

Programme 108: Gender differences

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How men and women experience pain, arming yourself with the right information, and not being embarrassed about your condition

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Do women and men experience pain differently, or is it only our attitudes towards pain that differ? In this edition of Airing Pain, Paul speaks to healthcare professionals about their findings with the literature surrounding chronic pain and the changing outlooks when it comes to seeking help

Deputy Director of the Bath Centre for Pain Research, Professor Ed Keogh, speaks about his review of men's health literature in the context of chronic pain, and found that women are more likely to report pain in more body regions in their lifetime compared to men. He considers whether this is due to biological or social/emotional reasons, but emphasises that the variation within males and females is much greater than the variation between the sexes.

Can the gender roles society pushes on us affect how we deal with our pain? Senior clinical psychologist of the National Specialist Pain Service in Bath Dr Gauntlett-Gilbert talks to Paul about how the societal expectations of how we handle pain can feed into depression and guilt.

Specialist physiotherapist at UCL Hospitals' Pain Management Centre Katrine Petersen discusses the lack of literature on men's pain, especially pelvic pain, as well as her experiences in using physiotherapeutic strategies in the context of chronic pain syndromes.

Paul Evans: This is ***Airing Pain***, a programme brought to you by Pain Concern, the UK charity providing information and support for those of us living with pain, and for healthcare professionals.

I'm Paul Evans. And this edition has been funded by the Women's Fund of Scotland.

Jeremy Gauntlett-Gilbert: Men will very often speak of their loss of a role in the family, the fact that they can't provide anymore, they can't be a breadwinner anymore. That they can't go out to work or provide that kind of leadership or physical help around the house that they hope to.

Katrine Petersen: If you consider how women have accessed healthcare for pelvic issues such as menstruation, first sexual encounter, contraception, pregnancy, smear tests. Women are just used to talking about the abdominal pelvic area.

Evans: Do men and women experience pain differently? In terms of understanding, what's known about men's pain falls short of what we understand about women's pain? In 2015, psychologist Professor Ed Keogh, who is the deputy director of the Bath Centre for Pain Research at the University of Bath, completed a selective review of men's health literature to consider them within the context of men's pain. Under the heading 'Men, Masculinity and Pain', its purpose in taking a men's health approach to pain was to view existing evidence in a different way, and to identify potential gaps in our understanding, not just of men's pain, but of women's pain too.

Ed Keogh: There are sex and gender differences, for example we know that men are different in terms of the amount of pain they experience and report. Here we know that, for example women tend to report more pain, in more body regions over their lifetime in comparison to men. So we know that there are these differences, and we are quite interested in some of the reasons why there are differences.

Evans: So you're talking about the occurrence of pain, rather than the severity of pain?

Keogh: Well it's all types of pain, so it's actually pain conditions. So, if you look at some pain conditions and look at men and women, how represented are they in the clinic, we know for some conditions women are coming in with more pain, so headache and lower back pain, those sorts of pains. We typically find numbers are higher in women in comparison to men in the clinic. In addition to that we also know for example, in laboratory pain induction type environments, so inducing pain, there are differences in the amount of pain reported. The pain thresholds, the pain tolerance levels tend to be different in men and women. I think the key question is why are there differences?

Evans: Well first of all, we men, as no doubt you'll say, we feel pain more than women.

Keogh: Well the evidence is actually contrary to that. In fact if you look at the amount of pain that's being reported then certainly women are reporting more pain in comparison to men. Now that's not to say that men aren't experiencing pain. Men are in pain, they are suffering and we certainly do need to do things about this.

Evans: So what's going on there then?

Keogh: I think this comes back to the explanations around why there might be these sex and gender differences in pain. So we know there are differences, why are there

differences? Some of the explanations are very biological, so we know there may be sex hormones may be involved in mediating some of the differences.

But as we also know, sex and gender, there are more biological factors, but also social and emotional factors, and psychosocial factors are also important. So we are quite interested in the way these psychological and social factors have an impact on, both the experience and also the reporting of pain, and we think that might be particularly important for both men and women.

Evans: I would take a stab at it and say we don't like going to the doctors, we are not as open about our own bodies as women are?

