SEXUAL ABUSE: WHY IT IS AN IMPORTANT HEALTH RISK FACTOR

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What is the relevance of a past history of sexual and physical abuse for patients with functional gastrointestinal disorders? Studies of patients with gastrointestinal disorders have shown that psychosocial factors are important predictors of health status and clinical outcome, regardless of the nature and severity of the illness condition. In the past decade, researchers have focused on the health impact of past trauma, particularly sexual and physical abuse, among patients with a variety of chronic painful conditions. In this article, we will review the evidence that abuse history may increase the chance that someone will develop a painful condition such as irritable bowel syndrome and that such trauma may also adversely affect symptom severity and quality of life. Like smoking, poor eating habits, and high blood pressure, we will show that abuse history is an important risk factor for later health problems.

Experiences of sexual and physical abuse are occurring in epidemic proportions. Based on national probability studies, it is estimated that 15% to 20% of women have been victims of childhood sexual abuse[1, 2]. If we include sexual abuse after childhood, physical abuse and domestic violence, the estimates of abuse are even more daunting. Prevalence rates of abuse history tend to be the highest among patients in pain clinics, gastroenterology clinics, and other referral practices, especially among those with unexplained pain and psychiatric illness. In our studies among women patients in a referral based gastroenterology clinic, we found that 51% of patients reported a history of sexual and/or life threatening physical abuse[3]. Those patients with functional disorders (e.g., IBS, unexplained abdominal pain) had more severe types of abuse such as rape and life threatening physical violence compared to patients with organic disorders (e.g., ulcerative colitis, Crohn's disease)[4].

In addition to a high prevalence of abuse among patients in referral based GI clinics, abuse history has been linked to worse health status. Drossman, Leserman and colleagues performed a series of studies among patients in a referral based gastroenterology clinic to examine how previous sexual and physical abuse history might affect health status and physical functioning. These studies of more than 200 women showed that those with abuse history had on average 3 more medical symptoms (e.g., pelvic pain, headaches, genitourinary complaints, shortness of breath), greater pain, twice the number of days spent in bed due to illness, greater disability in all areas of functioning (e.g., physical, work, home management, and psychosocial), more psychological distress, and even more lifetime surgeries compared to women without abuse[3,5]. The differences between the abused and not abused were particularly striking among those with severe forms of abuse (e.g., rape, life threatening abuse). Most of the women were last sexually or physically abused many years before the study, and yet major health differences persisted between those with and

without abuse. Figure 1 below shows women with severe abuse had on average 15 doctor visits during a one-year period compared to 7 visits for those without any abuse and 10 visits for those with less severe abuse(6).

Other studies have also shown that abuse is associated with worse health status among patients with gastrointestinal disorders. A large study among patients undergoing routine examination in an HMO compared patients with severe symptoms of IBS, to those with less severe IBS and to healthy patients(7). Researchers found that 10% of the healthy controls, 21% of the less severely ill IBS patients, and 36% of the severely ill IBS patients reported sexual abuse. In another study of 50 female patients with recurrent pain (e.g., IBS, gastroesophageal reflux and non-cardiac chest pain), those with physical and/or sexual abuse histories had a greater number of psychiatric diagnoses, more functional disability, more non-GI pain (back, headache, pelvic) and lower pain thresholds to experimental pain stimuli than nonabused patients(8). Furthermore, those with the two GI disorders (IBS and reflux) were much more likely to have a sexual/physical abuse history compared to the non-cardiac chest-pain patients. Finally, another study of male and female patients with GI disorders (N'217) found that those with a history of sexual abuse were almost 3 times more likely to have an unexplained GI disorder(9). Once again this is evidence that sexual and physical abuse may contribute to the development or at least the exacerbation of GI symptoms.

Studies conducted among patients with pelvic pain report similar findings to those performed on patients with unexplained GI pain. In other words, abuse is more prevalent among those with unexplained pelvic pain compared to those with other gynecological conditions, and those with abuse have more somatic symptoms and poorer functioning compared to those without abuse. It seems there is reasonable evidence that once a person has a chronic painful condition like IBS or pelvic pain, that sexual and/or physical abuse history may exacerbate the symptoms of that condition, leading to more doctor visits, poorer functioning, more pain and worse overall health. What is less clear from the research presented above is whether abuse puts someone at greater risk for developing such painful conditions? There have been many population-based surveys and studies comparing matched groups of abused and nonabused persons that have helped address this question. Felitti and colleagues performed a clinic chart review comparing matched clinic patients with and without childhood sexual abuse history(10). Sixty-four percent of the abused patients had gastrointestinal disorders compared to 39% of the nonabused patients. Eighty-three percent of the abused had depression versus 32% of the nonabused. Headaches, obesity and doctor visits were also found to be more prevalent among the abused, despite the fact that the abuse occurred on average 30 years before the study.

