Nacionalni inštitut za javno zdravje

Svit

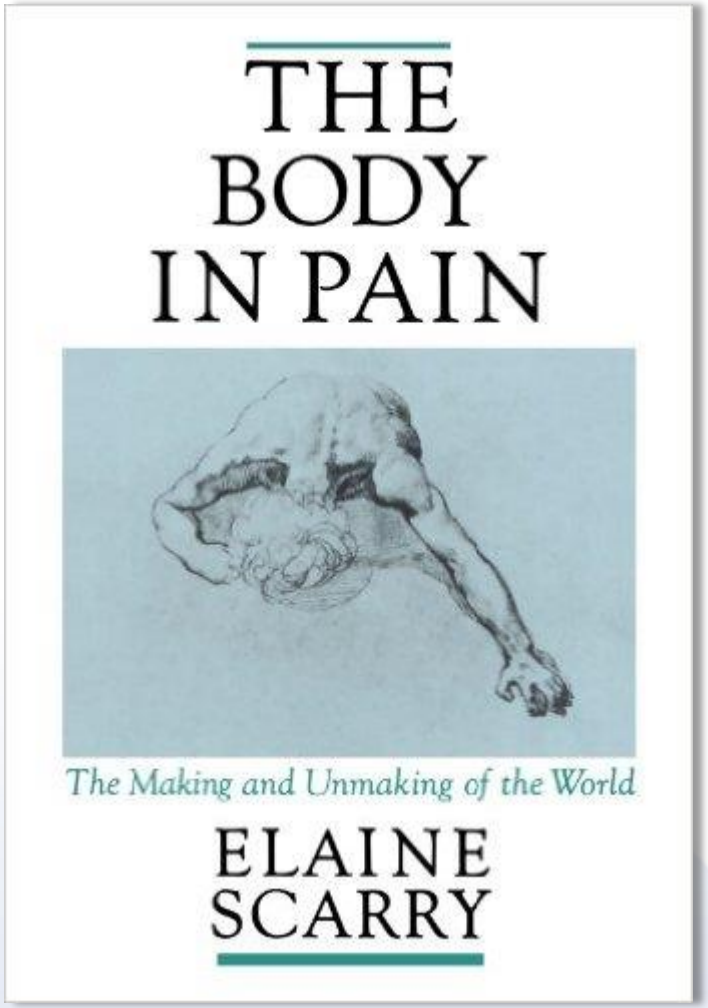
DRŽAVNI PROGRAM PRESEJANJA IN ZGODNJEGA ODKRIVANJA PREDRAKAVIH SPREMEMB IN RAKA NA DEBELEM ČREVESU IN DANKI

Vpliv kulture na dojemanje in obvladovanje bolečin

Marjeta Keršič Svetel
Mag. Ajda Jelenc

NIJZ, Center za upravljanje programov preventive in krepitve zdravja

SVITOV DAN 2016

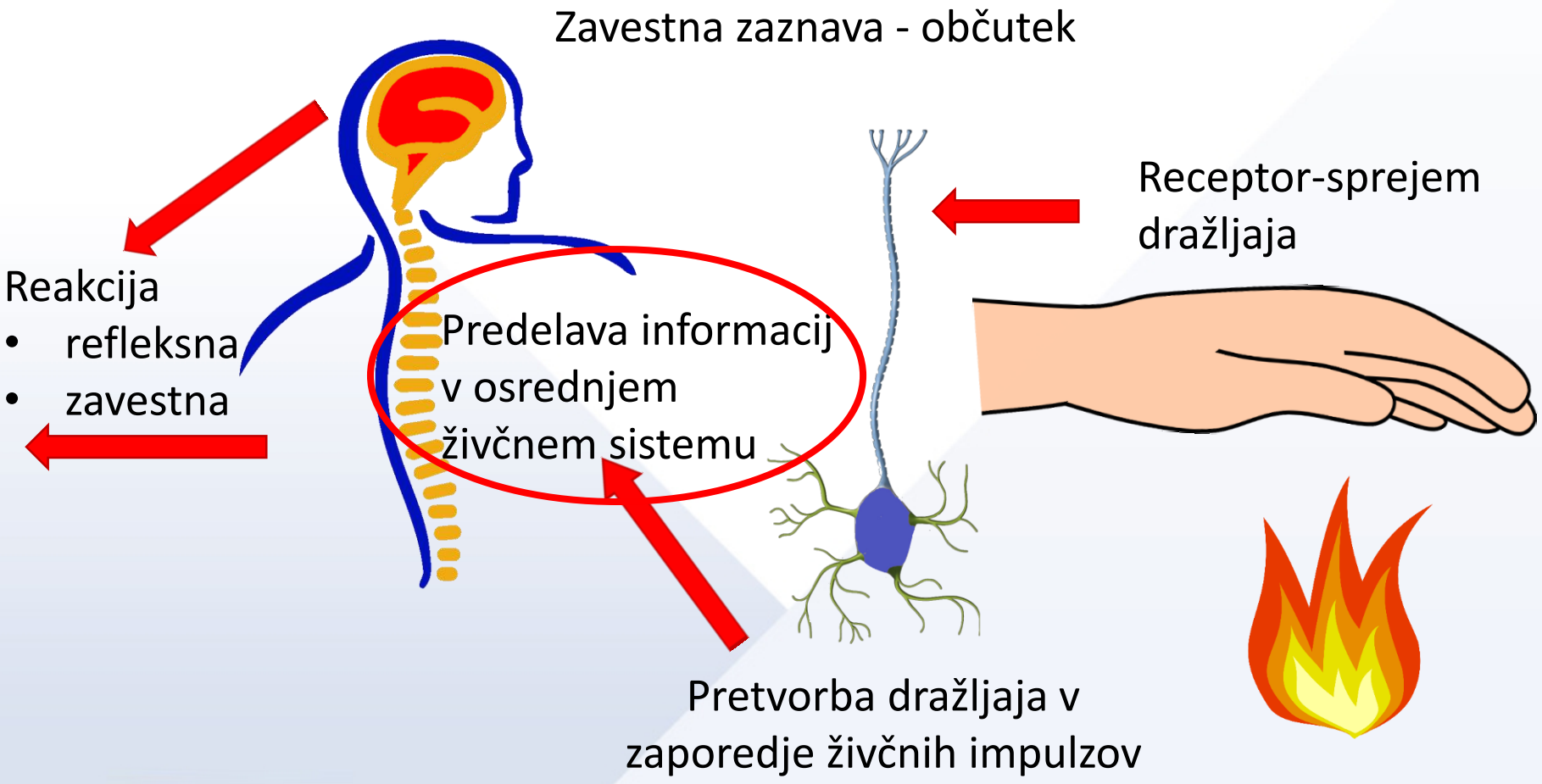


Bolečina ni samo negativna izkušnja – bolečina je negacija vsega. Močna bolečina izbriše vse ostalo dojemanje sveta, izbriše celo jezik, s katerim se sicer lahko izražamo in svetu posredujemo svoja doživetja, se dotikamo svetov drugih ljudi in gradimo skupno stvarnost.

Kogar doleti bolečina, občuti popolno gotovost glede tega, kaj čuti… poslušati o bolečini drugih pa pomeni dvomiti o tem, kaj se v resnici dogaja.

Scarry, Elaine (1985) The Body in Pain: The Making and Unmaking of the World. New York, Oxford University Press

Bolečino so dolgo razlagali kot linearen proces odziva na čutni dražljaj.
Taka razlaga pa je mnogo preveč poenostavljena!



