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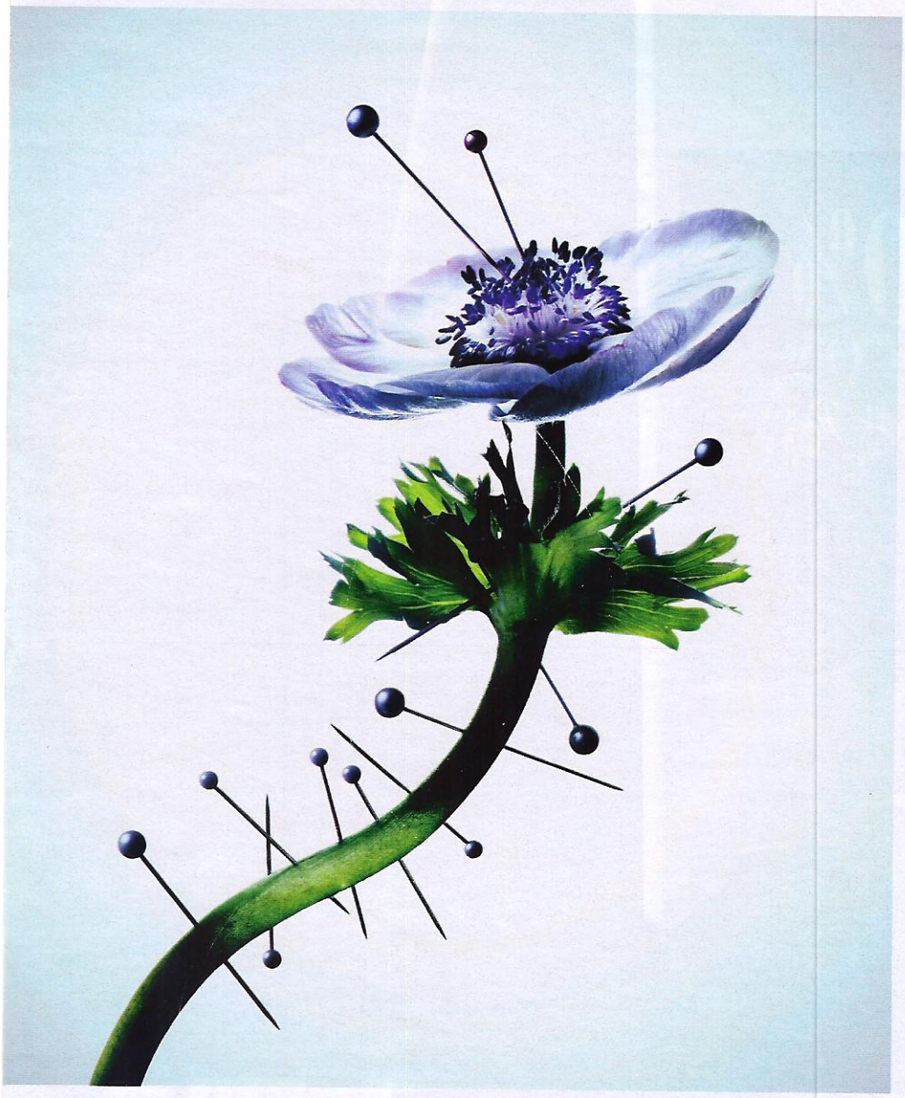

THE MALE-FEMALE PAIN GAP

Women ache more often than men, but guys get better pain relief from doctors. What's going on? And what can you do about it? >> *by* ALICE LESCH KELLY

FOR four years, Candy Pitcher experienced agonizing back pain from a spinal fracture she suffered while cutting down a tree. And for four years, a series of doctors, including neurosurgeons and orthopedic surgeons, failed to relieve her misery. "They didn't take me seriously," complains Pitcher, who lives in Cary, North Carolina. "One doctor entered the exam room and said, 'There's nothing I can do for you. Lots of people suffer from back pain—you just need to learn to live with it.' And that was before he had even examined me!" she says.

