Psychiatr. Pol. 2014; 48(3): 573–597
PL ISSN 0033-2674
www.psychiatriapolska.pl

Childhood sexual traumatic events and sexual life and relationship of a patient

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Summary

Aim: The assessment of links between traumatic events of sexual nature recollected from the past and patients' later functioning insexual life and relationships.

Materials and methods: Comorbidity of memories of traumatic sexual events from childhood and adolescence in patients with the features of their current partner relationships was analysed on the basis of Live Inventory completed by 2,582 women and 1,347 men, undergoing treatment between the years 1980-2002, before they were admitted to a day ward of neurotic disorder department.

Results: The existence of numerous significant links was observed e.g. the information regarding incest or incest attempt experience was related with a significant risk of a sexual life assessment as completely dissatisfying in women (OR=2.71) and almost completely dissatisfying in men (OR=2.38). Sexual initiation by rape was related with women's more frequent incidence of getting married as a result of social pressure (OR=3.77) and a feeling of hatred towards a partner (OR=5.41). Men and women who considered themselves completely sexually uneducated (before the age of 18) assessed their sexual life as completely dissatisfying (OR=2.48 and OR=2.07), which was similar to men who would get punished for masturbation or sexual plays by their guardians (OR=2.68).

Conclusions: Traumatic events and circumstances relating to sexuality, indicated in the questionnaire interview, turned out to be connected with the risk of dysfunctions in a sexual life and relationship. The traumas included, among others, rape during initiation, early initiation, incest, but also unfavorable circumstances of less traumatic nature such as a lack of sexual education, punishment for masturbation, „mostly undesired initiation". Their likely effects were rooted in relationship dysfunctions: reasons for their formation, power division, instability, problems with resolving conflicts and, most of all, sexual life dysfunctions. The results were obtained on the basis of simple questionnaire questions, which allows for the recommendation that they be used in a routine interview.

Key words: childhood and adolescence sexual adversities, traumatic sexual events, partnership relation, sexual functioning

Introduction

Different types of trauma resulting from sexual, physical and psychological abuse, especially the one occurring in childhood and adolescence are related in a complex manner to symptoms [1, 2] and increase the risk of various mental disorders ([3-7]) and death [8]. However, they are frequently particularly related to sexual dysfunctions [3, 9] and dysfunctions in partner relationships, procreative families and other victim's relationships including the risk of revictimisation [10, 11]. The effects of childhood abuse are long lasting. First reactions occur immediately and they are followed by the ones in adolescence when the victims enter dysfunctional interactions with peers and frequently experience further trauma or inflict it onto others [12-17]. The next ones occur in early [18] or middle adulthood and they disrupt the formation of correct erotic or sexual relations [19-20] and are related, among others, to risky sexual behaviour and sexually transmitted infections (STIs) [21]. Traumatic events cause dysfunctional choices, among others, due to misperception of oneself and others [22]. They hinder the formation and maintenance of partner relationships and marriage [23-26] or having offspring including even completing pregnancy [27], children upbringing and cooperation in their individualisation and separation. Recent research observes that the effects of trauma last until advanced age [28], which seems more prevalent in women [29] but men are generally affected as well [30] but in a different manner [31].

The effects of trauma are conceptualised in different ways. They caused the following dysfunctions observed in literature: disorder of emotional regulation [32], attachment disorders [33], sub-optimal defence mechanisms and coping strategies (e.g. denial, dissociation, conversion, placing a danger in id/drive) [34], extreme distrust and susceptibility to abandonment or provocation to be abandoned by partners, as well as avoidance of forming relationships [35]. The consequences of the trauma include also negative self-perception [36], the feeling of lost control [37], change of sexual preferences and adopting an ego-dystonic sexual orientation. The role which is particularly unfavourable and traumatic, usually not isolated, seems to be played by sexual traumas which are frequently related with incorrect parents' attitude to sexuality [38]. The accumulation of such traumas [39] and their complex character [40] seem frequent. The diversification of trauma effects, known from clinical practice, seems to be mostly dependent on patient's resources including the functioning of their families [41]. Inter-generation passing of risk [42] can be noted, which is not only limited to the repetition of the same traumas but also their risk factors such as disagreement between patient's parents or their mental disorders [43], the use of therapeutic interventions and the aforesaid severity and complexity of a trauma [44].

The relationships of the patients who suffer from neurotic and personality disorders and are often victims of psychological traumas (deteriorating the course of disorders)

are disrupted in many aspects as well [45, 46] if such relationships are formed at all. A successful relationship life requires good communication, particularly in the area of sexuality, which is usually disrupted in neurotic disorders by e.g. a fear of judgement [47]. In patients who are victims of trauma or less serious unfavourable traumatic circumstances (such as negative parent's attitude to a child's sexual maturation, their own or the patient's intimate life) [38], a higher risk of dysfunctions in many aspects of later relationships can be expected. That includes dysfunctional conceptions of their formation, asymmetric power wielding (often by means of sexual contact rationing or related sexual satisfaction [48], the use of symptoms e.g. agoraphobia to patient's or partner's "self-control").