Keogh: Yes, the whole men's health agenda around how men are not going to the doctors, not explaining to others, things about their pain, about their health conditions. We've sort of moved into the pain area and asked, if there are limitations in how well men are reporting health experiences, does that then translate into pain clinics as well? Are men not very good at reporting pain? Men's health literature is beginning to highlight that there are these differences, and there are possible explanations around why men may be under-reporting health conditions. When we start looking at pain, relatively little research has actually looked at men and the way in which they report pain itself.

Evans: Could something to do with it be that, if I sit in the waiting room of my GP practice I'm bombarded with posters about women in pain, there are only two posters that I can think of about male only pain: testicular cancer, and I can't even think of the second one?

Keogh: Yeah I think there's a lot of expectations around pain and who experiences pain. In fact women are much better at going to their GPs and talking about health conditions including pain. Pain is much more regular, of course for a number of women, so menstrual cycle related pain, for example, is very common. Of course, women then are therefore more able to discuss this more regularly. When it comes to males and male pain, it's not as normalised if that makes sense. And so therefore there maybe inhibition around discussing these sort of experiences.

Evans: The interesting thing about what you said earlier, is the word masculinity, which is – well, masculinity's being a man.

Keogh: Exactly, this is what's interesting, we're not talking about sex differences, differences between men and women. We know there are differences between men and women. But the variation that occurs within males, and within females, is much greater than the variation between the sexes. So we need to understand this, and one of the explanations could be something along the lines of gender. Which is the social norms, the

conceptualisation of what it means to be masculine, what it means to be feminine. We think some of these are very important in terms of how people discuss, and how they behave in front of others when it comes to pain.

Evans: And I said tongue in cheek, that we feel pain worse than women do, well of course, that was tongue in cheek. But there is the expression man-flu, and the general feeling that a man will stay in bed, it will be flu and not a cold. Do we confine our pain to the people we know?

Keogh: There's a couple of things embedded within that. I'll start off with how media, society, represents the expression of pain. I think this is a very good example of the way in which the expression of emotions, the expression of pain can actually be inhibited in some ways. So, actually, if you think about the way in which we develop as children, whether or not crying as a boy is punished in some ways, through saying "don't act like that", etc. Whether that's being played out in the way in which men actually express their emotions, express painful conditions. That might be reflected there.

Again, from the men's health literature, what we actually know is that in terms of social support there do seem to be differences, especially as we age. So the men's health literature certainly indicates that later on in life, in terms of the support networks that are around, women have very good social support networks *outside* of the home. Whereas men on the other hand tend to restrict it more within the home. So the problem is, if you lose your partner then for women there is actually a social support network around them, but for men it's not there as much. So we have to think about ways in which we can get men that sort of help. One of the examples that is being used and developed in a number of countries has been the men's shed movement, which is a way of getting men together, through activities, but actually that could be a very good medium by which you could actually start talking about other sorts of issues, such as health related issues, of which we can of course include pain.

Again, in terms of men's health literature, where you'll see lots of emphasis now on recognising how there might be differences in how you might approach men and women, especially around health conditions and getting men to actually go to their GPs to talk to people about their concerns, especially around pain and other health conditions. Talk about it, don't leave it to the last moment, which of course can sometimes happen. So I think by making it much more acceptable to talk about emotions and feelings, and the way in which pain affects you in going to be good for men and women.

Evans: That's Professor Ed Keogh, Deputy Director of The Bath Centre for Pain Research at the University of Bath.

Now, he talked about pain being an expression of hurt and vulnerability, and that maybe men are less likely than women to come to terms with those feelings. But what about other self-conscious emotions, like shame, embarrassment or humiliation? Jeremy Gauntlett-Gilbert is a Senior Clinical Psychologist at The National Specialist Pain Service in Bath.

Jeremy Gauntlett-Gilbert: Historically in chronic pain research and practice, people have always been interested in understanding things like depression in pain, things like anxiety. But it also really seems true that people with chronic pain live with a condition that is poorly understood, they don't always get nice, encouraging responses from other people. And therefore they're very often in a position where they're constantly feeling embarrassed, self-conscious. "What's wrong with you?" "I've got a bad back". It's a rubbish answer. And so we just became interested in that from our clinical experience, and then wanted to do some research on it.

