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Sexual health symptoms and problems in a population of patients in a day hospital for neurotic disorders

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Summary

Aim: Analysis of prevalence of symptoms and problems connected with sexuality in patients admitted to a day hospital for neurotic and behavioral disorders treatment.
Material and method: The results of symptom checklists KO"0" and Life Inventory of 2582 women and 1347 men, admitted to psychotherapy in a day hospital, because of neurotic, behavioral and personality disorders.
Results: Symptoms from the sexuality area turned out to be frequent in population of patients entering psychotherapy in a day hospital for neurotic disorders, and they were not directly linked to sexological treatment. Also traumatic events potentially disturbing psychosexual development were reported by patients, however with different frequency: higher for self-assessed lack of sexual education in childhood or forced sexual debut, low for incest or very early debut, and for being punished for masturbation.
Conclusions: Psychotherapists as well as other professionals treating neurotics, should expect – besides numerous typical symptoms: anxiety, somatization etc. – complaints from area of sexual dysfunctions.

Keywords: sexual dysfunctions, neurotic disorders, childhood sexual adversities, traumatic experiences of childhood sexual abuse, symptom checklist

Introduction

From the times of the cases of hysteria and sexual neuroses described by Sigmund Freud, attempts to conceptualize the connections between sexual disorders and neuroses can be found in psychiatric literature [1, 2, 3, 4, 5, 6, 7]. In general, it has been assumed that sexual disorders occurring in the picture of mental disorders, are not the basic symptoms, but comorbid, and sometimes preceding basic symptoms, and they are mainly connected to disorders in the area of impulses and emotions [8].

The hypothetical connections indicated by Freud, justified mainly on the basis of case reports, and developed also by more contemporary theories (cognitive, systemic, attachment), has been statistically confirmed for selected groups of disorders. It seems that special attention has been paid to the researches concerning the occurrence of sexual disorders, especially premature ejaculation, in the patients with social phobia [8, 9, 10, 11]. Some

authors see the explanation for the connection between social phobia and premature ejaculation in – inter alia – common biological background of the disorders (adrenergic hyperactivity), and similar psychological mechanisms, namely avoidance and fear of evaluation, or lower – secondary to social phobia – sexual experience in this population.

Araszkiewicz and Krzemińska [8], referring to the review of literature, have indicated that although sexual disorders occur in as many as 75% of the patients (female and male) with panic attacks (most frequently sexual aversion, loss of sexual needs, premature ejaculation) and 33% of patients with social phobia (most frequently orgasmic disorders, premature ejaculation), the problem of sexual disorders comorbid to the course of neurotic disorders, is often devalued. Jodko et all [12] have confirmed in their study that one of the most frequent disorders in the group of 66 female patients of day hospitals treated because of anxiety disorders, was anorgasmia (61%), then failure of genital response (55%), fear of intercourse (53%), periodical doubts concerning sexual orientation (11%), and ego-dystonic orientation (12%). Male patients (38 persons) most often have exhibited decrease in sex drive (57%), fear of intercourses (55%), difficulties in keeping erection (45%). Just over a quarter of respondents have revealed doubts concerning orientation (26%) and 23% - ego-dystonic orientation. The results, although concerning small groups of subjects, have indicated frequent occurrence of sexual dysfunctions in population of patients treated because of anxiety disorders in day wards. Tejkowski [13] in a study conducted with the use of the symptom checklist KO “0”, in a population of 387 female patients and 274 male patients treated in a day hospital because of neurotic and personality disorders, has also confirmed the prevalence of “sexual symptoms” (in about 3/4 of the respondents) and the relation between their intensification and the intensification of other neurotic symptoms (assessment by means of the whole scales does not allow for detailed conclusions).

