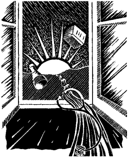

*From the front lines*

*Aux premières lignes*

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# A pain consultation clinic for women

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Are specialized services useful for women?[1,2] A pilot study addressing usefulness was undertaken in 1990 at the Craniofacial Pain Research Unit of Mount Sinai Hospital, Toronto (which is affiliated with the University of Toronto). This unit is an interdisciplinary clinical research service mainly involving the departments of Neurology (Medicine), Dentistry and Psychiatry, with significant input from the departments of Nursing, Anaesthesia and Otolaryngology.

About 2000 patients are seen annually in this unit, of whom 70% to 75% are women. Common presenting conditions are episodic tension headache, temperomandibular disorders, trigeminal neuralgia and atypical face pain, the last of which occurs in 10% to 15% of the unit's population, predominantly women.[3,4] Most of the patients with atypical face pain complain of severe, constant pain accompanied by sadness, poor sleep, fatigue, back pain and generalized muscle pain. The pain is frequently precipitated by dental or other procedures. Inquiry often reveals family and marital difficulties; job dissatisfaction; physical, sexual and emotional abuse; or other psychologically charged issues. Patients in one subgroup, predominantly women, experience chronic myofascial pain in the area of the temperomandibular joint and chronic tension or medication-induced headache accompanied by multiple somatic complaints. Patients in a second subgroup, also predominantly women, suffer intractable and severe facial and head pain arising from a combination of articular, myogenous and neuropathic sources. These people are severely disabled, often depressed and often addicted to one or more opiate or adjunctive pharmaceutical agents; they are the subject of a forthcoming prospective clinical trial. A third, smaller subgroup, for which the ratio of men to women is not clear, suffer more clearly defined trigeminal nerve injuries and neuropathic lesions producing severe allodynic or hyperpathic pain.

Several female professionals currently work in the unit, and all patients, men and women, are now routinely referred for psychiatric input whenever appropriate. In 1990, however, the physicians and dentists performing the initial consultations for admission to the unit were all men, and they had not yet established a close working relationship with the Department of Psychiatry. Accordingly, in our capacities as psychiatrist and neurologist respectively, we decided to carry out a pilot project to see whether referring women with chronic cranial pain for psychiatric assessment would be acceptable to the patients (i.e., would they agree to go?), whether seeing a woman professional would make it easier for such patients to speak about personal concerns and whether referral of patients for psychiatric assessment would allow the establishment of closer links between the Department of Psychiatry and the other pain specialties.

## Why do women suffer more chronic pain than men?

For reasons that may depend heavily on outmoded assumptions and biased rating scales,[5] women are more likely than men to "somatize," that is, to complain of somatic problems (such as pain, altered sensation or disability), especially when no immediate cause for the problems can be identified.[6] Women may have a lower threshold for pain.[7] They self-medicate pain with alcohol less frequently than men and are less likely to distract themselves from somatic concerns by physical or mental activity.[8] The personality traits associated with women permit, even encourage, looking to others for help and support in times of suffering[9–12] so



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that complaints of pain are more likely to be brought to the attention of a health care provider when the sufferer is a woman.

Pain disorders are associated with depression.[13–16] Whatever the direction of effects (i.e., whether pain leads to depression or depression leads to pain), depressive disorders are well recognized as being more common among women than men.[17,18] These differences in prevalence have varied over time, which suggests that both depression and pain disorders may be sequelae of changing roles and social expectations.[19,20] It is interesting that women who meet the criteria for depression have more somatic symptoms than men who are depressed.[21] The psychological concomitants of hormonal fluctuations have been implicated in this association,[22] as have child-rearing practices and socialization pressures leading to divergent development. For instance, girls are described as less assertive than boys and are raised to restrain the expression of anger.[23,24] Unexpressed anger is commonly held to be responsible for depressed mood and physiological dysfunction. A few studies have shown that girls grow up feeling less in control of events around them than do boys,[25] which may translate into an associated perception of having little power to control physical sensations. Child abuse has been held potentially responsible for many psychosomatic conditions of adulthood.[26,27] The relative proportion of men and women who have experienced childhood sexual abuse is roughly equivalent to the relative proportion of men and women with many pain-related physiological disorders, such as myofascial pain.

## Consultation service

Between 1990 and 1992, 30 women agreed to see a psychiatrist. Unfortunately, no record was kept of those who refused. Some participants were motivated by the hope that psychiatric confirmation of injury or disability would serve them in subsequent legal claims for compensation or pension benefit, but most were simply curious about the influence of psychological stress on pain. A few had marital problems, a few were bereaved, and a few were subjectively very stressed and felt this stress was due to the pain they suffered and to their subsequent inability to function as before. Several women welcomed the referral because of past psychological trauma that they felt accounted for their symptoms.