Aim

The study assessed the links between traumatic events and other unfavourable circumstances in sexuality, recollected by the patients, and their current dysfunctions in relationships and sexual life.

Materials and Methods

A Life Inventory [49] was used as a source of information concerning childhood and adolescence traumatic life circumstances, subjectively recollected by the patients. It was routinely completed before psychotherapy treatment in a day ward of neurotic treatment department. The currently used version of the Life Inventory was modified in 2002 (the data collected by means of it has not been sufficient as yet). In the current study, the Life Inventory version and data of 1982-2002 were used. Qualification for treatment usually entailed questionnaires and at least two psychiatric examinations, psychological assessment and a battery of several questionnaires, which allowed for the exclusion of other disorders (affective disorders, schizophrenic, exogenous or pseudo-neurotic and severe somatic diseases), which were unfeasible to be treated with psychotherapy in the local day ward [50].

The data about patients with identified neurotic, behavioural and personality disorders (codes: F4, F5, F6 under ICD-10) was collected. The majority of the 3,929 respondents (median age: women - 33, men – 32) had one of neurotic or personality disorder and secondarily occurring neurotic disorder identified (Table 1), (see also [38]).

The data collected from diagnostic tests was used with the patients' consent. It was stored and processed anonymously. Estimates of odd ratio (OR) for the coexistence of the two nominal variables (life circumstances) were done by logistic regression. A 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 (387)	349±151 (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%

GSL - the total value of the symptom checklist - sum of the weights assigned to answers to questions about the nuisance of individual symptoms (labeled a-b-c shown at the Likert scale).

Table 2. **Socio-demographics characteristics**

	Females (n=2582)	Males (n=1347)
Age in years mean±SD (median)	33±9 (33)	32±9 (28)
Education		
None/Primary school	9%	12%
Secondary school (including students)	57%	56%
University	34%	32%
Employment		
Is working	59%	70%
Is not working	41%	30%
Including pensions	10%	7%
Students	23%	24%

table continued on the next page

Marital status/relationship		
Stable relationship/marriage	43%	47%
Unstable relationship/marriage	26%	21%
Not in a relationship	31%	32%

Prevalence of some traumatic events and unfavourable life circumstances the examined group was partially discussed elsewhere [38] as well as their links to symptoms [2].

Results

Information regarding prevalence of the patients' sexual life and relationship dysfunctions was listed in the following Tables 3-8.

Table 3. **Feelings towards the partner, the perceived feelings from the partner and the assessment of the relationship**

		Females	Males
Feelings towards the partner	Sort of loved	31%	32%
	Loved very much	25%	27%
	Indifference	5%	5%
	Reluctance	8%	3%
	Hatred	8%	3%
Perceived feelings from the partner	Sort of loved	33%	31%
	Loved very much	24%	27%
	Indifference	8%	5%
	Reluctance	1%	1%
	Hatred	1%	1%
Assessment of the relationship	„Sort of good"	36%	38%
	„Sort of bad"	15%	13%
	„Very good"	11%	12%
	„Very bad"	7%	4%

Blank answers and information about not being in a relationship were omitted

Most patients of both sexes "sort of love" their partners (31% and 32%), whereas as many as 25% women and 27% men "love very much" their partners, which indicates that some group of patients who love their partners very much do not assess their relationship as going very well). Indifference to a partner was felt by relatively few respondents (5% women and men), whereas reluctance was present in 8% of women and 3% of men. Only around 1% of both male and female patients felt hatred. The perception of partners' feelings towards the patients was most commonly described as "sort of loved" (33% of women and 31% of men), whereas 24% and 27% felt "loved

very much". Partner's indifference was sensed by 8% and 5% of the respondents, reluctance by 3% of each group and hatred by 1%, respectively. Having analysed the responses to questions pertaining to current relationship assessment, it was noted that the most common relationship assessment was "sort of good" both in female (36%) and male group (38%), which was followed by "sort of bad" (15% and 13%). The highest value of "very good" was indicated by only 11% and 12%, "very bad" by mere 7% and 4% and the remaining 32% of women and 33% of men currently were not in a relationship (Table 4).

Table 4. **Sexual intercourse**

		Females	Males
Sexual contacts	Long-term relationship	55%	53%
	Fleeting and casual	3%	7%
	Fleeting and long term	2%	5%
Frequency of intercourses	Several times a month	34%	37%
	Less than once a month	17%	12%
	Several times a week	11%	13%
Satisfaction with sexual intercourses	Mostly satisfying	29%	33%
	Always satisfying	10%	15%
	Only as an exception satisfying	16%	13%
	Completely dissatisfying	10%	7%

Blank answers and information about not having sexual intercourse were omitted.