Meanwhile, the sexual issue, which should be included in each psychiatric examination, is often overlooked. Lack of spontaneous reporting of the symptoms of sexual dysfunction by patients as well a clinicians’ attitudes, contribute to the state of things [1, 12, 14, 15, 16]. Improvement of the situation can be expected when the symptom checklists are used, taking into consideration, inter alia (or exclusively) the symptoms from the area of sexual dysfunctions. Despite the shortcomings of the symptom checklists and the dependencies of the results from the set of questions and from the construction of the scales, which has been pointed out by, inter alia, Hayes and colleagues [17], the use of the questioners allow to attain a lot of cohesive information about the sexual life of the examined persons.

The aim of the study

Analysis of the frequency of occurrence of symptoms and problems related to sexuality in patients of a Day Hospital for Neurotic and Behavioral Disorders, in the years 1980-2002.

Material and methods

The results of preliminary tests of all patients admitted to a day hospital treatment in the years 1980-2002 have been used. The material for 3929 people diagnosed with neurotic disorders, behavioral and personality disorders (subsections F4, F5, F6 according to the current version of ICD-10) have been obtained. Their qualification for treatment included in each case two-time psychiatric examination, psychological examination and a battery of psychological tests, which allowed for the exclusion of other psychiatric disorders such as bipolar disorder, schizophrenic psychosis, exogenous or pseudoneurotic disorders and severe somatic illnesses that make it impossible to undergo therapy. Most of the patients have had one of the neurotic disorders diagnosed, or behavioral disorder with secondarily occurring comorbid neurotic disorder (Table 1).

Table 1. Intensity of symptoms and the type of disorders according to ICD-10

	Females (n=2582)	Males (n=1347)
Global Symptom Levels (OWK) mean ± SD (median)	394±152 (median 387)	349±151 (median 336)
Diagnosis (main)		
F44/45. Dissociative or somatoform disorders	29%	25%
F60. Personality disorders	23%	29%
F40/F41. Anxiety disorders	17%	16%
F48 Neurasthenia	7%	14%
F34.1 Dysthymia	7%	5%
F50. Eating disorders	5%	0%
F42. Obsessive-compulsive disorder	2%	2%
F43. Reaction to severe stress, and adjustment disorders	1%	2%
Others	3%	2%
Lack of data	6%	6%

Table 2A. Sociodemographic characteristics

	Females (n=2582)	Males (n=1347)
Age in years mean ± SD (median)	33±9 (median 33)	32±9 (median 28)
Education		
None / primary	9%	12%
Secondary (including students)	57%	56%
Higher	34%	32%
Employment		
Working	59%	70%
Not working	41%	30%
Including pension	10%	7%
Students	23%	24%

Table 2B. Information about relationships and sexual activity

	Females (n=2582)	Males (n=1347)
Marital status/ relationship		
A stable relationship / marriage	43%	47%
An unstable relationship / marriage	26%	21%
Not in a relationship	31%	32%
Has no sexual contacts	39%	35%
Has sexual contacts	60%	64%
In a longer relationship	55%	53%
Short-lived, incidental	3%	7%
Short-lived and longer	2%	5%

The patients have reported the events and circumstances of their life through retrospective detailed biographical questionnaire, consisting of 138 questions (with options of answers to choose from), concerning, inter alai, description of the family, living conditions during childhood and adolescence (before 18 year of life), the course of education and peer relationships, sexual development, traumatic events, maturity period, including functioning at work, material conditions, the current relationship [18] (Table 2A and 2B). The second of the tools used – the symptom checklist KO „0", has enabled gathering information about the presence and the intensity of 135 symptoms from the previous seven days [19]. It is one of a very few original Polish tools, in which the criterial approach has been applied, as well as a common language which allows the patients to report the most common aliments [20, 21]. It is characterized by a satisfactory psychometric properties [22, 23, 24]. Of the variables included in the KO "0", six symptoms of sexual dysfunctions (listed in the Appendix) have been selected, as well as five biographical circumstances: subjective evaluation of sex education before 18 years of age, punishment for masturbation or sexual play, time and course of initiation, incest.

The data obtained from routine diagnostic tests have been used with the consent of the patients, however they have been stored and processed in an anonymous form.