Evans: From my own experience, I have chronic pain, I have fibromyalgia, sometimes you're embarrassed to smile in company, just in case people think you're better, or they judge you.

Gauntlett-Gilbert: I think it's true isn't it, because all of these conditions, they fluctuate in their severity, so people have better days and worse days. And one of the risks of that is, people see somebody on a good day, and they say, "What's wrong with you then, you're obviously fine". And so it's that kind of incomprehension which does make people very nervous. They're just not well understood conditions, they're not seen as legitimate. Fibromyalgia being a case in point, people don't take it seriously, it's not leukaemia.

Evans: You have to look ill to be ill.

Gauntlett-Gilbert: Yes, this is true. One of the other things that happens around trying not to feel embarrassed, or trying not to feel ashamed, is people trying desperately not to look ill. Lots of people spent a lot of their time trying to put on a good face, or only going out when they feel fine. And it's the flip side of what you were just saying, the embarrassment drives people to either try and make damn sure that people understand how ill they are, or because they feel so misunderstood they put a terribly brave face on things and only go out when they feel well.

Evans: Embarrassment, I've never felt embarrassed about my condition. But I can see what you're saying, that if I don't look ill enough then I will be judged as a shirker, a malingerer.

Gauntlett-Gilbert: I think it's a real problem for people with pain, cos you're damned if you do and damned if you don't. People might well see you looking in pain, looking visibly

uncomfortable and judge you as hamming it up. Or people see you on a good day, or when you're trying to put a good face on things, and say "Well, what's wrong with him?"

Evans: And I think for people who are in work with chronic pain, there is the impression if you take sick leave you are sick, but when you go back to work you are better.

Gauntlett-Gilbert: Completely, yeah, for some reason we've got this model, which probably does work for the flu, that you're either sick or you're well. Which just doesn't apply to the kind of conditions you see in chronic pain. And it's a real shame because very often people are almost punished for getting back to work, people who struggle back to work, half time, do a graded return. Instead of being treated with respect for their effort, they are almost hurried along, "Why can't you improve it quicker?"

Evans: "If you can't do all the work then why are you here?"

Gauntlett-Gilbert: [laughing] That has a ring of authentic and painful truth about it, yes. That's one of those things, and I think that people end up being implicitly punished and then employers say some things which can't be legitimate or legal sometimes about health and safety, not sure we can have you around here cos you don't look terribly safe on that chair. And the upshot is, although probably nobody is trying to do the bad thing, is that people with chronic pain end up almost getting a little bit punished for their very brave attempts to go back as much as they can and do as much as they can, which isn't perfect.

Evans: The flip side of somebody in that situation is that they punish themselves, because they don't want the employers to manage their condition, they want to keep their employers at arm's length, if you like, because "I can manage this myself, don't get involved. Because if you get involved you're going to cut my work down to half, and somebody else will look at me and say, what's he doing here". So it's not just employers.

Gauntlett-Gilbert: People can, as you say, keep employers at arm's length because they are trying to self-manage, though possibly trying to self-manage in a worried way. Like you say, worried what the employer will do. But also a lot of people with chronic pain are just, before they ever had pain they were people with very high standards, people who want to do a good job, they're people who dislike the idea of half measures. And these are temperamental things, human beings were human beings before they got pain. And a lot of people with chronic pain have really strong values for themselves, and strong values for their working lives, and actually genuinely hate having to do what they feel is a half effort because of pain. So either because of fear of what their employer will do, or because of their own standards for themselves, they can end up really flogging themselves I think.

Evans: Is there a gender difference for people with chronic pain? Do men act differently from women?

Gauntlett-Gilbert: I think it differs in form. Men will very often speak, and it's a little stereotypical, but a little true, of their loss of a role in the family, the fact that they can't provide anymore, they can't be a breadwinner anymore. That they can't go out to work, or provide that kind of leadership, or physical help around the house that they hope to. In many ways that's not a million miles from women, who are used to having, again stereotypically, these are stereotypes, more of a caring role, who value their ability to look after other people, to be a mother, to help other people, and who have strong values around nurturing other people, they feel pretty ghastly too. So I think the form is different, but I don't know if underneath it's all that different.