As indicated in Table 4, the majority of the respondents reported sexual contacts in a long-term relationship (55% of women and 53% of men), 3% of female respondents and twice as much male respondents i.e. 7% indicated "fleeting and casual" contacts. Similarly, 2% and 5% chose both fleeting contacts and the ones in a long-term relationship. Additionally, 39% of female patients and 35% of male patients denied having sexual contacts. The most common approximate frequency of sexual contacts (in the past few months) was "several times a month" both in women and men (34% and 37%). 17% of women and 12% of men had a sexual intercourse "less often than once a month", whereas the response "several times a week" was given by only 11% of female patients and 13% of male patients. The highest number of the respondents believed their current sexual life (in the past few months) was "mostly satisfying" (29% women and 33% men), more than twice as few said it was "always satisfying" (10% and 15%). However, the group of "dissatisfied" respondents of both sexes was substantially numerous as they described their sexual life as satisfying "only as an exception" (16% and 13%) and "completely dissatisfying" (10% and 7%).

Table 5. **Power division and position in a relationship**

		Females	Males
Power division	Together in power in the relationship	33%	37%
	Partner in power in the relationship	17%	13%
	Patient in power in the relationship	17%	15%
	More than one person in power in the relationship	1%	1%
Position in relationship	Equal to the partner	42%	48%
	Worse, weaker from the partner	21%	12%
	Better from the partner	6%	7%

Blank answers and information about not being in a relationship were omitted

The patients (Table 5) believed they wield equal power in a relationship (33% women and 37% men). An asymmetric wielding of power by partners was indicated by 17% of women and 13% of men. The patients who believed they wielded power amounted to 17% of women and 15% of men. 1% of both sexes responded that "the other person" wielded more power. The position the respondents had in a relationship was seen as equal to their partner's by 42% of women and 48% of men. However, as many as 21% of women and only 12% of men felt worse and weaker than their partners. Only 6% of female respondents and 7% of male respondents believed they had a better position.

Table 6. **Dealing with conflicts and the perceived stability in the relationship**

		Females	Males
Dealing with conflicts in the relationship	Communication	31%	35%
	Silence	13%	12%
	Quarrels or fights	16%	14%
	Brawl	<1%	<1%
	Other, unspecified ways	9%	7%
	* including fights with interventions of the Police	5%	2%
The assessment of stability of the relationship	Permanent	43%	47%
	Just falling apart	11%	9%
	Uncertain due to the outside circumstances	8%	6%
	Patient thinks about breaking up	5%	3%
	(according to the patient) partner thinks about breaking up	1%	1%
	"Fleeting" relationship	1%	2%

Blank answers and information about not having a relationship were omitted

As far as dealing with conflicts (Table 6) was concerned, the patients of both sexes (31% women and 35% men) most frequently indicated "discussing and reaching agreement" as a means of solving them. Arguments and quarrels turned out to occur quite commonly (16% and 14%). The solution of fight was adapted extremely rarely (less than 1% of the respondents: 2 women and 4 men). However, keeping silent occurred often (13% and 12%). Other unspecified methods were adapted by 9% and 7%, respectively. 5% of female patients and 2% of male patients experienced arguments with police intervention. The patients often perceived their relationship as stable (43% women and 47% men), whereas 11% and 9% thought it was just falling apart. 8% and 6% of the respondents described it as uncertain due to external circumstances, 5% and 3% was considering leaving the partner, whereas only 1% of both sexes believed their partners wanted to leave them. Finally, 1% of women and 2% of men indicated their relationship was fleeting.

Table 7. **Reasons for getting into the current married (relationship) and the proportion of input into the relationship**

		Females	Males
Reasons for getting into the relationship	Love	38%	36%
	Fear of loneliness	5%	3%
	The desire to become independent	5%	3%
	Being accustomed	3%	3%
	Pressure and coercion	2%	1%
	Financial reasons	1%	<1%
	Liabilities to partner	1%	5%
	Other unspecified reasons	8%	5%
Proportion of input into the creation of the relationship	Both of the partners equally	46%	42%
	Mostly the patient	9%	11%
	Mostly the partner	14%	13%
	Family and friends	1%	1%

Blank answers and information about not having a relationship were omitted

The most common response to the question about the reasons for getting into the current married relationship (Table 7) was love (38% women and 36% men but 38% of the female patients and 44% of the male patients were single at the time of the study). Other much less common reasons were: a fear of loneliness (5% and 3%), a desire to become independent (5% and 3% as well), out of routine (both groups 3%), pressure and coercion (2% and 1%). Only 1% of women and even fewer men said it was because of financial reasons. Much higher number of men (5%) than women (1%) indicated that obligations towards the partner as the reason. Additionally, 8% of women and 5% of men gave "other reasons". Most commonly both partners desired to form a relationship equally (46% women and 42% men),

9% of women and 11% men said it was mostly their desire, 14% of women and 13% of men responded that the desire was their partner's, whereas 1% of each group indicated family's and friends' desire.

