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The Impacts of Gender Bias & Trauma on GI Patients

Dr. Buch:
Decades of research have shown that gender bias and history of abuse and trauma can impact a patient's gastrointestinal disorders and clinical outcomes. So what do we need to know about these factors and their relationship to GI disorders? And how can we improve the patient experience?

Welcome to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and joining me in this unique, patient-centered discussion about gender bias and early trauma with relation to functional GI disorders is Dr. Douglas Drossman and patient advocate, Ms. Johannah Ruddy. Dr. Drossman is Professor Emeritus of Medicine and Psychiatry at the University of North Carolina, and president of the Rome Foundation. Dr. Drossman, thanks for being here today.

Dr. Drossman:
Well, thanks for having me again.

Dr. Buch:
It's a pleasure. And Ms. Johannah Ruddy is one of Dr. Drossman's patients, as well as the Executive Director of the Rome Foundation. Ms. Ruddy, it's great to have you joining us again today.

Ms. Ruddy:
Thanks so much, good to be here.

Dr. Buch:
Thank you. Starting with you, Ms. Ruddy, can you give us a little bit of background into your patient experience. Specifically, did bias have an impact on your treatment and health outcomes?

Ms. Ruddy:
Sure. So, I think anyone familiar with my story would remember a ten-year timeframe of struggling with these functional GI illnesses or disorder of gut-brain interaction, and very severe chronic abdominal pain, severe bowel issues, and no real diagnosis or treatment method that had ever been proposed to me. Instead, just kind of getting from physicians that I sought out for care a sense of stigmatization and dismissiveness that my complaints were maybe being overexaggerated because of my gender, or maybe because I was a wife and a mother and working full time and having a lot of stress in my life. And my concerns were not really taken seriously and there are some studies that kind of tend to show that my experience is not one that's unique. Lots of women report being stigmatized or being told that their pain is not as bad as they're reporting, not being treated equally as maybe a male patient who would be reporting the same level of pain – those sorts of things. And so, that certainly was my experience, and it was quite frustrating, and just really kept driving this vicious cycle of me seeking new providers, and being told the same thing, and my symptoms not resolving, and me getting more frustrated, and the pain getting worse. It was just this cycle that went round and round and round. So it left me feeling quite a bit of hopelessness and despair, and just thinking that this was just gonna be the way my life was gonna run.

Dr. Buch:
Staying with you, Ms. Ruddy, how has your patient-physician relationship changed since then, and can you give us some examples of how doctors have better validated your experiences?

Ms. Ruddy:
Sure, so, once I was able to meet Dr. Drossman and begin working with him as my physician, he approached my symptom description completely differently. He was the first physician that asked me about the impact of my symptoms on my quality of life, on my

relationship with my children and my spouse, my job. No other physician had ever asked me about those issues, those factors which was really validating because it made me feel like, okay if he's asking me about the impact on my life, then he must think that they're real and that I'm not overexaggerating and I'm not making them up. And so then we were able to kind of work from there, to talk about why they were happening, and he was able to explain the pathophysiology of them to me, and we were able to decide together how to best treat them. And he really sought my input on them. I think, you know, really listening to me describe the severity and the impact, and then asking follow-up questions, saying things like, "Gosh, that must be really hard for you. How do you feel about this? How does that impact that?" You know, really showing empathy and compassion made a huge difference and was very therapeutic for me, and I think that for most patients when they find that kind of relationship, it is very therapeutic for them as well.

Dr. Buch:
So moving on to you, Dr. Drossman, can you give us some insights into gender stereotyping in the diagnosis and treatment of DGBIs?

Dr. Drossman:
Sure. I think in general, what we've seen for decades is that when women come to a doctor, they often are perceived more than men as having a psychiatric disturbance or an emotional issue going on. And decades ago, it was recognized that women with cardiac disease are under-recognized when they come in with chest pain, because they think it's psychological. And the same thing happens in GI. When they come in with GI disturbances, the immediate response is to say, "Well, this must be stress." What follows that is a not-so-helpful response like, "You need to learn to relax, or take yoga," whereas with men, it's taken a little bit more seriously. Now, of course, stress is going to play a role. It's the attribution that makes the difference. When men or women have GI disturbances, stress can be playing a role, but it can be playing a role as a result of having chronic pain or GI disturbance, not necessarily a primary psychiatric disorder. So, men and women need to be treated equally in terms of the role of stress and the approach to it.

Dr. Buch:
For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and today I'm speaking with Dr. Douglas Drossman and patient advocate Ms. Johannah Ruddy about the impact of gender bias and early trauma on patients with DGBIs. Switching gears, Dr. Drossman, can you tell us a little bit about your study on the relationship between abuse, trauma, and GI disorders? And specifically, why is it important for providers to take this into consideration when examining a patient?