Beecher Henry Knowles
(1904-1976)

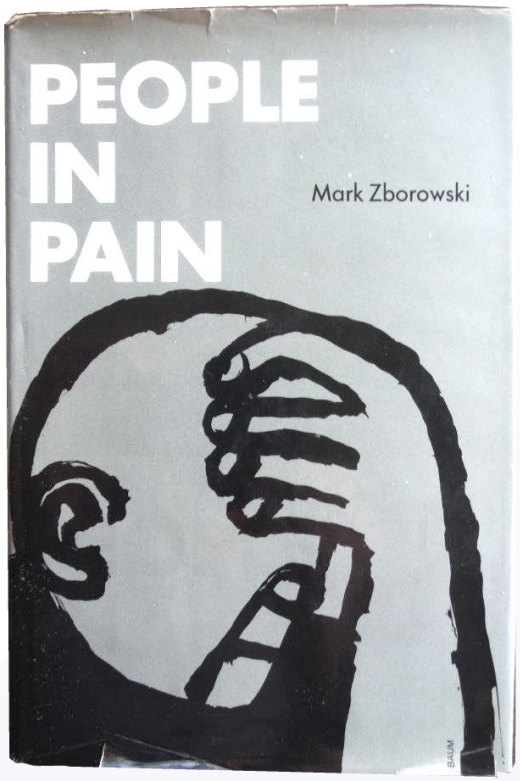
Three-quarters of badly wounded men, although they have received no morphine for a matter of hours (Table I), have so little pain that they do not want pain relief medication, even though the questions raised remind them that such is available for the asking. This is a puzzling thing and perhaps justifies a little speculation. It is to be remembered that these data were obtained entirely from wounded soldiers. A comparison with the results of civilian accidents would be of interest. While the family automobile in a crash can cause wounds that mimic many of the lesions of warfare it is not at all certain that the incidence of pain would be the same in the two groups. Pain is an experience subject to modification by many factors: wounds received during strenuous physical exercise, during the excitement of games, often go unnoticed. The same is true of wounds received during fighting, during anger. Strong emotion can block pain. That is common experience. In this connection it is important to consider the position of the soldier: His wound suddenly releases him from an exceedingly dangerous environment, one filled with fatigue, discomfort, anxiety, fear and real danger of death, and gives him a ticket to the safety of the hospital. His troubles are about over, or he thinks they are. He overcompensates and becomes euphoric, as Douglas Kelling has found. Whether this actually reduces the pain remains unproved. On the other hand, the civilian's accident marks the beginning of disaster for him. It is impossible to say whether this produces an increased awareness of his pain, increased suffering; possibly it does.

Mark Zborowski, medicinski antropolog (1908 –1990)

Z načrtnimi raziskavami je potrdil izkustveno opažanje, da pripadniki različnih etničnih skupin v ZDA zelo različno doživljajo bolečino in različno ravnajo, ko doživljajo bolečine.

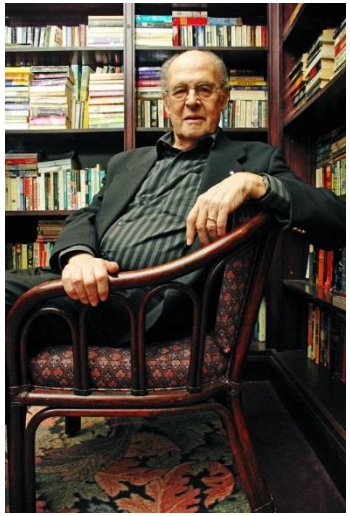
Ugotovil je, da gre predvsem za razlike v priučenih obrazcih razmišljanja in ravnanja – torej za kulturne razlike. Te se kažejo predvsem:

- Pri razvrščanju na različne tipe bolečin;
- Pri opisovanju bolečine;
- Glede tega, ali je bolečina pričakovana;
- Glede sprejemanja bolečine;
- Glede osmišljanja bolečine;
- Glede izražanja bolečine.

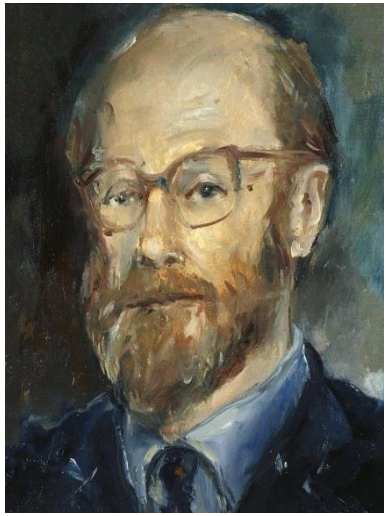


Mark Zborowski (1969) People in Pain. San Francisco: Jossey-Bass

Zborowski je ugotovil tudi, da strah igra zelo pomembno vlogo pri doživljanju bolečine.