Estimations of the differences between the corresponding figures have been carried out by means of two-tailed test for two stratum weights. Estimations of the odd risk have been done with the logistic regression method. Licensed STATISTICA PL package has been used.

Results

The most common complaint of sexual health in the study group turned out to be dissatisfaction with sexual life, of which both the presence and significant nuisance have been reported by the highest proportions of females and males. The second symptom present in at least half of the respondents has been the decrease of sexual drive. The least frequently reported symptom has been discomfort accompanying masturbation. Males have reported

significantly more often than females: dissatisfaction with sexual life (59% vs 53%, p <0.05), difficulties in sexual intercourse (36% vs 25%, p <0.05), discomfort accompanying masturbation (22% vs 9%, p <0.05). Females have more often reported an aversion to heterosexual contacts (43% vs 33%, p <0.05), also with the maximum intensity. (Table 3).

Table 3. The occurrence and intensification of symptoms connected with sexuality

		Females	Males
		n=2582	n=1347
SYMPTOMS	Percentage of total	66%	34%
7. Dissatisfaction with sexual life	maximum intensity	19%	20%
	presence	***53%	***59%
27. Difficulties in sexual intercourses	maximum intensity	**8%	**11%
	presence	***25%	***36%
47. Aversion to heterosexual contacts	maximum intensity	***17%	***9%
	presence	***43%	***33%
67. Significant decrease or loss of sexual drive	maximum intensity	***18%	***9%
	presence	53%	50%
70. Difficulties in contacts with persons of the opposite sex	maximum intensity	9%	8%
	presence	41%	42%
87. Unpleasant feelings related to the practice of masturbation	maximum intensity	**3%	**5%
	presence	***9%	***22%

**p<0,05, ***p<0,005 – test for two stratum weights

The presence of at least one of the six analyzed symptoms in the week preceding the survey (before treatment) have been reported by 2131 (83%) females and 1133 (84%) males.

The psychometric properties of the scale composed of the six variables describing the presence of symptoms in the field sexual health have been estimated. The results of this analysis summarize the reliability coefficients (Table 4), the relatively low values of which suggest that these variables must be considered separately.

Table 4. Reliability of the scale composed of six sexual complaints

	Females n=2582		Males n=1347	
	Correlation between the item and the scale	Alpha after removal	Correlation between the item and the scale	Alpha after removal
Dissatisfaction with sexual life	0,444	0,556	0,452	0,566
Difficulties in sexual intercourse	0,446	0,559	0,430	0,576
Aversion to heterosexual contacts	0,500	0,531	0,415	0,582
Significant decrease or loss of sexual drive	0,478	0,540	0,450	0,566
Difficulties in contacts with persons of the opposite sex	0,180	0,662	0,223	0,654
Discomfort connected with masturbation	0,132	0,654	0,265	0,633
Cronbach's alpha for the whole scale	0,633		0,641	

Table 5. Correlations between symptoms in the group of females defined by odds ratio (OR) and their 95% confidence intervals.

	7. Dissatisfaction with sexual life	27. Difficulties in sexual intercourse	47. Aversion to heterosexual contacts	67. Significant decrease or loss of sexual drive	70. Difficulties in contacts with persons of the opposite sex	87. Discomfort connected with masturbation
7. Dissatisfaction with sexual life	---	8,95 (7,03-11,41)	4,20 (3,55-4,97)	4,51 (3,82-5,32)	1,62 (1,38-1,90)	1,85 (1,41-2,43)
27. Difficulties in sexual intercourse	8,95 (7,03-11,41)	---	4,95 (4,08-6,01)	5,53 (4,46-6,85)	1,83 (1,53-2,19)	2,15 (1,64-2,81)
47. Aversion to heterosexual contacts	4,20 (3,55-4,97)	4,95 (4,08-6,01)	---	11,98 (9,87-14,54)	1,72 (1,47-2,02)	1,59 (1,22-2,06)
67. Significant decrease or loss of sexual drive	4,51 (3,82-5,32)	5,53 (4,46-6,85)	11,98 (9,87-14,54)	---	1,43 (1,23-1,67)	1,26 (0,97-1,63)
70. Difficulties in contacts with persons of the opposite sex	1,62 (1,38-1,90)	1,83 (1,53-2,19)	1,72 (1,47-2,02)	1,43 (1,23-1,67)	---	2,40 (1,84-3,13)
87. Discomfort connected with masturbation	1,85 (1,41-2,43)	2,15 (1,64-2,81)	1,59 (1,22-2,06)	1,26 (0,97-1,63)	2,40 (1,84-3,13)	---

