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Sexual traumatic events and neurotic disorders picture – sexuality-related and sexuality-unrelated symptoms

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Summary

Introduction. There is an ample evidence of the impact of severe traumatic events, such as sexual abuse in childhood, on the formation of disorders - especially the non-psychotic ones: sexual, neurotic and personality. So far, an increase of the risk with the accumulation of traumatic factors has been indicated, but less attention has been paid to adverse events such as lack of sexual education, negative attitudes of the caregivers towards sexuality, etc.

Aim. Assessment of the risk of such adverse events in childhood and adolescence, concerning the symptoms from the area of sexuality as well as other neurotic disorders areas.

Material and method. The coexistence of the earlier life circumstances and currently present symptoms was examined on the basis of KO „0" Symptom Checklist and Life Inventory, completed prior to treatment in a day hospital for neurotic disorders.

Results. In the group of 2582 females and 1347 males, there was a significant prevalence of symptoms related to sexuality, as well as of other neurotic symptoms. Patients reported traumatic events of varying frequency (from a relatively rare incest, to much more frequent sense of lack of sex education). Regression analyses showed a significant relationship between the analyzed events and symptoms, for instance, lack of sexual satisfaction in adulthood co -occurred in women with punishing for childhood sexual plays or masturbation. The other analyzed symptoms – 'sexuality-unrelated ', such as panic attacks, were not so clearly related to the burdensome circumstances.

Conclusions. The presence of adverse life events concerning sexuality, not necessarily the most serious ones e.g. abuses, but such as inadequate sex education, child punishing for masturbation or sexual plays, unwanted sexual initiation, are associated with a higher occurrence of most of the analyzed symptoms in the sphere of sexuality. Weaker connection for other than sexual neurotic symptoms suggests that the impact of childhood sexual trauma is mainly focused on the area of sexual dysfunctions.

Keywords: childhood trauma, sexual dysfunctions, symptoms of neurotic disorders, neurotic disorders' picture, etiopathogenesis, risk factors

Introduction

On the emergence, exacerbation and relapse of symptoms of various mental disorders, including neurotic disorders and the stress-related ones, influence both traumatic events from the past, particularly those from the connected with special vulnerability to injury periods of childhood and adolescence, as well as the more contemporary conflicts in families of procreation and other difficulties in social functioning (e.g. unemployment) or somatic diseases comorbidity [1-2]. Various psychological theories (e.g. concerning defense mechanisms) and „biological" hypotheses explain this state of things, not gaining, however, the ultimate primacy, but rather getting to conclusions of neurotic disorders multifactorial etiology and some broadening of boundaries of the stress-related disorders group no longer limited to events of extreme intensity.

Undoubtedly, patients applying for treatment mainly because of neurotic disorders often turn out to be burdened with both problems and symptoms concerning sexuality [3], as a matter of fact just like their doctors and future doctors [4]. Not rare are also traumatic sexual events, although their level of pathogenicity in terms of the proportion of causing disorder is not fully determined, due to the lower availability of information concerning the population not receiving treatment and healthy people. It was repeatedly stated, however, that the more severe the traumatic events were (excessive duration of impact, more perpetrators, their close and frequent contacts with the victim), the stronger the symptoms [5-6], but numerous reports of clinicians and researchers from a number of decades indicate the diversity of event-symptoms relationship, and thus the multiplicity of the possible directions of the impact of pathogenesis mechanisms.

All categories of such life events, those potentially most traumatic ones (persecution of the family, childhood sexual abuse, maltreatment), and those pathogenic in a less evident way (such as hostile divorce of the patient's parents [7]) should include an interview, especially that obtained from patients being prepared for psychotherapy treatment.

With regard to the most frequently treated with psychotherapy neurotic disorders and their symptoms, the following major groups of links can be distinguished: traumatic events (various types: sexual abuse, physical abuse, physical injury, adverse events) - dissociative, sexual symptoms, anxiety of the type of phobia, panic attacks, symptoms of dysthymia. Numerous reports associate such traumas with the presence and even the severity of personality disorders [8], particularly borderline personality [9-11]), behavior disorders (especially eating [12-16] and sexual [17-21]); obviously there are also reports showing alongside with sexual dysfunctions [20], the presence of other (related) mental dysfunctions such as anxiety, catastrophic thinking, excessive vigilance etc.; or co-occurrence of symptoms or syndromes distinct from sexual dysfunctions. Some studies indicate relationships: sexual trauma - secondary disorder (sexuality-unrelated), „mediated" for example by personality disorders [22] or depressive disorders [23].

Apart from sexual abuse in childhood, also other traumas contribute to the increased risk of anxiety and depressive disorders - and both types simultaneously [24-25], agoraphobia, social phobia, and simple phobias [24-26], panic disorder [27-28]

(in etiology of the latter, sexual traumas seem to have a smaller part than physical abuse, parental dysfunctions, or their loss), dissociative and conversion disorders [5, 29-35], as well as obsessive-compulsive disorder [36], substance abuse [37-38], and even the presence of non-psychiatric diseases [39-40], or impaired coping with pain [41]. Many authors emphasize the non-specificity of the effects of sexual trauma type events [42-44]. Another important aspect of the discussed relationships is, as it seems on the basis of clinical experience, the partial specificity of the direction of impact of traumas: it may be presumed that the sexual traumatic events are at least to some extent more related to (slightly more frequently cause?) sexual disruptions of the type of full dysfunction (sexual disorders) or partial (only residual symptoms associated with neurotic disorders) than to the sexuality-unrelated neurotic symptoms. Of course, more difficult to pinpoint complex sequences of pathogenesis such as sexual trauma → preference for dissociation mechanism educational difficulties → unemployment → dysthymia, as well as multidirectional relationships, parallel and multifactorial (so-called multifactorial stress models [45]) cannot be excluded.