Dr. Drossman:
Sure, I mean this is an area that's been of great interest to me, going back three decades ago or more. And when I was a young fellow and a young attending, I started to see patients, women in particular, with more severe chronic pain disorders, and I started to notice that most of them were having experiences of early trauma. Now that wasn't volunteered. It came because I was basically questioning about factors affecting their illness, and when you keep an open ear, you start to hear about it. Based on that information, I felt I needed to understand this more, so we did a research study looking at the women coming to the GI clinic – not just my clinic, but the GI clinic in general at the University of North Carolina – and found that over 50% of the women coming to the GI clinic reported a history of current or early, usually early, abuse and trauma. But only about 10% of the doctors were aware of it because it wasn't volunteered. And that study was published. It was in the *Annals of Internal Medicine* in 1990. It was the first publication attesting to the role of abuse in the GI illness. We also found in that, that it affected clinical outcome. Those with an abuse history reported more severe symptoms and went to the doctor more. That led to an NIH grant where we went into more detail, asking about how it affected illness. And we learned that it had profound effects on the nature of the symptoms reported, conditions like chronic pain, pelvic floor dyssynergia, or dyssynergic defecation, vomiting disorders, and so on. And then we also found that it led to more doctor visits. Having a history of abuse gave you a greater likelihood to have surgery for any GI condition, like gall bladder and the like.

Dr. Buch:
And considering, Dr. Drossman, asking about abuse and trauma history can be a sensitive issue for providers and patients, how do you approach bringing up this topic?

Dr. Drossman:
Yeah, that's a great question because women who've had abuse experiences are often very sensitive to being asked about it, so usually what I do is the first thing is I listen. I listen to what the patient's telling me. So if I'm hearing a story about how their illness began when they were 13 years old, and if the patient says, "Well, things were pretty tough back then," I stop at that point and I say, "Can you tell me more? What was tough?" Because that gives an opening where the patient can more comfortably describe what might be going on. If I don't hear that, I might at the end of the story say, "Was there anything else going on that might have affected your symptoms or affected your life in general?" And the patient might volunteer it at that point. The next level would be is if I'm really thinking it's important, and I've given you reasons before why I think it's important, because it does affect the illness, I might say, "Well, you know, these days, sometimes people can have experiences like early trauma, that can affect their symptoms and how they experience them." So I think it's really important to keep that in mind – to do this in a hierarchical fashion. First, to have an active ear, to listen and then to

gently ask the questions in a way that's viewed as nonthreatening. The other thing I would point out is you don't just routinely ask it, like a check list. You have to have established a relationship with the patient on that visit, so that the patient feels comfortable disclosing that kind of information.

Dr. Buch:
Turning to you, Ms. Ruddy, from the patient perspective, what are some ways that providers can approach addressing patients' pain and trauma history in their practices?

Ms. Ruddy:
Yeah, so like you mentioned, it can be pretty sensitive, and I think for patients with these types of histories, there's still many times a lot of unresolved issues there. Whether or not they have dealt with the pain of being victimized and have cycled through that in a healthy way will really determine whether they want to talk about it with their provider in this kind of a GI setting. I certainly agree with Dr. Drossman that you're soliciting information as the patient is telling their narrative, and not just going down a checklist. Being sensitive to the emotion involved there and the stigma and the pain that is attached to having a history of abuse or trauma is gonna be really important. Overall, I don't think that GI patients tend to think about or know that there is a connection between the severity of their symptoms and the previous trauma that they suffered. I certainly did not know that. I think there needs to be a little bit more education for patients – female patients particularly – about that correlation, and Dr. Lin Chang is doing some work on this issue as well at UCLA and has a great talk about this as well looking at the prevalence rates of functional GI conditions and chronic pain and ACEs, you know, adverse childhood events. And I think the more education that patients can have on this, reducing the stigma of being a victim of trauma or abuse, and educating them on how that past influencing their GI symptoms currently is really enlightening and frankly, for me, was validating to say, "Oh, okay. So, yes I had this history, and I'm working through it in a healthy manner with a professional. Now I understand the role that it played in my current health and where I am now, and taking all of that into account, I can work together with Dr. Drossman now to find treatment and relief for this."

Dr. Buch:
Finally, Dr. Drossman, is there anything else our audience needs to know about gender bias and trauma when diagnosing and treating DGBIs?

Dr. Drossman:
Yes, I would like to add that this can be an area that many doctors feel uncomfortable with. I remember, in 1990, when this paper first came out, and presenting it at academic meetings, the pushback was remarkable. I had one doctor say, "My patients aren't abused, therefore I don't ask them," and I think it reflected the lack of awareness. Nowadays, doctors do ask about it. But the next step is what do you do about that information? The general gastroenterologist or primary care physician may not want to carry this further, and I think what you need to do is if you identify it, you make an assessment how much that experience is affecting the illness, and then you offer the opportunity for the patient to go to a psychologist or other mental health provider. So in some ways, you're acting as the one to identify the information, and then you continue to follow the patient. Patients don't want you to abandon them, not just send them to the psychologist, but also continue to work with them medically. And in that way, I think both the doctor and the patient are comfortable in that shared interaction.

Dr. Buch:
Those are some great thoughts on such prevalent issues facing our patients. Thank you, Ms. Ruddy, for sharing your insight, and Dr. Drossman, thanks for sharing your expertise.

Dr. Drossman:
You're welcome.

Ms. Ruddy:
Thanks for having us.

Dr. Buch:
It's a true pleasure. I'm Dr. Peter Buch. To access this episode and others in our series, visit ReachMD.com/GIInsights, where you can Be Part of the Knowledge. Thanks for listening.