All coefficients OR were statistically significant (p <0.05), except where shaded

Table 6. Correlations between symptoms in the males group determined by the odds ratio (OR) and their 95% confidence intervals

	7. Dissatisfaction with sexual life	27. Difficulties in sexual intercourse	47. Aversion to heterosexual contacts	67. Significant decrease or loss of sexual drive	70. Difficulties in contacts with persons of the opposite sex	87. Discomfort connected with masturbation
7. Dissatisfaction with sexual life	---	7,96 (5,94-10,67)	3,50 (2,70-4,54)	3,50 (2,78-4,40)	2,03 (1,62-2,55)	3,41 (2,52-4,63)
27. Difficulties in sexual intercourse	7,96 (5,94-10,67)	---	3,41 (2,69-4,34)	6,38 (4,94-8,24)	1,48 (1,18-1,86)	1,57 (1,21-2,05)
47. Aversion to heterosexual contacts	3,50 (2,70-4,54)	3,41 (2,69-4,34)	---	8,47 (6,41-11,18)	1,65 (1,31-2,07)	2,09 (1,60-2,72)
67. Significant decrease or loss of sexual drive	3,50 (2,78-4,40)	6,38 (4,94-8,24)	8,47 (6,41-11,18)	---	1,48 (1,19-1,84)	1,70 (1,31-2,21)
70. Difficulties in contacts with persons of the opposite sex	2,03 (1,62-2,55)	1,48 (1,18-1,86)	1,65 (1,31-2,07)	1,48 (1,19-1,84)	---	3,75 (2,85-4,92)
87. Discomfort connected with masturbation	3,41 (2,52-4,63)	1,57 (1,21-2,05)	2,09 (1,60-2,72)	1,70 (1,31-2,21)	3,75 (2,85-4,92)	---

All coefficients OR were statistically significant (p <0.05)

Beyond the reported symptoms, also potentially patogenic factors have been estimated, such as adverse circumstances and traumatic events in the area of sexuality (Table 7).

About half of the patients reported that they feel they had not have wholly or partially explained the facts of sexual life to – it was slightly more commonly reported among males (47% vs 51%, p <0.05).

Repressive attitude of parents or caregivers towards masturbation or sexual play have

encountered 5% of patients (regardless of gender). The supposition that their behavior was known about, but not punished has been reported by a significantly greater proportion of men ($p < 0.0001$). The examined males significantly less frequently ($p < 0.005$) than females underwent an initiation. The prevalence of definitely premature onset of sexual life in the form of penetration before 14 years of age (first intercourse) was relatively rare, it has concerned approximately 1% of females and males. Females have significantly more often ($p < 0.0001$) evaluated their first intercourse as rather unwanted or having the character rape. As many as one fifth of the patients had the feeling of at least unwanted initiation. The percentage of males and females who reported being a victim of an incest or its attempt has been similar (4% vs 3%, $p > 0.05$).

