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Headaches: A Gendered Illness

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Abstract
Headaches are not a symptom but a neurological disorder which mainly affects females and is the human race's third most frequent and second most disabling illness, according to the World Health Organisation (WHO). Headaches are the epitome of chronic pain in females during their peak years of life. Those who are prone to this disorder suffer not only physically during an acute headache attack with its resulting incapacitating effects but also because of the anguish associated with the onset of new attacks. Its lack of 'social' recognition as a genuine, severe and incapacitating pathology is a further aggravation for those who experience this condition.

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Introduction

Headaches are a widespread disorder and when recurrent and persistent can affect and damage all areas of life, from family-sentimental relationships to social relations and work. Experiencing pain-illness, as in this case, affects not only sensory aspects related to nociceptive hyperstimulation but also emotional, cognitive, behavioural and relational features, severely affecting quality of life [1]. The severity and recurrence of symptoms typical of this pathology, their incapacitating effects and the anguished anticipation of new attacks can all lead to psychosocial changes. These subsequently become an integral part of the problem, amplifying suffering and aggravating disability [2]. Pain can render even the simplest daily activity an unbearable burden and the inability to perform family, domestic, work or leisure commitments may generate feelings of guilt, frustration, dissatisfaction and inadequacy, often exacerbated by a lack of understanding in those nearby [3]. Dynamics such as these characterise headaches as well as all forms of chronic pain in general and can be a root of deterioration in affective and social relations [4]. They can often constitute fertile ground for the onset of mental disorders, mainly anxiety and/or depression, so further compromising the situation by establishing a vicious circle. A cultural gap has persisted on this issue up to now, meaning that the disease is frequently underestimated, underdiagnosed and consequently undertreated. In many cases it is managed incorrectly, with self-medication and drug abuse [5] (as well as all the problems that these entail in terms of side effects) prevailing among some patients. Epidemiological data show that many of the pathologies responsible for chronic pain tend to have a higher incidence in females. In addition to women's higher prevalence of single chronic pain conditions, they are also much more frequently susceptible to multiple accompanying pain conditions. This greater proneness to pain is due to differing gender characteristics on a sensory and emotional level. As far as the sensory aspect is concerned, anatomical, hormonal and physiological differences play a fundamental role, paving the way for a greater probability of developing pathologies that cause pain with an accompanying lower threshold of pain perception than men. In particular, high concentrations of oestrogen influence the activity of the nervous system, making it more sensitive and reactive to stimuli in general and thus also to painful ones. Women are essentially more receptive to painful stimuli which they experience with greater intensity and greater recall. On an emotional level, women have an intimate relationship with pain since they are often called upon to take responsibility for the suffering of others and thus develop empathy in dealing with it.

Headaches are among the most frequent conditions of chronic pain in women. Female sex hormones play a decisive role in explaining the threefold prevalence of the condition in women as compared to men; mast cells, which have receptors for oestrogen and progesterone, are recognised as playing a crucial role in determining gender differences observed in the evolution of chronic pain and headaches.

There appears to be a correlation between cyclical hormonal variations, particularly oestrogen, and the recurrence of migraine attacks [6]. Headaches generally emerge with the onset of puberty [7], a typically regular crisis recurrence during a fertile age which correlates with the menstrual period, with an improvement of symptoms during pregnancy and menopause. Thus, the condition reaches its peak in the most productive period of a woman's life, inevitably impacting on study or work and couple, family and social relations [8]. Comorbidities often aggravate the clinical picture: headaches may be accompanied by other pathologies strongly associated with typically female chronic pain [9], such as endometriosis and chronic pelvic pain [10] or irritable bowel syndrome and fibromyalgia. In these cases, the effects of comorbidity [11] on the quality of life do not result from a straightforward sum total of individual problems but rather their multiplication. The frequent association of headaches with the onset of anxiety and/or depression further impair a patient's quality of life [12].

Sleep disorders are also linked to headaches, with a worsening reciprocal interaction that, just as in anxiety and depression, induces a vicious circle where causes and consequences feed off one another.

The role of women is central to the family and reflects society as a whole. It is generally agreed that the well-being of an entire community passes through the welfare of its female components [13]. Women play multiple roles: they are workers, partners, mothers and caregivers. Conquering the professional world has not stripped them of being the family unit's backbone and performing care and nursing tasks. We can identify in women the role of family managers. In many cases even today it is they who oversee family organisation, the domestic *ménage* and caring not only for children in all its multiple dimensions (health, school, sport and leisure) but also, in an increasingly ageing population, of the elderly. The association of female with the role of caregiver has its roots in cultural heritage and in a strongly marked social context within Italy [14] which identifies women as having a natural inclination to care [15] and unselfishness in providing for the needs of loved ones, especially the most fragile and needy [16]. Moreover, women boast an approach which is characterised by an all-encompassing emotional involvement [17], with a tendency to assume full responsibility and little inclination to delegate. It is here where headaches can have a significant socio-economic impact. The interference with family and social life caused by the pathology is undoubtedly a real problem which is acutely felt by patients and which contributes significantly to worsening their quality of life [18]. Furthermore, patients often experience stigma during their work activities (and before that, education) due to a lack of understanding on the part of colleagues and employers who commonly tend to trivialise the problem or have a distorted interpretation of the severe physical and cognitive limitations which can result from headaches [19].

The full impact of this condition is difficult to quantify but is easily identifiable as a variable of great weight [20], especially if a woman with an important social role falls ill. The frenetic pace of life dictated by work stress and pressing family duties is undoubtedly a contributing factor. Moreover, women who suffer from headaches are severely restricted in their daily lives and may feel forced to make sacrifices while carrying a physical and emotional burden which does not only affect them but also the entire network of family and relationships around them. The extent of this burden and the impact in terms of quality of life depend on numerous and varied factors related to the pathology itself, including the presence of co-morbidities, the possible abuse of analgesic drugs and other aspects intrinsic to the biological, psychological and social background of the patient. Living with chronic pain leads to impoverished social relationships [21]. Mention has already been made of the working environment but in broadening the perspective we find frequent social withdrawal in headache sufferers. This is caused by the onset of headaches which, during acute attacks, may prevent participation in social life [22] or provoke frequent states of depression. This is further exacerbated by the weight of stigma linked to the trivialisation of headaches, which are erroneously attributed to everyday experience [23], as well as the constant experience of “pain” in the distressful anticipation of a new attack.

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