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# The Gendered Language of Pain

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*Women's pain is shaped by biology, cultural beliefs, and healthcare systems that have been historically dismissive. A personal discussion of how women feel pain differently, face longer diagnostic delays, and receive poorer care-and why believing women in pain is itself a clinical imperative.*

I have lived with chronic pelvic pain for more than a decade. It is a constant heaviness and the ache gets worse as the day goes on. Sitting for too long, prolonged standing, physical activity, sex-most things seem to aggravate it. Over time, it has slowly reshaped how I live: how I work, how I make love, how I travel, how I exercise, even how I play with my children, or what I choose to wear.

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I saw several doctors over the years, mostly gynaecologists, who could not find anything obvious to fix. Routine scans looked fine and most of my tests were normal. There was not much effort to look beyond what showed up on standard tests. And somewhere along the way, the question changed. It stopped being about what might be causing the pain and became about why I was feeling it. Perhaps stress, maybe anxiety, or my lifestyle were the "triggers"?

None of the doctors I saw said it out loud, but the advice that followed made their opinion clear: if nothing shows up on a scan, maybe it was an imagined pain. That is when I realised my pain was not just something I had to live with; its very existence was something I had to keep proving.

It was frustrating that despite my background in biology, which trained me to understand my body at least to some extent, and despite having access to doctors, tests, and the kind of care that many people did not, I still had no idea why I was in pain. Over time, I started to doubt myself. *Maybe it is stress. Maybe I'm overthinking it. Maybe there really is nothing there.*

I began coming across similar stories of women in pain, online. They described years of pain, being told nothing was wrong, and made to feel like it was all in their head. It was hard to ignore the pattern. It could not be that all of us were imagining it.

That is what made me start thinking more seriously about pain itself. What actually shapes pain-biology, the mind, or the world around us? And why does it seem to play out so differently for men and women?

## Experience of Pain

Pain is not just a signal from damaged tissue, even though that is how we often think about it. The International Association for the Study of Pain defines it as both a sensory and emotional experience. Imaging studies show that pain activates not just sensory areas in the brain, but also regions linked to fear, memory, and threat. Pain is shaped not just by damage but also by what we anticipate, what we remember, and how safe we feel.

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At a basic level, pain begins with specialised receptors-sensory nerve endings across the body-that detect potential damage. They send signals to the spinal cord and brain, where these are processed and experienced as pain. Signals travel through different neural pathways depending on whether it is sharp pain or a dull one, or an aching pain. Different parts of the brain map where it hurts, how intense it is, and the emotional response to it.

Pain is not a one-way process. The brain can also send signals back to turn pain up or down, for instance, by releasing endorphins, the body's pain-killing hormones. These and other hormones act as chemical messengers that can influence how pain is processed and how much inflammation is present. Even as a biological mechanism, pain is not a simple, linear pathway, but the result of many factors coming together to shape how we experience it.

## Womanly Pain

Across countries, cultures, and conditions, women consistently report more frequent, more intense, and chronic pain. Migraine is a good example. Women get it about three times more often than men. Fibromyalgia is another. Many common pain conditions, from joint and muscle pain to irritable bowel syndrome and nerve pain, are known to be more common in women. Women are also more likely to report stronger pain during and after surgery. In addition, some chronic pain conditions affect only women, like endometriosis, interstitial cystitis, and pelvic girdle pain.

What stood out to me was that these differences do not disappear in lab settings. Even when pain is measured in a controlled environment-heat, pressure, electrical stimulation-women, on average, feel pain earlier and tolerate it for a shorter time than men. This suggests these differences are not only about reporting or communication but also may reflect underlying biological variation. This prompts the question: do men and women process pain differently?

## Hormones and Pain Pathways

Before puberty, boys and girls respond to pain pretty much the same way. But things start to change once puberty sets in. Girls begin to report higher sensitivity to pain and deal with more chronic pain than boys, which hints that sex hormones might play a part, though it is not all that straightforward.

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Take oestrogen, the primary sex-defining hormone in women. Its levels fluctuate throughout the menstrual cycle, and some research suggests women's pain sensitivity shifts with these changes, although the results are not always consistent. Oestrogen seems to turn pain sensitivity up or down, depending on which pain pathway it is affecting.

Scientists recently have been looking into other hormones like prolactin, a hormone essential for lactation and breast development. Though this field is in its nascent stages, some studies link higher prolactin levels to nerve pathways that respond more strongly to pain, exacerbating chronic pain conditions like migraine in women with endometriosis, for example.

In contrast, testosterone, the predominant male hormone, has in some studies been linked to higher pain tolerance. This is seen in both human and animal models. But here too, the picture is not entirely clear, and the mechanisms are still being worked out. Taken together, our limited understanding today points to specific sex hormones working with specific nerve pathways either to increase or decrease the sensation of pain, with the former being mostly true for hormones that are dominant in women.

Beyond hormones, there are also gender differences in how pain is regulated in the brain. What matters is not only how intensely the pain is felt, but also how quickly it can be dampened once it begins. Evidence suggests that women, on average, do not have strong internal cellular and molecular systems when compared to men for shutting off pain signals, leading to more stubborn, long-lasting pain.

Then there is the immune system. Chronic pain is closely linked to inflammation in the nervous system and researchers are starting to realise that immune signalling works differently in men and women. Scientists are still trying to figure out what these differences mean, but it seems to be another piece of this complicated puzzle.

What emerges from all of this is not a single explanation, but a consistent pattern. Men and women are not on an equal footing when it comes to pain, either in how it is experienced or how long it lasts. Women are more likely to end up living with lingering pain, sometimes for years. And yet, why is it so often not taken seriously when women complain of persistent pain?