In a large study of several primary care practices, McCauley and colleagues compared women with childhood (and no adulthood) sexual abuse (N'204) to those without abuse (N'1257) on many health status measures(2). Compared to women without abuse, adult women who have experienced childhood sexual abuse were more likely to report abdominal pain (46% versus 28%),

diarrhea (36% versus 24%), constipation (39% versus 27%), and pelvic pain (24% versus 11%). Other conditions reported more often by those abused in childhood were: nightmares, back pain, headaches, tiredness and problems with sleep, choking sensations, loss of appetite, vaginal symptoms, urinary tract symptoms, chest pain, face pain, shortness of breath, depression and attempted suicide. Fully 86% of the abused reported 3 or more medical symptoms compared to 62% of the nonabused. McCauley concludes, "Overall, our study suggests that patients who have experienced childhood but not adult abuse have levels of physical symptoms and psychological problems that are as severe as those patients experiencing current abuse."

Another general population survey of men and women in the United States (N'6,024) showed that sexual assault was associated with poorer physical functioning (e.g., more disability days, more medical symptoms, more depression), especially for those reporting physical violence, repeated abuse, or invasive sexual abuse(11). In another large population survey (N'1,610) by the same researcher, women with sexual abuse history had over twice the chance of having gastrointestinal symptoms, pain, neurological symptoms, and genitourinary symptoms compared to those without sexual abuse history(12). For example, 41% of the women with sexual abuse history had gastrointestinal symptoms (e.g., abdominal pain, diarrhea) and 62% reported neurological symptoms (e.g., voice loss, fainting, trouble walking) compared to 26% and 42% respectively, of the nonabused women.

Similar large studies among women patients in health centers or HMOs, have shown comparable findings. Among 523 female health center patients, history of childhood sexual abuse was associated with three times more gastrointestinal disorders, twice the respiratory illness, three times more neurological symptoms and generally a greater number of complaints in other medical areas(13). In another study of women patients attending a rural family practice clinic, sexually abused women were more likely to report pelvic pain, vaginal infections, bladder infections, obesity, and a greater number of symptoms and surgical procedures than the non-abused(14). Those with more severe abuse (e.g., a history of penetration, victim of multiple abusers) had more medical symptoms. Although researchers have done a good job demonstrating the health effects of abuse, we know much less about why and how abuse could result in such poor health so many years after this trauma. Drossman, Ringel, Leserman, Whitehead and colleagues are investigating this question currently to see if there are some differences in brain activity during painful stimuli that might explain the effects of abuse history. Stay tuned for an update on this research in a later issue of the newsletter.

Although the devastating health effects of sexual abuse appear extremely consistent across many studies using different methods of research, it should be remembered that not everyone who experiences abuse will have harmful health effects. Also, there are many promising psychological and pharmacological treatments for those who have experienced abuse. Cognitive behavioral stress management, emotional expression, exposure therapy, and anti-depressants may help patients deal with their past abuse and pave the way for their recovery. Drossman and colleagues have shown

that behavioral treatment and anti-depressants can help many patients with IBS improve their quality of life. Although abuse experiences can be damaging, there are many resources in the community to help patients cope with such stressful events and overcome being victims. The first step is acknowledging these experiences so that help can be sought. Discussing abuse and past trauma with a health care provider may be a second step so that appropriate referral for treatment can be made.

Despite the fact that many women experience sexual abuse during their lifetime, health care providers rarely ask about these experiences during routine medical care. The vast majority of sexually abused patients have never discussed these experiences with a physician or other health care worker, and many have never discussed them with anyone. Given the potentially damaging health consequences of abuse, it is important that these experiences are discussed within the context of one's health care so that proper treatment can be attained. Just like tobacco use and poor eating habits, the trauma of sexual abuse can be an important risk factor for poor health and greater dysfunction in later life. Like tobacco use and poor eating, there is something you can do to change how the past experience of abuse affects your life today.

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