Gender & History ISSN 0953-5233
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Gender & History, Vol.32 No.1 March 2020, pp. 8–12.

Conceptualising Gender and Pain in Modern History

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Pain is a defining feature of the human experience. We have all, at some point in our lives, felt physical or emotional discomfort that fits under the broad umbrella of 'pain'. Though the phenomenon of pain is universal, the ways it is experienced, perceived and conceptualised are shaped by the wider social, cultural and political milieu. The characterisation and articulation of pain is profoundly influenced by gender. In some historical and contemporary contexts, the female body has been associated with heightened sensitivity of various types. At other times, female bodies have been singled out for their ability to bear extreme pain, especially during childbirth. In a 1932 American survey published by the *Journal of Social Psychology,* 70 per cent of physicians and dentists believed that women were superior to men in withstanding pain.[1] Even at the end of the 1980s, a British study commissioned by the drug company that made Nurofen found that 75 per cent of people agreed that women were 'better able to tolerate pain than men'. Interestingly, the generalisation was held to be correct by 86 per cent of women compared with only 64 per cent of men.[2]

Representations of male stoicism – or the perceived lack thereof – in the face of physical and emotional discomfort have also been powerful images in a range of national and historical contexts. In particular, men's experience of and responses to wartime suffering have tended to convey powerful messages about national as well as personal character, the 'rightness' of the cause, and the 'valour' of manliness itself. In brief: women and men have long been thought to experience bodily sensations, including pain, in a variety of culturally and historically specific ways. And in both past and present contexts, it matters whether a person has been categorised as male or female.

In recent decades, medical researchers have attempted to delineate the multi-faceted impacts of gender, in addition to sex, on individual pain experiences. In a 1993 editorial published in the American journal, *Pain*, National Institutes of Health (NIH) researcher M. A. Ruda posited that 'with the emphasis on equality of the sexes that occurred in the 1980s, it has not been politically correct to suggest that men and women are different'. Ruda nonetheless asserted that 'we all know that men and women *are different!'* and went on to argue that the time had come for further study of the physiological and psychological 'gender issues that relate to pain'.[3] Though social scientists

had focused on the role of culture in shaping individual responses to pain since the immediate postwar decades,[4] the early 1990s saw renewed attention from researchers in disciplines across the social sciences and humanities to the role of gender differences, in particular, in shaping experiences and perceptions of pain.[5] Such trends in both the medical and social sciences coincided with broader institutional shifts in national health research bodies. In 1990, not only did the American NIH establish the Office for Research on Women's Health, but there were also growing critiques of the normative standard of relying on male bodies in the vast majority of clinical trials. Such trials assumed that the male body was the 'universal' one, forcing scientists and medical practitioners to extrapolate existing research findings to the bodies of women. These challenges culminated in the American National Institutes of Health Revitalization Act of 1993, which demanded the inclusion of women in NIH-funded research.[6]

With the male body no longer held up as the universal standard in medical research, scientists continued to unpack the complex relationship between gender and pain, publishing hundreds of studies on the subject in the interceding years. In 2012, a team of Quebec-based researchers undertaking a systematic review of the literature published between 1998 and 2008 concluded that the majority of scientific studies showed no significant sex-based difference in pain sensitivity.[7] Some researchers, nevertheless, have made valuable inroads into understanding the ways in which gender shapes individual experiences and the treatment of physical and emotional pain. Their research has focused on biological explanations for gender variations in pain response – including the influence of reproductive hormones, sex-differences in stress-induced analgesia responses and anatomical differences in the brain and central nervous system – as well as psychological and cultural differences in how individuals respond to pain.[8] British scholars have identified differences in the ways female and male subjects cope with pain, with women preferring 'emotion-focused' coping as compared to men favouring a sensory-focused coping strategy.[9] Australian experts have highlighted how gender shapes the language used to describe a past pain event: in relaying pain, women were found to use more descriptive and evocative language as compared to men, who generally relied on fewer words in their pain complaints.[10] These findings point to the ongoing shortcomings of language in understanding pain – a point originally raised by Elaine Scarry, who, in her now classic 1985 work, *The Body in Pain*, posited that 'pain does not simply resist language but actively destroys it'.[11] While some have disagreed with Scarry's interpretation of the relationship between language and pain, scholars from a variety of backgrounds – including historians – have pointed to the value of studying the gestural languages of pain, non-verbal performances of discomfort that are, themselves, inherently gendered.[12]

