



## Original Article

### ACUTE PAIN AND GENDER RELATION: DIFFERENT PERCEPTIONS IN MEN AND WOMEN

*DOR AGUDA E RELAÇÃO DE GÊNERO: DIFERENTES PERCEPÇÕES EM HOMENS E MULHERES*

*DOLOR AGUDA Y RELACIÓN DE GÉNERO: DIFERENTES PERCEPCIONES EN HOMBRES Y MUJERES*

Margaret Olinda de Souza Carvalho e Lira<sup>1</sup>, Maria de Fátima Alves Aguiar Carvalho<sup>2</sup>

The investigation had as objective, analysing the pain perception differences between men and women. It explores different authors' comprehensions about the pain in a gender perspective. It presents results referring to admitted clients on emergency service, medical and surgery clinics of a public hospital in the city of Petrolina - PE. The data quantitative analysis found pain perception differences between the 12 emotional components investigated. It's pretended to provide elements that contribute to the enlargement of the knowledge about the theme as also to the implantation of mensuration scales of pain.

**Descriptors:** Perception of Pain; Gender; Pain measurement.

A investigação teve como objetivo, analisar diferenças de percepção da dor entre homens e mulheres. Explora compreensões de diferentes autores, acerca da dor em uma perspectiva de gênero. Apresenta resultados referentes a clientes admitidos em serviços de emergência, clínicas médica e cirúrgica de Hospital Público em Petrolina-PE, Brasil. Análise quantitativa dos dados constatou diferenças de percepção da dor entre os 12 componentes emocionais investigados. Pretende-se deste modo, fornecer elementos que contribuam para a ampliação do conhecimento sobre o tema, como também, para a implantação de escalas de mensuração da dor.

**Descritores:** Percepção da Dor; Gênero; Medição da dor.

Esta investigación tiene como objetivo analizar las diferencias de percepción del dolor entre hombres y mujeres. Explora comprensiones de diferentes autores acerca del dolor en la perspectiva de género. Presenta resultados diferentes a clientes admitidos en el servicio de emergencia clínica quirúrgica de Hospital Público de Petrolina-PE, Brasil. Mientras el análisis cuantitativo de los datos, fueran constatadas diferencias de percepción del dolor entre los 12 componentes emocionales investigados. Pretende-se, de esto modo, fornecer elementos que contribuyan para la expansión de los conocimientos acerca del tema, así como para implantación de escalas de medición del dolor.

**Descritores:** Percepción del Dolor; Genero; Dimensión del Dolor.

<sup>1</sup> Nurse, Master in Psychology from the Federal University of Espírito Santo (UFES). Assistant Professor, School of Nursing of the Federal University of Vale do São Francisco (UNIVASF). E-mail: olindalira@gmail.com

<sup>2</sup> Nurse, Master in Psychology from the Federal University of Espírito Santo (UFES). Assistant Professor, School of Nursing of the Federal University of Vale do São Francisco (UNIVASF). E-mail: fatimaaguiar@hotmail.com.br

Corresponding Author: Margaret Olinda de Souza Carvalho e Lira.

Avenida Manoel de Sá Maniçoba S/N. Centro. CEP: 56304-917. Petrolina- PE, Brasil. E-mail: margaret.olinda@univasf.edu.br

## INTRODUCTION

The pain, negative experience in human life, represents a public health problem, considering its consequences, both physical and emotional, which can result in anxiety states and temporary or permanent disabilities.

The pain represents a major reason that justifies the demand for health care and, at some point in life, everyone will be affected by painful episodes<sup>(1)</sup>. In this sense, despite the fact that national data are scarce<sup>(2)</sup>, epidemiological studies explain that around 80% of cases in health services, are motivated by painful complaint<sup>(3)</sup>, having disorders of the musculoskeletal system as its main cause<sup>(2)</sup>.