However, it can be assumed that the prevalence of a given type of trauma (e.g. sexual abuse) or for instance, dysfunctions of the family of origin (e.g. hostile divorce of parental couple), regardless of the time of occurrence of these events, is associated with a greater likelihood of current presence of symptoms of related type (e.g. separation difficulties in childhood → agoraphobia, and separation difficulties in adulthood, or sexual trauma → sexual symptoms). This increased likelihood can be disclosed in the form of significant risk factor only in studies based on a very large a heterogeneous group of patients as well as in observations of clinicians (only partially systematized). To conclude, it can be expected that the traumatic events and adverse life circumstances from the area of sexuality (e.g. education repressing sexuality) will be associated first of all with complaints of a sexual nature, more so than with other symptoms for which still will remain partial, weaker, but possible to be observed relationships. Analysis comparing which of sexuality-unrelated symptoms are more or less related or not related to such traumas of a given type, also may be a source of interesting hypotheses for further research and clinical practice.

Aim

This study evaluated the risks associated with exposure of patients to adverse potentially traumatic events in childhood, taking into account the effects for selected symptoms from the domain of sexuality in comparison to other areas of neurotic disorders.

Material and method

Coexistence of the reported by patients adverse life circumstances in childhood and adolescence, and currently present symptoms were assessed using data from the Symptom Checklist KO „0" [46] and Life Inventory [47] routinely filled in before psychotherapy treatment in the day hospital for neuroses in the years 1980 - 2002 (after that

period the set of diagnostic tools were modified, and the groups of currently obtained data have not reached yet the size needed for analysis). The data were obtained from patients with diagnoses of neurotic, behavioral and personality disorders (categories F4, F5, F6 of the classification ICD-10). These diagnoses were assigned to some of the patients (hospitalized before the introduction of ICD-10 classification), based on analysis of equivalence of the described sets of symptoms and also, in some cases, on the basis of archival medical records, which allowed the use of only less specific diagnoses (e.g. code F42) or even their combined groups (e.g. F40 and F41). Qualification for treatment included in each case at least two psychiatric examinations, interview and psychological examination, as well as a battery of questionnaires, which allowed to eliminate other disorders (such as bipolar, schizophrenic psychoses, exogenous or pseudo-neurotic disorders and severe physical illness), which exclude undertaking psychotherapy in this day hospital. [48] Most of the respondents had diagnosed one of the neurotic disorders or personality disorder with the secondary neurotic disorder co-occurring (Table 1) (see also [3]).

Events and life circumstances were reported by the patients through a detailed retrospective questionnaire Life Inventory, consisting of 138 questions (with answers options to choose from), concerning inter alia description of the family, living conditions during childhood and adolescence (before 18 year of age), the course of education and peer relationships, sexual development, traumatic events, the period of maturity, including occupational functioning, material conditions, current relationship [47]. The second applied tool - a symptom checklist KO „0", allows to gather information about the presence and intensity of 135 symptoms during the previous 7 days. It is one of the very few original Polish tools created on the basis of criterial approach [49], using everyday language, enabling the patients to report the most common symptoms [50], and characterized by satisfactory psychometric properties [46, 51].

From among the variables included in the KO „0", 6 symptoms of sexual dysfunctions, and 9 from the scope of other than sexual ailments („sexuality-unrelated") were chosen, and from Life Inventory - 5 biographical circumstances (subjectively mentioned), namely the assessment of sexual education before 18 year of age, punishment for masturbation or sexual plays, the time and the course of initiation, incest actual or attempted.

Data obtained from routine diagnostic tests were used with the consent of the patients, they were kept and developed in the anonymous form.

Estimates of the differences between percentages were performed using two-tailed test for two stratum weights. Estimates of risk factors (OR) for the co-occurrence of two nominal variables (life circumstances and the symptom, coded as 0-1) were made by logistic regression Licensed statistical package STATISTICA PL was used.

Table 1. **Severity of symptoms and type of disorder according to ICD-10**

	Females N=2582	Males N=1347
Global Symptom Level score: mean±SD (median)	394±152 (median 387)	349±151 (median 336)
ICD-10 diagnosis (primary)		
F44/45 Dissociative and somatoform disorders	29%	25%
F60 Personality disorders	23%	29%
F40/F41 Anxiety disorders	17%	16%
F48 Neurasthenia	7%	14%
F34 Dysthymia	7%	5%
F50 Eating disorders	5%	0%
F42 Obsessive-compulsive disorder	2%	2%
F43 Reaction to severe stress, and adjustment dis.	1%	2%
Other	3%	2%
No data	6%	6%

Table 2. **Socio-demographics features**

	Females (n=2582)	Males (n=1347)
Age in years mean±SD (median)	33±9 (median 33)	32±9 (median 28)
Education		
Primary school	9%	12%
Secondary school (includes students	57%	56%
University	34%	32%
Employment		
Is working	59%	70%
Is not working	41%	30%
Including pensions	10%	7%
Students	23%	24%

Table 3. **Information about relations and sexual activity**

	Females (n=2582)	Males (n=1347)
Marital status/relationship		
Stable relationship/marriage	43%	47%
Unstable relationship/marriage	26%	21%
Not in a relationship	31%	32%
Has no sexual contacts	39%	35%
Has sexual contacts	60%	64%
Long-term sexual relationship	55%	53%
Temporary, occasional	3%	7%
Both occasional and long-term	2%	5%

Results

In a group of 3929 patients, 2582 females and 1347 males, who were treated in day hospital (mean age of females 33 years, of males 32), there was a significant (reaching more than 50% of respondents) prevalence of sexuality-related symptoms and problems, as well as other symptoms of neurotic disorders. These symptoms were accompanied by reporting by patients in life inventories traumatic events of varying frequency (from the relatively rare (4% of females) cases of incest or its attempt, to a sense of lack of sexual awareness before adulthood in more than 20% of respondents). Logistic regression analyses showed a significant correlations between the analyzed events and symptoms, for instance lack of sex life satisfaction in women co-occurred with punishing for masturbation or sexual plays in childhood (Odds Ratio 2.13, in men 1.92). Selected - other than sexual - symptoms typical for neurotic disorders, such as panic disorder, were not associated in such a clear way with the adverse life circumstances