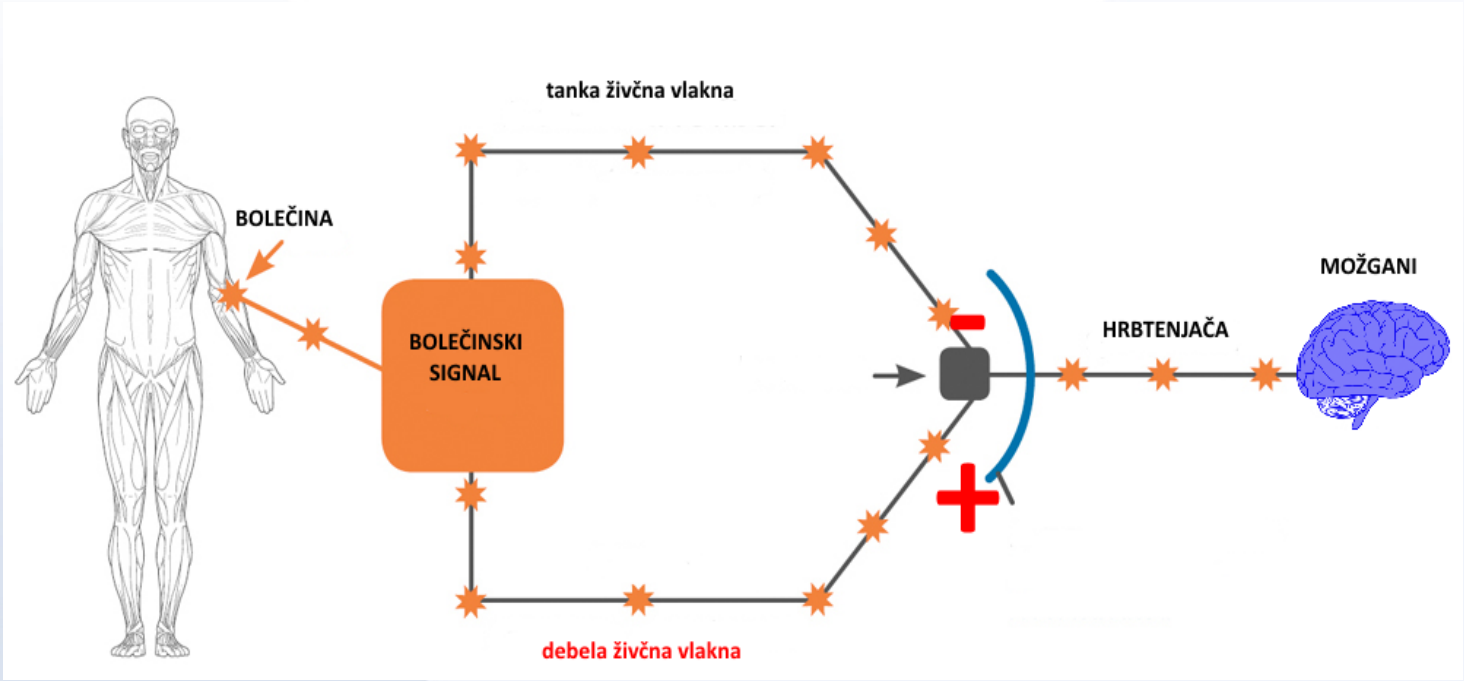


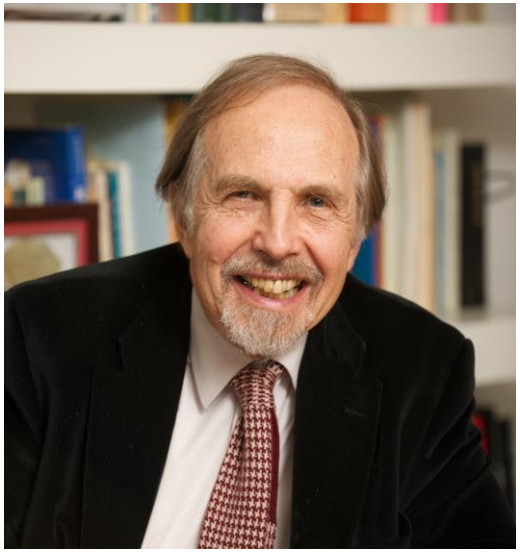
Ronald Melzack

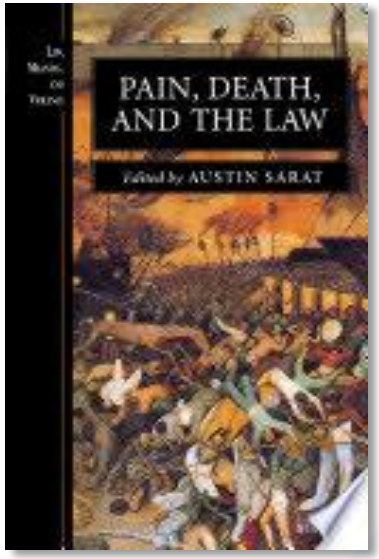


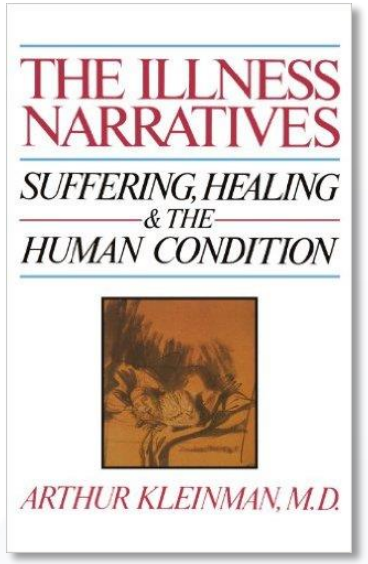
Patrick David Wall

Teorija kontrolnih vrat 1965: pojasnjuje, kako lahko psihološki procesi in zunanji dejavniki vplivajo na zavestno zaznavo bolečine.





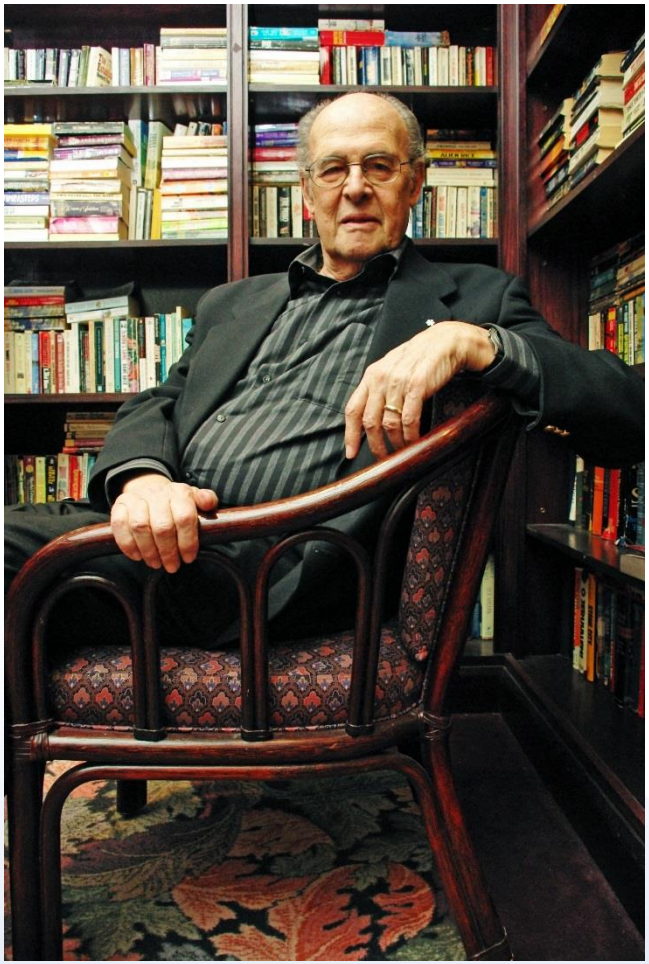




Arthur Kleinman (1941 →)
Psihiater in medicinski antropolog

- Bolečina je ena od temeljnih človeških izkušenj in kot taka igra pomembno vlogo v vseh družbah – se pa ta vloga od okolja do okolja lahko močno razlikuje;
- Bolečina in trpljenje sta pogosto orodji za obvladovanje;
- Kulturo pomembno zaznamujejo obrazci soočanja z bolečinami in trpljenjem drugih.

„Podcenjevanje trpljenja drugega in odrekanje pravice, da oseba sama pove, koliko in kako boli, je eno najhujših orodij ponižanja in razvrednotenja človeka.“



Dr. RONALD MELZACK

BOLEČINA

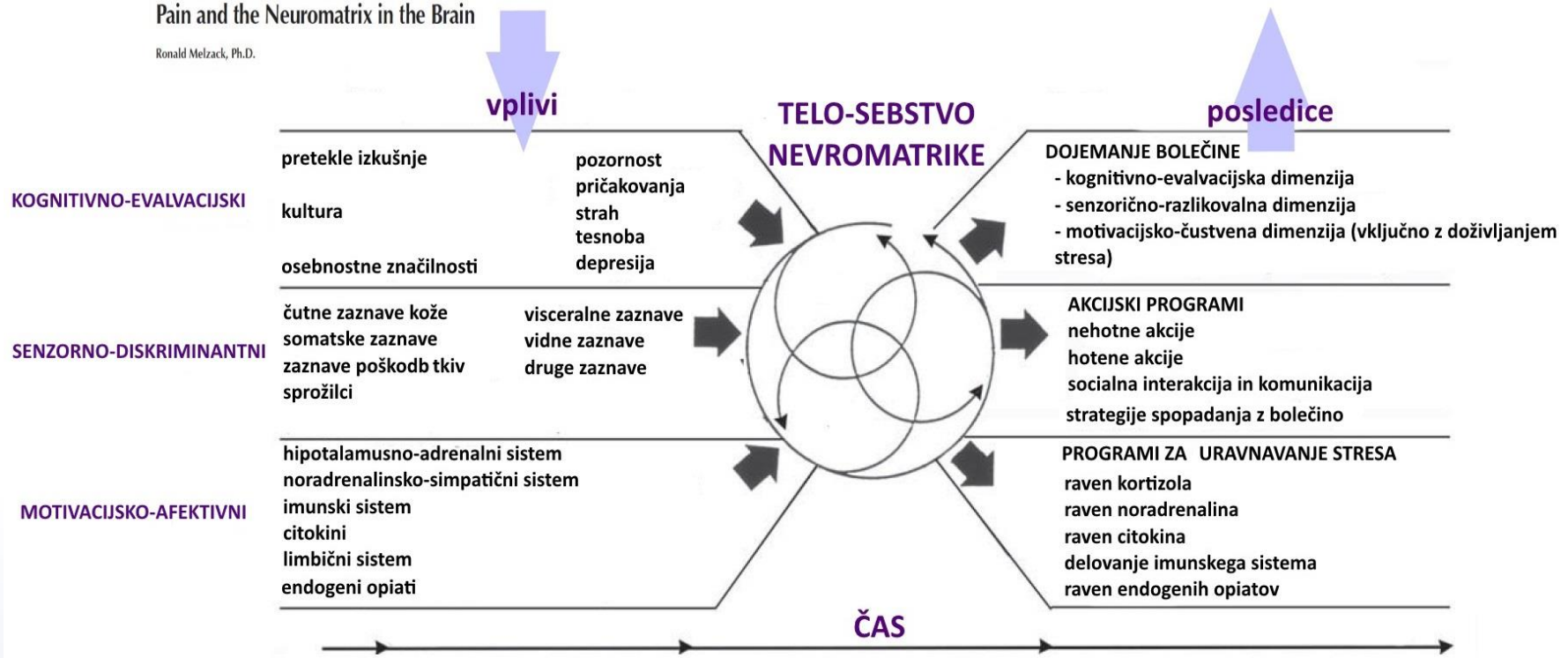
Bolečina je osebna, subjektivna izkušnja. Nanjo vpliva kultura, priučeni obrazci vedenja, pomeni, okoliščine, pozornost, pa tudi drugi psihološki vplivi.

