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## Beyond abuse: the association among parenting style, abdominal pain, and somatization in IBS patients

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### Abstract

This study assessed the relative strength of the association between abuse, negative parenting style, and somatization in irritable bowel syndrome (IBS) patients. Drawing from preclinical stress physiology and abuse research identifying the family social climate as a frequently stronger and independent determinant of long-term health effects than abuse-specific variables, we predicted that negative parenting behaviors would more strongly correlate with somatization than abuse. Subjects were 81 consecutively evaluated patients, who at baseline underwent psychological testing, measuring perceived parental style, abuse history, somatization, and pain. Although abuse correlated with maternal and paternal rejection, abuse was not associated with somatization. Higher levels of rejection and/or hostility among fathers (not mothers) were more strongly correlated with somatization than was abuse. Further, paternal parenting behaviors were more predictive of somatization than abuse, age, and gender. The lack of an association between abuse and somatization is discussed in light of limitations of biopsychosocial IBS models, whose strong focus on “pathological stressors” (e.g., abuse, trauma) as risk factors may overlook the importance of “less extreme” parenting variables in influencing somatic complaints. The relationship between parenting and somatization is discussed in the context of broader behavioral science research linking disruptions in the quality of parenting to dramatic and long-term changes in patterns of stress reactivity and brain abnormalities seen in IBS patients.

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## 1. Introduction

Irritable bowel syndrome (IBS) is a functional gastrointestinal (GI) disorder, characterized by pain and altered bowel habits. Although psychological factors do not comprise diagnostic criteria for IBS, they influence its expression and course, particularly in more severely affected patients (Drossman et al., 1999; Lackner, *in press*). One way psychological factors may influence IBS is by mediating its risk of onset. This line of research has largely focused on the role of abuse. A history of sexual abuse (as defined by nonconsensual sexual contact obtained through unwanted touching/fondling and physical contact with the sexual parts of the victim's or the offender's body through force or threat of harm or rape) and/or physical trauma (i.e., frequent beating, life threat) occurs in 20–60% of treatment seeking IBS patients and corresponds with refractory symptoms, greater healthcare utilization, and susceptibility to undergoing unneeded medical procedures (Drossman et al., 1990; Drossman, Talley, Leserman, Olden, & Barreiro, 1995). These data have been interpreted (e.g., Mayer, Naliboff, Chang, & Coutinho, 2001) as evidence that a trauma history represents a major vulnerability factor for the development of IBS.

The notion that “a history of abuse is part of the causal chain leading to IBS” (Koloski & Talley, 2002) is difficult to reconcile with a number of recent findings. Although IBS patients with self-reported histories of abuse describe their symptoms as more severe, they are neither experienced by all survivors nor are they adequately explained by a positive history of abuse (Drossman et al., 1990; Hobbis, Turpin, & Read, 2002; Talley, Fett, & Zinsmeister, 1995). Whitehead, Cromwell, Davidoff, Palsson and Schuster (1997) tested the notion that a history of trauma amplifies visceral sensitivity among abused IBS subjects using a rectal distension task. Contrary to predictions, subjects with documented abuse histories did not exhibit lower pain thresholds to rectal stimuli than subjects without an abuse history. Two large prospective studies indirectly challenge the casual role of abuse in benign pain disorders like IBS (Linton, 2002; Raphael, Widom, & Lange, 2001). In both studies, patients with abuse histories at baseline were not at subsequent risk for increasing pain symptoms or functional limitations. In the Raphael study (Raphael et al., 2001), the odds of reporting one or more unexplained pain symptoms, including abdominal pain (the cardinal feature of IBS), were not associated with any documented cases of childhood abuse (e.g., sexual abuse, physical abuse). Further, individuals with positive abuse histories were not more likely to develop a mood disorder which some IBS researchers (Blanchard, 2000) have identified as a mechanism linking abuse to the IBS symptoms. Interestingly, Raphael et al. found a relationship between a history of depression and unexplained pain symptoms among subjects *without abuse histories*. These prospective data raise questions about whether the strength of relationship between an abuse history and clinical pain problems is at least partly an artifact of using retrospective victimization self-reports data from cross-sectional studies.

These findings also invite speculation about whether early adverse experiences that do not necessarily involve trauma may underlie vulnerability to and later expression of symptoms associated with IBS. One unexplored variable involves the psychosocial structure of the family environment. Developmental psychopathology research has found that within the family system the quality of parent–child interactions and parental behaviors can have an independent and frequently more powerful influence over long-term health problems than abuse, even when the abuse involves extrafamilial trauma (Edwards & Alexander, 1992; Friedrich, Beilke, & Urquiza, 1987; Harter, Alexander, & Neimeyer, 1988; Peters, 1988). Not only do parent–child interactions exacer-

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