Evans: Perhaps men and women seek help in different ways?

Gauntlett-Gilbert: I think so, I mean it's a legendary issue in the broader literature, of men's terrible healthcare seeking behaviour, and tendency to avoid things.

Evans: The shame, and the guilt, and the anxiety, for someone who has chronic pain, depression and guilt, they all feed into the chronic pain and the chronic pain feeds into all that, it's that cycle of pain, isn't it? And you need to break that cycle. So which comes first do you say?

Gauntlett-Gilbert: Another question is which can you change easiest? None of these things are easy to change, but if a person has got chronic pain then the chances are they have a pretty nasty, unpredictable set of symptoms which comes and goes, and there's not a right lot you can do about it. Perhaps it's just my bent as a psychologist, it always seems to me that perhaps you could get in there with the emotions, using some psychological techniques that we use. It's not easy because people were able to feel shame, or were able to feel low long before they had chronic pain, these are things which everybody feels a little bit of their whole lives. So I don't think you can ever wave a magic wand and get people to a point where they never feel shame or guilt, and I'm not sure it would be a good idea if you did. I rather think that's what psychopaths are like, so shame and guilt is probably not necessarily a bad thing. But, yes we're certainly experimenting with using fairly established, nothing radical, but established psychological techniques and current psychological therapies to see if we could target those things directly.

Evans: So what are those therapies?

Gauntlett-Gilbert: You've got to ask yourself, if people are living with an obviously visible condition, somebody who is using a stick, has chronic pain, and they're living in a society

which isn't always kind to people with disabilities, I certainly wouldn't go down the line of thinking we could get people to some lovely positive thinking world, in which they never feel embarrassed. I think that's probably unrealistic. Instead we tend to use more acceptance based approaches, which kind of acknowledges that these unpleasant emotions are there, and they will be there. And until there's a revolution and everybody becomes nice to people with disabilities, and I don't know when that's coming, until that happens then people may have to find ways to carry their embarrassment with them, whilst they get on with the stuff they care about. You can tell there is not a should in that, I don't think people should put up with their embarrassment, but very often these are the bargains which are in front of people with long term conditions. Either do it and risk feeling embarrassed, or don't risk feeling embarrassed but never do it.

So we're looking at acceptance based, and mindfulness based techniques in the psychological therapies that might, if a person chooses it, help them be able to be a little bit more embarrassed and carry on doing what they care about as well. It's not an easy sell, it would be a great deal easier to sell the lovely positive idea that you could walk around your life free from shame, but I'm not sure that's always realistic. And so that's one of the ways we tend to go at things.

Evan: The acceptance side of things I guess is accepting you have a condition, and that it's something you have to live with, but the condition isn't the driver of your life?

Gauntlett-Gilbert: I think that's right. I think there's accepting that you have the condition. And the other thing, when you're talking about what drives your life, and what makes you do things, and what stops you doing things, is that if you can accept that you might feel a bit rotten while you are doing this, you might blush, you might feel like a bit of an idiot, people aren't really taking you seriously, but that is something you aren't happy with but are willing to take as the price of doing something that you care about. Then that's the kind of acceptance that we're talking about. It's a tricky business, but it's an honest, psychological approach. And also one that makes it clear that difficult emotions aren't dangerous themselves, they're just uncomfortable. And if we choose to then sometimes we can make the choice to do more of our lives and have that discomfort.

Evans: Jeremy Gauntlett-Gilbert senior clinical psychologist at the National Specialist Pain Service in Bath.

We're talking about gender differences in the experience of chronic pain, and we've talked about emotional or psychological differences between the sexes, but physically and biologically - and this is not new science - men and women are different. We also differ in

our willingness to discuss or own up to problems, particularly if those problems are leading to pain in the pelvic region.

Katrine Petersen is specialist physiotherapist at the University College London Hospital's pain management centre. So what do we men suffer from that women don't?