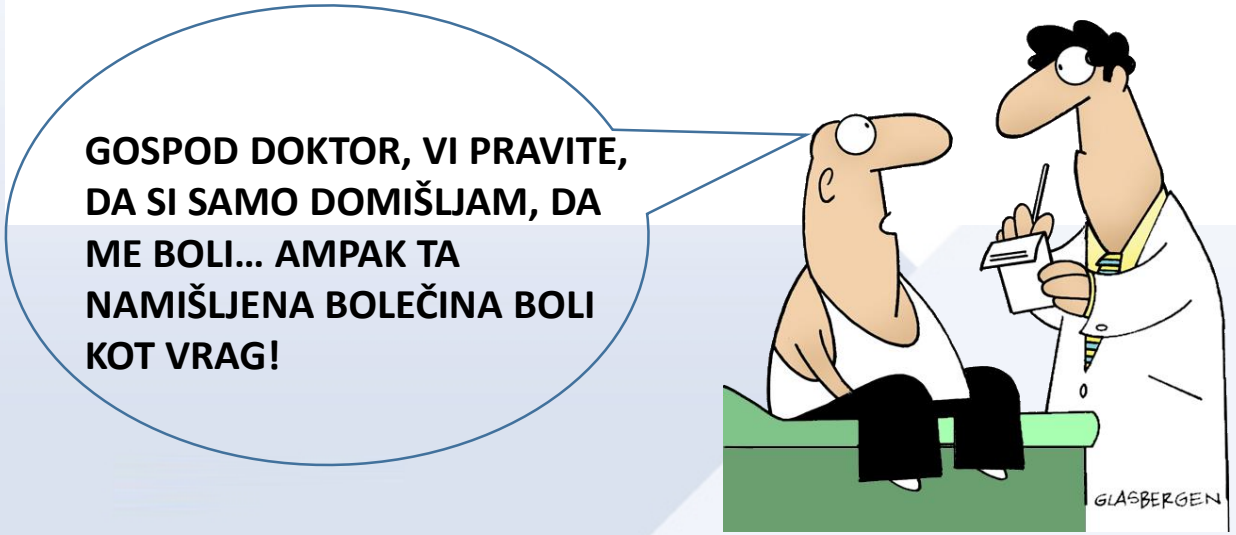
Proces bolečine se ne začne z dražljaji živčnih receptorjev. **Poškodba ali bolezen povzročita živčne signale, ki vstopajo v dejaven živčni sistem, ki je pri odraslem organizmu kompleksen preplet preteklih izkušenj, kulture in še cele kopice okoljskih in osebnostnih vplivov**.

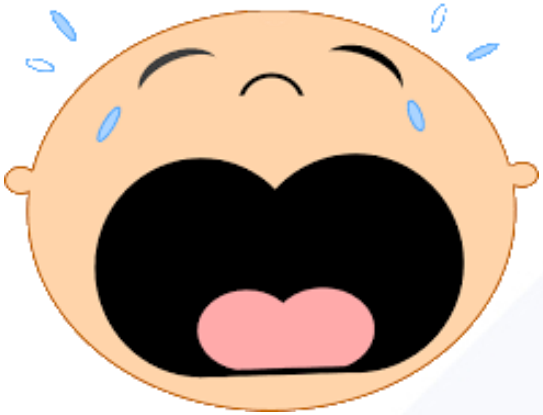
Ti številni procesi v možganih dejavno sodelujejo pri razvrščanju, abstrahiranju in analizi informacij, ki jih dobimo preko čutnih zaznav. **Bolečina ni preprosto rezultat linearnega prenosa informacij po živčnem sistemu. Bolečina je dinamičen proces, v katerem nenehno sodelujejo zelo kompleksni sistemi**, ki lahko delujejo zaviralno ali pospeševalno, doživljanje bolečine pa potencirajo ali omilijo.

Teorija nevromatrik nas vodi stran od kartezijanskega dojemanja, da je bolečina linearna posledica poškodbe, vnetja ali kake druge tkivne patologije in v smeri razumevanja, da je bolečina izkušnja z mnogimi razsežnostmi, na katero vplivajo številni dejavniki.

Melzack, Ronald, Katz, Joel (2013) Pain . Wiley Interdisciplinary Reviews: Cognitive Science, 4/1, str. 1939-5086.


Pain and the Neuromatrix in the Brain
Ronald Melzack, Ph.D.
vplivi
TELO-SEBSTVO
NEVROMATRIKE
posledice
KOGNITIVNO-EVALVACIJSKI
pretekle izkušnje
kultura
osebnostne značilnosti
pozornost
pričakovanja
strah
tesnoba
depresija
DOJEMANJE BOLEČINE
- kognitivno-evalvacijska dimenzija
- senzorično-razlikovalna dimenzija
- motivacijsko-čustvena dimenzija (vključno z doživljanjem stresa)
SENZORNO-DISKRIMINANTNI
čutne zaznave kože
somatske zaznave
zaznave poškodb tkiv
sprožilci
visceralne zaznave
vidne zaznave
druge zaznave
AKCIJSKI PROGRAMI
nehotne akcije
hotene akcije
socialna interakcija in komunikacija
strategije spopadanja z bolečino
MOTIVACIJSKO-AFEKTIVNI
hipotalamusno-adrenalni sistem
noradrenalinsko-simpatični sistem
imunski sistem
citokini
limbični sistem
endogeni opiati
PROGRAMI ZA URAVNAVANJE STRESA
raven kortizola
raven noradrenalina
raven citokina
delovanje imunskega sistema
raven endogenih opiatov
ČAS


GOSPOD DOKTOR, VI PRAVITE, DA SI SAMO DOMIŠLJAM, DA ME BOLI… AMPAK TA NAMIŠLJENA BOLEČINA BOLI KOT VRAG!
GLASBERGEN



bolečina zaradi zavrnitve

+

bolečina zaradi potolčenega kolena

ZELO BOLI!

Odlomek iz neke diplomske naloge – s citatom iz strokovne literature:

Vzroki napak pri oceni bolečine s strani bolnikov so v njihovi nepoučenosti, neosveščenosti in pretirani potrpežljivosti. Bolniki in svojci imajo pogosto napačne informacije o analgeziji in zdravljenju bolečine. Bolniki zdravstvenih delavcev ne obveščajo o prisotnosti bolečine zaradi napačnega prepričanja v zvezi z bolečino. Bojijo se neprijetnih stranskih učinkov analgetikov (bruhanje, slabost) strah jih je prevelikih odmerkov in odvisnosti. Bolniki se ne pritožujejo, da ne bi motili zdravstvenega osebja pri njihovem delu. Pogosto je nejasna komunikacija med medicinsko sestro in bolnikom (Šmitek in Krist, 2008, str. 188).

Kako lahko te trditve premislimo v luči kulturno kompetentne zdravstvene obravnave?

Odnos do bolečine (fizične ali psihične) se kaže tudi v frazah in zapovedih, ki jih posameznik sprejema preko bližnje okolice (družina, prijatelji idr.) ter širše družbe (npr. avtoritete v šolskem sistemu ali v delovni organizaciji, preko množičnih medijev).

