agree at all) to 5 (Agree very much). Mean scores for the total scale and subscales are used for analyses, with higher scores indicating stronger barriers. The psychometric properties of the BQ-II have been assessed in different clinical samples of patients with cancer, and have been shown to be robust (Gunnarsdottir et al., 2005; Gunnarsdottir et al., 2017). The BQ-II total had an internal consistency of 0.89, and Cronbach alpha for the subscales ranged from 0.75 to 0.85. Mean and standard deviation (SD) scores on the total scale was 1.52 (0.73) (Gunnarsdottir et al., 2005; Gunnarsdottir et al., 2017). The BQ-II in its Arabic version was used to evaluate attitudinal barriers to cancer pain management. Internal consistency (Cronbach’s Alpha) for the ABQ-II total scale is .815, and the alpha for the subscales ranged from 0.60 to 0.81.

2.2.3. Pain severity and pain interference with life activities

The Brief Pain Inventory (BPI) is a frequently used multiple-item measure of pain severity in cancer research (Daut et al., 1983; Cleeland and Syrsjala, 1992; Cleeland and Ryan, 1994). The BPI in its Arabic version (ABPI) was used to evaluate presence of pain, severity of pain, and pain interference with life activities in the sample of participants. Internal consistency for the total ABPI (Cronbach’s Alpha) was 0.92, for the severity scale was 0.88, and for the interference scale was 0.94. The BPI contains one item that evaluates the presence of pain, and another that evaluates location of pain. Four items are used to assess pain severity. Participants report their worst, least, and average pain during the past 24 h, and their current pain level on a scale of 0 (no pain) to 10 (pain as bad as I can imagine). Participants also used a scale of 0–10 to report how much their pain has interfered with various activities of daily function, and to estimate the percent of relief they received from their current pain treatment. One item, designed to record the treatments or medications used by the individual, was evaluated with an open-ended question. Many studies have shown that the BPI has a high internal consistency with Cronbach alpha reliability ranging from .77 to .91 for the total BPI. Coefficient alphas in six international studies were ranged from 0.78 to 0.88 for the Pain Severity Scale. And 0.78 to 0.92 for the Pain Interference Scale in a variety of samples of persons with cancer (Furler, 2013; Webber et al., 2014; Ham et al., 2015; Ferreira et al., 2015; Budnick et al., 2016; Azevedo et al., 2017; Majedi et al., 2017; Shin et al., 2017).

2.3. Ethical consideration

Ethical approval for the study was obtained from the Institutional Review Board (IRB) of Wayne State University in the USA and then from the Ethics Committee of the regional comprehensive cancer center in Jordan. A research assistant explained the study aims, procedures, and participants’ role in the study to all prospective participants before they started. Participation in the study was voluntary, and the participants had the permission to withdraw at any stage of the research. The identities of the participants were not disclosed, and only aggregate data were reported.

2.4. Procedure

Patients in the outpatient waiting area of the regional comprehensive cancer center in Jordan were screened by asking them if they had pain during the past week or not. Those responding positively were asked to participate in this study. Data were collected from patients in the waiting area prior to their scheduled appointment at the outpatient clinic. Because the waiting area was used by multiple oncology services, data were collected on different days of the week and at different times of day; so that all appointment time intervals were equally represented ensuring the sample was representative of patients in the cancer center.

3. Results

3.1. Descriptive statistics

The majority of the sample was male (61%), with a mean age of 44 years (SD = 16.6) and a range from 19.0 to 74.5 years. Thirty-three percent of the sample listed university education (length of education 16 years) as their highest level of education, 25% had completed high school (length of education 12 years), and 16% had a college education (length of education 14 years). Most of participants were married (61%) and only 34% worked full time outside of the home. Almost half of all
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