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Is The Meaning of Symptoms the Same in Women And Men?

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Abstract

The author hypothesize that patient gender could have an effect on expression and communication of symptoms. Symptoms may be defined as "any subjective evidence of a health problem as perceived by the patient". Symptoms are the result of an interpretation process. Symptom experiences are embedded in a complex interplay between biological, psychological and cultural factors. The expression of symptoms depends more on psychosocial aspects than biological. In consequence there must be a variety of interpretations of sensations, which are not equivalent to expressions of underlying disease. Moreover, this interpretation of sensations, being fundamentally of a psychosocial character, must be different according to the gender of the patient. So, symptoms of the same disease could differ between women and men, and the same symptom could have different meanings in females and males. If diagnosis of disease is based exclusively on the presence of specific symptom characteristics, we may risk not take into account the different meanings by reason of gender, and give rise to misinterpretations and misdiagnoses. The implications of this perspective are immense. There is a need for developing research designs that test alternative conceptions of symptoms as a complexity phenomenon, with gender/sex differences in health, more rigorously.

Keywords: Women; Family medicine; Diagnosis; Disease; Anxiety

Discussion

What do we mean by "sex" and "gender"?

Sex tends now to refer to biological differences, while gender often refers to cultural or social ones. Gender varies from society to society and can be changed. While most people are born either male or female, they are taught appropriate norms and behavior's including how they should interact with others of the same or opposite sex within households, communities, work places and medical office. Gender norms, roles and relations influence people's susceptibility to different health conditions and diseases and affect their enjoyment of good mental, physical health and wellbeing. They also have a bearing on people's access to and uptake of health services and on the health outcomes they experience throughout the life-course [1].

What is a symptom and what does it mean?

There is one concept in medicine which is prominent, the symptom. The omnipresence of the symptom seems, however, not to be reflected by an equally prominent curiosity aimed at investigating this concept as a phenomenon [2]. A symptom is an indication or a signal of something that is already happening or is going to happen in the future. It is, in the medical field, the phenomenon that reveals the existence of a disease. This phenomenon is narrated by the patient in a subjective way when he notices something abnormal in his organism.

The interpretation and meaning that the individual attributes to the symptoms or diseases are influenced by different variables such as previous personal experiences with the symptom, family experiences or other significant actors, learned models, beliefs and social norms. All these factors not only influence the individual's perception, but at the same time shape the reaction to symptoms as a result of their cognitive process [3]. The severity of the disease, physical deterioration, and disability are mediators in the personal assessment of the disease, in addition to health beliefs (i.e., locus of control), psychological characteristics (i.e., anxiety, anger, depression and optimism), and social support available. All these factors can intervene in the final result of what a symptom means for a person and how he expresses it.

The symptoms expressed by patients in the consultation (especially in Family medicine, can have different meanings: expressions of biochemical alterations, symbolic expressions, expressions of the group context, expressions of family stress when going through developmental transactions, expressions of coping with a situation or event, expressions of "family character or style" symptoms, somatic expressions associated with mental problems and functional or psychosocial expressions associated with organic problems, or social and historical expressions [4,5].

Symptoms are always subjective

Symptoms are not easily recognized, and can be presented by symbols, as does the arrangement of notes in a musical score: as a mysterious constellation. Therefore, symptoms (and signs!) are always subjective. The singularity of the patient, his "subjective symptoms", his imaginations about the illness in the body, his tensions, pains, etc., are discussed in his objectivity by the reductive discourse of the doctor and based on his positivist gaze. The disease should be understood as an integral personal process associated with complex chemical and metabolic changes and accompanying the development of symptoms. Personality as an organizing principle uses disease as a means of expressing its lack of ability to satisfactorily confront social, psychological, political, or economic contextual forces. The symptoms are a focus of attention because they indicate in some way the internal

conflict or the evidence that the defensive systems have been activated. Symptoms are also the way in which the patient defines his problem: a way to make something accessible or available to someone.

The expression of symptoms depends more on psychosocial aspects than biological

The expression of individual symptoms is more related to certain contextual psychosocial factors than to apparently specific pathological factors. It can be said that the disease is born of situations or contexts that do not allow the containment of the symptoms. In addition, illness refers not only to organic symptoms, but to the body of experiences or sensations of the person in a series of contexts or situations. The common denominator of disease is that it occurs or is born in situations and is a relational concept.

Symptoms of the same disease differ between women and men

Assessment and management of symptoms is a main task in primary care. Symptoms may be defined as "any subjective evidence of a health problem as perceived by the patient". In other words, symptoms do not appear as such, symptoms are rather the result of an interpretation process. Symptom experiences are embedded in a complex interplay between biological, psychological and cultural factors.

Health surveys and morbidity studies have found higher female morbidity rates, as reflected by indices such as general health status, number of acute conditions or physical symptoms and medical care utilization [6]. Such findings can lead to the conclusion that women are the "sicker sex" in terms of objective health status. Some major methodological sources of bias, that have been held responsible for part of the sex differences found in health surveys, such as the poor definition of the morbidity concept and aspects of the data collection. Part of the sex differences found in health surveys can be explained by higher female symptom sensitivity, defined as a readiness to perceive physical sensations as symptoms of illness [7], and a biologically grounded greater sensitivity and vulnerability of women to adverse/stressful events [8].

Existing data suggest that women seem to report many more subjective symptoms than men. Also, much of the excess chronic illness reported by women is in part a reflection of how they define and respond to illness and to their life situations [9,10]. Differences by sex occur particularly in the rates of common mental disorders: depression, anxiety, psychological alterations and somatic complaints; these disorders affecting 1 in 3 people occur twice in women than in men. And, moreover, depressive episodes are among them longer, the recurrences more frequent and with a greater tendency to chronicity than among males. Women's greatest impact is due to psychological as well as social and gender factors, as the traditional role of women in societies exposes them to more tensions, while depriving them of the ability to modify their stressful environment, As well as the high rate of domestic and sexual violence to which they are exposed [11].

Conclusion

In consequence to all the above, we can say that there must be a variety of interpretations of sensations, which are not equivalent to expressions of underlying disease. Moreover, this interpretation of sensations, being fundamentally of a psychosocial character, must be different according to the gender of the patient (among other psychosocial variables). If diagnosis of disease is based exclusively on the presence of specific symptom characteristics, we may risk not take into account the different meanings by reason of gender, and give rise to misinterpretations and misdiagnoses. The implications of this perspective are immense. There is a need for developing research designs that test alternative conceptions of the sex differences in health more rigorously. Future research in primary care could gain from exploring symptoms as a phenomenon and raised awareness of symptom complexity [4]. It is suggested that further research on sex differences in morbidity should control for methodological sources of sex bias and should focus explicitly on differences in the perception of physical symptoms by men and women [7].

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