While Pitcher ultimately found a compassionate physician who has ameliorated her discomfort, plenty of other women can recount stories about doctors who brushed off their pain. Cynthia Toussaint of Los Angeles spent 13 years hearing from MDs that she was imagining her pain, which began in her right leg after a ballet injury, then spread throughout her body. "One doctor CONTINUED ON PAGE *142*

PROP STYLIST: THEO VAMVOUNAKIS

PHOTOGRAPHED BY *Yasu + Junko*

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patted me on the head and said, 'Darling, you're making a mountain out of a molehill.' Then he sent me to a psychiatrist," says Toussaint, who was eventually told she had a condition known as complex regional pain syndrome. Toussaint was so outraged by that doctor's cavalier attitude that in 2002 she founded For Grace, a nonprofit organization dedicated to addressing gender disparity in pain treatment.

Research corroborates the experiences of these women. For instance, in a study reported last year in the *Journal of Pain*, University of Michigan Health System researchers found that doctors at a specialty pain center prescribed strong opioid painkillers to 33 percent of male patients with chronic pain but only to 21 percent of female patients in the same situation. Similarly, a 2008 analysis of an urban hospital emergency room's experiences concluded that women with abdominal pain were 7 percent less likely than comparable men to receive pain relievers—even though the two sexes had almost the same pain scores. It also took women longer to receive pain medication: 65 minutes versus 49 minutes. "Women are treated less often for pain than men," concludes Scott M. Fishman, MD, chief of the division of pain medicine and a professor of anesthesiology at the University of California, Davis.

The irony is that on a daily basis, women tend to experience more discomfort than men, notes Roger Fillingim, PhD, a University of Florida, Gainesville, psychologist and pain researcher who was the lead author in a 2009 review of studies on sex, pain and gender in the *Journal of Pain*. Women are much more likely to suffer from long-lasting conditions that can cause pain, such as fibromyalgia (tenderness in joints, muscles, tendons and other soft tissues), osteoarthritis in the hands and knees, irritable bowel syndrome and migraine headaches. Plus, the odds are higher that a woman, not a man, will have more than one painful condition at a time.

So why are women in pain being brushed off? And what can you do if you're the one suffering?

WOMEN SEEN AS TOUGHER

One explanation for the brush-off: "Many doctors believe that women can handle more pain than men," says Fishman. This is presumably based on women's ability to get through childbirth. However, "it's abundantly clear that women tolerate pain less well than men do," says Fillingim. In his studies, volunteers are subjected to a painful stimulus—for example, placing their hands in a bucket of ice-cold water—and are asked to endure it until it becomes intolerable. Women nearly always give up sooner, an outcome consistent with findings by other pain researchers. Fillingim has also shown that women have a lower pain threshold, the point at which a stimulus starts to hurt.

The male-versus-female pain experience stems from some unknown mix of biology and differing sex roles (men are supposed to be stoic; women are freer to report weaknesses). Sex hormones in particular may play a part in pain severity, although researchers aren't exactly sure how the relationship works. "It is clear that estrogen influences some clinical pain conditions," says a recent review article in *Clinical Orthopaedics and Related Research*. For instance, migraines tend to become more frequent in women when their estrogen levels dip around their periods but less frequent when this female hormone hits high levels during pregnancy. Postpartum, when estrogen declines rapidly, the occurrence of migraine headaches increases.

"Menopausal fluctuations in estrogen are believed to affect pain levels as well," explains Tarvez Tucker, MD, director of the headache and pain clinic at the University of Kentucky Medical Center in Lexington. Estrogen appears to play a protective role. "A drop in estrogen can make women more vulnerable to pain syndromes," Tucker adds.

While no one is sure why there's a sex-hormone connection, research suggests that one of the body's networks of internal painkillers (called the endogenous opioid system) responds more strongly when estrogen levels are higher in women. And some subtypes of opioid painkillers work better in women, while others are more effective in men.

