

CHAPTER FIVE

IRRITABLE BOWEL SYNDROME AND ABUSE

“The body says what words cannot”

Martha Graham

The aftermath of violence, contends Sanford (1997), is not all in the head. The body knows those acts that break the heart and the spirit. The body “ becomes a museum, filled with artefacts from childhood. Trauma is stored in the tissue of the body until the day it is expressed and resolved” (Sanford, 1997, p.79). She points out that when considering the phenomenon of anniversary reactions, often a person feels different on the anniversary of a trauma; this may be even if the person is not conscious of the trauma occurring. Throughout that day they may feel an unexplained anxiety, shortness of breath, depressed and sad. If the original trauma involved the invasion of the body, that person may feel distinct pain in the injured area.

In the case of sexual abuse, the victim learns that her body is not her own, and that other people’s wishes for her body are more important than her own. She may have limited opportunity to learn about her body in a soft and pleasurable manner, and so she becomes alienated from her body because it causes so much trouble. Alienation from the body leads to an alienation from the self (Sanford, 1997).

Sanford (1997) points out that beyond the acute injuries it can cause, violence affects how the body functions. She holds the view that experience influences physiology.

Drossman et al. (1990) were the first to document an association between functional gastrointestinal disorders and both physical and sexual abuse. Since then there have been other studies, some of which have confirmed these findings, and others which have not. The following sections are an attempt to investigate abuse and the body, and abuse and pain. Then follows a summary of the existing data on abuse history and gastrointestinal illness, and thereafter a conceptual scheme is suggested to explain these associations.

The Mind, the body and Abuse

The memory is much more than a “bank” in which bits of information are stored (Kritsberg & Miller-Kritsberg, 1993), it is a process that is interwoven throughout the human system. Even if the victim of sexual abuse does not have visual (mind) memories of the abuse, she will still “remember” through her body and emotions. Traumatic memories can surface emotionally, cognitively, or physically, or in any combination of these. The body, the emotions and the mind each have a unique way of remembering.

As the body remembers what

The mind cannot face.

Alex Benjamin (in Malone et al., 1996, p.14)

People have a body that accompanies them from the moment of birth until the moment of death. Everything that has happened to a person in their lifetime has also happened to their body. No matter the type of abuse, the body was there and affected by that abuse. Kritsberg and Miller-Kritsberg (1993) contend that this memory of abuse is etched into the survivor’s body, and these memories may surface at any time, and usually quite unexpectedly, as headaches, nausea and other digestive problems, sexual dysfunction, pelvis pain or sudden fatigue. According to Levine (1991), memories can also trigger bodily sensations. Body memories are closely related to flashbacks and are mostly experienced by survivors of physical sexual abuse. During body memories the body will re-experience the abuse without any apparent reason. A survivor who was anally raped may have extreme soreness or swelling, unexplained rectal bleeding, or a sudden onset of severe constipation.

“What is always speaking silently is the body”

Norman O Brown (in Moore, 1992, p.175)

Abuse and Pain

It has been reported that those women with an abuse history have a four-fold greater risk of pelvic pain and two to three times more nonabdominal symptoms such as headaches, backache and chronic fatigue (Leserman, Drossman, Li, Toomey, Nachman, & Glogau, 1996). This study found a strong relationship with current poor health so that women with sexual abuse history report more pain, more non-gastrointestinal somatic symptoms, more bed-disability days, more lifetime surgeries, more psychological distress, and worse functional disability.

Walker et al. (1988) report that 64 % of the women with chronic pelvic pain had experienced some type of sexual abuse before the age of 14, compared to 23% of the women in the comparison group. They further state, “chronic pelvic pain may be a metaphorical way of describing chronic psychological pain and may act as a defense or coping mechanism to protect against painful, emotion-laden memories” (p. 79).

According to Scarinci, McDonald-Haile, Bradley and Richter (1994) sexual and/or physical abuse is associated with relatively low pain threshold levels, and high levels of psychosocial distress, disability, and painful symptoms. These factors may interact with one another, leading abused individuals to display high levels of disability or seek medical treatments that are unlikely to relieve their symptoms. They further note that histories of abuse should be assessed among all patients with painful gastrointestinal disorders.

