



Gender and the language of pain in chronic and terminal illness: A corpus-based discourse analysis of patients' narratives



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ABSTRACT

Drawing on the notion of gender as a socially constructed category performed *inter alia* through language, this study examines the ways in which women and men use language to do person-in-pain in real-life interactions about chronic and terminal illness. It is based on a secondary analysis of a large corpus of health and illness narratives collected by the Health Experiences Research Group at the University of Oxford and published by the DIPEX charity. Sixteen chronic and terminal conditions were identified in which men and women talked about physical pain and their narratives examined using the linguistic approach of a corpus-assisted discourse analysis. Our study shows that there are significant quantitative and qualitative differences in the ways in which women and men report pain pointing to the existence of distinctive feminine and masculine lexical repertoires of pain talk. While these repertoires conform to some of the dominant societal stereotypes surrounding masculinity and femininity, they also transgress those. Women refer to pain more frequently and have a wider lexical repertoire for pain reporting. They use more specific and factual references as well as cognitive and psychological words in their pain talk. In contrast, men tend to use fewer descriptors in general, most of which are highly emotive suggesting that they report pain when it becomes unbearable enduring it until this point. There is also a conspicuous absence of references to psychological processes in the male narratives and the focus is on pain killers. Understanding this nuanced role of gender in communicating pain can help health professionals respond effectively to people's talk about pain and develop more holistic practices in pain consultation, assessment and treatment leading potentially to the reduction of gender biases and inequalities in healthcare.

1. Introduction

Pain is a common symptom and one of the primary reasons why people seek medical help (Walid et al., 2008). Given the pervasiveness of pain, since the 1970s pain has been recognised as the fifth vital sign alongside blood pressure, pulse, respiration and body temperature. New diagnostic pain assessment techniques have been developed including numeric rating scales (NRS), visual analogue scales (VAS) and verbal categorical rating scales (VRS). These scales are routinely included in patient assessment of acute and chronic pain (Breivik et al., 2008). Although pain scales have contributed to a recognition of pain experience in clinical practice, they are rather reductionist and their effectiveness in improving patient care seems to have been patchy (Walid et al., 2008). This is partially due to the rather narrow understanding of pain prevalent in medical sciences which relies on bodily signs and neglects the personal and social dimensions of the pain experience.

Research in social sciences has shown that pain is first and foremost

the subjective experience of a person-in-pain (Bourke, 2014) and as such largely influenced by personal moods, attitudes and beliefs that are impossible to capture by a single number on a pain scale (Walid et al., 2008; Bendelow, 1993). As Bourke (2014) argues in her extensive historical analysis of pain experience, pain is a social action and communicative act mediated through language and influenced by social factors including gender, class, ethnicity, cultural expectations and beliefs. Thus, pain cannot be reduced to a sensory state to be explained by the medical profession: it needs to be understood at the nexus of affective, psychological, social and communicative practices of people-in-pain (Bendelow, 1993).

The role of language and patients' communicative styles has recently been recognised as critical for advancing our understanding of pain and for the development of a more holistic approach to pain consultation, assessment and treatment (Padfield and Zakrzewska, 2017; Walid et al., 2008). The large body of research on language in health communication has demonstrated the critical role which the *how*

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of communication plays in medical consultations and in the perception of illness (Hamilton and Chou, 2017). Yet, with a few exceptions (Semino, 2010; Halliday, 1998), research on the language of pain is sparse.

This study seeks to contribute to this slowly growing body of research by exploring communicative repertoires utilised by women and men to describe pain experience in the context of chronic and terminal illness. Following Otsuji and Pennycook (2010: 248), a communicative repertoire is understood as a more or less conventionalized gamut of lexico-grammatical resources that people use to convey meanings and to take action. We focus on patient's gender because gender is a central category that people use to make sense of social relationships and one of the major sources of social stereotyping. Research in social sciences has shown that gender and related social stereotypes exert a powerful influence on how health and illness are experienced by patients and treated by medical practitioners perpetuating gender biases and gender inequalities in medical practice (Modica et al., 2014; Lorber and Moore, 2002). The ways in which pain is treated seems no exception and here too gender stereotypes play a substantial role in reinforcing gender inequalities. Yet, we know little about the ways in which the gender of the person-in-pain impacts on the communicative repertoire through which pain experience is verbalised. This is relevant to examine because the kind of language that women and men in pain use is the only source of information about their pain experience having consequences for treatment. The present study turns therefore to the little understood role of language in the pain experience of women and men. In contrast to previous research on pain and gender which is mostly based on experimental techniques and concerned with biological differences, we examine the ways in which women and men use language to do person-in-pain (Bourke, 2014) in real-life interactions about chronic and terminal illness.