Another sex difference may play an important role in how doctors treat women. "Women tend to report their pain experience with more emotion," says Linda S. Fidell, PhD, a professor emeritus of psychology at California State University, Northridge, who studies the effects of sex-role stereotypes on American physicians. That's because male and female brains process pain differently. Functional MRI

» THE LANGUAGE OF PAIN

Describing your pain precisely rather than generally can go a long way toward getting you the treatment you need. Try characterizing your experience in the following terms, which have definitions that are understood by doctors:

THROBBING PAIN Pulsating or pounding

SHARP PAIN Sudden, abrupt and intense

BREAK-THROUGH PAIN Happens while your pain medication is supposed to be in effect

SHOOTING PAIN Sharp and radiating

PERSISTENT PAIN Lasts 12 hours or more every day

BURNING PAIN Fiery or inflamed

ACHY PAIN Dull and persistent

INTERMITTENT PAIN Comes and goes, sometimes in waves or patterns

CRUSHING PAIN Intense pressure or heaviness

FLARING PAIN Occurs suddenly, without any apparent trigger

scans, which measure changes in blood flow in response to neural activity in the brain, show that women experience pain more in the limbic area of the brain, a center of emotions, while in male brains, pain lights up the frontal cortex, where intellectual processing takes place. As a result, women's response to pain tends to be more dramatic and raw, and men's response is more tempered and intellectual, says Tucker.

Why this matters: "The expression of emotion can lead a doctor to discount a woman's pain experience," Fidell says. It becomes easy for a physician to label a woman as hysterical. Partly for that reason, the medical establishment may continue to perpetuate the myth that women make up pain where it doesn't exist and that their pain is in their heads, says Fishman.

THE PROBLEM OF AMBIGUITY

Pain is invisible, and people with similar physical signs of damage in, for instance, osteoarthritic knees can have wildly different levels of discomfort, ranging from nonexistent to debilitating. But health care providers "tend to focus on conditions and diseases in which there is an objective test that can show that something is wrong," says Sean Mackey, MD, PhD, chief of the division of pain management at Stanford University School of Medicine. In other words, many doctors are simply less practiced at dealing with the subjective experience of pain.

Without an objective test for pain, physicians must formulate treatment plans on the basis of their patients' reports and descriptions. This situation does not serve women well if their doctors believe, consciously or subconsciously, that women exaggerate their discomfort. Here's one example of how this bias might interfere with adequate treatment, based on a 2008 study in the *Canadian Medical Association Journal*. Researchers tasked a two-person team, one male and one female, with consulting 71 physicians and presenting nearly identical cases of moderate osteoarthritis of the knee. The two team members suffered from the condition, and both had been deemed candidates for a knee-replacement operation by physicians.

Using a script during their doctor visits, the patients described the same symptoms, including morning knee stiffness and pain when they walked up stairs. But when they asked the physicians, "Do you think I need a new knee?" they got different responses. Some 42 percent of the doctors recommended a total knee replacement to the male patient, but only 8 percent suggested it to the female, according to study coauthor James G. Wright, MD, a professor of surgery at the University of Toronto.

Women also appear to bear the brunt of a general reluctance among physicians to prescribe potentially addictive opioid drugs such as morphine and codeine—a reluctance that is not supported by the research. "Most patients who are prescribed opioids for pain, even those undergoing long-term therapy, do not become addicted to the drugs," says a report from the National Institute on Drug Abuse.

Nonetheless, women pay the price for physician prejudice. For example, research published in the *Journal of Pain and Symptom Management* shows that among cancer patients who were experiencing pain, women were significantly less likely than men to be prescribed high-potency opioids. Women in the study were also much more likely than men to report that their pain was not adequately controlled.

A case can be made that African-American women are even more likely to miss out on proper treatment. Deborah Chenault-Green, an author and actress who lives in Detroit, began having severe headaches and pain and numbness in her shoulder, hand, neck and arm in 1996. The cause was two herniated disks in her neck, but it took seven years for doctors to make the diagnosis, and in that time she was prescribed few effective pain-relief medications in doctors' offices and emergency rooms. Instead, she received what she calls "fluff drugs," mild pain relievers like Motrin that did not affect her discomfort. Chenault-Green attributes her undertreatment to race. "In the inner city, hospitals are overly concerned about drug abuse. They tend to think that if you come in complaining of pain, you're just looking for drugs," she says.

In fact, a 2008 study found that African-American women are less likely than comparable white women to receive adequate opioid treatment for chronic lower-back pain.