Abuse and Gastrointestinal disorders

An article appeared in a Johannesburg newspaper, The Star, reporting on high-risk areas for rape attacks on women. In this same article a young woman named Thandeka was interviewed after having been raped by her ex-boyfriend and an accomplice. Thandeka reports, “ I felt dirty and could not trust people. I still find it difficult to trust men.....Men feel they have a right to do this....They do not know what sex means: they turn you into their toilet to regain their own feeling of power” (The Star, 27 June, 1998). This feeling

of being soiled after an abusive incident may be a very good place to begin looking at the links between gastrointestinal disorders and abuse.

Drossman, Talley, Leserman, Olden and Barreiro (1995) point out that psychologists and psychiatrists recognize that there are several psychiatric disorders (such as depression, post-traumatic stress disorder, somatization disorder and personality disorders) that may develop as a consequence of abuse. They report however that only in the last few years has attention been turned to the physical concomitants of sexual, emotional and physical abuse. One area of recent interest relates to the association of abuse history with gastrointestinal illness (GI). This link is supported by the following epidemiological information (Drossman, 1994):

- Abused children often complain of gastrointestinal and genitourinary symptoms
- Adult women seen in primary care settings with a history of abuse describe gastrointestinal symptoms as their most common somatic complaint
- Women seen by gastroenterologists at referral centres when compared with those in primary care settings report higher frequencies of physical and sexual abuse
- There appears to be a higher frequency of abuse reporting among patients with functional gastrointestinal disorders compared with those suffering from structural gastrointestinal disease.

Drossman (1994) describes these observations as being of more than academic interest, since, regardless of medical diagnosis, a history of abuse is associated with poorer health outcomes in terms of symptom severity and health care utilization, as well as increased numbers of surgical procedures (Drossman et al., 1990).

In one of the first studies to document the high prevalence of sexual and physical abuse among female patients in a gastroenterology clinic, Drossman et al. (1990) found that 44% of these women reported some form of sexual and /or physical abuse. Since then there have been a number of other studies that have sought to further study this phenomenon. The following sections are a review of studies about the relation between abuse history and gastrointestinal symptoms.

Frequency of Gastrointestinal Symptoms among Sexually Abused Patients

A common theme in the literature is the development of gastrointestinal and genitourinary symptoms as a consequence of abuse in victimized females (Drossman et al., 1995). In a study carried out by Rimsza et al. (1988), the mothers of 72 children who had experienced forced sexual activity with an adult were interviewed, comparing the frequency of behavioural and physical problems with a matched control group of 26 children. The researchers found that the abused group reported significantly more physical symptoms and that the duration of abuse affected symptom reporting, specifically the reporting of gastrointestinal and genitourinary symptoms. They found that 71% of children who were abused for more than 24 months reported gastrointestinal symptoms.

In a health maintenance clinic (HMO), Felitti (1991) found that patients with a history of sexual abuse compared with a matched clinic group had a higher frequency of depressive symptoms (83% compared with 32%), and the next most common symptom was gastrointestinal problems (64% compared with 39%). In another study, Lechner et al. (1993) administered a questionnaire to a sample of female patients seen in the waiting room of a family practice clinic. Once the presence of sexual abuse was confirmed, further questions about illness symptoms were asked. There were significant differences found between the abused and non-abused sample group, namely, the abused group reported more gastrointestinal symptoms (30,1% compared with 10,9%), higher rates of respiratory problems (15,4 % compared with 6,2 %), and higher rates of neurological problems (7,4 % compared with 2,1%). Abuse history was also associated with more mental health treatment (60% compared with 28%). Thus the above findings indicate that female victims of early abuse are more likely than others to have physical (in particular, gastrointestinal) symptoms later in life.

Prevalence of Abuse History in Patients in Gastrointestinal Practices

A study by Drossman et al. (1990) was one of the first to report a high frequency of reports of sexual and physical abuse in a cohort of gastrointestinal patients. They reported

that 44% of those studied reported a history of sexual and/or physical abuse in childhood or later in life. Furthermore, sexual abuse was strongly associated with physical abuse, and child abuse was strongly associated with a history of abuse in adults. They also found a higher percentage of abuse was reported in those suffering from functional gastrointestinal disorders than those who suffered from organic gastrointestinal disorders. For example, the frequency of rape or incest was 31% for patients who had a functional gastrointestinal diagnosis (IBS, functional dyspepsia, constipation and chronic abdominal pain) compared with 18% for those with organic disorders. In general this history of abuse was concealed, with only 17% of the abuse victims being known to their physicians, and 30% who had never told anyone of their experiences.