Table 7. Dysfunctional upbringing and other sexual traumas

	Females (n=2582)	Males (n=1347)
Sexual awareness before 18 years of age		
65.1. Completely aware	23%	22%
65.2. Partially aware	*30%	*27%
65.3. Rather aware	26%	28%
65.4. Completely not aware	21%	23%
Attitude of caregivers to masturbation or sexual plays		
66.0. There was no masturbation or sexual plays	***69%	***34%
66.1. Did not punish although knew about the behaviors	***26%	***61%
66.2. Punished for masturbation or sexual plays	5%	5%
Beginning of sexual life, age of sexual initiation		
72.0. Has not had sex yet	**14%	****18%**
72.1. Initiation before 13 years of age	1%	1%
72.2. Initiation at the age 14-16	*6%	*8%
Assessment of sexual initiation		
73.1. Rather wanted initiation	****64%**	***76%
73.2. Rather unwanted initiation	****17%**	***4%
73.3. Initiation had the character of a rape	****4%**	***1%
Incest or an attempt of an incest		
74.2. Incest or an attempt of incest did occur	4%	3%

***p<0,0005, **p<0,005, *p<0,05 two-tailed test for two stratum weights (percentages)

Discussion

Sexuality is an area of life particularly vulnerable to any disruption of mental functioning. Sexual arousal and capacity for sexual activities require mental and physical peace, which is the background for excitement, sense of security and freedom in a relationship with a partner, an attitude to get pleasure, adequate self-esteem, etc. All these aspects are usually disrupted in the course of neurotic disorders. The emergence of problems in sexual life is often associated also with the lack of even basic knowledge about this area of functioning, which lowers self-

esteem, increases fear of negative evaluation, resulting in avoidance or withdrawal from the relationship. Not without a meaning here are also more or less conscious inner conflicts of patients, concerning, for example, values, religion, having children, taking responsibility, etc. It should be emphasized that the study population – young patients without severe somatic illnesses, allows to a focus on psychogenic causes of sexual symptoms.

If at least one of the six symptoms of dysfunctions related to sexual life has been reported by the vast majority of respondents, the question about the meaning of sexuality in all neurotic disorder arises. At the same time, significantly greater in this population prevalence of symptoms from the area of sexuality than the situations from childhood and adolescent, potentially disturbing sexuality (even taking into account the underestimation of this second factor), suggests that probably not only they affect the occurrence of sexual disturbances of people with neurotic disorders. This is not a new conclusion: Winid [25], emphasized the background of "neurotic sexual disorders", in the form of marital conflicts, similarly Jabłoński [26] describing couples with "psychogenic sexual dysfunctions" as "mainly neurotic disorders, though complicated or even expressed by sexual symptoms ", classified them to “symptoms of a neurotic syndrome”. Dominik and Żuchowicz [27, 28] have also described numerous sexual conflicts (blaming partners or oneself for “sexual sabotage" of the relationship or for punishing by refusing intercourse), in patients of neurotic wards. A contemporary publication by Jodko and colleagues [12] also provides data emphasizing the importance of sexual problems for neurotic patients and their partners. The surprisingly small number of modern scientific publications on the coexistence of neuroses and sexual dysfunction shows how often the issue of sexuality of neurotic patients is marginalized.

It can be difficult to determine the relationship of cause and effect for the disclosed relationship, the complaint most often reported by respondents – dissatisfaction with sexual life - can be either associated with the current limited ability to pursue their sexual needs (also common in the general population) or with the difficulties in sexual life, decreasing its quality. In the case of people with neurotic disorders, the aspect of the incorrect cognitive schemas should also be taken into account, when the negative subjective evaluation of sexual functioning is associated with, for instance, excessive requirements from oneself or the expectations from others.

The decrease of sexual drive - the second most common symptom in the examined group of patients, poses clear problems of assessing the real prevalence in the general population (the corresponding figures are in a broad ranges 17% -33%), but in physically

healthy and young patients it is surprisingly common. Here once again a number of possible directions of interpretation can be found: perhaps in neurotic disorders, like in depression, sexual needs are hampered by increased levels of anxiety and stress, or, conversely, for example, in the psychoanalytic terms a reduction of the sexual drive constitutes the primary inhibition of libido, and reliving the tension resulting from it is responsible for the formation of anxiety symptoms.