Response of varied health changes, the pain signal is defined by the International Association for the Study of Pain (IASP) as "an unpleasant sensory and emotional experience that results from an actual or potential harm to the human tissue"<sup>(4:3)</sup>. Three types are recognized: acute pain, identified as being short, chronic pain, named like this for having extended duration of more than six months, in most cases, following the evolution of a disease and thirdly, the recurrent pain, when it is an acute pain, in short episodes, but which is repeated over several months<sup>(5)</sup>.

Being the object of this study, acute pain is defined as "an unpleasant sensory and emotional experience caused by real or potential tissue damage, or described in terms of these injuries; it starts suddenly or slowly in any intensity (mild to severe) with expected or predictable regression and duration smaller than six months"<sup>(6:236)</sup>. It is usually the reason for care demand in health services<sup>(7)</sup>.

In a painful state there may be defining characteristics of subjective order, as verbal or coded report, changes in appetite and food intake. Among the defining characteristics of acute pain one identifies the ones of objective order: antalgic position; protecting gestures; defense behavior, facial expression, sleep disorders, whose patients have haggard and dull look, fixed or loose movements and grimaces; dejected looks and expressive behavior, demonstrated by physical agitation, moaning, crying, insomnia, irritability and sighs; dispersive behavior, represented by moving from one place to another and repetitive activities<sup>(6)</sup>.

It may lead to changes in the functioning of different body systems, including cardiovascular, respiratory, immune, gastrointestinal and urinary, musculoskeletal and sleep disorders<sup>(8)</sup>.

Although it represents one of the most common complaints from customers in emergency rooms and wards of various specialties and despite its frequency in emergency services, the interruption of pain is not a priority in these environments. It is noticed that relief of pain conditions is not valued instead of other complaints, and in many cases, undertreated<sup>(9)</sup>.

It is in this context that the quality of intervention in a context of acute pain becomes pretty important and it has attracted attention from several researchers of the subject. There are some authors who explain that in cases of accidents, pain control, besides being an action of humanity, is also vital for immediate assistance to customers, contributing to the maintenance of basic physiological functions<sup>(10)</sup>.

In another aspect, there is evidence suggesting the existence of important differences between men and

women in their painful experience being listed physiological, perceptual social, behavioral and, especially, hormonal factors. The increased prevalence of pain in women is due to hormonal changes occurred<sup>(11)</sup>.

In this regard, the authors emphasize attention on the variation in painful experiences between genders. They explain that women, for finding themselves more exposed than men to certain situations, including dysmenorrhea and delivery, do not only have more severe levels of pain, but also painful episodes more frequent and more durable<sup>(12)</sup>. Considering that they seem to feel pain more intensely than men, the authors mentioned that national publications, focusing on the influence of sex hormones on pain perception in women are scarce. So, they understand that expanding knowledge about this approach will contribute not only to better understand the gender differences in pain perception, but also to its confronting, by health professionals, which will have elements for the understanding and treatment of pain conditions presented, regardless of gender<sup>(12)</sup>.

In this sense, considering that men and women experience painful experiences differently, it is assumed that there are also differences in responses to treatment of pain conditions. It is explained that because they are women, responsible for a higher prevalence of pain in those cases, they use more analgesics. In this sense, drugs like opioids have been the focus of comparative studies on the effects of its use by men and women<sup>(11)</sup>.

Contextually, regardless of the gender issue, it is understood to be also important to investigate the care given to customers with complaints of pain. Due to its subjective and multidimensional character, investigating

pain demands reasoning and determination, through mechanisms able to measure it. Despite the subjectivity involved in the phenomenon, understanding its mechanisms and processes becomes essential to their better understanding.

Current discussions acknowledge the pain as the fifth vital sign<sup>(1)</sup>. In this sense, conceptualizing it had the purpose to arouse the interest of health professionals in relation to its treatment<sup>(13)</sup>. Like other vital signs, it needs to be measured by integrating the activities of the healthcare team, particularly nursing staff, considering the greater amount of time that they stay with the patient<sup>(14)</sup>.