One study has compared abuse frequencies with different functional gastrointestinal disorders (Leroi, 1993, in Drossman et al., 1995). These researchers found the frequency of sexual abuse was greater in patients with functional lower gastrointestinal disorders than in those with functional upper gastrointestinal tract disorders. Abused patients were more likely to report constipation, diarrhoea or pelvic floor dyssynergia (obstructive defecation).

Only one population-based study has been reported (Talley et al., 1994). The researchers postulated that a history of sexual abuse in childhood would be associated with functional gastrointestinal symptoms and that abuse at any time in the past would help to explain, over and above psychological distress, health-care seeking behaviour for gastrointestinal symptoms. A self-report questionnaire that included questions about abuse was mailed to a random sample of 919 people in Minnesota who had been seen at least once at the local medical clinic during the period 1988-1991. Twenty-six percent of the population reported some form of abuse in the past, and most (22%) in this sample reported sexual abuse. Sexual abuse history was also associated with functional gastrointestinal symptoms in 14 % of the subjects. When compared with a normal sample, those who had been sexually, emotionally or verbally abused as children or adults were 1,9 times more likely to develop a functional gastrointestinal disorder. Those

who reported abuse in adulthood and childhood were about three times as likely to have IBS. This study is in contrast to an earlier study carried out by Talley, Kramlinger, Burton, Colwell and Zinsmeister (1993) where 32 married patients (both male and female) with IBS were evaluated, using their healthy spouses as controls. It was found that although abuse was reported more frequently in IBS sufferers than in the controls, it could not be confirmed that there is a relationship between childhood sexual abuse and IBS. The subjects were not evaluated for abuse in adulthood, and this may be a shortcoming of this study.

Walker et al. (1993) conducted a study with 28 patients with IBS and 19 patients with inflammatory bowel disease. They found that patients with IBS were significantly more likely to have a history of previous severe sexual victimization, as well as less severe forms of sexual trauma than were patients with inflammatory bowel disease. The researchers note that sexual trauma has been significantly associated with chronic pelvic pain, and there may be considerable overlap between patients reporting symptoms like those of IBS and those with chronic pelvic pain.

From the above discussion it would appear that sexual and physical abuse history seem to be common among women seen in gastroenterology clinics. This has increased the medical community's awareness of these problems and the interplay that they may have upon health and illness. Walker and Katon (1996) are of the opinion that sexual and physical abuse are important medical, psychological and social problems that deserve a priority in scientific agendas. However, they feel that this will only occur when these future studies make use of sufficiently sophisticated designs to document the complex interplay between psychological trauma and disease. In order to lead to more accurate measures of the true effects on health status, these studies will need to combine categorical information (*that* the abuse happened) with dimensional information (how traumatically it was perceived).

Relation between Abuse History and Psychiatric Disturbances

A history of physical or sexual abuse during childhood is associated with psychiatric disturbances. Tobin and Griffing (1996) found that sexually abused patients had a more

serious clinical presentation in terms of comorbid psychiatric symptoms, and were more likely to present with personality disturbance than those patients without abuse. Young, Alpers, Norland, and Woodruff (1976), classified 72% of 29 IBS patients as psychiatrically disturbed compared with 18% of controls. Enck and Wienbeck (1993) describe IBS patients as being, on average, more psychologically disturbed than the general population, but less disturbed than the average psychiatric inpatient or outpatient.

A study carried out by Talley et al. (1993) confirmed that current psychiatric disorders are more frequent in IBS patients who presented for medical care than in patients with organic disease or healthy controls. They found that most of these psychiatrically diagnosed patients had somatoform disorder. In fact, they could not confirm an association between IBS and current depression or panic disorder; the majority of IBS patients (69%) had no current psychiatric disturbance, although 50% had a history of psychiatric disorders.

In a survey of a non-clinical population (278 female university students), Briere and Runtz (1988) found that 15% reported having had unwanted sexual contact with an older person before they reached the age of 15 years. They further found that these women had significantly higher levels of dissociation, somatization, anxiety and depression than those women who had not been abused. These findings are confirmed by a study carried out by Walker et al. (1992), who found that the risk for lifetime diagnoses of major depression, panic disorder, phobia, somatization disorder and drug abuse was significantly increased when a woman had suffered severe childhood sexual abuse. Current diagnoses of major depression and somatoform pain disorder were significantly higher in a group of women who had been severely abused, when compared to those who had not been abused.

Relation between Abuse History and other Medical Diagnoses

Several studies have shown that abuse history is independently associated with certain other (nongastrointestinal) medical syndromes (Drossman et al., 1995), and is strongly associated with increased symptom reporting (Briere & Runtz, 1988; Morrison, 1989).

