Blame It on the Roaming Uterus: Representing Women in Chronic Pain Cases

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I step into Julia's house a little after 9:30 on a Saturday morning.

The home reeks of angst and resentment. A young man, no more than 14 years old, shuffles through the living room with headphones on. He doesn't register my presence. The nine-year-old, who let me in, is yelling at the five-year-old who is now crying in the kitchen, where Julia is attempting breakfast. She stands at the stove, looking ten years older than her 42 years, disheveled, in dirty sweats. Most obvious is the splint around her right wrist.

Julia screams at her husband, who has retreated to the backyard. A defeated-looking man comes in and rounds up the girls, taking them to another room. I gingerly poke my head into the kitchen and greet Julia, who sighs and forces a smile, apologizing for the chaos. As this is only our second meeting, I want to see how she lives and what her days are like.

After a few minutes, she inadvertently scoots some egg out of the pan and onto the stove. I barely notice, but Julia throws the spatula across the room and starts wailing. I am only catching every third word or so. She regains her composure, only to lose it again a minute later. On this second breakdown, seemingly triggered by nothing, I think to myself, for a fraction of a second: "Damn. This chick's crazy."

And there it is.

Blame It on the Roaming Uteri

Chronic pain cases make up the majority of my work. I routinely meet with clients in unrelenting pain and misery in all stages and walks of life. Men and women. Young and old. Rich and poor. Of all shapes and sizes and colors. Pain is the great equalizer. Pain syndromes, however, are not.

Diagnosable pain syndromes affect women over men by a ratio of nearly two to one. Julia's story isn't unusually tragic; it's common. I have seen it over and over. I know the science. I know the statistics. I know the agony as well as anyone who has not actually lived through it. I'm also a woman. A righteous feminist. A mother. Yet for a moment, my inherent, ugly bias wants to call this woman crazy.

That's the power of bias. The history of sexism in science, medicine and psychology is well-documented. As far back as Aristotle, philosophers thought the cause of most physical problems in women was a roaming uterus that wreaked havoc wherever it went. For hundreds of years, problems that women experienced were routinely blamed on "hysteria," a uniquely feminine "disorder" that continued to have a place in psychology's revered *Diagnostic and Statistical Manual of Mental Disorders* (DSM) until the 1980s—seriously. It was believed that women acted out, suffered from anxiety or depression, and exhibited signs of overt sexuality and a host of other "unacceptable" attributes because they needed to have orgasms. The cure for this was to get married. Getting married meant getting pregnant, thus putting women into the place that society deemed fitting.

Freud taught that women experienced hysteria when they realized that they did not have a penis. The cure for that was to get one, in the form of a husband. Today, hysteria has morphed into a term used to describe an overly emotional response. It is nearly always used in reference to women.

The scientific community has done little to add any actual "science" to our understanding of female health, although it's not for lack of trying. Oh wait, it *is* for lack of trying:

- The famous Physicians Health Study which found that low-dose aspirin could lower your risk of heart disease used 22,000 men for its study … and zero women.[1]
- For its first twenty years, the Baltimore Longitudinal Study of Aging followed 1,000 men. And zero women, even though women represent the majority of the elderly population.[2]
- And a very recent study looking at the effects of mixing alcohol with flibanserin (commonly known as "female Viagra") used twenty-five participants. Two were female. Again, this was a study of a drug made for, and marketed to, women.[3]

This pattern is notable because between 1997 and 2001, eight of ten FDA-approved drugs that were pulled off the market because of "unacceptable health risks" were found to be more harmful to women than to men.[4] And while it may seem like the problem is the risks themselves are unknown, it should concern us far more that the medical community has not identified—or even tried to identify—why women respond differently to drugs than men.

That's where the research gap becomes truly harmful. It's not that women are seen as the same as men. It's that they haven't really been seen at all.

The Defense Approach to Female Pain

The defense commonly employs what I like to call the Fox

News Approach: gently but noticeably, lean into the bias more and more until the end of the case, when their closing argument reads like a turn of the (last) century psychology textbook.

This approach begins subtly. Defense counsel will attempt to subpoena mental health records. They will ask questions in deposition about history of mental illness, depression, anxiety and, specifically, post-partum depression. They will get a doctor who is entirely unqualified to make a psychiatric diagnosis (an orthopedic surgeon, for example) to recommend a psychiatric evaluation to explore mental or emotional pain triggers. This recommendation will take the form of a motion, thus contaminating the judge's view of your client. And all of a sudden, without any evidence and based almost completely on bias, the defense has hijacked your case and reframed its issues.