Katrine Petersen: That's a really good question, because there's so little literature on it. We've got some data ourselves on the service we run for chronic abdominal pelvic pain. That's a definition and term that we have developed because it fits the population that we see, but when you actually look at the literature it's very difficult to define exactly, but we have a list of syndromes, pain syndromes, based around the pelvic area and the abdominal area that we see.

So typically male pelvic pain will be described in the literature often as chronic prostatitis, so men will get pain in that area affecting potentially their bladder and urinary frequency and sexual function. And often they will go to urology and have their prostates checked.

Evans: There's a gender difference here isn't there? Men don't talk about their private parts, or anything below their navel at all.

Petersen: Absolutely. So it used to be quite difficult to get men coming forward, but I recently looked at our data on patients attending our chronic abdominal pelvic pain clinics and it turns out that we nearly have a third of patients who are men. So they are starting to come forward. One of the reasons why men don't come forward is if you consider how women have accessed healthcare for pelvic issues, such as menstruation, first sexual encounter, contraception, pregnancy, smear tests, women are just used to talking about the abdominal pelvic area, whereas men really have no particular reason to go unless they have a problem.

Chronic prostatitis or chronic prostate pain syndrome is one of the typical syndromes that we see, but we also penile pain, testicular pain, non-specific pelvic pain and rectal pain, lots of different conditions all affect that particular area.

Evans: Now prostate is something that possibly many men will recognise, through tests for prostate cancer and things like that.

Petersen: Exactly. So typically patients will go to urology for that particular concern of prostate cancer, because that's something that gets talked about. What doesn't get talked about is when patients have pain from an unidentifiable cause, or non-pathology, non-bacterial symptoms that they are getting that very much look like an infection, for example.

Evans: So who do you see?

Petersen: So that's also a very good question. I have men come into my clinic with very specific pain such as testicular pain, penile pain, and I have had patients come through the door looking at me, saying "I have no idea what you could possibly do for me". Because in the traditional sense physiotherapy would be about working from a musculoskeletal model of exercise and potentially some manual therapy to stretch and relieve muscles, whereas I much more come from a chronic pain model. So once we have excluded any bacterial infection, anything cancerous, any form of pathology, we're now working with a chronic pain model. So I use the same strategies that I would use for any other pain condition, I just have to include things like urinary frequency and urgency, bowel movement and sexual function, but again using the same strategies as I would do for any other pain condition as a pain management physiotherapist.

Evans: So as a physio, what do you do?

Petersen: Good question again [laughter], because once it comes to pain management people get a bit more confused. So we are trained in cognitive behavioural therapy, most of us who work in pain management. Because the traditional medical model where you look at the end organ and trying to fix something doesn't tend to work. So we need to look at a much more complex model in terms of chronic pain, first of all working out why the patient is here to see us, and often it's because they have some real, good questions about why am I pain. And they have some good questions about what can I do, is it ok for me to exercise, is it ok for me to bend, am I going to cause any further damage. And I think physiotherapists are very well placed because they've got the credibility of assessing risk in terms of movement and damage to tissues versus what can you get back to in terms of activity.

So, a lot of what I do is talking about how does pain work in your body, why is it ok for you to have sexual intercourse, why is it ok to let your bladder fill even though it's painful, why is it ok for you to get on with your life basically.

Evans: It seems like a reassurance thing, rather than treatment, perhaps the treatment is the reassurance?

Petersen: Well, absolutely. So the newest research that's coming out in terms of what you might term as reassurance, what we might call explained pain, or helping the patient to reconceptualise pain as not being due to damage or a pathology or a bacteria, but actually due to a dysfunction in the nervous system. That can really help patients to shift the way they live their life, or improve the quality of their life. But the newest research also show that it probably has a real impact on neuroplasticity, so we can potentially actually change the nervous system by providing those explanations and getting the patient thinking differently about their pain.

Evans: Now neuroplasticity, that's a fancy term for rewiring the brain?