Table 4. **Dysfunctional upbringing and other sexual traumas**

	Females (n=2582)	Males (n=1347)
Educated about sex before 18 years of age		
Fully educated about sex	23%	22%
Partially educated about sex	*30%	*27%
Rather not educated about sex	26%	28%
Not educated at all about sex	21%	23%
Caregivers attitude towards masturbation or sexual play		
There was no masturbation or sexual plays	***69%	***34%
Not punished although it was known abort the behavior	***26%	***61%
Punished for masturbation or sexual plays	5%	5%
Beginning of sex life/age of sexual initiation		
There was no sexual initiation yet	**14%	**18%
Sexual initiation before 14 years of age	1%	1%
Sexual initiation at the age 14-16	*6%	*8%
Assessment of sexual initiation		
Initiation rather wanted	***64%	***76%
Initiation rather unwanted	***17%	***4%
Sexual initiation had the character of a rape	***4%	***1%
Actual or attempted incest		
There was actual or attempted incest	4%	3%

***p<0.0005, **p<0.005, *p<0.05 two-tailed test for two stratum weights

As it results from Table 4, (as well as from previous publications [3]), the repressive attitude of parents or caregivers to masturbation or sexual plays experienced 5% of patients (regardless of gender). Supposition that it was known about their behavior, but not punished, was reported by the significantly higher percentage of men ($p < 0.0001$). The surveyed males significantly less frequently ($p < 0.005$) than females underwent initiation. Prevalence of definitely premature start in sex life in the form of first intercourse before 14 year of age was relatively rare, concerned approximately 1% of women and men. Females significantly more often ($p < 0.0001$) assessed currently their first intercourse as rather unwanted or having the nature of rape. As many as one fifth of the patients felt that their initiation was unwanted (or it was a rape). The percentage of women and men who reported being a victim of incest, or its attempt was similar (4% vs. 3%, $p > 0.05$). Approximately half of the patients reported that before 18 years of age were not completely or partially educated about sex, this feeling was slightly more common among men (47% vs. 51%, $p < 0.05$) [3].

Table 5. **The occurrence and severity of symptoms from the area of sexual health**

		Females	Males
		n=2582	n=1347
SYMPTOMS	Percentage of the total	66%	34%
Symptoms of sexual dysfunctions			
Dissatisfaction with sexual life	max severity	19%	20%
	present	***53%	***59%
Difficulties in sexual intercourse	max severity	**8%	**11%
	present	***25%	***36%
Aversion to heterosexual contacts	max severity	***17%	***9%
	present	***43%	***33%
Significant reduction or loss of sexual desire	max severity	***18%	***9%
	present	53%	50%
Difficulties in contact with the opposite sex	max severity	9%	8%
	present	41%	42%
Discomfort connected with masturbation	max severity	**3%	**5%
	present	***9%	***22%
Sexuality-unrelated symptoms –markers of selected neurotic disorders			
Anxiety in an open space	max severity	***9%	***4%
	present	***27%	***21%
Social anxiety	max severity	26%	24%
	present	72%	74%

table continued on next page

Panic attacks	max severity	***18%	***10%
	present	***51%	***41%
Compulsive checking	max severity	**22%	**18%
	present	65%	65%
Temporary paresis	max severity	**5%	**3%
	present	**23%	**19%
Heartache	max severity	*16%	*13%
	present	*63%	*59%
Diarrhea	max severity	6%	5%
	present	30%	31%
Hypochondriacal anxiety	max severity	17%	16%
	present	***46%	***55%
Pessimism	max severity	***36%	***24%
	present	***81%	***74%

*p<0.05, **p<0.005, ***p<0.0005 –test for two stratum weights

The most common complaint of sexual health (Table 5) in the studied group was dissatisfaction with sexual life, which both the presence and considerable nuisance were reported by the highest percentages of females and males. The second symptom present in at least half of the respondents was the weakening of sex drive. The least frequently reported symptom was discomfort accompanying masturbation. Men reported significantly more often than women: dissatisfaction with sex 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 more frequently reported a reluctance to heterosexual contact (43% vs. 33%, p <0.05), also in the maximum intensity. Of the 9 „sexuality-unrelated „ symptoms, pessimism and social anxiety occurred most frequently (in more than 70% of respondents).

The table shows the odds ratios (OR coefficients) calculated for 95% confidence intervals, the statistical significance of their assessment was determined: * p<0.05, ** p <0.005, *** p <0.0005

The data contained in Table 6 – *next page*, for a group of female patients, indicate a greater number of statistically significant relations between traumatic events and adverse life circumstances in childhood and adolescence of the respondents with the 6 symptoms and sexual problems, than of such relations for the 9 sexuality-unrelated symptoms. There were no correlations for diarrhea, for several symptoms only marginal. Clearly traumatic “educational” situation, which was in the scope of sexuality the punishment for masturbation or sexual plays, was not associated with any of the analyzed „sexuality-unrelated „ symptom of neurotic disorders. The burden for the female patients which was complete lack of sexual awareness in childhood and adolescence, and the favorable fact - their complete sexual awareness (two extremes of the 4 answers to the question in the Life Inventory) were associated significantly with

Table 6. **Associations between the female patients' childhood sexual adversities with symptoms of sexual dysfunctions and sexuality-unrelated symptoms of neurotic disorders**