Of those who have been referred to a gastrointestinal clinic and who have a history of abuse, many are found to have medical diagnoses of pelvic pain (Walker et al., 1988); Drossman et al. (1990) found that abused patients have a fourfold greater risk for pelvic pain. Lechner et al. (1993) found that as a group, abused women reported problems in twice as many body systems, as did their non-abused counterparts. The difference factor between abused and non-abused women varied from 1,5 times to 3,5 times as many problems reported.

Walker, Gefland, Gefland, Koss and Katon (1995) examined the sexual victimization histories of 100 women who were laparoscoped for chronic pelvic pain or other selected gynaecological problems. After classifying the women according to the severity of their sexual experiences they found that childhood sexual trauma that involved penetration predisposed those women to having significantly higher lifetime prevalence rates of major depression, panic disorder, and substance abuse. Members of a particular health plan, in a study carried out by Felitti (1991), who had been sexually assaulted in childhood or adolescence, were more likely than controls to have a medical record indicating recurrent gastrointestinal distress, chronic headaches, or morbid obesity. A unique contribution of this study is the finding that sexually abused women were at elevated risk not only for symptoms of somatization disorder but also for most of those same symptoms with a medical explanation. Thus, it appears that sexual assault history may be related to a wide range of both medically explained and unexplained symptoms.

Lechner et al. (1993) posit several explanations for the mechanism controlling the relationship between childhood sexual abuse and self-perceived medical problems. First, the abuse victim's presentation may well fit a somatoform disorder, where the symptom is not under voluntary control and may well be related to psychological factors or conflicts. Briere and Runtz (1988, p.55) note, "Implicit in the notion of somatization is a preoccupation with bodily processes and their vulnerability to disease or dysfunction. Such heightened concern may arise, in part, from the experience of physical invasion and vulnerability involved in sexual victimization, processes that may increase the salience of bodily stimuli." Secondly, a frequently heard statement of women as they try to move

from the status of victim to that of survivor of sexual abuse, is that they often feel like “damaged goods.” The violated and hurt body of a sexual abuse victim may express the pain and damage of the assault in tangible, physical ways, in addition to the often-described emotional sequelae of abuse. And thirdly, another possible contributing factor is the tendency on the part of abuse victims toward unhealthy, unsuccessful lifestyles. Springs and Friedrich (1992, in Lechner et al., 1993) point out that adult abuse victims are more likely than others to engage in more health risk behaviours, such as smoking, drug abuse and low frequency of Pap smears, and thus they are also more likely to contract actual serious disease entities.

Relation between Abuse History and Health Status

Moeller et al. (1993) found that the more types of maltreatment a woman experienced as a child, the greater her chances of being hospitalised for both illnesses and surgeries, and the more likely she was to perceive of herself as having physical and psychological problems. Golding (1994) hypothesizes that it is possible that sexual assault directs the person’s attention to her body, and attention to internal, physical state is associated with symptom reporting and illness behaviour. The relation between abuse history and poor health status has implications for treatment and recovery. In the University of North Carolina study of gastrointestinal patients (Drossman et al., 1990), those who had an abuse history were more likely than those who had not been abused to report pelvic pain, multiple somatic symptoms, and more lifetime surgeries. In the population-based study carried out by Talley et al. (1994), the odds of visiting a doctor were significantly higher in those with a history of any type of abuse, sexual abuse, and emotional or verbal abuse, but not for those with a history of physical abuse alone. A study of rape crisis center clients found that sexually assaulted women reported worse health perceptions, more general symptoms, and more female reproductive symptoms, compared with non-assaulted women (Golding, 1994). Therefore, it seems that abuse history is associated with poor adjustment to illness and adverse clinical outcomes, including an increased amount of health-care seeking behaviour and an increased risk for surgical procedures.

The relationship between abuse (sexual and physical) and later medical morbidity is complex, with health effects occurring via several different pathways (Walker & Katon, 1996). *Direct effects* may result either from acute traumatic processes, such as injuries resulting from violence or infection, or through potential effects, such as the gradual modification of fertility by chronic sexually transmitted diseases. *Indirect effects* may be mediated by poor self image, lowered self-esteem, depression, and impaired interpersonal skills which may result in the development of maladaptive, high-risk behaviours such as drug and alcohol abuse, smoking, obesity and unsafe sexual practices. These, in turn, are often associated with medical morbidity. Other indirect effects may be mediated through the process of somatization and high medical utilization, which may expose the patient to the risks of having unnecessary surgeries, medical procedures and testing. Walker and Katon (1996), further point out that the possible long-term alterations in immune and endocrine functions that have been associated with persistent stress are less clearly understood.