Table 8. **Difficulties in forming of the relationship**

		Females	Males
Reasons for lack of emotional relationships with the opposite sex	There have been first relationships	83%	78%
	Inhibited by shyness	9%	15%
	Fear of consequences	3%	3%
	„Lack of occasion"	3%	2%
	Lack of interest in the opposite sex	1%	2%
Engagement in the so far relationships	Impediments directly caused by parents	1%	1%
	Greater on the part of the patient	41%	42%
	Equal on both sides	36%	36%
	Greater on the part of the partner	16%	12%
	No experience in a relationship	7%	10%

Blank answers and information about not having a relationship were omitted

Most patients (Table 8) had already experienced an "emotional relationship with opposite sex" (83% women and 78% men); others usually said they had not experienced that as they were "inhibited by shyness" (9% women and as many as 15% men). Other responses included a "fear of consequences" (both sexes 3%), "no opportunity" (3% women and 2% men), "no interest in opposite sex" (1% women and 2% men) and "impediments directly caused by parents" (both groups 1%). Both female patients (42%) and male patients (41%) believed they were more engaged in relationships they had experienced, a significant number of the respondents said it was equal for both parties (both 36%), the lowest number indicated that their partners were more engaged (16% and 12%). 7% of women and 10% of men did not have a relationship experience.

In further presentation of the results concerned with searching for the links between traumatic events and patients' relationship dysfunctions and obtained by means of regression analysis (the coefficient of odd ratio and confidence interval), only the links statistically significant ($p<0.05$) were shown (Tables 9-14).

As presented in Table 9, incest is significantly related to coercion: "mostly undesired" initiation (women: OR=2.05) or even initiation by rape (women: OR=4.55, men: OR=12.07) and with very early (women: OR=17.61, men: OR=7.39) or early sexual initiation (women: OR=3.15, men: OR=2.85). One of the first consequences of incest is a victim's higher risk of greater engagement in later relationships (women: OR=2.10, men: OR=2.16) or women's fleeting and casual character of sexual contacts (OR=3.11), men's thoughts of ending a relationship (OR=5.21). It also contributes to the fact that family or friends make a female incest victim get married (OR=3.63).

In both sexes love is a less common reason for getting married and in women it is pressure and coercion (OR=3.81) and a desire to become independent (OR=2.33) that are declared as much more common reasons. Men (but not women) much more often feel reluctance towards their partners (OR=7.99) and they project it onto their partners (OR=3.73). They believe their relationship is going mostly badly (OR=2.25). Men who experienced incest are of the opinion that they experience a satisfying sexual life "only as an exception" (OR=2.38), whereas the women claim it is completely dissatisfying (OR=2.71).

Table 9. **Link between incest (or its attempt) with subsequent disturbances in relationship**

	Females	Males
Striving to the establish the current relationship (or marriage)		
Family and friends	*3.63 (1.39; 9.49)	---
Reasons for marriage		
Pressure and coercion	**3.81 (1.57; 9.22)	---
The desire to become independent	*2.33 (1.21; 4.47)	---
Liabilities to partner	---	*3.39 (1.27; 9.02)
Overall assessment of sexual intercourse		
Only as an exception satisfying	0.89 (0.51; 1.56)	*2.38 (1.13; 4.98)
Completely dissatisfying	***2.71 (1.68; 4.39)	1.15 (0.35; 3.80)
Ways of resolving conflicts with the partner		
Quarrels, fights	*1.65 (1.04; 2.61)	0.95 (0.37; 2.46)
Feelings towards the partner (spouse)		
Reluctance	1.59 (0.86; 2.96)	***7.99 (3.11; 20.57)
Perceived feelings form the partner (spouse)		
Reluctance	1.78 (0.76; 4.18)	*3.73 (1.26; 11.03)
The nature of the current sexual intercourse		
Fleeting, casual	**3.11 (1.51; 6.41)	1.52 (0.53; 4.38)
Perceived stability of the relationship and the reasons for its threat		
Uncertain. thinking about breaking up	1.24 (0.57; 2.73)	**5.21 (1.92; 14.11)
Overall assessment of the relationship (marriage)		
I goes sort of bad with the partner	1.38 (0.84; 2.28)	*2.25 (1.04; 4.83)
The age of sexual initiation		
Before or about 13 year of age	***17.61 (7.96; 38.98)	***7.39 (2.05; 26.74)
14-16 years of age	***3.15 (1.80; 5.51)	*2.85 (1.22; 6.65)
The course of sexual initiation		
Rather unwanted	**2.05 (1.34; 3.16)	1.24 (0.29; 5.30)

