

Speaking about the unspeakable poop

Living with the psychosocial effects of Irritable Bowel Syndrome and food intolerances

Joanne M. McGrath

Abstract

Often women in New Zealand who live with hidden illnesses such as Irritable Bowel Syndrome (IBS) and food intolerances suffer in silence or learn to live with them (Pimentel, 2007). Many of these women never have a chance outside a doctor's room to say what it is like for them, especially how they cope with the psychosocial effects. The aim of this small qualitative study was to give New Zealand middle-aged women, aged 40 to 60 years old, an opportunity to have a voice and share their experiences, and gain an understanding of how they have learnt to live with the psychosocial effects of IBS and food intolerances. After a brief definition of IBS, food intolerances, and their psychosocial effects, this article explores the journey of making the unspeakable poop speakable for ourselves, within family and with friends, and areas clients can explore within the counselling room.

Keywords: biopsychosocial model of IBS, Irritable Bowel Syndrome, food intolerances, low FODMAPs, speakability of poop

Irritable Bowel Syndrome (IBS) is a chronic debilitating gastrointestinal (GI) and functional bowel disorder (Adeyemo & Chang, 2008; Nott, 2011; Yoon, Grundmann, Koepf, & Farrell, 2011). Depending on whose work is cited, IBS affects between 14% and 20% of adults in the Western world (Adeyemo & Chang, 2008; Burstall, Vallis, & Turnbull, 1998; Jerndal et al., 2010; Lasalandra & Friedman, 2001; Nott, 2011; Shepherd, 2014). Women are between two and four times more likely to experience IBS than men (Adeyemo & Chang, 2008; Bolen, 2010; Herman, Pokkunuri, Braham & Pimentel, 2010; Luscombe, 2000; Mathieu & Matricon, 2014; Stenner, Dancey, & Watts, 2000). It is the most common functional GI disorder (Mathieu & Matricon, 2014; Parker & Lewis, 2015), is seriously underdiagnosed, and the number one reason people see

gastroenterologists (Lasalandra & Friedman, 2001). After the common cold, it is the biggest cause of absenteeism from school and work (Burstall et al., 1998). For many, their symptoms can be chronic in nature and incapacitating, costing society lowered productivity and absenteeism (Jerndal et al., 2010).

IBS does not show up on medical testing as the bowel is normally a healthy bowel, with no identifiable structural abnormalities, bacterial imbalances, or biological markers (Phillips, Wright, & Kent, 2014). Diagnosis is based on the patient's symptoms according to the Rome Criteria for IBS (Adeyemo & Chang, 2008; Bolen, 2010; Burstall et al., 1998; Drossman, 2006; Hunt, 2016; Shepherd, 2014). Recurrent changes in how the bowel functions—that is, its oscillation between working well and working badly due to the disordered coordination (Burstall et al., 1998, p. 4)—causes symptoms such as abdominal pain, wind, bloating, diarrhoea, and/or constipation as well as extra sensitivities to food and stress (Barrett & Gibson, 2007; Burstall et al., 1998; Hertig, Cain, Jarrett, Burr, & Heitkemper, 2007; Nott, 2011).

IBS is subtyped according to the bowel's predominant altered stool form: as IBS diarrhoea-predominant (IBS-D); IBS constipated-predominant (IBS-C); or IBS-M, where there is a mix of both diarrhoea and constipation, which occurs 25% or more of the time (Adeyemo & Chang, 2008; Bolen, 2010). IBS-M is also referred to as IBS-A, meaning alternating between diarrhoea and constipation (Hertig et al., 2007).

Sufferers experience pain amplification, hypervigilance (Elsenbruch et al., 2010, p. 1310), and food intolerances as a result of changes in the GI tract (Adeyemo & Chang, 2008; Bolen, 2010; Nott, 2011; Park & Camilleri, 2006; Stenner et al., 2000). As well, women often experience comorbid illnesses such as fibromyalgia, migraine, chronic pelvic pain, chronic fatigue syndrome, anxiety, and depression with IBS (Mathieu & Matricon, 2014).