Summary of Clinical Data

Drossman et al. (1995) summarize the preceding data as follows:

- Abuse history, psychiatric disturbance, and medical symptoms are significantly associated
- The apparent preferential association of abuse history with gastrointestinal symptoms requires epidemiological confirmation
- Abuse is more commonly reported by women
- Abuse history is more frequent in referral practices than in primary health care
- Patients with functional gastrointestinal disorders report abuse more frequently than patients with organic disorders
- Abuse history is associated with an increased tendency to seek health care and with poorer health status
- The patients' physicians are usually unaware of the history of abuse.

A history of abuse is associated with certain chronic medical conditions, particularly in women seen at referral centres for functional gastrointestinal disorders (Drossman et al., 1995). If these associations are to be more fully understood, a conceptual model for explaining the links between abuse history and gastrointestinal symptoms is needed in order to aid in identifying patients at risk.

The Link between Abuse History and Gastrointestinal Symptoms

- A Conceptual Model

Drossman et al. (1995) propose a conceptual model to explain the relation between abuse history and psychosocial disturbance, gastrointestinal illness, and health care utilization (Figure 5.1).

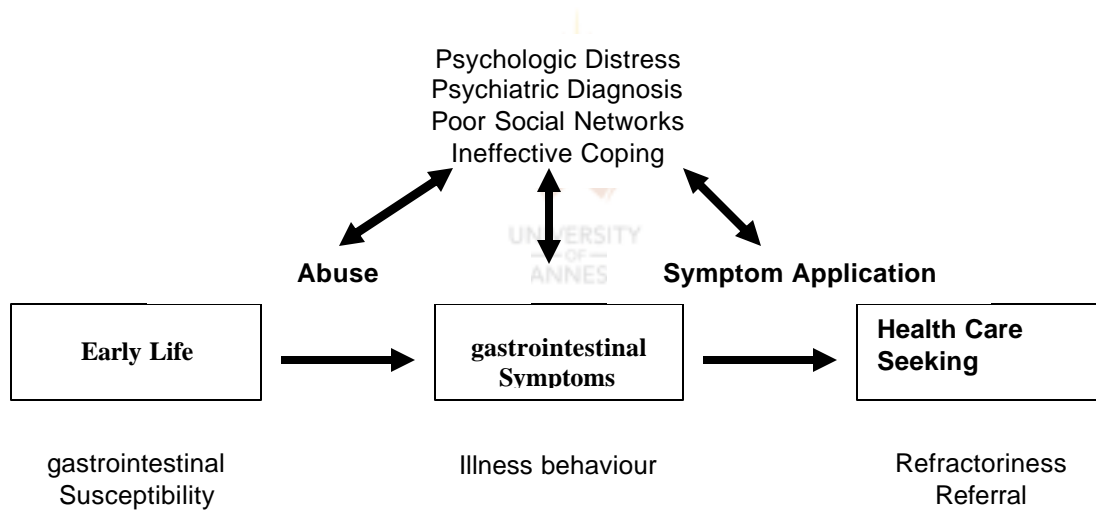


Figure 5.1 Conceptual scheme for relation of abuse history to psychosocial disturbance, gastrointestinal illness, and health care utilization. (Drossman et al., 1995)

- **Abuse** is a traumatic event that may produce a number of long-lasting psychosocial consequences. Abusive experiences may produce long-standing symptoms of *psychological distress* that may precede a *psychiatric diagnosis* of, for example, depression, anxiety, somatoform or personality disorder, and post-traumatic stress

disorder (Briere & Runtz, 1988; Morrison, 1989; Walker et al., 1992). In addition, abusive experiences are often part of, and contribute to, an environment of *poor social support* and the development of *ineffective coping strategies* (Scarinci et al., 1994).

- **Susceptibility to gastrointestinal illness** in combination with psychological disturbances may mediate the development of, or increase the intensity of gastrointestinal symptoms. Psychological distress generally lowers symptom threshold, thus increasing the number and severity of symptoms reported for many medical conditions. Since there are so many people suffering from functional gastrointestinal disorders, there must be many who are particularly susceptible to these disorders. There are a number of plausible complex and interacting mechanisms whereby these disorders may occur (Drossman, 1994):

Psychophysiologic effects: Psychological distress can, through the central nervous system-enteric nervous system, produce increased motility, abdominal pain and discomfort. So every time a person suffers any amount of stress, this is automatically paired with a response from the digestive system.