Peterson: Rewiring the whole nervous system. So we tend to not just talk about the brain, but the brain's influence on the spinal cord, and on the peripheral nervous system, so the hypersensitivity in the peripheral receptors is important. So we shouldn't just be talking about the brain, we should also be talking about the connection between the brain and the painful structure and all the connections that could be affected by neuroplasticity

Evans: So as a man, as in many men, if I had enough courage to come to you, a woman as well, about problems down below and you started on at me and said, "This is all in the mind, this is all in the head" - I mean how do you bridge that gap?

Petersen: It very much depends on the patient and what knowledge and beliefs they already have. By the time they come to see me they've already seen one of our pain consultants, who will have introduced them to the concept of chronic pain. Often they will have seen one of our pain nurses, talking about medication, they will also have introduced them to the concept of chronic pain. They may also have attended what we call an information session for people with chronic abdominal pelvic pain, which is this unique opportunity for men to be in a forum with other men with similar problems. And again we talk about chronic pain mechanisms, practical strategies to manage pain long term. And that really means that by the time they come to see me I can sit them down individually and ask them, what do you think of that model, does that fit with your symptoms, does that fit with what you've been told, is there anything we need to reconceptualise so to speak, or help you understand? Of course some patients will say "This is not for me, I'm still looking for a medical solution".

Evans: I know very few men who would admit to having pelvic pain.

Petersen: I think you're absolutely right and hence why it's so important to air it today for example, but also get the information out there, that there are services that can help, there are a large proportion of men out there with chronic pelvic pain and abdominal pain, and it can be treated in the same way as any other chronic pain condition. And it should be recognised, and hopefully if we can validate it and normalise it for men, they're much more likely to come forward and talk about it.

Evans: What advice would you give to men who have pain who are perhaps too shy to talk about it?

Petersen: Well, one of the things that Doctor Williams, one of our research psychologists, did was look at what's available on the internet. So my first advice is don't go on the internet, because unfortunately there is very little out there and the information is not good, and not really in line with current practice.

In the study that Williams did she also asked men, after they'd had consultations, what were their main concerns. And I was interested to hear that men weren't necessarily overly concerned about a sinister disease such as cancer, they were actually just more concerned about a proper explanation. And that does require in the first instance an examination and ruling out any sinister disease. But then it does require probably a pain specialist to enable patients to fully understand the mechanisms, because the last thing we want is going straight from, "You haven't got cancer, it's all in your head", that's not helpful.

I also have to say that lots of GPs will not know what to do with pelvic pain. They wouldn't know where to send them. But there is a pelvic pain network, which is a charity, which I would recommend people look at as well, because that will list pelvic pain services that you can say to your GP, I know there's a pelvic pain service here, please could I at least have a chance of being assessed there and see what's going on.

Evans: So being forearmed with a little bit of good information to help your GP help you is a good idea?

Petersen: Yes, most certainly. The GP will be mainly concerned with ruling out any serious underlying pathology or disease, after that it is hard for GPs to know exactly what to do because these services for chronic male pelvic pain are few and far between. But there are services out there that will see men and support them with what is essentially a very difficult condition.

Evans: Katrine Peterson, specialist physiotherapist at University College London Hospital's pain management centre.

I'll just remind you that whilst we in Pain Concern believe the information and opinions on **Airing Pain** are accurate and sound, based on the best judgments available, you should always consult your health professional on any matter relating to your health and wellbeing. He or she is the only person who knows you, your circumstances and therefore the appropriate action to take on your behalf.

Don't forget that you can download all editions of **Airing Pain** from Pain Concern's website, which is painconcern.org.uk. For Pain Concern's YouTube channel, just put Pain Concern and YouTube into your search engine, and the same applies to Facebook.

Now at the start of the programme we heard Professor Ed Keogh talking about gender differences in the experience of chronic pain, and so to end this edition of **Airing Pain** how relevant is this study of men, masculinity and pain to women?

Keogh: When you start thinking about gender and you start talking about masculinity and femininity, well actually these are very fluid terms. They apply equally to both men and women, ok quite clearly when we think about men we'll be thinking about masculinity, but these ways of thinking, the beliefs we have, the norms we have, they're relevant to both men and women. So I think by looking at the men's health literature this really does apply to women's pain as well as men's pain. There's a lot we can learn here that will hopefully help both men and women who are in pain.

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