The patients were offered a 2-hour consultation with a woman psychiatrist and 1 or 2 psychiatry students but were given the choice of seeing the consultant alone if they preferred. When a family member accompanied the patient, either separate or joint interviews were conducted, according to the patient's preference. A thorough life history was obtained, and psychological contributions to the genesis of the pain or dysfunction were explored. Also explored were feelings toward important others (family, employers, love partners, close friends or physicians). Life-style factors were assessed, and level of disability was evaluated. In collaboration with the patient, psychological symptoms were elicited to test whether they belonged in diagnosable categories such as anxiety or depressive states. Issues of significance to women were routinely raised. These included topics such as violence in the home, incest, eating and body-image difficulties, menstrual discomfort, love relationships, pregnancies, motherhood, marital infidelities, self-esteem and self-control problems, obligations toward parents and friends, work–family conflicts and perceived social pressures.

Pharmacological agents and individual or marital counselling were recommended, as deemed appropriate. Case work, nutrition counselling, massage, fitness programs, addiction counselling, specific medical work-up or supplemental income assistance were occasionally suggested. To help counteract the frequent emergence of themes of perceived powerlessness on the part of the women, they were always invited to be present at all diagnostic and treatment discussions.

For the most part, the patients were seen only once, but some required a second or even a third appointment to complete the assessment.

On the first visit back to the craniofacial clinic, the assessment letter was read to the patient, and a joint decision was made as to whether to follow the psychiatric recommendations.

## Emerging themes*

Certain themes surfaced repeatedly during the consultation interviews. Concerns about reproductive functions — menstruation, conception, pregnancy and menopause — were especially common.

Mothering was a frequent theme. One patient was preoccupied with guilt about an abortion. Another, who had been adopted as a child, mourned her own lack of opportunity to become a mother.

Another major theme was aging and the attendant loss of "looks" and threat of widowhood, loneliness and economic hardship. The expression of these concerns was often associated with women whose children had recently moved away from home.

Caring for others — an invalid husband, seriously ill friends or aging in-laws — was a pervasive theme. For some, long-buried resentment over infidelities and demeaning treatment in the past made the burden of caring

*Details of the examples have been altered to protect patient confidentiality.

that much more conflictual. The following is an illustrative quote from one of the consultation letters.

> It is not clear why the attacks of pain come and go. Ms. A spoke at great length about her life and her relationship to important people in her life. It seems as if Ms. A, the youngest in the family, was always the caretaker in the home. She looked after her parents until her mother's death and then continued to be her father's main support until his death 2 years ago. She feels that the story of her life could be summarized by: she works hard, others lean on her, but she is never rewarded for it. The story has been repeated in many ways at her job. She has worked in the company for 14 years, now does the work formerly done by 2 employees, and yet all her attempts to obtain an increase in pay have been turned down. In some ways, the situation is also repeating itself in relation to her boyfriend, who is unemployed and dependent on her. Ms. A often feels resentful and taken advantage of in these situations, and it may be that the timing of her attacks of pain corresponds to the disappointments in her work and personal life.

When this letter was read to the patient, it helped her to organize her thoughts about a thread of resentment that linked her to people in her past and her present. Whenever she felt pain, she thought of how she had been used in her life and, in a curious way, this gave her the courage to stand up to the pain and not allow this, too, to take advantage of her.

During the course of the study, psychological connections such as these were not made in the sense of causative explanations for pain but rather as interesting and sometimes distracting perspectives on the coming and going of episodes of pain.

## Aspects of outcome

In terms of the first goal of our pilot project, we found that patients at the Craniofacial Pain Research Unit were indeed willing to participate in a psychiatric consultation. When questioned by the neurologist (A.S.G.), the patients who came for consultation over the study period expressed satisfaction with the process. About 20% returned for further appointments or requested referral to a psychotherapist. The second aim of the study was to determine whether the patients would readily speak of their psychological pain to a woman professional. Again, without exception, those who came did not hesitate to speak about concerns other than the pain itself. Finally, the pilot project did forge linkages with the Department of Psychiatry to the extent that, by 1998, a psychiatrist was participating regularly in multidisciplinary patient discussions within the Craniofacial Pain Research Unit. The gender mix of physicians (and psychiatrists) has changed but the psycho-social-biologic model of chronic pain and attention to gender-related issues remain.

The issue of psychiatric diagnosis (whether any given constellation of symptoms and presentation constitutes depression, somatization disorder, personality disorder or post-traumatic stress disorder) has gained prominence and increasingly determines treatment interventions but, to the patients, still appears secondary to their need to be listened to and understood.

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