Consulters and Nonconsulters in Irritable Bowel Syndrome: What Makes an IBS Patient a Patient?

by Stephen Y. Chang and Michael P. Jones

Symptoms consistent with a diagnosis of Irritable Bowel Syndrome (IBS) are common in the community yet only a minority of these individuals seek care. Consulters and nonconsulters with IBS generally do not differ greatly with respect to symptoms and there is little evidence to suggest that digestive pathophysiology differs between these two groups. There is, however, substantial evidence demonstrating that IBS consulters do differ with respect to concomitant psychiatric disorders, psychosocial and personality factors and recent life events. While symptom resolution is the ultimate goal in managing any patient with IBS, clinicians must be attentive to the fact that the path to improvement in many IBS consulters involves addressing psychosocial issues in addition to the digestive tract.

INTRODUCTION

Digestive symptoms are common in the population and usually self-limited. Occasionally these symptoms are persistent or recurrent but even then significant digestive pathology is infrequently found. Individuals with persistent digestive symptoms who lack definable pathophysiology are labeled as having a functional digestive syndrome. While some individuals with persistent or recurrent digestive symptoms seek care, population surveys demonstrate that most do not. This fact raises a number of questions: At what point in their illness does a person with digestive symptoms seek care? What causes an individual to seek “patient status” for their digestive complaints? The answers to these questions are not as obvious as casual inspection would lead one to believe.

The high prevalence of functional digestive disorders, particularly IBS, makes these questions relevant. Community surveys report the point prevalence of symptoms consistent with IBS ranges from 4%–22% depending upon the diagnostic criteria applied (1). Increasingly, this is often restated as “IBS alone affects 10%–20% of adults (2)”Yet if the majority of people with symptoms never seek care (and most don’t), do those people really have IBS? Obviously the segment of the medical industry that stands to profit from expanding the IBS patient base wants us to believe this is the case. But the fact that only 30% of

Stephen Y. Chang, M.D., Fellow in Gastroenterology and Michael P. Jones, M.D., FACP, FACG, Associate Professor of Medicine, Division of Gastroenterology, Feinberg School of Medicine, Northwestern University, Chicago, IL.
persons with symptoms consistent with IBS will seek care raises the important question of how do IBS consulters differ from nonconsulters (3,4)?

Table 1
Factors influencing consultation in Irritable Bowel Syndrome

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<td>III.</td>
<td>Symptom Etiology</td>
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<td>B. Fear of “serious” etiologies</td>
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<td>IV.</td>
<td>Psychiatric Comorbidity</td>
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<td>E. history of sexual or physical abuse</td>
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**The Decision to Seek Care**

The decision to consult or seek care for a particular medical problem depends upon several factors (Table 1). In many respects, symptom severity is the primary determinant. However, patients and physicians often regard symptom severity in very different ways. There are clearly symptoms so disabling and severe that almost everyone would seek care (e.g. compound fracture of the femur; penetrating abdominal trauma). At the other end of this spectrum, there are symptoms so common and mild that virtually no one would seek attention. Superimposed on this background of perceived symptom severity is a threshold for consultation. This threshold represents the summation of several variables. These include the individual’s access to care; his or her concerns over the possible etiology of their illness; concomitant psychopathology such as anxiety, depression, somatiform disorder and a variety of personality factors including learned illness behavior and recent life events. Equally important is how various symptoms are perceived by society and the medical community. The “medicalization” of the human condition has a long history in allopathic medicine and often occurs where commercial opportunity exists. Recent examples of “medicalized” disorders include social phobia, male pattern baldness, female sexual dysfunction and, increasingly, IBS (5,6). The interaction of these factors is shown schematically in Figure 1.

**Access to Care**

The logistical and financial ease with which medical care can be obtained can also influence the probability that an individual will seek medical attention (7,8). While this has not been formally assessed in IBS, indirect evidence suggests it. In the United States, a country in which a substantial percentage of the population does not have easy access to healthcare, the consulting rate for IBS-type symptoms is about two-thirds of that in Australia where health care access is essentially uni-
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versal (9,10). These observations are clearly

Access to care is an important variable when com-

paring consulting and nonconsulting populations with

IBS. If care is readily available, the threshold for peo-

ple to seek medical opinion regarding their symptoms

will be low and differences between consultants and

nonconsulters will diminish. When access to care

becomes more difficult, consulting and nonconsulting

groups will grow increasingly distinct. This concept is

supported by the available literature. For example, Kettel, et al reported that within the National Health

Service (a system with somewhat restricted access to
care), IBS consultants had significantly greater per-
cieved symptom severity, more negative life events

and higher anxiety and depression scores than did non-

consulters (11). In this study population, only one-
third of participants meeting the Manning criteria for

IBS consulted a physician for this problem. In contrast,

Kолосki studied an Australian population with both

IBS and nonulcer dyspepsia (12). Fifty percent of

these patients had seen a physician within the past year

for their symptoms. While symptom severity was also

a predictor of health care utilization, psychological
distress was not.