Pain relief is recognized as a basic human right, going beyond the clinical phenomenon, representing a situation of ethical nature, which involves an interdisciplinary health team<sup>(14)</sup>. In this sense, different methods are used to measure it, in order to expand the understanding in this regard, including measurement scales, interviews and psychological tests. Concerning its intensity, it is evaluated by the use of scales, instruments existing on uni and multi-modalities.

Among the one-dimensional instruments, one highlights the Visual Analogue Scale - VAS, which gives good acceptance in emergency services<sup>(9)</sup>. It is represented by a straight line, whose ends are respectively marked by the absence of pain and worst pain imaginable. The second alternative to measure the intensity of pain is the Numeric Scale Category, which consists of a series of numbers in a range from 0 to 10 or 0 to 100. The extreme points represent experiences of pain, usually called no pain or worst pain possible, respectively<sup>(15)</sup>.

More complete than the one-dimensional instruments, the multidimensional ones assess different dimensions of pain through the use of indicators of responses and their interactions. The main dimensions assessed are the sensory, affective and evaluative. In the multidimensional diversity, we find the Initial Assessment Instrument of Pain conceived in the perspective of obtaining information about the characteristics of pain, its forms of expression, as well as its effects on daily life activities. It also has a scale indicating their intensity, followed by a diagram to its topography<sup>(16)</sup>.

Other variations of multidimensional scales are the McGill Questionnaire, Handbook of Pain Perception (PPP), Scale for Assessment of Remembered Pain - MPAC, Inventory of Psychological Aspects in Patients with Chronic Pain, related to Work (IAP-T). Still to measure sensory and affective component of the pain experience, it is used the Descriptor Differential Scale (DDS).

In this context, the present study aimed to analyze the differences in pain perception between men and women.

## **METHODS**

This study's scenario was the emergency department, medical and surgical clinics of a public hospital in Petrolina-PE, selected for treating users in situations of acute pain. Data collection occurred between April and May 2009, using mixed methods, where, in a convergence of quantitative and qualitative data, one analyzed in a comprehensive manner, the differences of perception and intensity of pain in men and women<sup>(17)</sup>.

The sample was composed by 30 women and 30 men, according to the inclusion criteria of being older than 18 years old, being a carrier of acute pain, being conscious and able to communicate verbally.

In this sense, through the Adapted Protocol of the Initial Instrument of Pain Assessment, designed by McCaffery (1999) enabling the exploitation of both quantitative and qualitative data. The document contained in the first part, a numerical scale for assessment of pain intensity and in the second part, a script containing questions about the emotional, sensory, cognitive and evaluative components. The observation was used to detect facial expressions, present in episodes of acute pain. Data were analyzed using simple descriptive statistics, using percentages, which are presented in tables. One counted on the aid of the Excel program, version 10.

Respecting the ethical aspects of research involving humans, the project was approved by the Research Ethics Committee from the UNIVASF through CAAE # 0029.0.441.000-10. All participants were informed about the study, its objectives, confidentiality, anonymity, and freedom to discontinue their participation at any stage of the investigation. After duly informed, they signed the Instrument of Consent (IC).

## **RESULTS**

The sample consisted of 60 participants, is equally represented by men and women, aged between 18 to 68 years of age. Although the maximum intensity of pain has been declared mostly by women, men also reported feeling it. Both resorting to the use of analgesics for relief. A big part of the women verbalized emotional, cognitive-evaluative overload, during pain conditions by

more negative feelings such as crying, sadness and decreased attention. The men, though far angrier than women, kept the balance in all cognitive-evaluative components. Among the unspoken changes, in response

to painful stimuli changes, facial movements such as grimacing, clenched teeth, wrinkled forehead and lip biting were observed.