Kaj se pa cmeriš!

Daj no, ne jamraj za prazen nič.

Fantje ne jokajo!

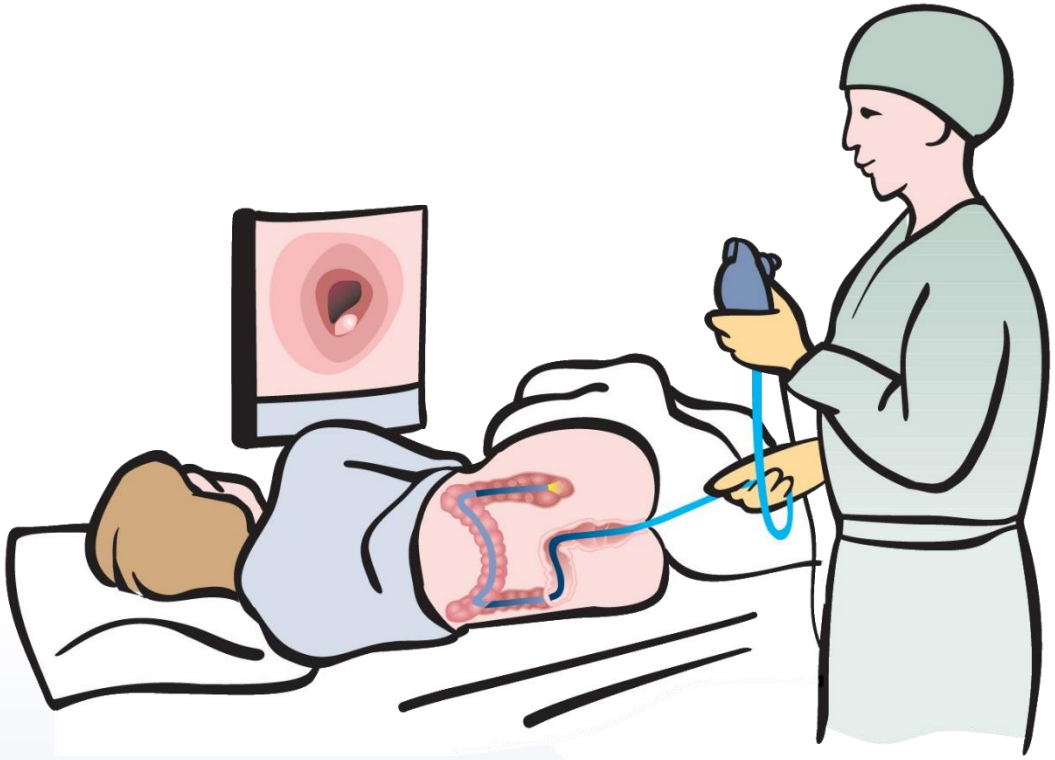
Saj si moški, boš že zdržal.

Treba je stisnit zobe!

Sedaj boš pa moral malo potrpet.

Boli me za znoret, boli me za umret!

Za lepoto (zdravje) je treba potrpet.



V Sloveniji kolonoskopijo rutinsko izvajamo brez sedacije – kar je naša posebnost. Med razvitimi državami je z nami primerljiva Finska – tudi tam okoli 80% kolonoskopij izvedejo brez sedacije.

Seveda na doživljanje bolečine pri kolonoskopiji predvsem vpliva izvajanje same preiskave (zlasti raztezanje mišic debelega črevesa).

Nič manj resnični pa niso drugi dejavniki, ki vplivajo na izkušnjo bolečine pacienta:

- **Osebnostni** (psihološki; pretekle izkušnje; strah in tesnoba; trenutni osebni življenjski položaj…)
- **Kulturni** (pričakovanja, vedenjske norme, vprašanje samopodobe, moči, naučeni obrazci soočanja z bolečino, vrednote.. …)

ALI SO BOLEČINE NA KOLONOSKOPIJI SMISELNE?

J.K. Spender, British Medical Journal 1887:

April 16, 1887.] THE BRITISH MEDICAL JOURNAL. 819

disease, chlorate of potash should be given, with the object of keeping the child alive during its further detention *in utero*. Simpson's theory was that, because chlorate of potash contained six atoms of oxygen to one of chlorine and one of potassium, it would sensibly increase the amount of oxygen in the mother's blood, and afford a larger proportion of this element for the placental respiration of the fœtus. The maternal blood-current being thus more abundantly charged with oxygen than under ordinary circumstances, a smaller portion of sound placenta could absorb more for the requirements of the fœtus, and so supplement the function of those parts of the organ damaged or destroyed. Whether this theory be true or not, it is certain that many practitioners have testified to its utility as well as to its harmlessness. Dr. Playfair suggests that it may act, in virtue of its tonic properties, on the constitution of the mother; and I think it may act usefully as an alkaline salt in preventing the formation of coagula and fibrinous deposits in the placenta. It is given in ten or fifteen grain doses three times a day, and may be administered at any period of pregnancy, but it is believed to be most useful in the latter half.

The induction of premature labour, also recommended by Simpson as a means of averting the death of the child *in utero*, is only available in those cases where it dies in successive pregnancies after the expiration of the seventh month. At any period antecedent to this the child would not be viable, or would be so feeble that nothing would be gained by the proceeding. But in a limited number of instances it has been observed that placental disease begins apparently just before the seventh month, and gradually and steadily advances until it kills the child and its movements cease to be felt by the mother. With such experience of past times to guide the practitioner, the induction of labour is perfectly justifiable if the movements of the child continue to be felt after the seventh month is completed; and the operation is the more imperative if the movements grow slower and feebler, and the stethoscope indicates a declension of strength in the beating of the fœtal heart. In this way children's lives have been saved which would probably have been sacrificed by further delay.

In patients in whom intra-uterine death is threatened or feared as the result of some form of poison, inorganic or organic, to which I have alluded, the treatment must necessarily be prophylactic, and consists in the removal of the cause. In those special instances where the progress of zymotic disease or of inflammation in some organ of the patient's body is attended with high temperature, it is possible some attempt may be made to avert the usual consequences so far as the pregnancy is concerned. As the experiments of Runge and others have shown that peril comes to the child *in utero* directly the temperature of the mother rises persistently up to 105°, while the infant's temperature rises still higher, it may be possible, in the progress of science, not only to keep down the general maternal hyperpyrexia, but I would throw out the suggestion that, where it is feasible, an attempt should be made to lower also the temperature of the uterus and of the fœtus, either by the application of ice-bags to the maternal abdomen, or of those tubular appliances so ingeniously invented for the application of cold, and which may be modified to fit any part of the body.

When all our most ingenious methods of diagnosis and treatment are exhausted in attempting to obviate intra-uterine death, there will still be a large number of cases in which no further clue can be found than an obvious constitutional feebleness, permanent or temporary, in one or both parents. In some of these the organic weakness or degeneration in health may be of such character that it is hopeless to expect a remedy, and perhaps it is well for the race in general that such constitutional faults or diseases should not be perpetuated in progeny. But where the constitutional weakness may be but temporary, attempts should be made to resuscitate the health. Everything that science and practice teach to be useful for the restoration of strength in single organs and in the entire system should be called into requisition.

Boerhaave is said to have recommended horse-riding as a remedy for abortion. In any case where it proved useful it would probably be by improving the general health. Apropos of this I may mention a case within my own experience, of a lady in India who, after aborting several times under the most careful system of rest—in some pregnancies amounting to absolute repose for many months in the recumbent posture—at length gave up the hope of bearing children, and took to riding on horseback, not only before a fresh gestation began, but after she had reason to believe that she was again pregnant. As the result she went for the first time to the full period, and was delivered of a living child.