	Fully educated about sex.	Not educated at all about sex	Punished for masturbation or sexual plays	There was no sexual initiation yet	Sexual initiation before 14 years of age	Sexual initiation at the age 14-16	Initiation rather unwanted	Sexual initiation had the character of a rape	There was actual or attempted incest
Symptoms of sexual dysfunctions									
Dissatisfaction with sexual life	0.73** (0.61-0.88)	1.51*** (1.25-1.83)	2.13*** (1.46-3.13)	0.34*** (0.27-0.43)	1.74 (0.78-3.88)	1.67** (1.18-2.37)	1.67*** (1.35-2.06)	2.11** (1.39-3.21)	1.82** (1.20-2.74)
Difficulties in sexual intercourse	0.63*** (0.50-0.79)	1.73*** (1.42-2.13)	1.22 (0.83-1.80)	0.19*** (0.12-0.28)	1.01 (0.47-2.18)	1.85*** (1.31-2.61)	1.63*** (1.31-2.03)	1.97** (1.33-2.93)	1.36 (0.90-2.07)
Aversion to heterosexual contacts	0.80* (0.66-0.97)	1.50*** (1.24-1.81)	1.19 (0.84-1.70)	0.51*** (0.40-0.65)	1.20 (0.56-2.58)	1.54* (1.10-2.15)	1.52*** (1.24-1.86)	1.21 (0.82-1.78)	1.24 (0.84-1.82)
Significant reduction or loss of sexual desire	0.75** (0.62-0.90)	1.58*** (1.30-1.91)	1.06 (0.74-1.50)	0.29*** (0.23-0.37)	1.77 (0.79-3.95)	1.42* (1.01-1.99)	1.50*** (1.22-1.85)	1.29 (0.87-1.91)	1.04 (0.71-1.53)
Difficulties in contact with the opposite sex	0.67*** (0.56-0.82)	1.31** (1.09-1.59)	1.47* (1.04-2.09)	2.35*** (1.87-2.94)	0.70 (0.31-1.56)	1.19 (0.85-1.66)	1.06 (0.86-1.31)	1.73* (1.17-2.55)	1.57* (1.06-2.31)
Discomfort connected with masturbation	0.86 (0.62-1.18)	1.13 (0.83-1.54)	2.39*** (1.52-3.75)	1.82*** (1.32-2.51)	0.73 (0.17-3.11)	0.81 (0.44-1.48)	1.08 (0.77-1.52)	1.04 (0.55-1.98)	2.20** (1.33-3.65)
Sexuality-unrelated symptoms – markers of selected neurotic disorders									
Anxiety in an open space	0.65*** (0.52-0.81)	1.28* (1.04-1.57)	0.81 (0.54-1.22)	0.68** (0.52-0.89)	1.12 (0.49-2.58)	1.49* (1.05-2.12)	1.18 (0.95-1.48)	1.13 (0.74-1.72)	0.80 (0.51-1.27)
Social anxiety	0.79 (0.58-1.08)	1.14 (0.81-1.60)	2.13 (0.93-4.90)	0.97 (0.66-1.41)	1.24 (0.29-5.26)	0.93 (0.53-1.65)	1.27 (0.86-1.86)	3.57* (1.12-11.35)	1.43 (0.66-3.12)
Panic attacks	0.72** (0.60-0.87)	1.36** (1.13-1.65)	1.24 (0.87-1.76)	0.62*** (0.50-0.78)	0.89 (0.41-1.91)	1.19 (0.85-1.66)	1.19 (0.97-1.46)	1.47 (0.99-2.19)	1.14 (0.77-1.68)
Compulsive checking	0.65*** (0.54-0.79)	1.52*** (1.23-1.87)	0.86 (0.60-1.24)	0.47*** (0.38-0.59)	1.26 (0.55-2.89)	0.93 (0.66-1.32)	1.17 (0.94-1.45)	1.62* (1.04-2.52)	0.78 (0.52-1.16)
Temporary paresis	0.62*** (0.49-0.78)	1.36** (1.10-1.68)	1.00 (0.95-1.05)	0.54*** (0.40-0.73)	0.74 (0.28-1.96)	1.02 (0.68-1.53)	1.13 (0.90-1.44)	1.04 (0.67-1.60)	1.41 (0.92-2.16)
Heartache	0.78* (0.65-0.95)	1.34** (1.09-1.63)	1.02 (0.69-1.52)	0.47*** (0.37-0.58)	0.99 (0.42-2.32)	0.91 (0.65-1.29)	1.28* (1.03-1.59)	1.34 (0.88-2.03)	0.79 (0.54-1.18)
Diarrhea	1.02 (0.81-1.28)	1.04 (0.86-1.27)	1.39 (0.96-1.99)	0.80 (0.62-1.02)	0.81 (0.34-1.91)	0.89 (0.61-1.28)	0.96 (0.76-1.20)	1.43 (0.96-2.14)	0.94 (0.62-1.43)
Hypochondriacal anxiety	0.61*** (0.51-0.74)	1.17 (0.97-1.42)	0.92 (0.64-1.31)	0.45*** (0.35-0.57)	0.81 (0.37-1.74)	1.31 (0.94-1.83)	1.39** (1.13-1.71)	1.23 (0.84-1.81)	0.92 (0.62-1.36)
Pessimism	0.86 (0.68-1.08)	1.00 (0.99-1.01)	1.37 (0.84-2.26)	0.97 (0.73-1.28)	1.00 (0.86-1.17)	1.12 (0.72-1.74)	1.42* (1.06-1.89)	1.43 (0.82-2.49)	1.22 (0.72-2.06)

4 out of 5 sexual symptoms (apart from masturbation), but with only 5 of 9 sexuality -unrelated symptoms (possibly indicating a generally unfavorable for adaptation to psychosexual development - especially for women but not for men, see Table 7, below - gaps in sexual education).