Differentiating between symptoms of IBS and food intolerances can be difficult as many food intolerance reactions mimic IBS (Adeyemo & Chang, 2008; Hunt, 2016). Food intolerances occur when certain types of food are malabsorbed by the GI, causing alterations to both the gut function and the enteric nervous system. Part of the GI tract's role is to protect the body against harm using a complex immune system. Food types which include short-chain carbohydrates such as gluten, fructose, fructans, lactose, mannitol, sorbitol, galacto-oligosaccharides,

polyols, and galactans are commonly the cause of food intolerances. These food types are referred to as FODMAPs, which stands for Fermentable Oligosaccharides Disaccharides Monosaccharides And Polyols (Barrett & Gibson, 2007; Murray et al., 2014; Shepherd, 2014; 2015). These foods ferment, and cause visceral sensitivity within the gut, therefore a low FODMAP diet is recommended to patients struggling with IBS and/or food intolerances.

The psychosocial effects of living with IBS and food intolerances

Psychosocial factors influence the experience of living with IBS and food intolerances, and these are often the reason people seek medical care. Psychosocial factors can affect the GI tract due to the increased messages between the brain and gut, affecting the nervous system and causing anxiety (Drossman et al., 2003). Several writers in the literature noted that stress, anxiety, and depression are part of the psychosocial effects of living with IBS and food intolerances (Bolen, 2010; Hertig et al., 2007; Jerndal et al., 2010; Konturek, Brzozowski, & Konturek, 2011; Stenner, Dancey, & Watts, 2000).

IBS and food intolerances may bring their own unique set of challenges, such as the fear of not being able to eat the same food as others, having to explain why they cannot eat the food, trying to find a toilet urgently, and the need for frequent visits to the toilet, resulting in stress, vulnerability, shame, embarrassment, and anxiety. For some, it is easier to avoid social settings, as Surdea-Blaga, Baban, and Dumitrascu (2012) note:

...patients describe IBS not only as symptoms but mainly as it affects daily function, thoughts, feelings and behaviors. Patients report the sense of losing freedom, spontaneity and social contacts, as well as feelings of fearfulness, shame, and embarrassment. All these could lead to changes in their behavior such as avoidance of activities and many adaptations in routine in an effort for patients to gain control.
(p. 620)

The Biopsychosocial Model of IBS (Van Oudenhove et al., 2016, p. 1356) is widely used by medical professionals (Hertig et al., 2007; Jerndal et al., 2010; Stenner et al., 2000; Van Oudenhove et al., 2016) and links the physiological reactions and symptoms in IBS to psychological, environmental, or social factors.

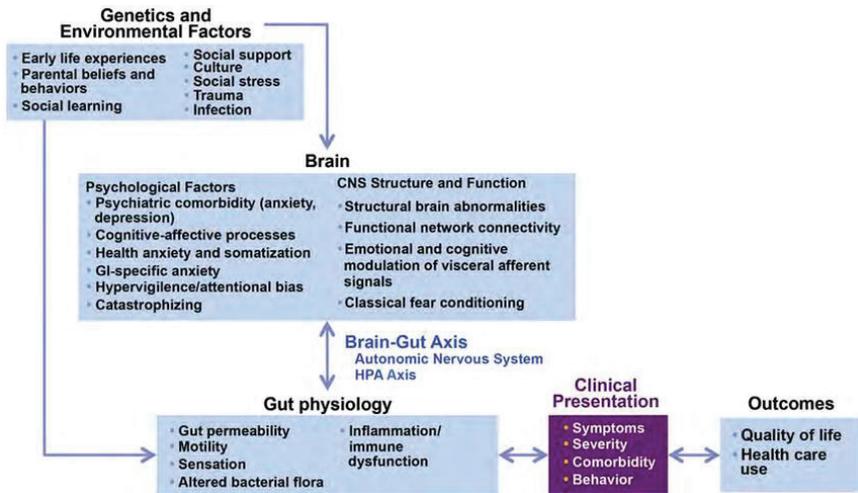


Figure 1: The Biopsychosocial Model of IBS (Van Oudenhove et al., 2016, p. 1356).