The notion of gender which underpins this study is influenced by the poststructuralist and feminist understanding of gender, specifically the work by Butler (1990), and its application in discourse analytical research (e.g. Cameron, 2007). We therefore see gender as a socially constructed category dependent upon normative social and cultural conventions, and expectations that impose social roles and 'produce' gendered personae which might not necessarily correspond to biological sex. As Butler contends (1990), gender is not what people *have* as a fixed biological characteristic but rather *what they do*. In Butler's sense, gender is simultaneously a condition and an effect of identity formation and this formation happens mostly through observing, adopting and repeating behaviours widely associated with a gender (e.g. boys don't cry). Gender is then in Butler's (1990: 145) words a "a regulated process of repetition" which reinforces gendered rules and behaviours. Language, alongside other symbolic means, is an important tool which simultaneously enacts gender and through which this 'doing' of gender becomes manifest. Specially, we argue that repeated language use could be an index and a reflection of gendered practices. Therefore, through an analysis of patterns of language use in female and male narratives of chronic and terminal illness we are interested in establishing the extent to which pain is a gendered communicative practice highlighting repeated lexical 'tools' through which the pain experience is communicated by women and men.

This study is based on a secondary analysis of a large corpus of illness narratives collected by the Health Experiences Research Group at the University of Oxford and published by the DIPEX charity on the HealthTalk website (healthtalk.org). Sixteen conditions were identified in which men and women talked about physical pain, and their narratives were examined. Whereas most previous research on health and illness narratives adopted qualitative research methodologies, our study is based on a combination of quantitative corpus-linguistic and qualitative discourse-analytical techniques. In doing so, it contributes to the nascent body of research that has advocated the use of corpus linguistics or a combination of corpus linguistics with discourse analysis to explore illness narratives (Gooberman-Hill et al., 2009; Seale and

Charteris-Black, 2008; Harvey et al., 2007; Seale et al., 2006).

2. Pain, gender and language

The recognition of pain as the fifth vital sign has led to a better recognition of patients' pain experience, yet differences seem to prevail in the ways in which female and male pain complaints are treated with several studies reporting gender biases (Arslanian-Engoren, 2000; Hoffmann and Tarzian, 2001; Abuful et al., 2005). For example, a systematic review by Hoffmann and Tarzian (2001) of research concerned with pain and gender showed that women are more likely to report pain than men but their verbal reports are initially ignored. Research in medical sciences reports that medical practitioners tend to focus on biological signs and are likely to regard women's pain reports as exaggeration, a sign of anxiety or emotional distress. There is mounting evidence in medical sciences suggesting that women are routinely undertreated for their pain complaints; men are more likely to be immediately referred to specialists and receive appropriate pain treatment (Abuful et al., 2005). In addition, women are more often prescribed sedatives (Calderone, 1990) and are given proper pain treatment after they 'show' some biological causes. The one-dimensional understanding of pain and the gender biases prevalent in medical sciences leads not only to misdiagnosis and prolonged pain experience, it also contributes to increased isolation and female mortality (Arslanian-Engoren, 2000).

Given that women seem to report pain more than men, several researchers in medical sciences have been interested in finding out whether there are inherent biological differences in how pain affects the two genders (e.g. Unruh, 1996; Pickering et al., 2002; Aloisi and Bonifazi, 2006). Using experimental techniques to test responses to pain and analgesics, some studies have shown that women and men respond differently to noxious stimuli with women reporting more pain and demonstrating greater sensitivity. Physiological differences, specifically reproductive hormones and the menstrual cycle have been regarded as major contributors to the different responses. Yet, the effect sizes of the differences observed are small and there are several validation issues with the experimental techniques used (Hurley and Adams, 2008). Thus, the evidence for a biological cause is not sufficient enough to explain the differences observed in clinical practice. For this reason, several scholars called for a shift in the understanding of pain and gender by exploring in more depth the social and cultural dimensions of the pain experience in women and men arguing that they could better explain the observed variance (Hurley and Adams, 2008; Hoffmann and Tarzian, 2001).

Several researchers in the field of sociology of health and illness have responded to this call showing that women's and men's experience of pain is much influenced by larger cultural scripts, gendered role expectations and different socialisation patterns (Bendelow, 1993, 2000; Paulson et al., 1998; Werner and Malterud, 2003; Bernardes et al., 2008). In doing so, they have widened the rather one-dimensional understanding of pain to include the socio-cultural context in which a person-in-pain operates. For example, Bendelow, 1993, 2000 research on the perceptions of pain in women and men shows how beliefs about pain are closely linked with gendered expectations of how both genders should cope with pain. Specifically, widely believed assumptions that female biology equips women with better coping strategies were linked with the perception of pain in women as a 'natural state', whereas pain in men was seen as something 'abnormal'. These 'natural' assumptions influence the socialisation process in that from early childhood, boys are often explicitly or implicitly taught to suppress pain experience because expressions of pain are seen as unmanly and feminine (Pollack, 1998). For both genders, such assumptions are double-edged: in the case of men, the association of masculinity with pain endurance can lead to identity threat and causes men to delay help seeking, putting their health at risk (Paulson et al., 1998). In the case of women, the perceived 'naturalness' of pain in the female body can

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