Table 7. **Associations between the male patients' childhood sexual adversities with symptoms of sexual dysfunctions and sexuality-unrelated symptoms of neurotic disorders**

	Fully educated about sex.	Not educated at all about sex	Punished for masturbation or sexual plays	There was no sexual initiation yet	Sexual initiation before 14 years of age	Sexual initiation at the age 14-16	Initiation rather unwanted	Sexual initiation had the character of a rape	There was actual or attempted incest
Symptoms of sexual dysfunctions									
Dissatisfaction with sexual life	0.58*** (0.45-0.76)	1.91*** (1.45-2.52)	1.92* (1.12-3.29)	0.83 (0.62-1.09)	2.45 (0.80-7.49)	0.96 (0.65-1.44)	1.44 (0.82-2.53)	2.08 (0.42-10.38)	1.72 (0.85-3.51)
Difficulties in sexual intercourse	0.58*** (0.44-0.78)	1.34* (1.03-1.74)	1.30 (0.79-2.11)	0.33*** (0.23-0.47)	2.28 (0.89-5.83)	1.44 (0.96-2.17)	0.74 (0.42-1.32)	1.08 (0.26-4.55)	1.32 (0.69-2.55)
Aversion to heterosexual contacts	0.70* (0.53-0.93)	1.56** (1.20-2.03)	1.79* (1.10-2.90)	0.78 (0.58-1.06)	2.08 (0.82-5.27)	0.79 (0.51-1.24)	N/A	2.06 (0.51-8.30)	1.07 (0.54-2.10)
Significant reduction or loss of sexual desire	0.65** (0.50-0.84)	1.65*** (1.27-2.13)	1.84* (1.12-3.04)	0.43*** (0.32-0.57)	N/A	0.89 (0.60-1.34)	1.07 (0.63-1.80)	0.99 (0.14-6.96)	0.72 (0.37-1.38)
Difficulties in contact with the opposite sex	0.58*** (0.44-0.76)	1.61*** (1.25-2.09)	0.96 (0.59-1.56)	2.94*** (2.20-3.92)	0.68 (0.25-1.82)	0.56* (0.36-0.87)	1.03 (0.61-1.74)	2.28 (0.54-9.61)	1.38 (0.72-2.62)
Discomfort connected with masturbation	0.74 (0.53-1.02)	1.56** (1.16-2.08)	1.55 (0.91-2.63)	3.12*** (2.32-4.21)	1.01 (0.45-2.26)	0.68 (0.40-1.16)	1.49 (0.83-2.66)	2.12 (0.50-8.95)	2.11* (1.07-4.13)
Sexuality-unrelated symptoms –markers of selected neurotic disorders									
Anxiety in an open space	0.85 (0.61-1.17)	0.98 (0.71-1.35)	1.09 (0.62-1.94)	0.53** (0.36-0.79)	1.42 (0.50-4.02)	1.27 (0.79-2.02)	1.30 (0.71-2.37)	2.22 (0.53-9.35)	0.83 (0.36-1.90)
Social anxiety	0.71 (0.49-1.04)	1.11 (0.74-1.67)	0.56 (0.30-1.05)	1.15 (0.74-1.80)	N/A	0.65 (0.37-1.12)	2.51 (0.77-8.12)	N/A	0.87 (0.33-2.28)
Panic attacks	1.06 (0.82-1.38)	1.10 (0.85-1.43)	0.95 (0.58-1.57)	0.67* (0.50-0.89)	0.71 (0.27-1.92)	1.87** (1.25-2.80)	1.81* (1.07-3.08)	1.44 (0.36-5.79)	1.17 (0.61-2.24)
Compulsive checking	0.74* (0.56-0.96)	1.17 (0.89-1.53)	0.95 (0.58-1.57)	1.03 (0.76-1.39)	0.83 (0.32-2.16)	1.32 (0.85-2.05)	0.86 (0.50-1.49)	0.53 (0.13-2.13)	0.58 (0.30-1.11)
Temporary paresis	1.02 (0.74-1.42)	1.10 (0.80-1.51)	1.07 (0.58-1.96)	0.43*** (0.27-0.66)	1.65 (0.58-4.68)	1.85* (1.18-2.90)	0.88 (0.44-1.77)	**7.22*** (1.71-30.47)	0.49 (0.17-1.40)
Heartache	0.84 (0.65-1.08)	0.96 (0.74-1.24)	1.36 (0.82-2.26)	0.49*** (0.37-0.64)	0.87 (0.34-2.22)	1.77* (1.14-2.75)	0.74 (0.44-1.25)	1.17 (0.28-4.90)	0.40* (0.20-0.77)
Diarrhea	1.19 (0.90-1.56)	1.02 (0.78-1.34)	1.27 (0.77-2.11)	0.76 (0.55-1.04)	0.64 (0.21-1.97)	1.55* (1.03-2.34)	1.40 (0.81-2.42)	3.80 (0.90-16.01)	0.70 (0.33-1.48)
Hypochondriacal anxiety	0.72* (0.55-0.93)	0.81 (0.63-1.04)	0.86 (0.53-1.40)	0.52*** (0.40-0.69)	0.41 (0.15-1.09)	1.51 (0.99-2.29)	1.17 (0.69-2.00)	1.37 (0.33-5.76)	0.73 (0.38-1.40)
Pessimism	0.99 (0.81-1.22)	1.42* (1.05-1.94)	1.75 (0.93-3.31)	1.01 (0.42-2.43)	1.78 (0.51-6.19)	1.51 (0.91-2.50)	1.24 (0.66-2.32)	2.49 (0.30-20.32)	1.14 (0.54-2.44)

The table shows the odds ratios (OR coefficients) calculated for 95% confidence intervals, the statistical significance of their assessment was determined: * $p < 0.05$, ** $p < 0.005$, *** $p < 0.0005$

Data concerning a group of men (presented in Table 7), even more than for a group of women (Table 6) show greater number of a statistically significant links between childhood traumatic events from the scope of sex life with six symptoms and dysfunctions concerning sexuality than with nine other marker symptoms for other areas of neurotic disorders. Also the protective, positive relationship between the favorable circumstance, which is the full sexual awareness with the absence of sexual disorders has been reported significantly less frequently for symptoms other than sexual. Lack of relationship between traumatic events in childhood and adolescence in male patients with symptoms of social anxiety and fear of open spaces also draws attention. Statistically significant relationship between unwanted sexual initiation (described as „rather unwanted" and as „having the nature of rape") was observed for most of the symptoms and sexual dysfunctions in women (Table 6) but not in the group of men (Table 7), while for the sexuality-unrelated symptoms in a relatively small group of men - but still - a very significant risk of conversion paresis was found (OR = 7.22, $p < 0.05$) such distinctive symptom of the of high risk in group of women raped during the initiation seems to be fear in social situations (OR = 3.57, $p < 0.05$).