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Had the character of rape	***4.55 (2.57; 8.06)	**12.07 (2.35; 61.92)
The proportion of involvement in the previous emotional relationships		
Patient	***2.10 (1.42; 3.11)	*2.16 (1.12; 4.19)

*p<0.05. **p<0.005. ***p<0.0005. in brackets there are values of 95% of confidence intervals estimated for the odds ratios coefficients '---'impossible to assess OR coefficients have been marked

Table 10 concludes that initiation by rape is related to different persons who desire a relationship: in women it is the victim who has such a desire (OR=2.49), whereas in men it is a partner who desires it (OR=6.79). In women pressure and coercion were more often indicated as the reason for getting married (OR=3.77) and a desire to become independent was a more common response in men (OR=13.19) than women (OR=2.31). Women who were raped during initiation feel mostly reluctance (OR=2.24) and hatred (OR=5.41) towards later partners. It is more common for them to project indifference onto their partners (OR=2.10) or reluctance (OR=3.22), less common love (OR=0.43). Their sexual contacts are more often casual (OR=3.50), their sexual life is less frequent than once a month (OR=1.83) and completely dissatisfying (OR=2.37). Men are not affected by similar traumas in a statistically significant manner (perhaps due to the subgroup being not very numerous or men experiencing a trauma in a different manner). More often men perceive their relationship as fleeting (OR=8.55) and women believe it is just falling apart at the moment when they started therapy (OR=2.89). Furthermore, women think their relationship is going badly (OR=1.74) or very badly (OR=2.80) and they believe they are more engaged (OR=1.69).

Table 10. **Links between initiation by rape and subsequent disturbancesin the relationship**

	Females	Males
Striving to the establish the current relationship (or marriage)		
Mostly patient	**2.49 (1.50; 4.13)	1.14 (0.14; 9.26)
Mostly partner	1.06 (0.62; 1.80)	*6.79 (1.68; 27.41)
Reasons for marriage		
Pressure and coercion	**3.77 (1.56; 9.13)	---
The desire to become independent	*2.31 (1.20; 4.42)	**13.19 (2.56; 67.91)
The frequency of sexual intercourse (last few months)		
Less than once a month	*1.83 (1.18; 2.83)	---
Overall assessment of sexual intercourse		
Completely dissatisfying	**2.37 (1.44; 3.89)	---
Feelings towards the partner (spouse)		
Reluctance	**2.24 (1.29; 3.90)	---
Hatred	**5.41 (2.01; 14.58)	---

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Perceived feelings form the partner (spouse)		
Indifference	*2.10 (1.21; 3.65)	---
Reluctance	**3.22 (1.62; 6.42)	---
The nature of the current sexual intercourse		
Fleeting, occasional	***3.50 (1.75; 7.01)	1.83 (0.22; 15.04)
Perceived stability of the relationship and the reasons for its threat		
Fleeting	0.65 (0.09; 4.80)	*8.55 (1.01; 72.62)
The current relationship is falling apart	***2.89 (1.82; 4.57)	---
Overall assessment of the relationship (marriage)		
It goes sort of bad with the partner	*1.74 (1.09; 2.78)	---
It goes very bad with the partner	***2.80 (1.65; 2.76)	3.10 (0.38; 25.65)
The proportion of involvement in the previous emotional relationships		
Patient	*1.69 (1.15; 2.49)	1.38 (0.34; 5.57)

*p<0.05. **p<0.005. ***p<0.0005. in brackets there are values of 95% of confidence intervals estimated for the odds ratios coefficients '---'impossible to assess OR coefficients have been marked

One can conclude from Table 11 that "mostly undesired" initiation is related to women's asymmetric desire of a relationship (OR=1.94), getting married due to a fear of loneliness (OR=2.09) and obligations towards a partner (OR=2.45) together with men's getting married out of routine (OR=3.90). Women describe their feelings towards partners as "mostly love" (OR=1.59) or reluctance (OR=1.62). They described it as "big love" less often (OR=0.63). Men indicated "mostly love" (OR=2.05) more often. Women perceived their partner as "mostly loving" (OR=1.38) a lot more often and they led a sexual life in a long-term relationship with one partner (OR=1.37). However, they believed more often their relationship is "uncertain because of external circumstances" e.g. short separation, threesome etc. (OR=1.57) or uncertain as they were thinking of leaving the partner (OR=1.69) or because the partner intended to leave them (OR=3.28). Men consider their relationship as uncertain due to external circumstances e.g. short separation, threesome etc. (OR=2.36) a lot more often. The male patients who experienced "mostly undesired" initiation felt much more frequently weaker/worse than their current partners (or wives) (OR=2.94) but the women after the same experience felt better/stronger than their partners (OR=1.61). The division of power in women's relationships was more often asymmetric meaning they more often assigned more power to themselves (OR=1.40) or to their partner (OR=1.36). On the other hand, the women much more often believed their relationship was going mostly badly (OR=1.78) or very badly (OR=1.54), whereas men said it was mostly badly (OR=2.11). Much more often women's sexual life occurred less often than once a month (OR=1.49) and its general assessment was satisfying "only as an exception" (OR=1.58) or completely dissatisfying (OR=2.41). No such links were observed in men.