RESEARCHERS DISCOVERED THAT FEMALE DOCTORS

WERE 16 PERCENT MORE LIKELY THAN MALE DOCTORS TO ADMINISTER PAIN MEDICATIONS TO EMERGENCY ROOM PATIENTS WHO EXPERIENCED MODERATE TO SEVERE DISCOMFORT.

OVERCOMING TREATMENT OBSTACLES

Experts say certain smart strategies can boost your odds of getting the best pain treatment.

» **PICK THE RIGHT DOCTOR** Even the most conscientious doctors can find it challenging to treat you effectively, because they may lack instruction and experience in managing pain. (Medical schools tend not to emphasize this subject.) So if your current physician isn't giving you the relief you need, consider seeing one who is well trained in treating pain or visit a multidisciplinary pain-treatment team. Go to pain.com to search for pain clinics near you.

» **TALK TO ANOTHER WOMAN** There are exceptions, of course, but many women feel that their concerns are better heard by female physicians. That suspicion was backed up in a 2008 *Pain*

Medicine study in which researchers discovered that female doctors were 16 percent more likely than male doctors to administer pain medications to emergency room patients who experienced moderate to severe discomfort, according to study author Basmah Safdar, MD, co-chair of the Chest Pain Center at Yale–New Haven Hospital.

» **KEEP A LOG** Provide useful diagnostic information by tracking the intensity and frequency of your pain in a journal that you show your doctor. Jot down what the pain feels like; how long it lasts; what makes it better or worse; when it strikes; whether menstrual or menopausal symptoms trigger, aggravate or improve it; and what medications you take and how well they work. Rate your pain on a 0-to-10 scale, 10 being the most severe. "You can tell your doctor, 'This past week I had two days when my pain was a 6 out of 10,'" recommends Marni Jackson, the author of *Pain: The Science and Culture of Why We Hurt*.

» **KNOW YOUR GOALS AND SHARE THEM** "Explain to the doctor that you have pain, you expect treatment, you want to know the risks and benefits of various treatments, and you want to leave with a treatment in hand and a plan about what to do if the treatment doesn't work," Fishman says.

» **COMMUNICATE SPECIFICS** "Doctors only know what you tell them," Jackson says. During your appointment, explain exactly how the pain interferes with your life. For example, rather than simply say you have migraines, report that twice a month you're in bed with a migraine for eight hours and you're so debilitated that you have to call a relative to take care of your children, Jackson suggests.

» **BE REALISTIC** Trial and error is a normal part of pain treatment. When a doctor at the Stanford University pain clinic prescribes a pain medication, there's only about a 40 to 60 percent chance that it will prove to be the right drug. "And we're pretty good at this," says Stanford's Mackey. "There's a huge individual variability in the way patients experience pain and how they respond to these medications."

» **DON'T RULE OUT ANTIDEPRESSANTS** Although many women feel that a prescription for an antidepressant is an insult, the fact is that some of these drugs may help reduce certain kinds of pain, even when depression is not present. For example, tricyclic antidepressants such as amitriptyline (Elavil) and imipramine (Tofranil) can lessen pain caused by lower-back troubles, tension headaches, arthritis, fibromyalgia and nerve damage resulting from diabetes. They appear to work by blocking pain-communication pathways in and near the brain.

» **STAY FOCUSED** If your doctor implies that your pain is all in your head, make sure you speak up. Say, "What do you mean by that, exactly? Are you suggesting that I'm imagining this pain or that I'm overreacting? Why would you say that?" If that is indeed what he is suggesting, don't let it shake you. "You know what you know, and you know what you feel," says Anita J. Tarzian, PhD, a health care ethics consultant and former hospice nurse. "You have a right to the best quality of life you can get." And that may well mean searching out another doctor, one who will take your problems seriously.

ALICE LESCH KELLY is an award-winning health writer who lives in the Boston area.

RESOURCES

The following organizations offer education, support, provider directories and other helpful information for women in pain:

» AMERICAN PAIN FOUNDATION
painfoundation.org

» AMERICAN PAIN SOCIETY
ampainsoc.org

» AMERICAN CHRONIC PAIN ASSOCIATION
theacpa.org

» NATIONAL PAIN FOUNDATION
nationalpainfoundation.org

» FOR GRACE forgrace.org