**Table 1** - Frequency of pain according to the intensity and type of clients served in Emergency and Trauma Hospital. Petrolina, PE, Brazil, 2010

Intensity	Men (n = 30)	%	Women (n = 30)	%	Total (n=60)	%
0	-	-	-	-	-	-
1	-	-	-	-	-	-
2	3	10	-	-	3	5
3	1	3,3	-	-	1	1,7
4	3	10	-	-	3	5
5	1	3,3	-	-	1	1,7
6	5	16,7	1	3,3	6	10,0
7	5	16,7	-	-	5	8,3
8	2	6,7	4	13,3	6	10,0
9	3	10,0	6	20,0	9	15,0
10	7	23,3	19	63,3	26	43,3

Source: Teaching Hospital - Petrolina-PE

Out of these women, 63.3% reported the perception of maximum pain possible, intensity 10. Comparatively, a percentage higher than the sample of

men (23.3%) showed the same pain intensity, that is, intensity 10.

**Table 2** - Distribution of medicines used to treat pain, according to the gender of customers treated in the Emergency and Trauma Hospital. Petrolina, PE, Brazil, 2010

Analgesic	Men (n = 30)	%	Women (n = 30)	%	Total (n=60)	%
Dipyrone	24	80,0	18	60,0	42	70,0
Dipyrone / diclofenac	3	10,0	4	13,3	7	11,7
Diclofenac	1	3,3	1	3,3	2	3,3
Buscopan	-	-	2	6,7	2	3,3
Unidentified	-	-	3	10,0	3	5,0
Did not use	2	6,7	2	6,7	4	6,7

Source: Teaching Hospital - Petrolina-PE

Out of the total sample of men, 93.3% used analgesics, emphasizing the use of dipyron in 80% of the total. Out of the 83.3% of women on analgesic use, 60% corresponded to the use of dipyron.

The variation in pain intensity between 9 and 10 was demonstrated in an approximate way between men (30%) and women (40%) in problems related to the musculoskeletal system. Among women, headache was reported as the greatest cause of pain (20%) and higher intensity (9 and 10).

**Table 3** - Distribution of present emotional components according to the gender of customers with painful complaint, treated at the Emergency and Trauma Hospital. Petrolina, PE, Brazil, 2010

<b>Emotional Components</b>	<b>Men (n = 30)</b>	<b>%</b>	<b>Women (n = 30)</b>	<b>%</b>	<b>Total (n=60)</b>	<b>%</b>
Irritation	14	46,7	3	10,0	17	28,3
Disquietude	12	40,0	12	40,0	24	40,0
Anxiety	11	36,7	9	30,0	20	33,3
Fear	9	30,0	1	3,3	10	16,7
Groan	9	30,0	12	40,0	21	35,0
Anger	8	26,7	2	6,7	10	16,7
Sadness	7	23,3	17	56,7	24	40,0
Cry	6	20,0	3	10,0	9	15,0
Growl	6	20,0	11	36,7	17	28,3
Standstill	3	10,0	12	40,0	15	25,0
Frustration	1	3,3	13	43,3	14	23,3
Depression	-	-	4	13,3	4	6,7

Source: Teaching Hospital - Petrolina-PE

All emotional components existing in the table above were kept in different intensities present in 95% of the patients, observing that in only 5.0% of the male respondents were not given any of the components listed here.

The results were approximated by notifying the anxiety and irritation, present in 36.7% of the men and 40% of the women; likewise irritation in 46.4% of men and 40% of women; groan in 30% of men and 36.6% of women, followed by restlessness, present in 40% of men and 43.3% of women; immobilization in 10% of

men and 13.3% of women. Discrepancies between the participating groups were observed between components, anger: 26.6% of men and 10% of women; sadness: 23.3% in men and 40% in women; crying: 20% in men and 56.6% in women; groan: 20% in men and 10% in women. Depression was confirmed in 6.7% of women.

The component with the highest percentage of men was presented irritation (46.7%) and among women, crying (56.7%).