Table 11 **Links between "rather unwanted" initiation with subsequent disturbances in the relationship**

	Females	Males
Striving to the establish the current relationship (or marriage)		
Mainly partner	***1. 94 (1.49; 2.51)	1.59 (0.81; 3.14)
Reasons for marriage		
Being accustomed	1.62 (0.98; 2.69)	**3.90 (1.58; 9.67)
Fear of loneliness	***2.09 (1.39; 3.14)	1.21 (0.28; 5.15)
Liabilities to partner	*2.45 (1.04; 5.77)	2.08 (0.80; 5.40)
The frequency of sexual intercourse (last few months)		
Less than once a month	**1.49 (1.16; 1.91)	1.14 (0.53; 2.45)
Overall assessment of sexual intercourse		
Only as an exception satisfying	**1.58 (1.22; 2.05)	1.54 (0.78; 3.03)
Completely dissatisfying	***2.41 (1.80; 3.22)	1.58 (0.66; 3.77)
Ways of resolving conflicts with the partner		
Quarrels or fights	***1.78 (1.38; 2.29)	1.50 (0.76; 2.95)
Fights with partner including interventions of the Police		
Occurred	***2.23 (1.52; 3.27)	0.79 (0.11; 5.93)
Feelings towards the partner (spouse)		
Sort of love	***1.59 (1.29; 1.97)	*2.05 (1.21; 3.47)
Reluctance	*1.62 (1.15; 2.29)	0.63 (0.09; 4.68)
Perceived feelings form the partner (spouse)		
Sort of loved	**1.38 (1.12; 1.71)	1.49 (0.87; 2.56)
The nature of the current sexual intercourse		
In long-term relationship with one partner	**1.37 (1.11; 1.68)	0.83 (0.49; 1.41)
Perceived stability of the relationship (marriage) and the reasons for its threat		
Uncertain due to the outside. circumstances	*1.57 (1.11; 2.20)	*2.36 (1.03; 5.38)
Uncertain. thinking about breaking up	*1.69 (1.13; 2.51)	0.53 (0.07; 3.96)
Uncertain. the partner wants to break up	*3.28 (1.33; 8.07)	1.24 (0.16; 9.46)
The perceived division of power in the relationship (or marriage) of the patients		
Partner	*1.36 (1.05; 1.77)	1.23 (0.59; 2.54)
Patient	*1.40 (1.09; 1.81)	1.24 (0.61; 2.49)
Overall assessment of the relationship (marriage)		
It goes sort of bad	***1.78 (1.37; 2.31)	*2.11 (1.11; 4.01)
It goes very bad	*1.54 (1.08; 2.21)	1.18 (0.36; 3.89)

table continued on the next page

Position of patients in their relationship (marriage)		
Worse/weaker	1.22 (0.96; 1.56)	***2.94 (1.61; 5.36)
Better/stronger	*1.61 (1.08; 2.39)	1.77 (0.78; 4.00)
The proportion of involvement in the previous emotional relationships		
Patient	*1.34 (1.09; 1.65)	1.51 (0.89; 2.55)
Partner	*1.34 (1.03; 1.75)	1.79 (0.91; 3.53)

*p<0.05. **p<0.005. ***p<0.0005. in brackets there are values of 95% of confidence intervals estimated for the odds ratios coefficients '---'. impossible to assess OR coefficients have been marked

It can be concluded from analysis results presented in Table 12 that early initiation was related to women's desire to get married as they wanted to become more independent (OR=5.75) and due to obligations towards a partner (OR=9.21). Men also decided to get married due to obligations towards a partner (OR=6.38). The female patients felt more often indifference from their male partners (OR=2.68). They also described their sexual contacts as fleeting/casual (OR=5.67) and their relationship as fleeting (OR=5.93). Men described their feelings towards a partner as "mostly love" (OR=2.69) more often. Men's frequency of sexual contacts was more often indicated as several times a month (OR=2.69) and they did not assess their sexual life with any available option more often. However, women regarded their sexual life as completely dissatisfying (OR=2.71) more often.