Some of the baths and waters on the Continent have a high reputation for their tonic properties and their favourable influence on pregnancy. Aix-les-Bains is said to be useful in these cases. I have seen courses at Schwalbach and Kissingen followed by happy results. Schwalbach, perhaps, is more appropriate for patients who are more or less anæmic; Kissingen for those in whom the digestion and portal system are at fault. One successful case is fresh in my memory where a mother who had previously borne healthy children was stricken with severe pleuro-pneumonia, and continued for some time after in comparatively feeble he
again after an interv
end of six months
occurred, and this t
four months. After
improvement in he
without misadventu
My task is now e
those who have liste
I have had a sense a
field; plucking, it r
but leaving an abu
may come after me,
same ground.

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By JOHN
Physi

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open a discussion
and Pharmacology.
this duty may be
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pædias, and text-bo
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like a master to pur
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best way, which cor
ject, and comparing
experience of one man to strengthen the experience of another, gathering illustrations from many sources, and garnering the knowledge harvested from all quarters so that it may illuminate the solemn and vital issue which we medical men are expected to grasp and control.

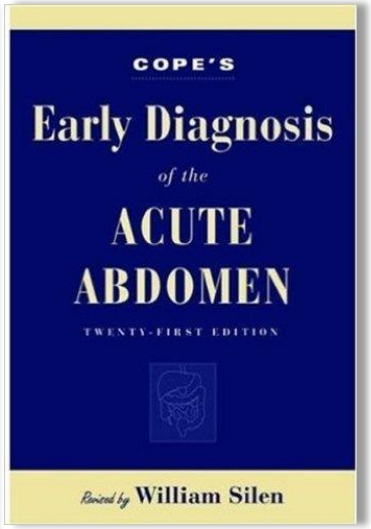
There is a charm of language in what Sir William Hamilton says when he tells us that "pleasure is the result of certain harmonious relations, of certain agreements; pain, on the contrary, is the effect of certain inharmonious relations, of certain disagreements." But Dr. Latham comes more truly home to us when he declares that "things which all men know infallibly by their own perceptive experience cannot be made plainer by words. Therefore, let pain be spoken of simply as pain." So far as the object of this paper is concerned, it is simply a waste of time to speculate upon the pathogeny of pain, or to try and define it with the precision of an axiom. And yet there lurks in every Englishman's mind a fervid desire to know the shape and the look of the enemy he has to battle with. Whenever pain is a sentinel and a beacon to warn us that something in the body is going wrong, it would be as absurd to abolish that pain as to put out the light of a lighthouse, or to obliterate the letters on a sign post; worse than absurd, it would be almost wicked. The faculty of the perception of pain, when needed as a safeguard against bodily peril, is to be cherished rather than destroyed. And it ought always to be distinguished from that disturbance of common sensibility which is purposeless, and therefore aggressive and disorganising.

A curious paradox, then, we have to face at the very opening of our debate—pain may save and pain may kill. The former comes within our scope now only as it may be out of proportion to the object which it serves; the latter claims our eager and quick regard, importunes us with shocks and cries, and will not be put out of court by the bland and trimmed phrases, "You will be better by-and-bye," "We will try and do you good," or by that most jejune formula, "The weather is against you." But, at the outset of our therapeutic business, we shall be met by the warning note which

[1] Read in the Section of Therapeutics and Pharmacology, at the Annual Meeting of the British Medical Association held at Brighton, August 10th-13th, 1887.

try and define it with the precision of an axiom. And yet there lurks in every Englishman's mind a fervid desire to know the shape and the look of the enemy he has to battle with. Whenever pain is a sentinel and a beacon to warn us that something in the body is going wrong, it would be as absurd to abolish that pain as to put out the light of a lighthouse, or to obliterate the letters on a sign post; worse than absurd, it would be almost wicked. The faculty of the perception of pain, when needed as a safeguard against bodily peril, is to be cherished rather than destroyed. And it ought always to be distinguished from that disturbance of common sensibility which is purposeless, and therefore aggressive and disorganising.

Zmožnost doživljanja bolečine, ki je varnostni mehanizem telesa in varstvo pred škodljivim dogajanjem, je treba ceniti, ne pa uničiti.



Early Diagnosis of the Acute Abdomen

Prva izdaja 1921, zadnji, 21. ponatis 2005

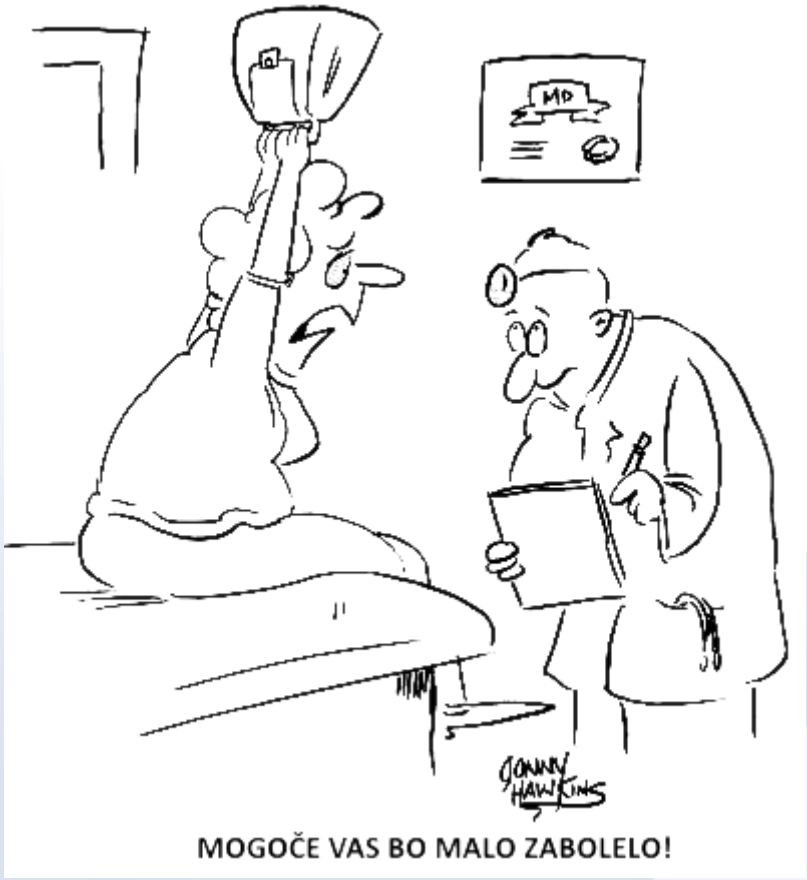
„In order to diagnose acute abdomen successfully, all clinical signs must be present in their unaltered state. Administration of analgesia would delay diagnosis and result in increased mortality.“

„Da bi uspešno postavili diagnozo v primerih akutnega abdomna, morajo biti prisotni vsi klinični znaki v nespremenjeni obliki. Predpisovanje analgezije bi povzročilo zamudo pri postavljanju diagnoze in rezultat bi biola povečana umrljivost.“

Sir Vincent Zachary Cope
(1881 –1974)