There is a link between the psychosocial factors and GI function through the brain-gut axis which is bi-directional, constantly signalling information about the physiology of the body to the brain through spinal and vagal nerves, and gut-brain pathways (Gerson et al. 2006; Luscombe, 2000; Phillips et al., 2014; Surdea-Blaga et al., 2012; Van Oudenhove et al., 2016). Experiences early in life, the learnt perception of coping with illness from childhood (Crane & Martin, 2002), genetics and environmental factors such as family members with IBS, or experiences of abuse, trauma, and major losses, may affect the way someone develops psychosocially, which then influences the function of the gut and brain connection, leading to IBS.

Luscombe (2000) notes that IBS negatively affects health-related quality of life (HRQoL) by affecting someone’s “vitality, social functioning, bodily pain, diet, sexual function, sleep, and is associated with lost time from work” (p. 161). Phillips et al. (2014) agree, noting IBS can also affect diet, travel, physical appearance, and sexual relationships.

Relationships with others can also impact on the severity of IBS, especially with

family, friends, and medical professionals. Stenner et al. (2000) note that people not only have to cope with the symptoms of IBS, but the “attitudes of friends, family and health professionals, who are often less than sympathetic” (p. 440). The attitudes of others and how they treat someone with IBS and food intolerances can help reduce or worsen the sufferer’s symptoms.

Social discourses and the unspeakability of poop

Moore (2013) entitled her thesis “The un-speakability of problems with gut functions: The taboo of talking about poop” as she explored living with Crohns. Adults do not generally advertise that sometimes they have sneaky poop accidents, sore guts, or raw tails. It is too embarrassing, shaming, and can put a person in a place of vulnerability. Bolen (2010) describes it as a topic of a “socially sensitive nature” (p. 31). We as a society expect babies, children, and the elderly to have issues with poop, gut aches, and incontinence, but not young people and adults (McGrath, 2018).

Generally people laugh when they hear tummies gurgling, or the windiness of flatulence. Terms such as “explosive defecation” or “the runs” are hilarious to some, especially if it is not happening to them. Some people seem to be both embarrassed and amused by someone else’s apparent lack of control over their bodily functions. This creates an environment where talking about such things is minimised or silenced. See Hilary Barry and Paul Henry laughing over the description of a diplomat’s difficulty as he struggled with an “emergency defecation situation” (Stuff, 2016) which made international news.

Methodology and method

This research was a small qualitative narrative thematic study undertaken as part of the Master of Counselling programme at the University of Auckland. The study used interviews with semi-structured questions, narrative inquiry, and incorporating the author’s autoethnographic account of her own experience of living with Irritable Bowel Syndrome (IBS) and food intolerances. A thematic analysis approach was used to find themes (McLeod, 2011) and meanings within the narratives, reporting on experiences, meanings, and the reality of participants (Braun & Clarke, 2006, p. 81).

Aim of the research

The aim of the research was to provide a safe place for the participants, and to record the experiences of these women as they found their voices and spoke about what had, up until then, been unspeakable for them—windy tummies, sneaky poop accidents, coping with others’ judgements and complaints, mental health issues, difficult interactions with the medical profession, and isolating and embarrassing social interactions around food with restrictive meal offerings. It was an opportunity to celebrate their tenacity and resourcefulness despite, at times, a lack of support, medical intervention, and therapeutic assistance. The research was trying to answer the overarching question: “What has helped, and not helped, women to cope with the psychosocial effects of living with Irritable Bowel Syndrome and food intolerances, and how does it affect their everyday life?”

Participants

Participants were recruited by putting posters up around the University of Auckland and in a counselling centre, and sending them to a gastroenterologist and a dietitian. Social media was also used, and the female participants were recruited through this and word of mouth.