Table 12 **Links between premature initiation of subsequent disturbances in the relationship**

	Females	Males
Reasons for marriage		
The desire to become independent	***5.75 (2.28; 14.51)	---
Liabilities to partner	**9.21 (2.05; 41.31)	**6.38 (2.03; 20.00)
The frequency of sexual intercourse (last few months)		
Several times a month	0.99 (0.32; 3.03)	*2.69 (1.04; 6.99)
Overall assessment of sexual intercourse		
Completely dissatisfying	*2.71 (1.08; 6.77)	2.72 (0.77; 9.58)
Feelings towards the partner (spouse)		
Sort of loved	0.61 (2.93; 1.34)	*2.69 (1.05; 6.86)
Perceived feelings form the partner (spouse)		
Reluctance	*2.68 (1.01; 7.15)	2.47 (0.56; 10.99)
The nature of the current sexual intercourse		
Fleeting, occasional	**5.67 (1.91; 16.81)	---
Perceived stability of the relationship and the reasons for its threat		

table continued on the next page

Fleeting	*5.93 (1.35; 26.06)	---
Reasons for not getting into emotional relationships with the opposite sex		
Not interested in persons of the opposite sex	---	*5.81 (1.27; 26.51)
The proportion of involvement in the previous emotional relationships		
Partner	1.49 (0.60; 3.71)	*3.82 (1.41; 10.32)

*p<0.05. **p<0.005. ***p<0.0005. in brackets there are values of 95% of confidence intervals estimated for the odds ratios coefficients '---'impossible to assess OR coefficients have been marked

Table 13 presents the links concerning a complete lack of sexual education (before the age of 18). Women who were affected with this biographical burden much more often said that it was mainly their family or friends who desired their current relationship or marriage (OR=2.45) and they also much more often indicated pressure and coercion (OR=4.18), a fear of loneliness (OR=1.91) and a desire to become independent (OR=1.89) as the reasons for getting married. The female patients much more often indicated they had a sexual life "less often than once a month" (OR=1.48) describing it as being satisfying as an exception (OR=1.47) or more likely as completely dissatisfying (OR=2.48). They more often chose to take offence and keep quiet (OR=1.43) as a method of handling conflicts with a partner. Arguments and quarrels came as second (OR=1.29) but more often than statistically expected, they called the police (OR=2.54). The female patients felt towards their partner indifference (OR=1.85), reluctance (OR=1.69) or even hatred (OR=3.00) more often. They perceived their partner's feelings as "mostly love" (OR=1.36) or indifference (OR=2.05). Sexual contacts occurred more often in a long-term relationship (OR=1.26) but at the same time the relationship was more frequently perceived as uncertain due to external circumstances e.g. short separation, threesome etc. (OR=1.58) or as one that was just falling apart (OR=1.54). They considered power in a relationship to be asymmetric either on the partner's side (OR=1.35) or their side (OR=1.70). General assessment of the relationship was "mostly bad" (OR=1.68) or "very bad" (OR=1.90) with their position in a relationship being assessed as "worse/weaker" (OR=1.57). The female patients were more engaged parties in the relationships they had experienced (OR=1.50). Men pointed at their partners as those who desired a relationship (OR=1.54) much more often. They said their sexual life was completely dissatisfying (OR=2.07), they felt indifference towards a partner (OR=2.02) and their relationship was going very badly (OR=2.07). They also felt worse or weaker. Some men (OR=1.81) did not start emotional relationships because of shyness (OR=1.61).

Table 13 **Links between the lack of sex education with subsequent disturbances in the relationship**

	Females	Males
Striving to the establish the current relationship (or marriage)		
Mainly partner	1.12 (0.86; 1.46)	*1.54 (1.08; 2.19)
Family and friends	*2.45 (1.27; 4.73)	0.29 (0.04; 2.20)

table continued on the next page

Reasons for marriage		
Fear of loneliness	**1.91 (1.29; 2.83)	1.76 (0.89; 3.46)
Pressure and coercion	***4.18 (2.30; 7.61)	0.34 (0.04; 2.69)
The desire to become independent	**1.89 (1.29; 2.78)	0.86 (0.37; 1.99)
The frequency of sexual intercourse (last few months)		
Less than once a month	**1.48 (1.17; 1.87)	1.27 (0.88; 1.84)
Overall assessment of sexual intercourse		
	**1.47 (1.15; 1.87)	1.29 (0.90; 1.85)
Completely dissatisfying	***2.48 (1.88; 3.27)	**2.07 (1.33; 3.23)
Ways of resolving conflicts with the partner		
Quarrels, fights	*1.29 (1.01; 1.64)	1.09 (0.75; 1.57)
	*1.43 (1.10; 1.86)	1.21 (0.82; 1.76)
Fights with partner including interventions of the Police		
Occurred	***2.54 (1.77; 3.63)	0.39 (0.12; 1.30)
Feelings towards the partner (spouse)		
Indifference	**1.85 (1.27; 2.70)	*2.02 (1.18; 3.46)
Reluctance	**1.69 (1.22; 2.33)	0.83 (0.36; 1.91)
Hatred	**3.00 (1.40; 6.45)	1.73 (0.43; 6.97)
Perceived feelings form the partner (spouse)		
Sort of love	**1.36 (1.12; 1.65)	1.09 (0.83; 1.43)
Indifference	***2.05 (1.51; 2.78)	1.11 (0.62; 1.98)
The nature of the current sexual intercourse		
In a long term relationship with one partner	*1.26 (1.04; 1.52)	0.82 (0.63; 1.06)
Perceived stability of the relationship and the reasons for its threat		
Uncertain due to the outside. circumstances	*1.58 (1.15; 2.17)	1.48 (0.89; 2.45)
The current relationship is falling apart	**1.54 (1.16; 2.05)	1.49 (0.98; 2.27)
The perceived division of power in the relationship (or marriage) of the patients		
Partner	*1.35 (1.06; 1.72)	1.43 (0.99; 2.04)
Patient	***1.70 (1.35; 2.15)	0.69 (0.46; 1.02)
Overall assessment of the relationship (marriage)		
It goes sort of bad	***1.68 (1.32; 2.15)	1.31 (0.90; 1.89)
It goes sort of bad	***1.90 (1.37; 2.63)	*2.07 (1.21; 3.56)
Position of patients in their relationship (marriage)		