Not all cases go this far, but this sort of psychiatric full-court, in-court press is becoming more and more common. So, how do we fight this? How do we combat thousands of years of medical and psychological and social and institutional sexism? Bias has the same half-life as nuclear fallout. Instead, we must adapt to our new surroundings. Here are a few strategies for doing that.

Call It Out for What It Is

Late diagnosis and missed diagnosis are common problems in pain syndrome cases. With the defense tactic of misdiagnosing a medical issue as a psychological one, the parallels to medical malpractice are obvious—so in voir dire, initiate a discussion about misdiagnosis. Ask about depression, anxiety, rumination and any case-specific diagnoses. You will have a juror who has a medical issue and also anxiety or depression. Ask a juror who suffers from migraines if anyone has ever suggested that they take anti-anxiety medication to fix the migraines. When jurors share their experiences with chronic pain, ask whether anyone has suggested that it was all in their head or that anti-depressants will take away their physical pain. You may even see patterns emerge between your male and female jurors, showing how seriously their respective complaints are taken by the medical community.

> We are ill-equipped to make case decisions if we don't understand our client's story. Before we can decide to embrace or waive our client's psychological claims, we must know how they are affecting her. Go to her home and spend a lot of time there. Talk to her friends and family frequently. Encourage experts to use her family as historians.

Use your pain management expert to talk about the problems with misdiagnosis of women. Start with the foundation: *Did you have an opportunity to review Dr. Defense's opinions of Ms. Plaintiff's condition? Do you believe those opinions have any merit?* What should evolve is not a discussion about the credibility battle between plaintiff and defense, you and the defense lawyer, or your expert and their expert: rather, it is a discussion about the credibility of women in general and the dismissive nature of the medical profession when it comes to women's complaints of pain.

In your experience, doctor, do women who complain to their doctors of persistent and chronic pain often get the kind of diagnosis that was made by the defense doctor? Don't lead them into it. Just say, *Say more about that. Why do you think that is? What does that mean, long term, for women who really are in chronic pain?* It's not enough for your expert to simply disagree with the defense diagnosis; he or she must be righteously indignant about their approach.

This is not an isolated incident that limits itself to the litigation context. This sort of sexism happens every day in clinics and hospitals and doctor's offices all over the world and it harms millions of women every year. Women's subjective complaints are discounted or ignored; when they continue to complain about them, doctors assume it's psychological. And women of color have it even worse. The studies in this field are robust. A 1990 study on post-operative patients found that where men were more likely to receive pain medication in response to complaints of pain, women making the same complaints of pain were more likely to be given sedatives.[5] If your doctor doesn't have that study, give it to them.

Keep in mind that the vast majority of chronic pain patients who are receiving medical care start taking an antidepressant or anti-anxiety medication after their pain becomes chronic. There is a robust body of medical literature showing a substantial link between pain and depression and anxiety. Pain causes depression and anxiety. Anxiety and depression make pain worse. An unfortunate and vicious cycle ensues. But depression and anxiety do not *cause* a pain syndrome. It is important that your jury understands the difference, especially if your client has a history of either.

Alternatively, Lean Into It

We have all tried the Eggshell Plaintiff case. Generally, it's the 50-year-old woman with a degenerated spine. Or the old man with osteoporosis who trips and falls. For clients with chronic pain disorders who have a history of documented psychological treatment or diagnosis that predates the injury in our case, the analysis is the same. Medical studies insist that there is no link between pre-existing psychological conditions and the development of chronic pain. Most pain management doctors I have worked with are skeptical of those findings. They agree that the majority of people who end up with chronic pain have a history of emotional trauma or significant depression or anxiety. That has been my experience as well.

There are times when we have to lean into our client's pre-existing struggles. The truth is that it is harder for people with emotional trauma to cope with pain. It is harder for people who had pre-existing anxiety or depression to combat pain once it starts. And pre-existing depression and anxiety put your client at a higher risk of developing an addiction to pain medication or committing suicide.