Enhanced visceral sensitivity: It is possible that chronic or traumatic stimulation (especially in the pelvic and abdominal regions) increases the sensitivity of visceral afferent receptors. This may amplify peripheral input to the central nervous system to produce persistent pain, even after the activity decreases. Therefore traumatic stimulation of the anus or vagina in children can lead to neural changes that increase perception of abdominal or pelvic pain or other bowel symptoms (Drossman, 1994).

Psychodynamic effects: Young children who have been sexually abused often believe that their sexual organs are dirty or bad; this can lead to feelings of shame and guilt. The psychological distress caused by these feelings may be compensated for through physical pain and suffering. The location of the pain in the pelvis, abdomen or genitourinary area

is “logical to the psyche because this area represents the bad or offending part of the body that is to be punished” (Drossman, 1994, p.106).

Response bias: Patients suffering from gastrointestinal disorders and abuse histories have been reported to have significantly lower pain thresholds than normal persons (Scarinci, et al. 1994). This relates in part to the psychological tendency to set low standards for judging stimuli as painful.

Psychiatric comorbid conditions: There is an association between abuse history and certain psychiatric diagnoses including anxiety and somatoform disorders (Briere & Runtz, 1988; Walker et al., 1992). Patients who are seen in medical centres with functional gastrointestinal disorders have a high frequency of psychiatric comorbid conditions and they are likely to communicate psychological distress through physical symptoms. They may find it difficult to acknowledge a relationship between psychological difficulties and their physical symptoms, as they communicate psychologic distress via bodily symptoms, which serves to reinforce their belief that they are suffering from a serious medical disorder. In some cases patients believe that, when they consult a physician for a medical problem, it is just that, and they might feel ashamed about discussing their emotional experiences.

Early-life reinforcement of illness behaviour: How disease is experienced in a family may condition illness behaviour. If a child was only taken care of when sick, there will be a tendency to ask for affection by being ill in the future. Increased attention paid to illness complaints early in life may lead to reinforcement of illness behaviours and the seeking of health care (Lowman et al., 1987). This would explain the higher frequency of abuse history and other psychosocial disturbances seen in referral centres.

- **Gastrointestinal Symptoms**, combined with existing psychosocial difficulties, amplify the symptom experience and lead to **health-care seeking**, refractoriness (a resistance to treatment), and then referral to other health care providers. Continued referral is reinforced because the health care system provides only partial relief of

somatic symptoms, a secure and socially acceptable social support system, an idealized parental figure in the form of a sympathetic doctor to take responsibility for the cure, and possible reinforcement of pain and suffering through the submission to many unnecessary medical procedures.

- **A vicious cycle** of psychological difficulties, **increased symptom severity** caused by refractory symptoms and health-care seeking is perpetuated. Symptoms that do not abate in any way increase psychological disturbance, which in turn worsens symptoms and illness behaviour. Drossman (1995) notes that since only a small proportion of patients with abuse history are recognized by their caretakers (Drossman, et al., 1990), it is incumbent upon physicians to elicit and attend to this factor in order to improve the patients' clinical outcome and to break this cycle. McDaniel et al. (1995) are of the opinion that symptoms can have both biological and psychological or interpersonal meaning, and as such all symptoms deserve assessment by competent medical providers who work in a holistic manner. Emotional burdens may not be spoken of, except through the language of physical pain. Many patients who have never spoken of their sexual abuse present to their physician with abdominal pain.

Conclusion

From the above data it does seem that abuse in childhood and adulthood is linked not only to IBS, but also to health-care seeking behaviour, as well as a higher prevalence of psychiatric and medical disorders. Talley et al. (1994) point out that the observed association between abuse and gastrointestinal symptoms does not necessarily indicate that this is a causal relationship. They suggest an alternative and plausible hypothesis is that abuse aggravates or otherwise modifies the illness experience in subjects already predisposed. On the other hand some people may be “positive reporters,” who are disposed to interpret normal somatic sensations as pathological and normal variants of the human experience as abuse.

Although relatively few victims of sexual trauma seek help from specialty trauma centres or counsellors, because of their high utilization of medical care, many of them see their doctor. Thus it is of utmost importance that medically unexplained physical symptoms are recognized, as they may be an important indicator of psychiatric distress and early abuse in these patients.