Sexual initiation before 14 years of age did not occur often enough to make the relationships concerning it statistically significant neither with regard to sexual symptoms nor to the analyzed sexuality-unrelated symptoms. Remarkably, however, it seems that in the males group sexual initiation at the age of 14-16 years was not associated with increased exposure to any of the 6 analyzed sexual symptoms, but it did with 4 of the sexuality-unrelated symptoms (probably because of the undoubtedly different experiencing initiation depending on gender - by women ambivalently, whereas by men - as a successes). In this context, it is also not surprising that the males early initiation was associated with a significantly lower risk of 'fear of contact with the opposite sex' (OR = 0.56, $p < 0.01$). Patients of both genders, who have not yet undergone initiation, were at greater risk of two symptoms: difficulties in contact with the opposite sex and discomfort associated with masturbation, but in relation to the other four sexual symptoms and the nine sexuality-unrelated symptoms, the risk of their occurrence was not changed or even smaller (perhaps they did not enter into certain types of closeness with others, associated directly with exposure to these problems, such as pain during intercourse).

To check the reliability of the results, and especially their independence from potentially interfering socio-demographic factors such as age, marital status, sexual experience, the decade of data collection, etc., analyzes of the above presented connections were carried out in subgroups formed taking into consideration these variables. Due to the space limit the presentation of results was restricted here to analyzes only of the symptom of dissatisfaction with sex life in groups of women and men (Tables 8 and 9). The dominant observation for all examined factors turned out to be the marginal impact on the previously shown picture and at the same time the influence consistent with the objective circumstances and clinical knowledge (e.g., certain relationships proved to be stronger for the group of people brought up in small towns and villages).

Table 8. **Associations between dissatisfaction with sex life and traumatic events in the female group, after controlling for selected socio-demographic features**

	Not educated at all about sex	Punished for masturbation or sexual plays	Sexual initiation before 14 years of age	Sexual initiation at the age 14-16	Initiation rather unwanted	Sexual initiation had the character of a rape	There was actual or attempted incest
Females – altogether	1.51*** (1.25-1.83)	2.13*** (1.46-3.13)	1.74 (0.78-3.88)	1.67** (1.18-2.37)	1.67*** (1.35-2.06)	2.11** (1.39-3.21)	1.82** (1.20-2.74)
Treated before 1991	1.97*** (1.37-2.85)	3.69** (1.49-9.10)	0.85 (0.12-6.05)	1.40 (0.65-3.01)	---	---	---
Treated after 1990	1.37* (1.09-1.72)	1.91** (1.24-2.92)	2.06 (0.84-5.04)	1.81** (1.22-2.69)	1.82*** (1.40-2.35)	1.83* (1.10-3.04)	1.84* (1.18-2.88)
Younger than 26 years of age	1.06 (0.65-1.74)	1.89 (0.85-4.20)	2.04 (0.34-12.34)	1.52 (0.83-2.78)	1.50 (0.89-2.54)	2.20 (0.71-6.82)	1.17 (0.53-2.57)
Older than 25 years of age	1.47*** (1.19-1.82)	2.15** (1.38-3.35)	1.60 (0.65-3.95)	1.90** (1.22-2.96)	1.30* (1.04-1.63)	1.93** (1.22-3.04)	2.19** (1.32-3.63)
Working	1.58*** (1.26-1.98)	2.07** (1.31-3.27)	2.08 (0.74-5.86)	1.74* (1.11-2.74)	1.55** (1.21-1.98)	2.03** (1.26-3.27)	2.42** (1.42-4.11)
White-collar worker	1.80*** (1.32-2.46)	2.02* (1.13-3.60)	1.90 (0.49-7.39)	1.30 (0.70-2.41)	1.80*** (1.30-2.48)	1.91 (0.99-3.71)	2.35* (1.17-4.72)
Blue-collar worker	1.43 (0.88-2.32)	2.61 (0.82-8.29)	N/A	2.52* (1.14-5.60)	1.18 (0.71-1.97)	1.33 (0.50-3.54)	3.19 (0.87-11.71)
Students	1.06 (0.56-2.00)	2.00 (0.78-5.10)	N/A	1.56 (0.50-4.89)	2.27* (1.13-4.56)	0.96 (0.06-15.72)	0.68 (0.27-1.75)
Brought up in a city	1.18 (0.89-1.56)	2.63** (1.47-4.70)	0.89 (0.31-2.57)	1.78* (1.15-2.76)	1.38* (1.02-1.88)	1.47 (0.78-2.77)	1.15 (0.65-2.03)
Brought up in a small town or a village	1.87*** (1.43-2.45)	1.79* (1.08-2.98)	4.63* (1.02-21.02)	1.55 (0.86-2.79)	1.96*** (1.46-2.63)	2.72** (1.53-4.84)	2.94** (1.57-5.51)
Not married	1.08 (0.74-1.57)	1.83* (1.02-3.27)	1.33 (0.33-5.36)	1.81* (1.02-3.20)	1.39 (0.94-2.04)	1.34 (0.65-2.78)	1.27 (0.64-2.49)
Married, divorced, widows	1.51** (1.20-1.90)	2.54** (1.49-4.32)	1.90 (0.68-5.31)	1.60* (1.02-2.50)	1.66*** (1.28-2.16)	2.51** (1.45-4.35)	2.25** (1.30-3.92)
Virgins	0.88 (0.42-1.84)	1.63 (0.64-4.18)	N/A	N/A	N/A	N/A	---
Long-term relationship	1.50** (1.16-1.95)	2.88** (1.52-5.47)	1.20 (0.40-3.60)	1.09 (0.71-1.68)	1.66*** (1.25-2.21)	2.15* (1.14-4.06)	1.61 (0.89-2.91)
Frequent intercourses	1.64* (1.22-2.20)	2.98** (1.47-6.06)	0.93 (0.28-3.07)	1.31 (0.83-2.07)	1.75** (1.27-2.40)	2.09* (1.03-4.24)	1.29 (0.70-2.39)
Currently no sexual contacts	1.32 (0.96-1.81)	1.82* (1.04-3.16)	1.31 (0.26-6.52)	3.21** (1.57-6.59)	1.50* (1.06-2.14)	2.41* (1.24-4.70)	1.64 (0.86-3.15)