**Table 4** - Distribution of cognitive and evaluative components present in clients with painful complaint, taken into the Emergency and Trauma Hospital. Petrolina, PE, Brazil, 2010

Cognitive Components	Men (n = 30)				Women (n = 30) %			
	Men (n = 30)	%						
Memory	Preserved	100	Reduced	0	Preserved	93.3	Reduced	6.7
Attention	Preserved	100	Reduced	0	Preserved	63.3	Reduced	36.7
Thoughts	Logical	100	Illogical	0	Logical	76.7	Illogical	23.3
Decision	Active	100	Passive	0	Active	86.7	Passive	13.3
Reasoning	Coordinated	100	Uncoordinated	0	Coordinated	66.7	Uncoordinated	33.3

Source: Teaching Hospital - Petrolina-PE

Despite the presence of pain, the cognitive/evaluative components: memory, attention, thoughts, decision and reasoning, remained preserved among men, in all intensities presented. Women showed reduced attention (36.7%), illogical thinking (23.3%),

uncoordinated reasoning (33.3%), passivity in decision making (13.3%) and memory not preserved (6.7 %).

As shown in Table 5, the facial expression grimace was the highest percentage, presented by 73.3% of the women and 46.7% of the men.

**Table 5** - Analysis of facial expression by gender of customers with painful complaint taken into the Emergency and Trauma Hospital. Petrolina-PE, Brazil, 2010

Facial expression	Men (n = 30) %		Women (n = 30)%		Total (n=60) %	
Grimace	14	46,7	22	73,3	36	60
Wrinkled foreheads	10	33,3	13	43,3	23	38,3
Clenched Teeth	7	23,3	6	20,0	13	21,7
Absence of Expression	6	20,0	2	6,7	8	13,3
Mouth or eyes firmly open or tightly closed	5	16,7	8	26,7	13	21,7
Biting lips	2	6,7	5	16,7	7	11,7

Source: Teaching Hospital - Petrolina-PE

## DISCUSSION

The intensity 10, mentioned by many of the women in this study, as maximum pain, finds support in authors, who state that "effectively a large body of experimental, clinical and epidemiological studies has shown that women feel, or at least report feeling more pain than men". They complement that they have lower

thresholds and less tolerance to experimentally induced pain<sup>(18:121)</sup>.

There are findings about the existence of differences between men and women, regarding pain intensity, as well as responses to the action of analgesics. It is evident that because they have prevalence higher than men when it comes to reporting

pain, women use more commonly, analgesic substances<sup>(11)</sup>.

Studies also demonstrate effectiveness in the use of non-pharmacological strategies for pain relief<sup>(19)</sup>. Thus, using the VAS, there are also differences in pain intensity, measured before and after the use of non-drug measures. The results show the differences in the two moments of intensity. Prior to application of strategies, the intensity ranged from 6 to 10 and declined after application, reaching values between 4 and 6 points in the scale<sup>(19)</sup>.

Despite the presence of all components in different intensities between men and women, a direct relationship between the component and the increased intensity of pain has not been established. Depression was not found among men. The information about the presence of anxiety in 36.7% of men and 40% of women, refer to a study conducted to investigate the association between anxiety sensitivity and pain experienced by men and women distinctly, whose sample was composed by 125 participants, consisted to evaluate the tolerance to thermal sensations (heat and cold) upon immersion of the arms in hot water and then in cold water until the threshold of each. Initially, we measured the lowest intensity of pain, then the greatest pain endured. The results showed a positive association between anxiety and pain sensitivity, observed primarily among women<sup>(20)</sup>. For researchers of this study, men and women use diverse strategies to cope with pain. They showed that while men used strategies focused on the physical aspects, aiming to develop mechanisms to optimize their tolerance and minimize soreness, women invested their energies in emotional aspects, raising

anxiety levels, which contributed to higher intensity of pain referred, in the end of exposure.

Regarding the presence of emotional changes, the results presented here, will find support in the research, which aimed to identify situations experienced by burned patients. 66% of responders showed changes expressed through crying, sadness, anger, guilt, loneliness and longing in it<sup>(21)</sup>.