Due to the small numbers of participants who came forward for recruitment—three women in their forties—I became both the researcher and a participant. Experiences of trying to cope with IBS and food intolerances were already recorded in my earlier autoethnographic accounts, and I had to learn how to sit with my own discomfort, and face my sense of shame and vulnerability as I remembered and shared the narratives of my personal journey. It took courage to bring the hidden out into the open and to use my voice to lead others to change the unspeakable to speakable, inviting them to join me.

Researcher reflexivity—the unspeakability of my poop

When I began my research, I knew that it would be hard for participants to talk about their journey living with IBS and food intolerances. What I had not anticipated was how hard it would be for me to talk about my poop and sharing narratives of how I felt, lived, struggled, and coped. I never prepared myself for everyone asking me the question of why I chose this topic to study, and explaining in the answer that it was because this was part of my journey. It took me weeks to start writing my autoethnography due to the battle with my own vulnerability.

What would people think? What would my colleagues think? I was terrified. Even with a safe person such as my supervisor, sharing was really hard. As I wrote at the start of my autoethnography:

I feel brave writing my autoethnography about my journey with Irritable Bowel Syndrome with food intolerances. While 10 to 20 percent of the western world have the syndrome, none of my friends have it. They might have it, but never discuss it. Such is the sense of shame...It's time we did and helped each other. I begin by telling my story to change this trend.

I delayed writing this for a few weeks because of the deep sense of vulnerability, the remembrance of guilt and shame, the positioning and accusations of others, deep hurt, fear, embarrassment, being the focus of others' sneers, the lack of presence and aid from the medical profession, and then the power dynamics from some of them. And then there's the lying of café and restaurant owners in order to get a sale—only to have me be ill for hours.

Even as I read these two paragraphs for the first time to my Supervisor, someone I know who cares about me and is a safe person, I dissolve into tears, stop reading, put my head down on my folded arms over her desk and sob deeply, raw tears from deep within. The impact of those words being felt in every part of my mind, body and spirit. As she comforts me and validates my rawness, I am able to continue, for the first time, sharing my very personal journey. The vulnerability stays with me, even with her assurance, as I consider whether to give her the rest of this story. (McGrath, 2018, p. 13)

I was in my early fifties and this was the first time I was going to tell someone else all about my journey with IBS and food intolerances. It was often overwhelming, and I was unprepared for the high level of shame, sadness, hurt, grief, and vulnerability that was interwoven throughout my journey. The daily struggles, psychosocial challenges, experiences with family, friends, and doctors, difficulties of eating out, and the grief and loss of missing out on social events, were all spoken of. There was an acknowledgement and celebration of the resources within myself to cope, the journey of finding foods I could eat, and finally having a supportive medical team.

For me, to talk about my journey also provided a celebration of all that I had learnt and achieved. I wrote:

As a fellow sufferer and participant, I longed for the opportunity to share my journey. I wanted to celebrate my hard earned, learnt, inner resourcefulness, tenacity and ability to cope, as well as to discuss the struggles and challenges. I wanted to celebrate the successes I had achieved such as my ability to be a loving daughter, a caring empathetic Counsellor, a student studying in the Masters programme, a leader and a volunteer, all done despite feeling disadvantaged and physically disabled at times. (McGrath, 2018, p. 141)

Ethics

At all times I was mindful of the similarities between being a counsellor and a researcher which could blur the boundaries (Dickson-Swift, James, & Liamputtong, 2008), such as providing a space for participants to talk, listening empathetically, asking questions, sharing a personal story.

Due to the sensitive nature of the interview topic, and the subjective nature of qualitative research, I was unable to remain emotionally unattached (Dickson-Swift et al., 2008). I disclosed to the participants that the topic was part of my journey, in order to build rapport, and help them to feel more comfortable. There was a need to monitor my transference and counter-transference (Hollway & Jefferson, 2013). I was mindful of distinguishing between my journey and theirs, and holding my own back.

Participants viewed an information sheet which outlined the intention of the study, and a copy of the possible interview questions prior to the interview in order that they provided informed consent to participate at the time of the interview (Bouma & Carland, 2016; Henn, Weinstein, & Foard, 2006; Hollway & Jefferson, 2013). An external transcriber signed a confidentiality agreement before the interviews were transcribed.