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Having children	1.37* (1.07-1.75)	2.24* (1.25-4.03)	2.36 (0.65-8.49)	1.67* (1.03-2.71)	1.52** (1.15-2.01)	2.52** (1.41-4.50)	2.06* (1.12-3.79)
Not having children	1.31 (0.94-1.82)	2.25** (1.34-3.78)	1.26 (0.40-3.94)	1.68* (1.00-2.81)	1.61* (1.14-2.27)	1.34 (0.68-2.64)	1.59 (0.88-2.86)

The table shows the odds ratios (OR coefficients) calculated for 95% confidence intervals, the statistical significance of their assessment was determined: * $p < 0.05$, ** $p < 0.005$, *** $p < 0.0005$ (– indicates situations where it was impossible to calculate the OR coefficients)

Table 9. **Associations between dissatisfaction with sex life and traumatic events in the male group, after controlling for selected socio-demographic features**

	Not educated at all about sex	Punished for masturbation or sexual plays	Sexual initiation before 14 years of age	Sexual initiation at the age 14-16	Initiation rather unwanted	Sexual initiation had the character of a rape	There was actual or attempted incest
Males – altogether	1.91*** (1.45-2.52)	1.92* (1.12-3.29)	2.45 (0.80-7.49)	0.96 (0.65-1.44)	1.44 (0.82-2.53)	2.08 (0.42-10.38)	1.72 (0.85-3.51)
Treated before 1991	1.98** (1.31-2.99)	2.13* (1.01-4.47)	2.95 (0.62-14.07)	0.84 (0.47-1.51)	1.73 (0.65-4.56)	1.83 (0.35-9.54)	3.23 (0.91-11.50)
Treated after 1990	1.86** (1.28-2.69)	1.74 (0.79-3.82)	2.01 (4.03-10.07)	1.11 (0.62-1.97)	1.30 (0.65-2.58)	N/A	1.17 (0.49-2.83)
Younger than 26 years of age	3.68 (0.94-14.35)	3.60 (0.30-43.52)	N/A	3.83 (0.63-23.18)	N/A	N/A	3.83 (0.63-23.18)
Older than 25 years of age	1.75 (0.95-3.25)	1.52 (0.41-5.74)	0.90 (0.08-10.13)	0.68 (0.38-1.21)	1.69 (0.45-6.26)	N/A	N/A
Working	1.68** (1.24-2.27)	1.83* (1.02-3.28)	4.25 (0.95-18.95)	1.00 (0.76-1.32)	1.45 (0.76-2.75)	1.29 (0.23-7.08)	1.96 (0.83-4.66)
White-collar worker	1.31 (0.80-2.13)	2.51 (0.93-6.79)	1.36 (0.26-7.14)	1.51 (0.62-3.68)	1.09 (0.36-3.25)	1.08 (0.10-12.08)	1.36 (0.26-7.14)
Blue-collar worker	2.05** (1.32-3.17)	1.42 (0.62-3.22)	N/A	0.89 (0.49-1.61)	1.25 (0.54-2.89)	---	2.30 (0.83-6.38)
Students	4.39** (1.70-11.33)	1.97 (0.49-7.92)	1.64 (0.14-18.71)	0.53 (0.09-3.31)	1.09 (0.23-5.06)	---	---
Brought up in a city	2.04** (1.35-3.10)	1.35 (0.69-2.63)	3.47 (0.40-29.96)	1.14 (0.65-1.98)	1.60 (0.77-3.32)	2.77 (0.31-24.98)	1.15 (0.41-3.21)
Brought up in a small town or a village	1.82** (1.26-2.63)	3.49* (1.31-9.28)	2.12 (0.57-7.90)	0.78 (0.43-1.44)	1.23 (0.51-2.97)	1.40 (0.13-15.53)	2.43 (0.89-6.67)
Not married	2.55*** (1.67-3.90)	1.90 (0.78-4.64)	1.08 (0.18-6.55)	0.76 (0.37-1.53)	1.79 (0.73-4.40)	---	1.79 (0.73-4.40)
Married, divorced, widowers	1.52* (1.05-2.19)	1.91 (0.97-3.76)	3.75 (0.82-17.08)	1.07 (0.65-1.78)	1.24 (0.60-2.55)	1.01 (0.29-3.47)	1.69 (0.52-5.45)

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Before initiation	3.17** (1.62-6.20)	1.88 (0.56-6.31)	N/A	N/A	N/A	N/A	1.65 (0.40-6.79)
Long-term relationship	1.41 (0.97-2.04)	1.94 (0.97-3.87)	2.62 (0.71-9.64)	0.97 (0.57-1.62)	1.04 (0.48-2.22)	1.55 (0.14-17.28)	1.73 (0.59-5.03)
Frequent intercourses	1.42 (0.97-2.07)	2.66* (1.23-5.75)	3.46 (0.97-12.40)	1.05 (0.63-1.74)	1.06 (0.49-2.30)	1.69 (0.15-18.84)	1.71 (0.63-4.63)
Currently no sexual contacts	2.86*** (1.76-4.65)	1.47 (0.59-3.68)	1.35 (0.12-15.08)	0.86 (0.32-2.36)	2.52 (0.92-6.93)	2.03 (0.21-19.80)	2.07 (0.66-6.53)
Having children	1.55* (1.04-2.31)	1.68 (0.76-3.69)	2.59 (0.54-12.35)	1.03 (0.61-1.74)	1.07 (0.51-2.24)	1.28 (0.12-14.26)	1.29 (0.38-4.33)
Not having children	2.29*** (1.56-3.36)	2.15* (1.03-4.51)	2.24 (0.45-11.21)	0.81 (0.42-1.57)	2.06 (0.85-4.97)	2.98 (0.33-26.92)	2.06 (0.85-4.97)