There are psychologists that specialize in counseling people with chronic pain. Most clients would certainly benefit from this treatment, but for clients with pre-existing psychological conditions, it is essential not only from a treatment perspective, but for your expert team as well. They need to talk to the jury about the devastating impact this injury has had on their prior con-

dition and how much more guarded the prognosis is for these patients. This expert is also a good medical starting point for the human losses your client has experienced and a before-and-after look at your client's ability to function in the world:

Q: Doctor, we have heard from other pain management experts and physicians about the physical effects of chronic pain, but your perspective on the effects of chronic pain are unique—can you talk about that?

Q: You mentioned that these patients have to retrain themselves to do even the most basic tasks of day-to-day living. Can you say more?

Q: Can you talk about setbacks in this context?

Q: How do you counsel a patient whose pain changes from manageable to unmanageable?

Q: Why is living with chronic pain different from any other emotional stress or injury?

Q: In what aspects of daily living do you find that the psychological effects of chronic pain take the greatest toll?

You can already start to see the myriad ways you can use these experts to add credibility to your non-economic damages and also give substance and nuance when you have a client whose pain became worse because of the injury.

Focus on Functional Loss

In chronic pain cases where the client has a history of psychological treatment, it helps to focus on the functional loss our client has experienced, told through the eyes of others. Our client should only testify to matters that no one else can speak to. Let her former supervisor or co-workers talk about her performance post-injury. Let her family talk about her mood and day-to-day function. Let her friends talk about her isolation.

This works particularly well for women clients. Women are generally responsible for the daily logistics, care and feeding of others. If they are employed, this means getting up early to get ready for work before getting the kids ready for school and making sure they have eaten breakfast and their lunches are packed, along with anything else they need for school. A mother must coordinate pick-ups, drop-offs, after-school activities, play dates, teacher conferences, grocery shopping, dinner, laundry, homework supervision, cleaning, bathing the kids, and bedtime stories. And we have not mentioned her commute or the eight-plus hours she spent at work. Every mom I know has done all of these things when they had a cold, a migraine or morning sickness. What none of them can imagine is having that migraine every day, with no end in sight.

Part of the reason the story is compelling is because it is relatable. The other reason is because there are so many details to work with. For example, a mother can lose the functional use of one arm after a CRPS diagnosis. It does not mean that she stops doing all of the things that are required of her. It does mean that she does them differently, while exhausted, with a great deal of sadness and anger and resentment.

It is essential that we see this first-hand, in our client's home, so when the client's family takes the stand, we know how to set the scene and what questions to ask so that our client's story connects to jurors who are ready to hear it.

So, What If It Is?

What do you do if the defense's argument is … kinda true?

Your client does seem histrionic; or maybe a somatoform disorder would explain why there aren't any objective signs during examination. Her depression and anxiety seem to have really spiraled her downward. Or maybe your client is just so unlikeable that a jury might decide that she is exaggerating. Make no mistake, all of these things are very real for your client. Depression, anxiety and somatoform disorders all make pain worse and your client feels them as acutely as they would feel organic pain. The defense likes to use them to imply faking or malingering, but nothing could be further from the truth. As a result, your only good option is often embracing the truth and saying, "yeah, so what?"

Embrace causation. Give the jury a choice:

> If you believe that she has a pain disorder, this is her life care plan and prognosis; if you believe that she has a psychological condition that is producing these symptoms, this is her life care plan and prognosis. Because no matter what you believe about her symptoms or diagnosis or treatment, there isn't any dispute that the accident was the event that triggered all of this. There isn't any dispute that she will continue to need medical and psychological care. There isn't any dispute that she has suffered because of her injury.

Talk about causation in jury selection. Your theme is how some people respond differently to trauma than others. PTSD is a good starting point. A lot of your jurors may have a narrow definition of "trauma" so you may want to substitute the word "loss" during jury selection. Talk to them about people they knew who had an unusual or perhaps what they saw as "overly dramatic" response to loss. *Did it seem fake? Were they less sympathetic? Why did they think the person responded that way?* You aren't necessarily looking to eliminate people who were unsympathetic. You are looking for people who can be introspective about it—who are open to the possibility that this response was more about their brain's wiring, stress at the time or other circumstances that made the response genuine, albeit, weird.

Use the jury instructions about causation in opening if your jurisdiction allows. Help your jurors to focus, from the start, on how the harm was caused and not necessarily whether that harm was a normal response to the injury. Tell them up-front that the defense is going to say that it's all in her head and that her injury is psychological; and that your response is it doesn't make one bit of difference. The law says that you compensate for the injuries the defendant caused. That includes psychological ones. Keep this same attitude during examination of witnesses.