Medical researchers have definitively demonstrated, however, that gender plays an important role in shaping the *treatment* of pain. In 2012, researchers at Stanford University (USA), demonstrated that across the majority of ailments, diseases and disease categories, women reported significantly higher pain scores than men.[13] Yet, despite these marked differences in clinically recorded pain scores, female suffering remains undertreated across a range of health settings. A 1996 article indicated that women were referred to specialist pain clinics after a longer period of suffering than male patients with similar complaints.[14] In one major American survey, it was found that physicians were more likely to prescribe the optimal pain management for men experiencing pain resulting from metastatic prostate cancer than for that resulting

from metastatic breast cancer in women. In fact, physicians frequently chose the *least-effective* analgesic regime for individuals undergoing caesarean section compared to prescriptions related to prostatectomy.[15] These persistent trends have led researchers including Diane E. Hoffman and Anita J. Tarzian to conclude that 'western medicine discounts female pain expression': as women's pain reports continue to be taken less seriously by medical practitioners than those of men, women remain disadvantaged in a range of traditional medical settings.[16] While the direct impact on the women in question is evident, such under-treatment also has broader social and economic consequences, with persistent pain impacting negatively on women's role in both the family and the workforce.

Gender-based disparities in the treatment of pain also have a marked impact in current health care systems across a number of national contexts. As Hoffman and Tarzian point out, 'a healthcare system that continues to discriminate in its treatment of women is also likely to lose the confidence of its female patrons', who, due to a number of factors, are more likely to turn to alternative therapies than men.[17] Focusing on the American example, historian Keith Wailoo has demonstrated that the treatment of pain is always political. Mid-twentieth century debates surrounding health insurance – including Medicare, Medicaid in the USA or, in the British and Canadian contexts, the introduction of universal health care in the form of the National Health Service and the Medical Care Act (Medicare) – positioned physicians and the courts as the medical and legal gatekeepers of relief, and worked to balance the costs of adequate treatment with the need for healthy and productive citizens.[18] The introduction of insurance schemes required effective treatment, an increasing concern given current pressures on health care systems across Britain and North America. In the context of a rapidly aging population, attention to persistent inequities in the treatment of pain – across not just gender lines, but also in terms of race and ethnicity[19] – has become all the more imperative. Taken together, these factors compel new and more sophisticated interpretations of the relationship between gender and pain, fueling ongoing and multidisciplinary research into these subjects.

The themes identified in contemporary pain research are rooted in historical contexts, and, as demonstrated by those scholars who focus on historical relationships between gender and pain, recur over time. Historians of the body have argued that, across time and space, western medicine has been largely characterised by the tendency to privilege physiological symptoms – objective, biologically-based indicators – over subjective, experiential reports of illness, discomfort, or pain. The introduction of medical instruments including the speculum facilitated this process, providing physicians, overwhelmingly male, with new opportunities to view, interpret, and understand the bodies of their female patients.[20] Each of the papers included in this forum grapples with the gendering of medical knowledge, and attempts to interrogate the question of who has the authority to know and interpret an individual's pain. In two of the case studies presented (Agnes Arnold-Forster's examination of the pain of breast cancer in nineteenth-century England and Lisa Smith's discussion of the hidden pain and, possibly, venereal disease of the Newdigate daughters), male physicians – including J. Weldon Fell and Hans Sloane – position themselves as the expert interpreters of the pains and discomforts of those women seeking, or subjected to, their 'treatment.' By contrast, Laura Carpenter's analysis of the discourses surrounding circumcision pain in mid-to-late twentieth-century North America offers an interesting counterpoint, as

women – whether as mothers, nurses and midwives – played a significant role in shaping understandings of male pain experiences. It is interesting to note, however, that their interpretations of male pain were centred around the pain of infants, and, to this end, can perhaps be seen as an extension of women's 'innate' maternal, caring identities. It is difficult to conjure up an equivalent example of women reading, interpreting and expertly knowing the pains of adult men in the same ways as the male physicians discussed elsewhere in the forum.