SYMPTOMS

IBS consultants report a greater number of symptoms

than nonconsulters and the symptom most strongly

associated with consulting behavior is abdominal pain

(10,11,13–15). Other symptoms reported more com-

monly among consultants than nonconsulters include

abdominal distension and bloating (13,11). There is

much less evidence to support specific alteration in

bowel pattern or stool form (15,16). Yet even if pain is

an important determinant in healthcare seeking in IBS,
it does not appear to be a dominant variable. In fact,

while Drossman and colleagues found that pain and
diarrhea were the most important symptoms associated

with consulter status, significant psychosocial differ-

ces existed between consultants and nonconsulters

when controlling for these symptoms (16). Compared

with nonconsulters, IBS consultants had a higher propor-
tion of abnormal personality patterns, poorer coping

skills, found illness more disruptive and exhibited
greater degrees of denial than did IBS nonconsulters or

normals. These data suggest that the difference between

IBS consultants and nonconsulters has more to do with

how the individual interacts with their symptoms than

with the symptoms per se.

Importantly, patient perceptions of symptom

severity may not be concordant with physician assess-

ments of severity. Hahn evaluated 126 IBS patients

using a variety of psychosocial and symptom assess-

ment measures (17). Patients rated their IBS as mild,

moderate, severe or very severe. There was no rela-
tionship between digestive symptoms and perceived

severity except for a feeling of unpassed stool. Quality

of life was inversely correlated with perceived sever-

ity. Healthcare utilization did not correlate with per-

ceived severity but productivity, absenteeism and the

number of bedridden days did.

Drossman addressed symptom severity using the

Functional Bowel Disorder Severity Index (FBDSI) in

a large group of female patients with IBS (18). The

FBDSI is a validated measure based upon the patient’s

rating of pain severity, the presence or absence of a

diagnosis of functional abdominal pain and the number

of physician visits in the past month (19). When com-

paring IBS patients with moderate and severe IBS by

FBDSI criteria, patients with severe IBS displayed

greater depression, poorer quality of life, poorer daily

function and poorer coping skills. Severe IBS patients

also had more healthcare contacts and bedridden days.

Rectal sensitivity was also assessed in this study using

a barostat. There was a trend for patients with severe

IBS to have lower rectal sensation thresholds but dif-

ferences were significant only for the volume to first

pain report. These data demonstrate that illness sever-

ity was best correlated with illness behavior. Thus, ill-

ness severity in IBS is largely dictated by psychosocial

features and that improved clinical outcomes likely
depend upon responding to these variables.

Finally, patient perceptions or concerns regarding

symptom etiology influence the decision to consult. In

one study comparing IBS consultants with nonconsul-
ters, IBS consultants were more concerned than non-

consulters about the potential seriousness of their con-

dition, particularly a fear of cancer (11,20). Actively

addressing these concerns is critical in achieving suc-

cessful outcomes.
PSYCHIATRIC COMORBIDITY

Just as patients’ concerns regarding symptoms are associated with increased consulting behavior, patients with psychiatric disorders consume significantly more healthcare resources than do patients with medical problems without concomitant psychiatric disorders (21). Anxiety and depression commonly have associated digestive symptoms. Patients with somatoform disorders manifest emotionality through physical symptoms. These individuals frequently seek care for a variety of medically unexplained symptoms (22,23).

Psychiatric disorders are common in patients with IBS but no symptom pattern is unique to these patients. The proportion of IBS patients meeting criteria for a psychiatric diagnosis ranges from 54%–100% (24). The most common diagnoses are anxiety, mood and somatiform disorders. It seems clear that the presence of a psychiatric disorder alone does not seem to cause IBS but does make it more likely that individuals with IBS symptoms will seek care. Using the Hopkins Symptom Checklist, Whitehead, et al compared IBS patients in a clinic with IBS nonpatients and healthy controls (Figure 2) (25). While the IBS patients had greater scores for distress on all scales, IBS nonpatients and controls did not differ. These data are consistent with previous reports using similar measures (25,26).

PERSONALITY FACTORS AND ILLNESS BEHAVIOR

Just as anxiety, mood and somatiform disorders impact upon consulting behavior, personality traits can influence the perception and reporting of symptoms and a variety of personality constructs and styles have been evaluated in patients with IBS. Using the Minnesota Multiphasic Personality Inventory (MMPI), and controlling for symptom severity, Drossman found that

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IBS patients had higher scores for hypochondriasis, depression and hysteria than did IBS nonpatients or controls (Table 2) (16). They also had significantly lower scores for ego strength and were more likely to distort information so as to present themselves in a favorable light. Bergeron and Monto also administered the MMPI to a group of 82 patients with IBS (27). Seventy percent of subjects had an abnormal MMPI profile. Using factor analysis, the investigators identified the four most common MMPI profile types in IBS patients: inadequate dependency, somatization, reactive depression and anger and denial.