The number of characters related to facial expression ranged from 1 to 4 among men, highlighting the "grimace", 46.7% (one understands by grimace, expressions made with his face). These characters did not maintain relations with pain intensity. Comparatively, women had facial expressions suggestive of the presence of pain in higher number, ranging from 3 to 5 components per participant. It was considered significant the percentage that responded with grimaces of pain (73.3%) followed by the percentage of wrinkled forehead (43.3%) maintaining mouth or eyes firmly open or closed (26.7%) and biting lips (16.7%). The percentage of 20% of men and 6.7% of women, showed no expression in the presence of pain.

## CONCLUSION

Pain is a subjective experience of nature, filled with meanings which contribute to difficulties of two types: assessment by the health team and reporting by the client. In this sense, it makes difficult not only to quantify it, but also its qualitative evaluation.

Successful treatment of this signal is influenced by the process of evaluation and measurement, which needs to occur reliably. Thus, when approaching the customer with pain symptoms, it is understood that it is the health professional's duty to dispense the deserved

attention to the difference in gender and age. It requires also the daily exercise of observation in order to understand the non-verbal communication through gestures and expressions expressed by the client.

The present study had some limitations in the data collection phase, arising from the big subjectivity of the theme worked. However, the use of mixed method allowed us to overcome them, working with three collection strategies, which supported the reasoning that there are differences in the statement of pain between men and women.

We consider it essential to highlight the applicability of the adapted protocol of the Initial Instrument of Pain Assessment, by McCaffery, developing better data collection. In this sense, its use has been useful for both the characterization of the participants, and for the identification of the subjective data, emotional, sensory, evaluative-cognitive components and facial expressions, confirming differences between men and women.

We conclude that although other results show different possibilities of demonstration of pain between genders, when addressing this complexity in such a convergent way, quantitatively and qualitatively, this study brought, more broadly, the differences of perception and pain intensity between men and women. This study brings its contribution to the understanding of this issue, which has increased the interest of many researchers.

## REFERENCES

1. Salvador M, Rodrigues CC, Carvalho MC. Emprego do relaxamento para alívio da dor em oncologia. *Rev Rene*. 2008; 9(1):120-8.
2. Patel NB. Physiology of pain. In: Kopf A, Patel NB. *Guide to Pain Management in Low-resources Settings*. International Association for the Study of Pain. 1ª ed. USA: Iasp Press; 2010. p. 13-17.
3. Bottega FH, Fontana RT. A dor como quinto sinal vital: utilização da escala de Avaliação por enfermeiros de um hospital geral. *Texto Contexto Enferm*. 2010; 19(2):283-90.
4. White W, Stein C. History, Definitions, and Contemporary Viewpoints. In: Kopf A, Patel NB. *Guide to Pain Management in Low-resources Settings*. International Association for the Study of Pain. 1ª ed. USA: Iasp Press; 2010. p. 3-7.
5. Sociedade Brasileira para Estudo da Dor. Conheça mais sobre a dor. [Internet] 2011. [citado 2012 ago 29]. Disponível em: <http://www.dor.org.br/publico/classificacao.asp>.
6. Doenges M, Moorhouse MF, Murr A. *Diagnósticos de Enfermagem: Intervenções, prioridades e fundamentos*. 1ª ed. Rio de Janeiro: Guanabara Koogan; 2009.
7. Loduca A, Nunes BC, Correa CF, Andrade DC, Ramalho GL, Melo ITV, et al. Epidemiologia do câncer e da dor no câncer. In: Minson FP, Garcia JBS, Siqueira JTT, Oliveira JO, Jales LJ, editores. *II Consenso Nacional de Dor Oncológica*. 1º ed. São Paulo: Moreira Jr. Editora Ltda; 2011. p. 13-23.
8. Chaves LD. Dor pós-operatória: aspectos éticos e assistência de enfermagem. In: Leão ER, Chaves LD,

organizadoras. Dor 5º sinal vital: reflexões e intervenções de enfermagem. 2ª ed. São Paulo: Martinari; 2007. p. 184-211.