In women, reducing the drive was associated with aversion to sexual contacts with men, however, the analysis of cause and effect relationship does not allow to specify the direction, moreover , it is also possible that both of the phenomena may co-occur because of some other reasons (e. g. unconscious homosexual orientation in some of the examined persons).

Incestuous intercourse, or an attempt of it, has been one of the rarest of traumatic events reported by patients. In Poland 2-3% of women and less than 1% of men admits to have such experiences [29], and it is claimed by many authors [30] that these values are lowered and that approximately 15% of women and 5% of men (before 18 years of life) have experienced an incest.

There is an interesting link between the lack of sexual satisfaction with the unpleasant feelings associated with masturbation, much stronger among males than females. Masturbation is a behavior which is of high importance for the psychosexual development and an integral element of a set of sexual behavior of healthy persons. Although it is often discussed in the context of a greater prevalence among males (which is also confirmed by the results of our study), it may be equally important for females - often negatively oriented towards it, also due to the greater social acceptance of sexual expression through masturbation by males [31, 32]. The more punishing for masturbation and other sexual plays is a heavy burden for psychosexual development.

The following study has been based on data from everyday clinical practice obtained from a large group of patients.. This is at the same time an advantage of the work - bringing the results and conclusions closer to the possibility of generalization, and its disadvantage - making it more difficult , inter alia, to ensure precise diagnosis. The retrospective nature and a longtime range of data, the inevitable subjectivity of assessments of patients, narrowing of the population only to persons qualified to psychotherapy - make the results relevant primarily for therapists taking similar inclusion criteria for treatment. Limitation to patients from the years 1980-2002 was forced by the change of the research tool in 2002. Focusing on the single variables of the symptom checklist and on an interview allow for taking into consideration

their diversity, making the use of the whole scale of sexual disorders less adequate.

Considering the features of the symptom checklist KO "0" and the material derived from retrospective analyzes, the subjective understanding of the variables cannot be discovered. According to the authors of this work, it is permitted only to directly interpret the meaning of the questions according to their content (as do the respondents), or possibly an in-depth investigation of their meaning on the basis of, for instance, statistical relationships between the answers and the results of other tools.. Another inaccuracy has been caused by the difficulty of the respondents to adjust to the instructions of reporting symptoms from the past week. Therefore, the analyzes of the symptoms occurrence must be considered more valuable than those concerning the assessment of severity, or strictly described time of their occurrence (the past week).

Conclusions

1. A significant prevalence of all analyzed symptoms from sexuality areas has been indicated even though the study group was treated for reasons other than sexual disorders.
2. The most common has been dissatisfaction with sex life, as well as a decrease of the sexual drive, which has occurred in more than a half of the respondents. The least frequently reported aliment have been the unpleasant feelings associated with masturbation.
3. Male patients have reported slightly more often than females the presence of dissatisfaction with sexual life, difficulties with intercourse, and discomfort accompanying masturbation. Females have more often reported the presence of aversion to sexual contact with men.
4. Some of the burdens of traumatic events in the studied group have been very common (a feeling of not being introduced into the subject of sexuality before 18 years of age has been reported by one fifth of respondents), others much rare: incest, forced initiation or premature beginning of sexual life.
5. The issue of sexuality should be regarded as important for the population of patients treated with psychotherapy because of symptoms of neurotic disorders, personality and behavior disorders, regardless of the "formally" declared reasons of coming for treatment.
6. It is advisable to design structured research and clinical instruments involving both the symptoms and traumatic events.

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APPENDIX

Selected items of the KO '0' symptom checklist concerning sexual life

7. Dissatisfaction with sexual life.
27. Difficulties in sexual intercourse caused by, for instance, painful muscle contractions in females, lack of erection or premature ejaculation in males, etc.
47. Aversion to heterosexual contacts.
67. Significant decrease or loss of sexual drive.
70. Difficulties (shame and embarrassment) in contacts with persons of the opposite sex.
87. Discomfort connected with masturbation.

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