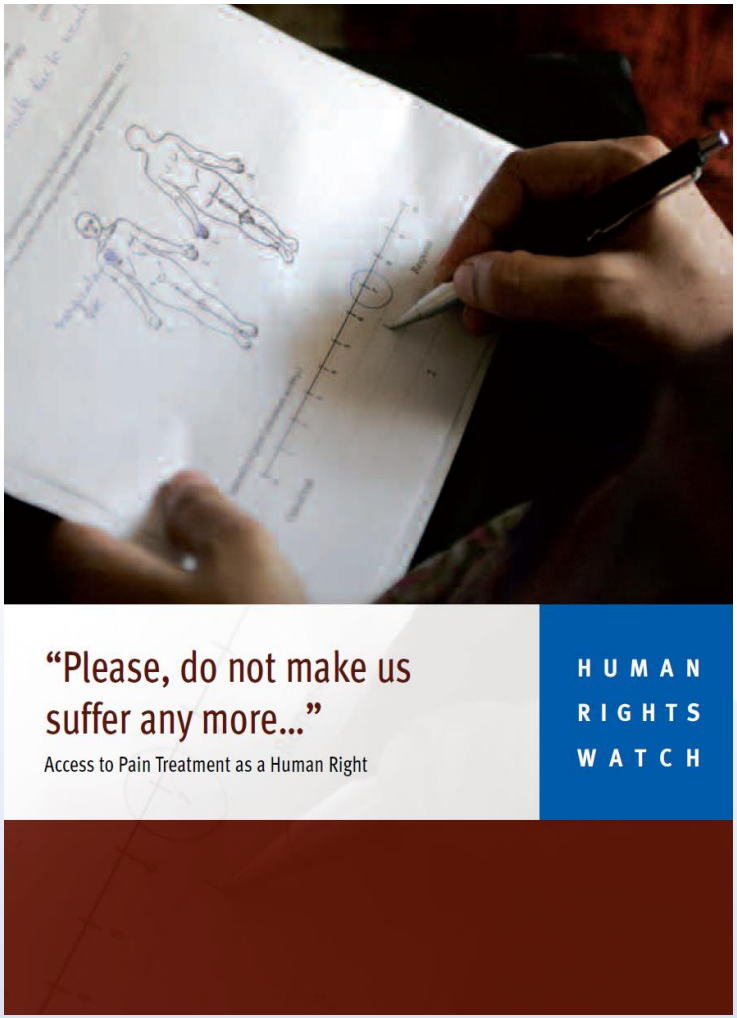
Angleški abdominalni kirurg

Izkušnja bolečine je subjektivna in intimna.
Z bolečino povezana vedenja, načini izražanja bolečine, pomeni bolečine in ukrepi za ublažitev ali odpravo bolečine pa so javna zadeva širše skupine ljudi, zmeraj odvisna od konkretnih okoliščin, odnosov, prepričanj, časa in prostora.



KULTURA VPLIVA NA:

- zaznavanje bolečine,
- dojemanje bolečine,
- odzivanje na bolečino,
- osmišljanje bolečine,
- izražanje bolečine,
- obvladovanje bolečine,
- zaznavanje in dojemanje bolečine drugega,
- odzivanje na bolečino drugega,
- norme glede tega, kdo komu lahko zadaja bolečino.



PROSIMO, NE PUSTITE NAS VEČ TRPETI… Poročilo Observatorija za človekove pravice 2009 o uresničevanju pravice do lajšanja bolečin

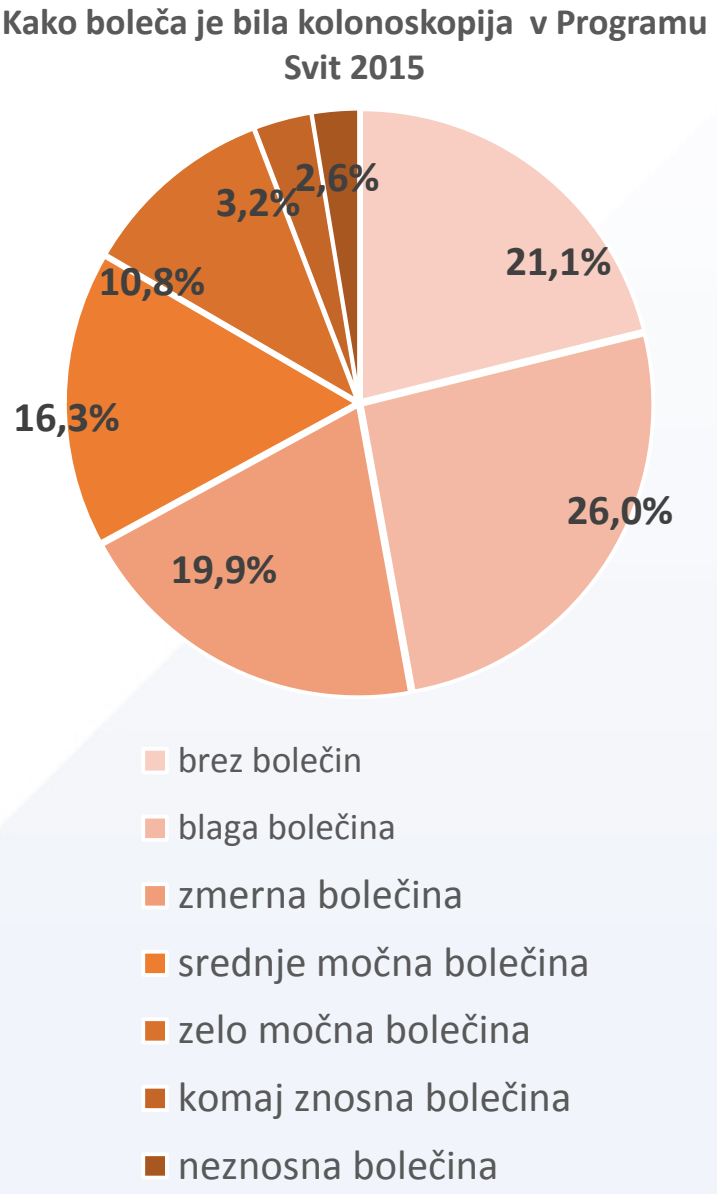
„Zdravniki se bojimo morfija. Tukaj v Keniji bolniki umirajo v hudih bolečinah… tega smo zdravniki navajeni. Če kdo umre, ne da bi prej trpel bolečine, se to nekako zdi sumljivo… Kot da je umrl prezgodaj, po nepotrebnem.“

Str. 1, zapis pogovora z zdravnikov v hospicu v Nairobiju, Kenija, junija 2007

Pokolonoskopski vprašalniki 2015:

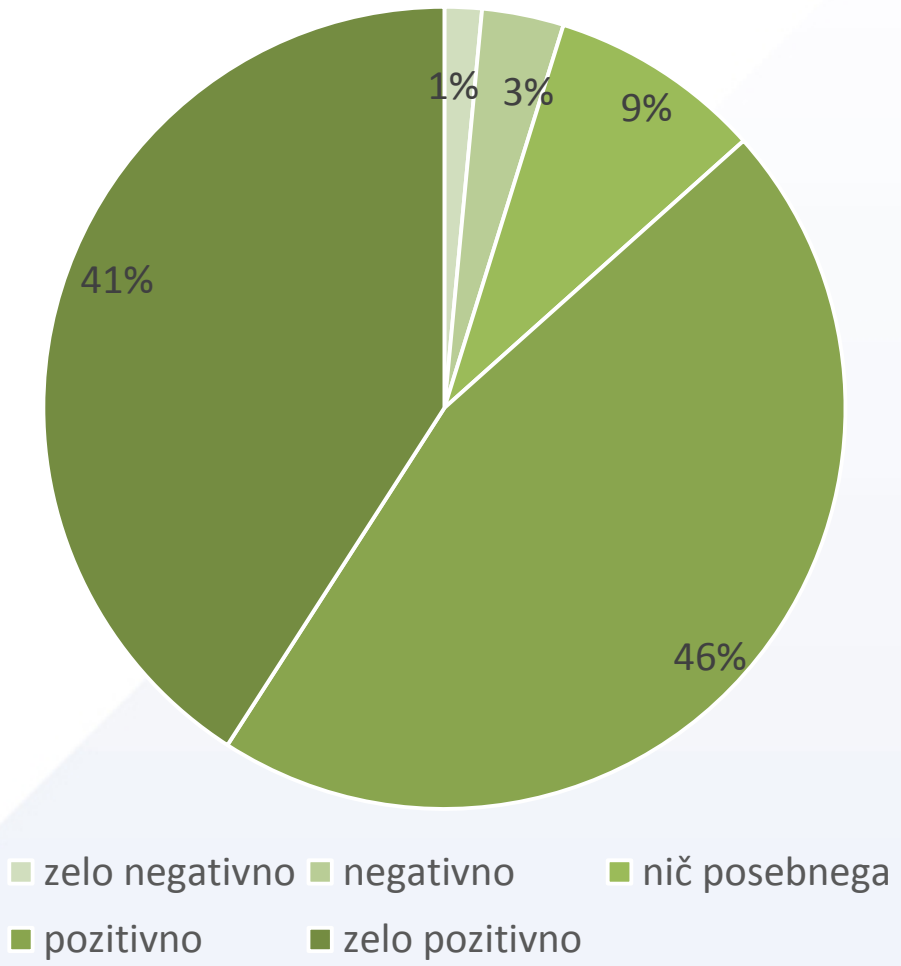
V10 Kako ocenjujete stopnjo bolečin med kolonoskopijo ?