9. Guimarães BAS, Dorneles BAS, Mello GC, Sampaio FH, Lima GC, Luppen LS, et al. Eficácia da mensuração do quinto sinal vital no controle da dor pós-operatória: um ensaio clínico randomizado. Projeto piloto. Rev Dor [periódico na internet]. 2010 [citado 2012 ago 28]; 11(4): [cerca de 4 p]. Disponível em: [http://www.dor.org.br/revistador/Dor/2010/volume\\_11/n%C3%BAmero\\_4/pdf/volume\\_11\\_n\\_4\\_pags\\_304\\_a\\_308.pdf](http://www.dor.org.br/revistador/Dor/2010/volume_11/n%C3%BAmero_4/pdf/volume_11_n_4_pags_304_a_308.pdf).

10. Callil AM, Pimenta CAM. Importância da avaliação e padronização analgésica em serviços de emergência. Acta Paul Enferm. 2010; 23(1):53-9.

11. Costa CMC. Diferenças de dor no homem e na mulher. Sociedade Brasileira para o Estudo da Dor [Internet]. 2008 [citado 2009 jul 23]; [cerca de 4 p]. Disponível em: [http://www.dor.org.br/profissionais/arquivos/diferenca\\_dor\\_homemmulher%281%29.pdf](http://www.dor.org.br/profissionais/arquivos/diferenca_dor_homemmulher%281%29.pdf).

12. Viana ESR, Bruno SS, Sousa MBC. Modulação pela progesterona: da sensibilidade dolorosa a estímulos mecânicos e isquêmicos em mulheres jovens e saudáveis. Rev Bras Ginecol Obst. 2008; 30(6):306-11.

13. Nascimento LA, Kreling MCGD. Avaliação da Dor como quinto sinal vital: opinião de profissionais de enfermagem. Acta Paul Enferm. 2011; 24(1):50-4.

14. Gomes RF, Silva JF, Pedras RBN, Melo JR. Dor: O quinto sinal vital. Rev Prat Hosp. [periódico na internet]. 2006 [citado 2011 ago 07]; 8(44): [cerca de 2

p]. Disponível em: <http://www.praticahospitalar.com.br/pratica%2044/pgs/materia%2018-44.html>

15. Souza F, Hortense P. Mensuração da dor. In: Leão ER, Duarte C. Dor 5º sinal vital: reflexões e intervenções de enfermagem. 2ª ed. São Paulo: Martinari; 2007. p. 75-84.

16. Scope E, Alencar M, Cruz RM. Medidas de avaliação da dor. Rev Digital [periódico na internet]. 2007 [citado 2011 ago 08]; 11(105): [cerca de 1 p]. Disponível em: <http://www.efdeportes.com/efd105/medidas-de-avaliacao-da-dor.htm>

17. Creswell JW. Projeto de pesquisa: métodos qualitativo, quantitativo e misto. 3ª ed. Porto Alegre: Artmed; 2010.

18. Bernardes S, Jácome F, Lima, ML. Questionário de Expectativas de Papel de Gênero Face à Dor: Estudo psicométrico e de adaptação do GREP para a população portuguesa. Rev Ana Psic. 2008; 26(1):121-33.

19. Davin BRM, Torres GV. Avaliação do uso de estratégias não farmacológicas no alívio da Dor de parturientes. Rev Rene. 2008; 9(2): 64-72.

20. Keogh E, Mccracken LM, Eccleston C. Do men and women differ in their response to interdisciplinary chronic pain management? Pain. 2005; 114(1-2):37-46.

21. Carlucci VDS, Rossi LA, Ficher AMFT, Ferreira E, Carvalho ECC. A experiência da queimadura na perspectiva do paciente. Rev Esc Enferm USP. 2007;41(1):21-8.

Received: Sep. 1<sup>st</sup> 2012  
Accepted: Aug. 29<sup>th</sup> 2012