



Age, Gender, and Women's Health and the Patient

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Patients with functional gastrointestinal disorders (FGIDs) often experience distress, reduced quality of life, a perceived lack of validation, and an unsatisfactory experience with health care providers. A health care provider can provide the patient with a framework in which to understand and legitimize their symptoms, remove self-doubt or blame, and identify factors that contribute to symptoms that the patient can influence or control. This framework is implemented with the consideration of important factors that impact FGIDs, such as gender, age, society, and the patient's perspective. Although the majority of FGIDs, including globus, rumination syndrome, irritable bowel syndrome, bloating, constipation, functional abdominal pain, sphincter of Oddi dyskinesia, pelvic floor dysfunction, and extraintestinal manifestations, are more prevalent in women than in men, functional chest pain, dyspepsia, vomiting, and anorectal pain do not appear to vary by gender. Studies have suggested sex differences in somatic, but not visceral, pain perception, motility, and central processing of visceral pain; although further research is required in autonomic nervous system dysfunction, genetics, and immunologic/microbiome. Gender differences in response to psychological treatments, antidepressants, fiber, probiotics, and anticholinergics have not been studied adequately. However, a greater clinical response to 5-HT₃ antagonists but not 5-HT₄ agonists has been reported in women compared with men.

Keywords: Sex; Development; Society; Symptoms.

This review discusses the patient's perspective and biological basis for sex and gender differences in functional gastrointestinal disorders (FGIDs). Attention is given to the lived experience of irritable bowel syndrome (IBS) as well as the importance of patient interaction with the health care provider. In addition, the review highlights the current literature related to gender- and sex-based differences in visceral and somatic sensitivity, pain, motility, and the overlap of FGIDs, in particular IBS, with other chronic conditions.

The Patient Perspective

The Patient Experience of FGIDs

"IBS is very frustrating: it dominates life style and daily activities mostly through its unpredictability. You must

always plan for the 'what if 'what if I eat more' 'what if toilet facilities are not available' 'what if I cannot break away.' It leaves you feeling 'dirty or unclean' and inhibits social mixing and sexual activity. IBS is frustrating. And that's the bottom line..." IBS study participant.

For patients with chronic symptoms, the psychological and social ramifications of their illness are often more important than the physical impairment. Three over-riding themes seem to dominate the experience of living with moderate to severe FGID: (1) a sense of frustration, (2) a sense of isolation, and (3) search for a niche in the health/sick role continuum/dissatisfaction with the medical system.^{1–4} The effects of IBS on quality of life (QoL) often are underestimated. Patients with mild to moderate disease severity report that IBS restricts daily activities on average 73 days per year (20%); resulting in loss of work (13% of patients).⁵

There is often a disconnect between patients' and physicians' views of the IBS experience, regarding perceptions of etiology, severity, treatment approaches, and efficacy.^{6–8} When 1014 patients and 508 physicians used identical scales to rate IBS-related pain and discomfort, responses showed that physicians rated discomfort as significantly less severe than patients.⁹ Conversely, 35% of more than a 1000 IBS patients in an international survey, reported their symptoms as severe. In the same survey, to receive a treatment that would make them symptom free, patients would give up 25% of their remaining life (average, 15 y) and 14% would risk a 1 in 1000 chance of death.⁵ Many patients are reluctant to accept the functional diagnosis and many misconceptions, for example, that anxiety, depression, and diet cause IBS, and fear that IBS leads to cancer.^{7,8} Such misconceptions likely affect clinical outcomes and health care utilization.

The Patient–Health Care Provider Encounter

"The biggest problem is that no one (in the medical field) treats the whole person. I feel more like I'm going to a drug

Abbreviations used in this paper: EAL, early adverse life event; FGID, functional gastrointestinal disorders; HRT, hormone replacement therapy; 5-HT, serotonin; IBS, irritable bowel syndrome; QoL, quality of life.

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0016-5085/\$36.00

<http://dx.doi.org/10.1053/j.gastro.2016.02.017>

dealer than someone that looks at the problem in its totality. As a result I have turned my attention to helping myself, and have had some degree of success. I wish doctors would listen to patients more when we talk about the symptoms and how they affect our daily lives," IBS study participant.