## Who Gets Believed, Who Gets Treated?

These gender disparities carry through into how pain is treated across our health systems, with many studies pointing to clear and not-so-subtle differences in how women's pain is managed. In emergency rooms, women usually wait longer for pain relief, and are less likely to be given strong painkillers for the same complaints. Their pain is also more likely to be brushed off as psychological or emotional rather than a physical phenomenon. Most of this evidence comes from Western settings, but smaller studies and reports suggest similar patterns in India too, especially when it comes to abdominal and pelvic pain.

Then there is pain that only women experience-pain that medicine has often failed to take seriously. Endometriosis affects about one in 10 women of reproductive age, yet getting a diagnosis can take anywhere from four to 12 years worldwide. In those years, many women are told their pain is normal, exaggerated, or just due to stress. What is this but apathy?

## Gaps in Research

Part of this gender gap comes from how medical knowledge was built in the first place. For decades, women were simply left out of clinical trials. Preclinical research relied heavily on male animals, partly to avoid dealing with hormonal cycles. The result is that many pain models, diagnostic criteria, and treatments were developed around male bodies and then applied more broadly, without much adjustment.

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That has several consequences, including misdiagnosis when symptoms do not match those typically seen in men. For example, women are 50% more likely to be misdiagnosed during a heart attack because their presentation does not mirror the "textbook" male symptoms. The scope of this disparity is staggering: a landmark Danish population-based study found that women are diagnosed later than men for 770 different diseases, facing an average delay of four years.

But the bias is most visible in the "diagnostic interval", the time between patients reporting their first symptom and receiving a diagnosis. Recent research across 208 million patients shows that for 112 acute and chronic diseases, women consistently wait longer for a diagnosis than men.

Drug dosing is another consequence of this research bias. It is a relatively recent realisation that women do not always respond to medication in the same way men do. One study found that women required roughly 30% more morphine than men to get the same amount of pain relief after surgery. Of course, this is not true for every drug or every kind of pain and the evidence is mixed. But it makes an uncomfortable point: the "standard" dose was never as neutral as we thought, especially for women.

Women are also 50% to 75% more likely to experience an adverse reaction from approved medications than men and the reason is similar. Most drug trials do not include enough women, so the recommendations that come out of those studies end up being based on men's bodies. That pushes women closer to the edge of what's considered "safe".

The gap widens further when we look at conditions that affect only women. There are major gaps in understanding issues like endometriosis, pelvic pain, and menopause, largely because they remain under-researched. Even in 2020, just 5% of global research and development (R&D) money was spent on women's health. And of that, about 80% went to cancers specific to women. The money left over covers everything else, with about a quarter of it focused just on fertility.

That leaves very little for chronic pain and other health struggles women deal with every day, especially gynaecological dysfunctions, autoimmune issues, or symptoms that do not fit neatly into one category. Women make up half the world, but somehow, their health is still often seen as a side note.

## Pain and its Consequences

What I learned from my own experience is that you cannot wish pain away or make it disappear by ignoring it. Over time, it can change in ways that make it more persistent. Neuroscience shows that untreated pain can reshape how the nervous system responds to it. Pain pathways become more sensitive and more easily triggered, a process known as central sensitisation, causing pain to become less tied to the original injury and harder to treat over time.

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This is also where mental health becomes relevant. Chronic pain increases the risk of anxiety and depression by two to three times. Yet pain is frequently dismissed as "just anxiety", rather than recognising that the anxiety may be the result of years of unresolved pain.

In India, this dynamic is especially stark because there is a strong cultural expectation that pain will be supressed. Chronic pain affects roughly one in five adults, but barely 5% ever see a pain specialist. Pain is treated just as a part of life, a sign to endure, a test of faith, or even a result of karma.

Women's pain is especially vulnerable to normalisation with additional layers of social and cultural bias. Women rarely prioritise their health and when they do complain, they are dismissed by families, by clinicians, and by society.

For those seeking care, and for women who have been living with pain for years, this matters in very real ways.

## Where This Leaves Us

I do not think "gendered pain" has just one cause. It comes down to an intersection of biology, cultural beliefs, and the way our healthcare system works. Each of these layers changes the experience of pain for women-how they feel it, how they talk about it, and the kind of care they actually receive.

Looking at each of these pieces, it becomes clear that there are still many gaps in the evidence -perhaps because these questions have not been asked enough. What is clear, however, is that pain in women is more likely to persist; they experience longer delays in diagnosis, poorer pain management, and more barriers to appropriate care across many conditions, especially gynaecological ones.

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These delays not only deepen suffering but also affect how people live their lives. They change how people relate to their own bodies, a feeling I strongly connect with. Pain that is not taken seriously spills into work, relationships, and confidence. Over time, it teaches people to doubt themselves.

Living with pain taught me that being heard can matter just as much as being treated. While we wait for science to catch up, maybe one small shift is to believe women when they talk about pain that has lasted for years. Even if there is no immediate solution, trusting people to know their own bodies, and not dismissing their experience, is not too much to ask.

After 12 years of living with it every single day, I eventually got a diagnosis for my pelvic pain: Pelvic Congestion Syndrome (PCS). It took a lot of reading on my own and pushing a gynaecologist for a specific scan to identify PCS. Just having a name for it, a reason, brought more relief than I expected, even before thinking about treatment.

What is hard to ignore is this: it is estimated that up to 30% of women presenting with chronic pelvic pain have PCS. And yet, it is still overlooked when women present with unexplained pelvic pain in India.

I had the knowledge and the access to keep pushing. Not everyone can push their way through the system. And that means there are many others still living with the same kind of pain, without any hope of finding names and answers.

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