



Sexual, physical, verbal/emotional abuse and unexplained chest pain

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ABSTRACT

Objectives: Approximately one third of patients with non cardiac chest pain (NCCP) report a history of abuse, however no data exists on the prevalence of abuse among people with unexplained chest pain in the general population. We aimed to determine if there is a relationship between childhood sexual, physical, emotional abuse and unexplained chest pain, and to identify whether any potential relationship is being driven by an association with psychological distress.

Methods: Subjects were identified from 2 previous random population surveys that included people with irritable bowel syndrome (IBS) and/or functional dyspepsia (FD) and healthy controls. People in the unexplained chest pain group ($n=27$) had chest pain in the past 12 months that was not heartburn or heart disease. People in the comparison group ($n=60$) did not have chest pain for more than 12 months. Self-reported abuse and psychological variables were assessed using validated measures.

Results: Emotional/verbal abuse (20.8% versus 4.4%, $P=0.032$) and physical abuse (16.7% versus 2.2%, $P=0.028$) were significantly more common in people with unexplained chest pain versus the comparison group. Only a history of emotional/verbal abuse was a significant independent predictor of meeting criteria for unexplained chest pain (OR = 5.66; 95%CI 1.01–31.80, $P=0.049$) even after controlling for IBS and/or FD (OR = 5.45; 95%CI 0.96–30.83, $P=.05$), but not when depression was controlled for (OR = 4.70; 95%CI 0.90–27.61), $P=0.08$.

Conclusions: A history of childhood emotional/verbal abuse is a risk factor for having unexplained chest pain but the association may be moderated by psychological distress, specifically depression.

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Introduction

The prevalence of abuse is high in Australia (Broadbent & Bentley, 1997; Child, 2010) and is associated with other sequelae including a greater number and more severe medical problems, increased health care utilisation and psychological problems (anxiety and depression) (Beitchman, Zucker, Hood, et al., 1992; Davis, Luecken, & Zautra, 2005; Felitti, 1991; Sansone, Wiederman, & Sansone, 1997). While it is well established that people with functional gastrointestinal disorders including irritable bowel syndrome (IBS) and functional dyspepsia report higher rates of abuse than healthy controls and outpatients with organic gastrointestinal diseases such as inflammatory bowel disease (Alander, Heimer, Svardsudd, & Agreus, 2008; Blanchard, Keefer, Payne, Turner, & Galovski, 2002; Delvaux, Denis, & Allemand, 1997; Drossman et al., 1990; Hobbis, Turpin, & Read, 2002; Koloski, Talley, & Boyce, 2005; Talley & Boyce, 1996; Talley, Boyce, & Jones, 1998; Talley, Helgeson, Zinsmeister,

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& Melton, 1994; Walker, Gelfand, Gelfand, & Katon, 1995), it is unclear whether this is also the case for other functional gastrointestinal disorders such as unexplained chest pain.

Biggs, Aziz, Tomenson, and Creed (2004) interviewed a consecutive sample of 133 patients (40 confirmed non-cardiac chest pain [NCCP], 43 functional dyspepsia [FD], 29 gastro-esophageal reflux disease [GORD] and 21 ischaemic heart disease [IHD]) attending a gastroenterology and/or cardiac clinic using the Childhood Experience of Care and Abuse scale (Biggs et al., 2004). This measure defines a variable labelled adversity as measured by parental antipathy, neglect, physical, sexual and psychological abuse, which is globally rated as marked or moderate. Of their sample, 30% had experienced one or more forms of childhood adversity, although there were no significant differences between the four diagnostic groups (NCCP 35%, FD 26%, GORD 31% and IHD 29%). Moreover, they showed that the negative effect of abuse on outcome was mediated by psychological distress (Biggs et al., 2004). Scarinci, McDonald-Haile, Bradley, et al. (1994) also assessed sexual and physical abuse in 50 paid volunteers from a tertiary referral centre. Abuse was significantly more prevalent among patients with GORD (92%) and IBS (82%) compared with NCCP (27%). These studies however, were limited to outpatient samples, which may be associated with a reporting bias, with clinic patients for example being more likely to exaggerate pain reporting (Talley & Boyce, 1996). There remains a lack of population-based data on the relationship between abuse and unexplained chest pain.

In a population-based study, we aimed to determine if rates of childhood sexual, physical and verbal/emotional abuse are higher in people with unexplained chest pain compared with a comparison group. In addition, we aimed to determine if childhood abuse is an independent predictor for unexplained chest pain after controlling for psychopathology.

Methods

Subjects

Sampling frame. Participants in the current study were selected from two previous population-based studies (Koloski, Talley, & Boyce, 2002; Koloski et al., 2005). They were all originally randomly selected for these previous studies from the 1996 Electoral roll for the local government area of Penrith, Australia, which is socio-demographically very similar to the Australian population according to 1996 Census data (Australian Bureau of Statistics, 1991). The methods of these previous studies have been described in detail elsewhere (Koloski et al., 2002, 2005).

Unexplained chest pain group. Participants in the unexplained chest pain group ($n = 27$) were selected based on their responses to two previous population-based studies. First, they had to have been part of an interview based follow-up study in 1999 on the psychosocial aspects of irritable bowel syndrome and/or functional dyspepsia versus healthy controls, in which abuse questions were part of the assessment protocol (Koloski et al., 2005). From this interview-based follow-up study, we were able to identify those people who had also taken part in a population-based mail out survey on the epidemiology of functional gastrointestinal disorders in 1997 in which data on unexplained chest pain was obtained (Koloski et al., 2002). More specifically, people in our unexplained chest pain group had to answer positively to the question in the 1997 survey "In the past 12 months, have you ever had pain in the centre of your chest that was not heartburn?" and also they had to have answered negatively to the question "Did a doctor tell you that this pain was due to heart disease." These questions were developed from the validated Bowel Disease Questionnaire (Talley, Boyce, Owen, Newman, & Paterson, 1995; Talley, Phillips, Wiltgen, Zinsmeister, & Melton, 1990). Within the unexplained chest pain group ($n = 27$), 22 also met criteria for IBS and/or functional dyspepsia and 5 did not.

Comparison group. Participants in the comparison group ($n = 60$) were selected based on their responses to two previous population-based studies. First, they had to have been part of an interview based follow-up study in 1999 on the psychosocial aspects of irritable bowel syndrome and/or functional dyspepsia versus controls in which abuse questions were part of the assessment protocol. From this interview-based follow-up study we were able to identify those people who had also taken part in a population-based mail out survey on the epidemiology of functional gastrointestinal disorders in 1997 in which data on unexplained chest pain was obtained (Koloski et al., 2005). Participants in the comparison group had to answer negatively to the question in the 1997 survey "In the past 12 months, have you ever had pain in the centre of your chest that was not heartburn?" (Koloski et al., 2002). Within our comparison group ($n = 60$), 46 met criteria for IBS and/or functional dyspepsia; 14 did not meet criteria for either of these disorders.

Measures

Abuse. Three types of abuse including sexual, physical, and verbal/emotional abuse were assessed in this study via self-report. The sexual and physical abuse questions were developed by Drossman et al. (1990), based on a national population survey in Canada (Badgley, Allard, McCormick, et al., 1984) and have been validated (Leserman, Drossman, & Li, 1995; World Health Organization, 1997). A subject was defined as having been sexually abused in this study if they had a positive response to any of the sexual abuse items: threatened to have sex with them, touched the sex organs of their body, made them touch the sex organs of someone else, or tried forcefully to have sex or succeeded in having sex with them. Four additional questions to assess emotional and verbal abuse based on a previous population based study (Talley et al., 1994) were also included in

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