Each participant was treated with respect, honesty, caring, and kindness, with their wellness being of primary importance as per sections 1.1, 1.3, 1.4, and 1.6 of the New Zealand Christian Counsellors Association's Code of Ethics and Practice (2018). All participants were referred to by pseudonym in the research, with the exception of myself.

Results

This research showed that participants have had difficulties living with and

explaining to others what it is like to live with the psychosocial effects of IBS and food intolerances. Themes explored below are: trying to find our voice; living with the psychosocial effects; and the speakability of poop in the counselling room. Participants are referred to by pseudonyms which they chose: Selena, Joanne, and Rose. I used my own name, Jo, as the fourth participant.

Trying to find our voice

All of the participants spoke of how hard it was to begin to share and face their vulnerabilities and sense of shame. They seemed driven by the hope that their story might help someone else who was struggling. This was especially challenging for one of the four participants in her forties who had never even told her grown up children or family. At times she struggled to find the words during our time together, as reported below:

Selena...didn't (or couldn't?) finish her sentences, for example, "I made a lot of mistakes along the way, yeah, had huge, yeah..." and when I asked her about not telling people about her living with IBS and food intolerances, "Coz it, I guess because it's, you know, attached emotionally, and yeah". ...It took her six months to build rapport and trust her counsellor as her "voice was beaten down really". She had to learn to cope on her own. (McGrath, 2018, pp. 141–142)

At times I wondered what it cost each of the participants to speak out so openly. I wondered about the stories behind the sense of shame and vulnerability which tried to silence us to avoid more embarrassment. As we tried to find our voices and speak about our experiences living with IBS and food intolerances, a deep rawness sometimes robbed us of the ability to finish our sentences, or even to start them! (McGrath, 2018).

Rose felt IBS and food intolerances needed to be discussed, and felt that as she got older, she needed to be honest. She concluded:

...I think lots of people don't talk about it, which I think is quite sad, because it's not going to help them heal. And I'm learning just it's okay to talk about issues, and because if you don't talk about it, then people don't know that you need support, or I can help somebody else if I know that they need support as well. (McGrath, 2018, p. 138)

While Selena felt sharing with others was pointless because no one believed her

if she did share, other participants felt that there had been a shift in how others listened and helped them, especially since the increased awareness of dietary and health issues such as eating foods which are gluten free. Despite this, Joanne felt it was easier to talk about her battle with depression than IBS and food intolerances.

Living with the psychosocial effects

Participants spoke of the pressures of living with restrictive diets, as well as coping with the impact of people's judgement, advice, and lack of support, which had caused considerable psychological distress. A sense of unfairness due to having to restrict food intake, especially those foods that looked and smelt great, caused a sense of grief and loss.

Joanne experienced feelings of loss and grief that people did not invite her over as much since she had been diagnosed with food intolerances, which caused a sense of isolation. She felt the best solution would be that the hosts could ask guests beforehand what they can eat so they could be catered for, and guests could be given the option of bringing their own food. Joanne did this when inviting people over, as she hoped this would improve the guest's sense of connection and wellbeing (McGrath, 2018).

Two of us hated it when others caused a fuss and made us feel we were being a nuisance (McGrath, 2018, p. 115). For Joanne and I, the question, "What am I going to feed you?" brought on the sense of apprehension, shame, and embarrassment, especially when it came from family members. People's attitudes and reactions make such a difference to our experience. We decided to take premade food to keep ourselves safe, and had a freezer stocked with meals, bread, and baking for such emergencies. For myself, having to explain to others why I am eating something different has almost been too much for me emotionally, especially when I am hungry and just want to eat. At these times, I have taken my meal elsewhere to be able to eat in private and to avoid the questions.