Neuroticism is a personality trait characterized by an exaggerated response to physiological changes and physical symptoms in the absence of disease (28). It has been suggested that IBS patients exhibiting this trait are more likely to seek care. Several studies have investigated this using either the Eysenck Personality Questionnaire or related NEO Five Factor Personality Inventory. The results have been conflicted suggesting that while IBS patients may manifest greater levels of neuroticism than healthy subjects, it is not a major determinant of healthcare seeking in IBS (10,18,29).

People learn how to be sick just as they learn how to be well. It was previously mentioned that concern over the nature of symptoms, particularly a fear of cancer, is one determinant of healthcare seeking in IBS. Patients with IBS not only tend to have greater concerns over the meaning of their symptoms but they also tend to be more symptom-attentive. For example, Farthing and colleagues used the Illness Attitudes Scale to demonstrate that, compared to patients with organic digestive disorders, IBS patients scored significantly higher on scales for bodily preoccupation, hypochondriasis and disease phobia (30). These types of illness behavior appear to be acquired through either parental modeling or reinforcement (31–33).

Severe life stress, particularly disruption of relationships, often occurs immediately prior to the onset of IBS symptoms and is more common than in patients with organic digestive disorders (34,35). Life stress is associated with increased symptoms in both consulters and nonconsulters with IBS (36). While life stress may provoke IBS symptoms, maladaptive coping skills may adversely affect symptom tolerance. IBS consult-

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ters report greater illness disruption than do nonconsulters (16). IBS patients also tend to display more problem-focused rather than emotional coping patterns (37). IBS severity also is predicted by the catastrophizing and decreased self-perceived ability to decrease or control symptoms (18,37).

SEXUAL AND PHYSICAL ABUSE

Rates of sexual and physical abuse based upon self-reports are seen in 30%–56% of patients with functional digestive disorders seen in specialty centers (38). Abuse does not seem to be etiologic for IBS but it is clearly associated with somatization, a variety of pain syndromes and higher healthcare utilization (39, 40). A population survey conducted by Talley found that a history of physical or sexual abuse was associated with both increased likelihood of developing a variety of digestive symptoms including IBS and higher rates of physician utilization for those symptoms (41).

CONCLUSION

IBS remains a symptomatically defined disorder whose pathophysiology is at best incompletely understood. Symptoms consistent with IBS are common in the community and only a small subset of people experiencing those symptoms will ever seek medical attention. The IBS consulter differs from the IBS nonconsulter in important ways that seem to not principally involve symptoms. The differences in psychosocial factors discussed above are significantly more robust and numerous than evidence supporting substantive differences in neuroenteric functioning between the two groups. While the goal of caring for these individuals is clearly to “quiet the gut,” that goal is often not effectively achieved by simply treating the gut. Establishment of an effective therapeutic relationship with the patient is essential. For patients not responding to standard treatments or simple reassurance, empathic discussions focusing on patient beliefs and concerns, inquiries into psychosocial issues and development of a plan formulated with and for the patient, offer the best opportunity for a satisfactory outcome.

For the practitioner, heightened awareness of the importance of psychosocial factors in symptom generation and enhancement is strongly encouraged and can produce significant clinical improvement in scenarios previously regarded as difficult. Attention should be paid to the role of psychosocial events as triggering or exacerbating factors for digestive symptoms. Queries regarding anxiety or mood disorders can be made once a therapeutic and nonjudgmental relationship with the patient has been established. Standardized questionnaires that address common psychiatric constructs can be incorporated into clinical practice. Examples of these include the Symptom Checklist 90 and the Hospital Anxiety and Depression Scale. While these measures do not diagnose psychiatric disorders they do demonstrate, in an objective fashion, behaviors consistent with those diagnoses. Physicians caring for patients with functional digestive disorders should also establish working relationships with colleagues in the behavioral sciences who have an interest in these patients. A growing body of evidence supports the effectiveness of behavioral therapies in functional digestive disorders and support continues to emerge. While the reductionist approach of medical science will continue to produce targeted therapies focusing on specific alterations in visceral function or sensation, the humanistic approach that defines clinical practice both demands and rewards attention to the biopsychosocial nature of patients’ problems.

For researchers in the area, the development of physical, biochemical and psychosocial biomarkers that better allow the implementation of effective therapies has become an important area of investigation. Our understanding of the role of the central nervous system in both symptom generation and visceral sensory processing in functional digestive disorders is expanding rapidly with the development of functional neural imaging. Studies addressing the role of behavioral therapies alone or in combination with agents that alter gut function and sensation are beginning to emerge but much more work in this area is needed.

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