At the end of the day, if they caused it, they have to pay for it. It's that simple. Resist the urge to complicate it by fighting on every point. When the jurors understand that the law says they have to compensate for all injuries, the defense of trying to

change one injury to another injury starts to feel really frivolous.

Decisions, Decisions

The proper treatment of chronic pain necessarily involves some psychological care. The defense believes that this entitles them to a full psychological history, and an examination by one or more psychological specialists. In many states, putting your client's psychological condition at issue opens them up to a full-scale inquiry. In California, you are able to prevent this deep dive by agreeing not to present any evidence of psychological injury beyond that which is normally associated with the injury. But this also prevents you from calling any experts on the subject and in some cases, making a claim for future psychological care and treatment.

That's a big trade-off. On the one hand, you keep those greasy insurance company fingers out of your client's history and save your client the indignity of being forced into a prolonged interview with a psychologist or psychiatrist whose only job is to build a case for diagnosing her with a personality disorder. On the other hand, psychological suffering is so deeply intertwined with chronic pain that removing psychological suffering from damages effectively amputates part of the story and closes off a significant avenue of recovery.

Like many lawyers who do these cases, I have struggled to find the right approach. Whichever choice I make inevitably makes me anxious that I have failed my client. Lately, I have been working up this part of the case in an effort to embrace the whole story and give myself and her treating physicians a better understanding of the extent of her suffering. One of these approaches is to consider having our client undergo neuropsychological testing well before expert designation. Chronic pain so significantly affects the brain that this testing can reveal deficits in concentration, memory and executive function. Scales on depression, anxiety and rumination are nearly always elevated. If the client takes pain medication, it will make her cognitive deficits worse. Prolonged chronic pain changes the pathways in the brain, essentially causing damage that may not be repairable. This has the added benefit of allowing us to take back the framing of our case.

Know Thyself. Then Know Thy Client.

Take inventory about what's going on with you. What is your danger point with this client? Do you have biases that cause you to see her claims differently than other clients? How do those biases affect your relationship with her? Clients who live with chronic pain can be difficult to love. They are raw, angry and sad. They are self-involved and negative. It's easy to make case-altering decisions because we don't believe a jury will like or relate to our client. This is projection—it develops when *we don't like or relate to our client*. It's easy to decide that we don't want to spend time with our client because she is so unpleasant. We know that it's impossible to get a jury to love our client if we don't love her first.

We are ill-equipped to make case decisions if we don't understand our client's story. Before we can decide to embrace or waive our client's psychological claims, we must know how they are affecting her. Go to her home and spend a lot of time there. Talk to her friends and family frequently. Encourage experts to use her family as historians.

Most of all, care. Believe her when she tells you she is suffering and care about the woman who has trusted you to tell her story. Embrace the injustices that women suffer in the medical world and be an advocate on behalf of those who have been marginalized or treated cruelly. Gender equality in the courtroom is more than a goal; it is a precondition for justice. It is incumbent on all of us to seek it, not only for our clients, but for ourselves and our profession.

Endnotes

1. See Steering Committee of the Physicians' Health Study Research Group (1989) *Final Report on the Aspirin Component of the Ongoing Physicians' Health Study*. N Engl J Med 321:129-135.
2. See Shock, Nathan W. and Greulich, Richard C. and Costa, Paul T, Jr. and Andres, Reubin and Lakatta, Edward G. and Arenberg, David and Tobin, Jordan D. (1984) *Normal Human Aging: The Baltimore Longitudinal Study on Aging*. NIH Publication, Washington, D.C.
3. See Stevens, D.M. and Weems, J.M. and Brown, L. and Barbour, K.A. and Stahl, S.M. (2017) *The Pharmacodynamic Effects of Combined Administration of Flibanserin and Alcohol*. J Clin Pharm Ther.
4. Elysium Health (2018) *Do Clinical Trials Have a Sex Problem?* Why Women Are Underrepresented in Clinical Trials—Endpoints.
5. See K.L. Calderone, "The Influence of Gender on the Frequency of Pain and Sedative Medication Administered to Postoperative Patients," *Sex Roles*, 23 (1990): 11-12, 713-25.

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