Only a small proportion ($\approx 25\%$) of IBS sufferers consult physicians.¹⁰ However, those who do, have high health care utilization.¹¹ The nature of the patient–physician relationship is complex. Factors within and outside the health care system are constantly molding patient and physician behavior. Patients feel frustrated with unsatisfactory explanations of FGIDs, which may be experienced as a denial of the legitimacy of their symptoms and perceive lack of empathy.² Conversely, physician frustration and dissatisfaction related to treating patients with FGIDs stem from a lack of understanding of the disease, limited treatment options, limited training in communication skills, increased workload, and the perception of personality characteristics of patients with IBS with psychiatric comorbidities.¹² Gastroenterologists perceive that patients with IBS require longer visits despite not being as sick as patients with other disorders that they manage⁹ and can show gender bias.¹³ Negative attitudes toward patients with IBS may form a barrier to objective patient assessment and effective physician–patient relationship building, and ultimately negatively impact clinical outcome.¹⁴ Effective communication skills can be learned and practiced and, importantly, do not increase the encounter time. Rather, effective communication skills make the process of assessment and diagnosis more efficient, improve clinical outcomes, and increase physician job satisfaction.^{15–17}

IBS can be challenging for both the physician and the patient. Patients must learn to self-manage a condition that can have a profound impact on everyday life. Health care providers can help by eliciting and addressing patient concerns; by offering a positive diagnosis and clear, understandable, and legitimizing explanations of the disorder; show empathy; and enter into a meaningful partnership that helps individuals replace feelings of helplessness with means of empowerment.

Gender

Sex refers to the biological make-up of the individual's reproductive anatomy whereas gender refers to an individual's lifestyle or personal identity. Often, these terms are used interchangeably. In this article we use *sex* to describe what is known about biological differences between males and females and *gender* to refer to what is known about behavior between men and women.

The literature on gender and health has discussed the detrimental impact of adherence to some traditional feminine gender roles on women's health and well-being.¹⁸ These include gender-related expectations, such as societal standards for attractiveness; social norms regarding women's caretaking role in relationships; and sanctions against anger expression by women. The messages women receive about gender-related expectations and the societal consequences of not measuring up to these expectations can

have health consequences.¹⁹ There are several common gender role concerns among women with IBS including shame and bodily functions, bloating and physical appearance, and pleasing others, assertion, and anger.¹⁹

One central theme that women with IBS commonly report is feelings of shame associated with losing control of bodily functions. Women are taught that bodily functions are something to be kept private and secret. One important implication of such teachings is that bowel functioning becomes a source of shame and embarrassment more so than it does for men.

The finding that women often score higher on indices of bloating and constipation also can be discussed as a gender-related theme. Society's focus on how women look (eg, thinness as a necessary standard of attractiveness)²⁰ can lead women to experience bloating not only as a source of physical discomfort, but of psychological distress as well. The physical and psychological distress that women may experience with abdominal discomfort, coupled with the perception that their pain is being minimized or trivialized by health care professionals, may lead women to respond by becoming more hypervigilant to any sign of pain or discomfort.

Women as compared with men are socialized to please others, often at the expense of their own needs. Women who express anger, make demands, or question authority are often given the label of being hysterical, have their complaints dismissed, or have their femininity called into question. Potential repercussions for women who express their own wants and needs often are sufficient to keep women silent. These social expectations of women can lead to the silencing of certain thoughts, feelings, and behaviors rather than jeopardize relationships that are in place.²¹ A study that compared women with IBS with women with inflammatory bowel disease found that women with IBS score higher on measures of self-silencing than inflammatory bowel disease patients.²¹ In another study, women reported shame in not living up to gender norm expectations for women in domains of relationships (taking care of others at the expense of their own needs), attractiveness (caused by bloating), and lack of desire to engage in sex (caused by IBS symptoms).²² Men in this study focused more on IBS symptoms impacting their paid employment and sense of control. They also found that in interactions with health care providers, women risked being trivialized and men risked being overlooked because IBS may be labeled as a women's health concern.

Gender and Social Factors

It is important to acknowledge that health and illness occur within a larger social context. The meaning and expression of illness occur against a complex backdrop of a multitude of social determinants of health. The social determinants that have been investigated in FGIDs include life stressors; history of sexual, physical, and emotional abuse; and early life experiences including gender role socialization, social support, and social factors as assessed by QoL scales.

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