The table shows the odds ratios (OR coefficients) calculated for 95% confidence intervals, the statistical significance of their assessment was determined: * $p < 0.05$, ** $p < 0.005$, *** $p < 0.0005$(--- indicates situations where it was impossible to calculate the OR coefficients)

Discussion

Sexual abuse in childhood or adulthood are not the only risk factors of sexual dysfunctions and other symptoms included in the neurotic disorders According to the theory of multivariate etiology of both neuroses and sexual dysfunctions, they are also inadequate sex education, repressive attitude of parents and carers towards sexuality as well as other adverse life events from the scope of sexual development, such as unwanted initiation. This following research confirms the association of such circumstances, especially strong with sexual symptoms, as well as with some sexuality-unrelated ones, such as social anxiety in women raped during the initiation or conversion paresis in men. In this scope, the obtained results are consistent with the literature, most often however referring to the most traumatic experiences in childhood, described by detailed research and clinical tools (e.g. Childhood Trauma Questionnaire; Abuse Inventory) that include the severity and location of the trauma in time, the perpetrators etc. [6, 52-53].

The results of this study, however, indicate the possibility to analyze the data obtained from patients during a routine interview prior to treatment in daily practice. These data provide more information with less detailed description, and include apparently less traumatic circumstances such as gaps in sex education) or experiencing sexual initiation as unwanted, as well as rarely discussed in the recent literature of the subject (such as punishment for masturbation). Despite this fact, we managed to demonstrate a consistent and statistically significant relationships of those burdens with the presence of sexual symptoms and to a smaller extent with the sexuality-unrelated ones, which confirms the „sexual" theories of neuroses formulated, among others, by psychodynamic psychopathology. An important aspect of this study seems to be the large size of the studied group, and also basing on subpopulation of patients being treated for other than sexual dysfunctions. This allows to emphasize the importance of both severe traumatic events and adversities disturbing the psychosexual develop-

ment, not only in the pathogenesis of sexual disorders but also of neurotic disorders, also in the formation of their picture - in the form of a set of symptoms. The results argue for the greater emphasis in the initial interviews and other diagnostic tools (e.g. questionnaires) on the issue of sexual abuse, incest, as well as less on the present in the literature aspects of education, attitudes of parents and carers, the age and course of initiation etc. These results are consistent with those obtained for example by Martins , and Abdo [54] linking a higher rate of erectile dysfunction with the lack of sex education and difficulties in beginning sex life.

Relationship of symptoms with a more contemporary life events (concerning relationships and sex life) will be the subject for further research, just as the extension of the analyzes on simultaneous impact of multiple variables.

At the end it should be noted that the analyzed group of patients is not representative for psychiatric treatment (rather for daily hospitals for neurotic and personality disorders), is relatively young (mean age is approximately 30 years) and free from serious somatic diseases and intensive pharmacotherapy. Other studies also typically related to the limited population [18-19, 55] or individual dysfunctions [21, 56], rarely described larger groups for example all insured persons from the wider region [18]. On the other hand, studies of narrower and more homogeneous groups of patients make it possible to generalize the results also in the evaluation of mechanisms important for practical individuals, and for the courses of therapy.

Another important limitation is the reliance in this retrospective study on the questionnaire material being after all, some simplification and approximation of the full interview and a psychiatric or psychological examination. On the other hand, many patients prefer to provide information regarding sexuality through questionnaires which causes the need for their adaptation and preparation also for use in therapy [4, 57].

This presented study confirms the reported by many authors in various groups and cultures, using various tools and methods, relationship between various degrees of sexual traumas with symptoms from the scope of sexuality. That link appears to be, as expected, stronger than for other sexuality-unrelated symptoms. The confirmation of these observations in a relatively large group of patients with a variety of disorders - usually from a group of neurotic, and personality disorders, is another aspect. Second, as it seems noteworthy, aspect is the successful verification of hypotheses by statistical assessment, of the risk of co-occurrence of simple bind pairs of information: 1) derived from interview memories on the presence of specific traumatic events and adverse life circumstances with 2) symptoms reported by the patients on admission to treatment in the symptom checklists. This method provides promising opportunities for further application in the analyzes of symptomatology of neuroses, being prepared for separate publications. Similarly, analysis of the combined impact of a number of traumatic factors would be included in another report.

Conclusions

1. The presence of adverse, traumatic life events related to sexuality, not necessarily from the group of the most serious abuses, but also the risk factors such as the ex-

perience of incest, too early sexual initiation, lack of sexual education in childhood and adolescence, punishing a child for masturbation or sexual plays, unwanted or forced sexual initiation, is associated with significantly higher incidence of majority of the several symptoms in the area of sexuality.

2. For the selected, other than sexual, symptoms of neurotic disorders the link has not proved to be so frequently statistically significant, which suggests that the impact of burden of sexual traumas in childhood is strong, but it is focused - specifically – first of all on the sphere of sexual dysfunctions. 3. The exceptions to the observations described in p.2, seem to be important for the understanding of psychopathology of neurotic disorders, including also the gender differences, for instance the „reaction" of the persons raped during initiation - paresis in men, social anxiety in women.
4. Explicit - but only in the group of women - connection between memories of being fully educated about sex in childhood and adolescence with a lower risk of symptoms in adulthood not only sexuality-related but also sexuality-unrelated, selected symptoms of neurotic disorders, as well as the opposite phenomenon - relation between the sense of a complete lack of sexual „awareness" with greater risk of disorders, probably also indicates a different „starting position" of psychosexual development of both genders.

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