The authors included in this forum also highlight the multifaceted ways in which gender has shaped the social, cultural and medical construction of norms surrounding the *expression* of physical and emotional pain. These standards are fundamentally rooted in broader gender stereotypes, and the act of transgressing or conforming to the role of the 'good' sufferer or patient is itself gendered. In one study of expressions of pain amongst Arab-American girls and boys, for instance, the boys noted that pain made them feel 'brave', 'like crying and they don't', and 'angry' while pain made girls feel 'sad', 'embarrassed', and 'like running away'.[21]

There are also gendered differences in the way people talk about their own suffering. Mechanical metaphors for pain were more likely to be used by male sufferers while women were much more likely to describe their pains in terms of childbirth. For example, Joanna Bourke's book on *The Story of Pain* explores gendered metaphors for pain, drawing on (amongst others) Carola Skott's 2002 analysis of the figurative languages used by cancer sufferers. In their research, female sufferers drew on metaphors derived from the domestic sphere while men employed those from war. In the words of a forty-five-year-old woman interviewed by Skott:

> 'I visualize it [cancer pain] as something similar to the clean-up you do before Christmas, you are scrubbing really hard and you are going on and on and you may demolish some jar and scrub some paint away from the furniture and you regret that and think that it may have been enough with only some soft dusting.'[22]

As Wendy Kline demonstrates in her discussion of the psychic pain of participants in early LSD research conducted at the Maryland Psychiatric Research Institute, however, these lines were at times blurred, as men such as Francesco drew on the language of childbirth trauma to describe their own psychedelic experiences.

Finally, each of the papers included in the forum fundamentally highlights the ways in which gender intersects with other categories and identifiers in shaping experiences and perceptions of pain. Arnold-Forster shows how gendered attitudes towards the pain experienced by individual women are inseparable from broader ideas about the race and class of those women in question. Looking at two very different contexts, Carpenter and Smith interrogate the ways in which age and gender intertwine in descriptions of the pain experienced by infant boys and elderly men. Kline, on the other hand, brings ability into the gender and pain equation, touching on the ways in which psychedelic therapies – and the 'peak experiences' these entailed – were conceptualised by psychologists including Stanislav Grof as having the potential to help individuals overcome conditions ranging from alcoholism to depression.

Why should the gendering of pain be important? Gender does a vast amount of ideological work for physicians, psychiatrists, psychologists and the pharmaceutical industry, as well as for the actual sufferers themselves and their families. Given the interconnectedness between physiological and mental processes, ascriptions of

masculinity and femininity have profound effects on the nature of individual and group suffering. Gendered bodies are actively engaged in the processes that constitute painful sensations. And, as such, they affect every aspect of the phenomenological experience of suffering.