Speakability of poop within the counselling room

One of the things I was curious about as I interviewed the participants was whether counselling had been a part of their journey and, if so, was it helpful. Both the participants and the literature show the importance of having supportive people is significant in how a sufferer copes. For the participants, others outside the circle of family and friends, such as therapists, can help to lower the stress, anxiety, and

isolation that IBS and food intolerances can bring. Sadly, the truth is that many women have no one to talk to, or have a sense they cannot speak about this to those close to them. Selena, for example, felt people do not believe it is a real thing to have IBS and/or food intolerance so she chose not to tell anyone, choosing to cope on her own.

With regard to the research participants, all had attended counselling and found it beneficial, particularly coping with the anxiety and depression which is part of living with IBS and food intolerances. Selena found counselling life-changing, and she said with real strength in her tone:

I think for me it actually validated my truth...which was good, because you've got all these perceptions that come through, or people saying, you know, just get over it, and move on. But actually, you know, I needed to process, and I never had that chance to process, and I'd lost my voice, well, I didn't have a voice full stop. But this gave me a voice. (McGrath, 2018, p. 136)

Discussion

It was evident that, for the participants, talking about their journey was difficult and much was kept hidden even from family members and friends. This was due to the high level of shame, guilt, and vulnerability they felt, and continued to experience, often resulting in living in silence and struggling on their own to find skills and tools to cope. Three of the four participants spoke of social discourses experienced with their family and workplaces, such as Being a Nuisance, You are Different, and Adults Don't Talk About Accidents.

As counsellors we can enable sufferers to find their voices and be given the opportunity to share what it has been like for them, as well as affirm and validate them through the challenges. At times this can all be a lonely journey, and the therapeutic relationship can provide support that may not be currently available from someone's family or friends.

The experiences of the participants in finding counselling helpful resonated with several writers in the literature who noted that non-pharmacological treatment, including the use of Cognitive Behavioural Therapy (CBT), helped to improve and reduce IBS symptoms thereby improving a patient's quality of life (Adeyemo & Chang, 2008; Ballou & Keefer, 2017; Bolen, 2010; Lackner et al., 2008;

Lee et al., 2009; Phillips et al., 2014; Smith, Hannah, & Richardson, 2014; Wald & Raket, 2008; Yoon et al., 2011). Phillips et al. (2014) note:

Psychological interventions (e.g. cognitive and behavioural, psychosocial, and long-term interpersonal psychotherapy) have been found to help IBS sufferers improve not only in psychopathology, social functioning, and quality of life, but also in gastrointestinal symptoms and pain independent of psychological distress. (p. 467)

Others recommend the use of mindfulness (Gaylord et al., 2009), yoga (Kavuri, Raghuram, Malamud, & Selvan, 2015), and gut-directed hypnotherapy (Wald & Raket, 2008).

Sometimes the issue for clients is how to tell someone what is going on. For example, one client of mine had been in a relationship for four years and her partner was totally unaware that she had IBS-D. She had to visit the toilet up to 10 times a day due to the diarrhoea, and often came home at lunchtime for a shower. We spoke of how she might talk to him about this and identified her fear that he would leave her. We tried to find an alternative story—that he might be very supportive and care for her. She did speak to him, and he instantly connected why she was too tired to go out, did not want to eat at others' homes, and why she used so many painkillers. He took her to his doctor, the first doctor she had ever seen, and they journeyed together to get her some medical assistance. It made a profound difference to their relationship, and they grew closer as a result of the improved communication.

Participants spoke of other areas which can be worked on in counselling such as the impact of a restrictive diet, lack of or changes to sleep, the vicious cycle of IBS and stress, impact of hormones, sexual functioning issues, workplace and family pressures, the inability to travel, loss of employment or career advancement, and the impact of sickness. In addition, the use of the Biopsychosocial Model of IBS, which notes the connection between the physiological symptoms and reactions to psychological, environmental, or social factors (Hertig et al., 2007; Jerndal et al. 2010; Stenner et al., 2000; Van Oudenhove et al., 2016) can also be considered, such as working with past trauma, abuse, and how classical fear conditioning impacts on sickness.