		Frekvenca	Veljavni odstotek
	brez bolečine	1443	21,1
	blaga bolečina	1780	26,0
	zmerna bolečina	1361	19,9
	srednje močna bolečina	1112	16,3
	zelo močna bolecina	741	10,8
	komaj znosna bolečina	221	3,2
	neznosna bolečina	181	2,6
	Skupaj	6839	100,0
	ni podatka	55	
Skupaj		6894	



Pokolonoskopski vprašalniki 2015:

V11 Kako ocenjujete izkušnjo kolonoskopije			
		Frekvenca	Veljavni odstotek
	zelo negativno	99	1,5
	negativno	224	3,3
	nič posebnega	579	8,6
	pozitivno	3080	45,7
	zelo pozitivno	2755	40,9
	Skupaj	6737	100,0
	ni podatka	157	
Total		6894	



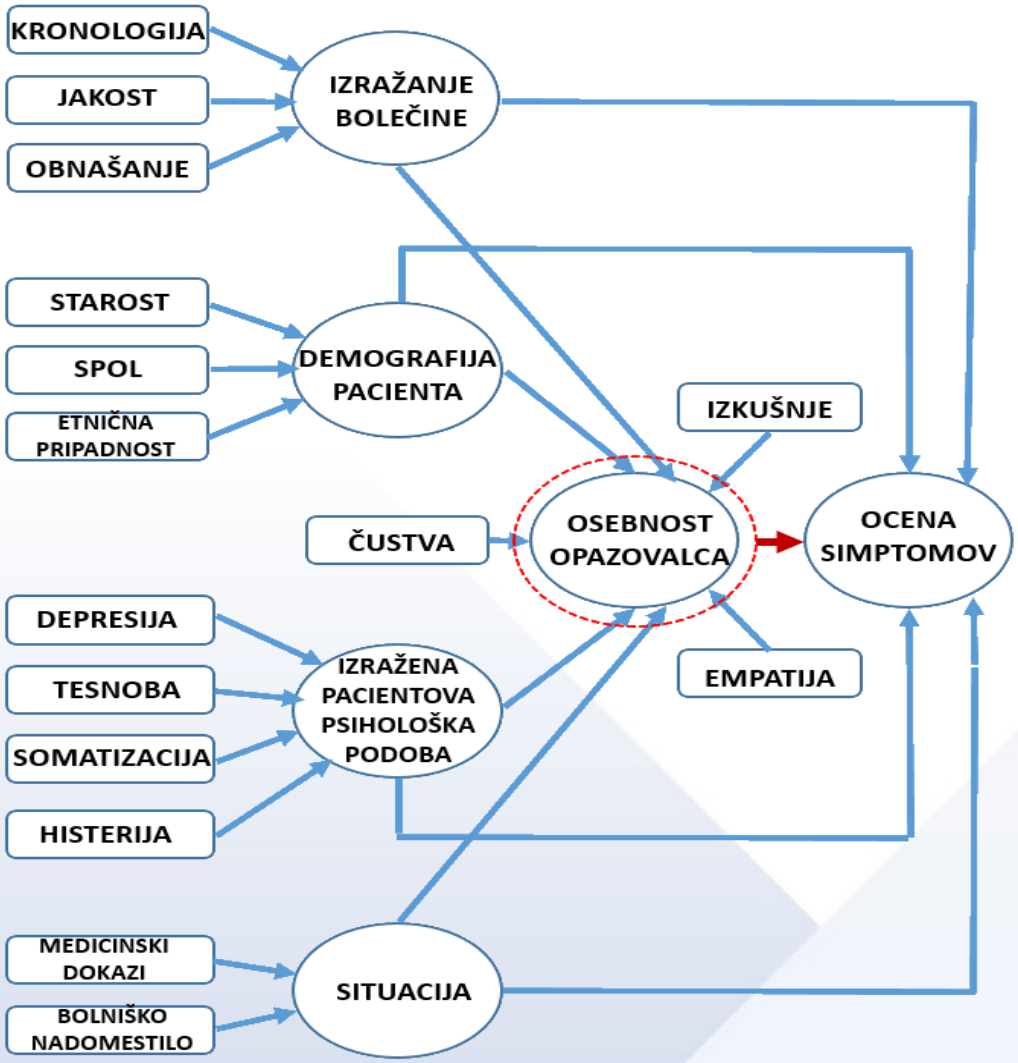
Zakon o pacientovih pravicah, 39. člen (Preprečevanje in lajšanje trpljenja)

(1) Pacient ima pravico, da se brez odlašanja ukrene vse potrebno za odpravo ali največjo možno ublažitev bolečin in drugega trpljenja, povezanega z njegovo boleznijo.
(2) Pacient ima pravico, da se pri njegovi zdravstveni oskrbi po strokovnih standardih preprečijo nepotrebne bolečine in drugo trpljenje, povezano z medicinskim posegom.
(3) Pacient v končni fazi bolezni in pacient z neozdravljivo boleznijo, ki povzroča hudo trpljenje, ima pravico do paliativne oskrbe.

Kolonoskopija, ki je potekala brez omembe vrednih bolečin, ni nujno pozitivna izkušnja.

Kolonoskopija, pri kateri pacient doživi hude bolečine, je lahko pozitivna izkušnja.

SOCIALNO-PSIHOLOŠKI DEJAVNIKI KLINIČNE PRESOJE BOLEČIN



VIR: Trait et al. (2009) Pain in Medicine, str. 25

Kultura opazovalca – klinika močno vpliva na presojo bolečin v različnih kliničnih situacijah.

OSEBNA KULTURA

DOJEMANJE PACIENTOVE BOLEČINE

miselna raven
EMPATIJA

čustvena raven
SOČUTJE

nevrološka raven
ZRCALNI NEVRONI

POKLICNA KULTURA

KULTURA VODENJA

Ugotovitve metaštudije kliničnih ocen akutnih bolečin v ZDA:

- Etnična pripadnost ali pripadnost specifičnemu kulturnemu krogu pacienta vpliva na klinično presojo bolečine;
- Trajanje bolečine navadno vpliva tako, da so kronične bolečine bolj podcenjene od akutnih;
- Stereotipi, ki zadevajo ženske, povzročajo, da so njihove bolečine podcenjene;
- Bolečine so pogosto podcenjene pri starostnikih;
- Bolečine, pripisane psihološkim vzrokom, so podcenjene;
- Intenzivnost izražanja pacientove bolečine ni v sorazmerju z oceno jakosti bolečine – bolečina je pri pacientih, ki zelo očitno izražajo svojo stisko, pogosto podcenjena;
- Zdravniki z daljšimi izkušnjami pri delu s pacienti z bolečinami sčasoma vse bolj podcenjujejo njihove bolečine;
- Zdravniki manj podcenjujejo bolečine takrat, ko imajo za doživljanje bolečin fiziološke dokaze.

Vir: Tait Raimond: The Clinical encounter. Implications for pain management disparities. V knjigi: Incayawar Mario in Todd Knox (2013) Culture, brain and analgesia. Understanding and managing pain in diverse populationss. Oxforduniversity Press.; str. 120-143