Notes

1. Charles C. Josey and Carroll H. Miller, 'Race, Sex, and Class Differences in Ability to Endure Pain', *Journal of Social Psychology*, 3 (1932), pp. 374–76, at p. 375.
2. Nurofen, *Pain Relief Study* (London: King's Fund, 1989), cited in Gillian Anne Bendelow, 'Gender Differences in Perceptions of Pain: Towards a Phenomenological Approach', PhD thesis, University of London, [no date], p. 65.
3. M.A. Ruda, 'Guest Editorial: Gender and Pain', *Pain* 53 (1993), pp. 1–2.
4. See Mark Zoborowski, 'Cultural Components in Response to Pain', *Journal of Social Issues* 8 (1952). pp. 16–30, and Irving Kennth Zola, 'Culture and Symptoms: An Analysis of Patients Presenting Complaints', *American Sociological Review* 31 (1966), pp. 615–30.
5. See, for example, the work of medical sociologists including Gillian Bendelow, 'Pain Perceptions, Emotions, and Gender', *Sociology of Health & Illness* 15 (1993) pp. 273–94.
6. National Institutes of Health Revitalization Act of 1993, Clinical Research Equity Regarding Women and Minorities, PL 103-43 (10 June 1993).
7. Melanie Racine and others, 'A systematic literature review of 10 years of research on sex/gender and experimental pain perception – Part 1: Are there really differences between women and men?' *Pain* 153 (2012). pp. 602–18; Melanie Racine and others, 'A systematic literature review of 10 years of research on sex/gender and pain perception – Part 2: Do biopsychosocial factors alter pain sensitivity differently in women and men?' *Pain* 153 (2012) pp. 619–35.
8. See Diane E. Hoffman and Anita J. Tarzian, 'The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain', *Journal of Law, Medicine & Ethics* 29 (2011), pp. 13–27, and Eva E. Johansson, Katarina Hamberg, Goran Westman and Gerd Lindgren, 'The Meanings of Pain: An Exploration of Women's Descriptions of Symptoms', *Social Science & Medicine* 48 (1999), pp. 1791–802.
9. Edmund Keogh and Malin Herenfeldt, 'Gender, Coping and the Perception of Pain', *Pain* 97 (2002), pp. 195–201.
10. J. Strong and others, 'Pain Language and Gender Differences When Describing a Past Pain Event',' *Pain* 145 (2009), pp. 86–95.
11. Elaine Scarry, *The Body in Pain: The Making and Unmaking of the World* (Oxford: Oxford University Press, 1985), p. 4.
12. See Joanna Bourke, *The Story of Pain: From Prayer to Painkillers* (Oxford: Oxford University Press, 2014), pp. 159–91, and Edmund Keogh, 'Gender Differences in the Nonverbal Communication of Pain: A New Direction for Sex, Gender and Pain Research?', *Pain* 155 (2014), pp. 1927–31.
13. David Ruau and others, 'Sex Differences in Reported Pain Across 11,000 Patients Captured in Electronic Medical Records', *The Journal of Pain* 13 (2012), pp. 228–34.
14. A. M. Unrah, 'Gender Variations in Clinical Pain Experience', *Pain,* 65 (1996), pp. 123–67.
15. Carmen R. Green and John R. C. Wheeler, 'Physician Variability in the Management of Acute Postoperative and Cancer Pain: A Quantitative Analysis of the Michigan Experience', *The Official Journal of the American Academy of Pain Medicine*, 4 (2003), pp. 8–20, pp. 8 and 16.
16. Hoffman and Tarzian, 'The Girl Who Cried Pain', p. 20.
17. Hoffman and Tarzian, 'The Girl Who Cried Pain', p. 22.
18. Keith Wailoo, *Pain: A Political History* (Baltimore: Johns Hopkins University Press, 2014), pp. 57–97.
19. Carmen R. Green and others, 'The Unequal Burden of Pain: Confronting Racial and Ethnic Disparities in Pain', *Pain Medicine* 4 (2003), pp. 277–94.
20. Kathryn Yeniyurt, 'When it Hurts to Look: Interpreting the Interior of the Victorian Woman', *Social History of Medicine* 27 (2014), pp. 1–19.
21. Huda Abu-Saad, 'Cultural Components of Pain: The Arab-American Child', *Issues in Comparative Pediatric Nursing,* 7 (1984), pp. 91–99, pp. 96–7.
22. Carola Skott, 'Expressive Metaphors in Cancer Narratives', *Cancer Nursing: An International Journal for Cancer Care*, 25 (2002), pp. 230–35, p. 232.