Coping skills such as deep breathing, acceptance, learning to work with the thoughts causing anxiety and apprehension, and how clients can communicate

their needs, can help assist with the depression, anxiety, hypervigilance, and the impact of genetics, and work through environmental factors such as trauma and social stress.

A large part of my work as a counsellor has been to help clients to learn how to talk about both the traumatic and positive experiences of their previous doctors' visits, and to coach them in how to communicate to doctors their medical history, beliefs, and expectations. As counsellors we can role-model to our clients how this can be done. We can debrief them about the negative or harsh experiences of the past, such as where they may have been judged by others to be a hypochondriac, stressed, exhausted, and dramatic, instead of validating that they have IBS and/or food intolerances. Before the mid2000s, doctors often said they could not help these patients. One participant spoke of feeling "brushed off...there was nothing they could do" (McGrath, 2018, p. 102). I was told by one doctor that she thought my tummy issues were "God's way of helping me to lose weight" (McGrath, 2018, p. 102). These experiences are damaging and need to be worked through.

Unexpected areas of growth can also be celebrated in counselling. For example, all the participants spoke of having a strong sense of learnt tenacity and being able to keep going. They are fighters, survivors, overcomers, and fiercely loyal to their loved ones and responsibilities (McGrath, 2018).

Limitations of this research

This research was limited to four women, three aged in their forties and one in her fifties. It would have been wonderful to have been able to interview more women and to explore the differences between the forties and fifties, for example how peri-menopause and menopausal stages might affect coping with the psychosocial effects of their conditions.

I have pondered on whether broadening the age range may have increased the number of participants and provided a richer depth of responses across the generations. I was contacted by several women in their early twenties who invited me to come and talk to their friends who had IBS and food intolerances. It seemed to me then that younger women share more easily and embrace the support received from each other. In contrast, middle-aged women tend to cope on their own, remain silent, and hope no one will notice or comment. I wonder how many others are struggling in silence—mentally, physically, psychologically,

emotionally, and socially.

Possibly if I had gathered research using an anonymous quantitative questionnaire, more women may have been encouraged to come forward and provide feedback.

Conclusion

There is a need to review our therapeutic practices with women making this journey, and to consider practices other than CBT and mindfulness, such as the use of narrative therapies, interactive drawing, and expressive writing (Halpert, Rybin, & Doros, 2010) to help these women reclaim their voices.

As a counsellor I work with clients who struggle daily with the psychosocial effects of living with IBS and food intolerances. I invite them to find their voices and speak to me about their journeys. I see my role as one of providing a safe place for them to share, validating their vulnerabilities and experiences, offering coping skills, and celebrating and acknowledging their resourcefulness and ability to keep going despite their suffering. As I gain more awareness of the impact these illnesses have on clients' lives, I hope to become a better advocate and ambassador for those who are suffering.

As counsellors and therapists we can learn so much from those brave enough to share their narratives about living with the psychosocial effects of IBS and food intolerances. Rose put it beautifully when she said, "I think...you can only learn by listening to other people's testimonies really, of their experiences" (McGrath, 2018, p. 114). I feel as a result of this research that we need to make this area of work a priority in our practices, especially as 10 to 20% of the population are experiencing IBS and/or food intolerances.

As discussed in this article, there are many opportunities for counsellors to use their skills to support and share coping skills and validation. When working with clients who live with IBS and food intolerances we need to focus on giving our clients a voice, witnessing with them as they share their narratives of traumatic and non-traumatic experiences, celebrate their resourcefulness, validate who they are, and help them to develop their own coping skills.

Telling my story has given me a sense of "surviving and overcoming, a huge achievement, filled with resourcefulness, allowing me to plan and live a good life despite the challenges of these debilitating conditions" (McGrath, 2018, p. 14). I

have realised that acknowledging my own sense of shame and vulnerability, while finding my voice to share my deeply personal story, was a gift which has helped me to build rapport with the participants of the research and my clients, allowed me to sit with and listen to their narratives with empathy and without judgement, and to treat them with the respect and admiration they deserve. I am after all one of them, an insider, as well as their counsellor.

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