table continued on the next page

Worse, weaker	***1.57 (1.27; 1.96)	**1.78 (1.25; 2.54)
Reasons for not getting into emotional relationships with the opposite sex		
Shyness	1.08 (0.77; 1.51)	*1.61 (1.15; 2.26)
The proportion of involvement in the previous emotional relationships		
Liabilities to partner	0.81 (0.55; 1.19)	**1.81 (1.23; 2.65)
Patient	***1.50 (1.24; 1.82)	1.09 (0.84; 1.40)

*p<0.05. **p<0.005. ***p<0.0005. in brackets there are values of 95% of confidence intervals estimated for the odds ratios coefficients '---'.impossible to assess OR coefficients have been marked

As Table 14 presents, among persons who were punished for masturbation or sexual plays in their childhood, it was women who were more likely to indicate that they were the ones who desired a relationship (OR=2.06), whereas men assigned this initiative to their female partners (OR=1.89). Women more often got married as a result of a fear of loneliness (OR=2.39), whereas men did so due to obligations towards their partners (OR=2.98). The traumatic circumstance discussed here had no noticeable link with the frequency of sexual life and in case of women with the assessment of its quality. However, in men it was related to their feeling it was completely dissatisfying (OR=2.68). Men were the ones who felt hatred towards their partners more often (OR=5.34) but women felt only reluctance (OR=1.76) which they also projected more often onto their partner (OR=2.56). Women's sexual contacts were more frequently fleeting and casual (OR=2.79), their relationships were less stable (OR=0.45) and less often the power division in them was symmetric (OR=0.56). Men more often described the relationship as fleeting (OR=5.38) or uncertain because the partner wanted to end it (OR=5.10), it was going very badly with the partner (OR=3.55) or the patient felt weaker/worse than her (OR=1.88). Women also less often regarded their current relationship as equal when it came to their position in it (OR=0.51) and themselves as more engaged parties (OR=1.95).

Table 14 **Links between punishment for masturbation or sex play with disturbances in relationship**

	Females	Males
Striving to the establish the current relationship (or marriage)		
Mainly patient	**2.06 (1.27; 3.36)	0.88 (0.40; 1.96)
Mainly partner	0.83 (0.49; 1.42)	*1.89 (1.04; 3.43)
Reasons for marriage		
Fear of loneliness	**2.39 (1.31; 4.38)	0.99 (0.37; 2.62)
	1.70 (0.40; 7.31)	*2.98 (1.36; 6.54)
Overall assessment of sexual intercourse		
Completely dissatisfying	1.41 (0.83; 2.38)	**2.68 (1.36; 5.30)

table continued on the next page

Feelings towards the partner (spouse)		
Reluctance	*1.76 (1.02; 3.04)	1.69 (0.50; 5.65)
Hatred	0.71 (0.10; 5.28)	*5.34 (1.09; 26.21)
Postrzegane uczucia ze strony partnera/partnerki (lub współmałżonka)		
Reluctance	*2.56 (1.29; 5.08)	1.87 (0.65; 5.40)
The nature of the current sexual intercourse		
Fleeting, occasional	**2.79 (1.40; 5.54)	0.98 (0.37; 2.62)
Perceived stability of the relationship and the reasons for its threat		
Fleeting	1.09 (0.26; 4.59)	**5.38 (1.94; 14.96)
Uncertain, partner wants to break up	---	**5.10 (1.65; 15.81)
Overall assessment of the relationship (marriage)		
It goes very bad	1.47 (0.81; 2.65)	**3.55 (1.67; 7.54)
Position of patients in their relationship (marriage)		
Worse, weaker	1.22 (0.81; 1.84)	*1.88 (1.02; 3.46)
The proportion of involvement in the previous emotional relationships		
Patient	***1.95 (1.37; 2.78)	1.49 (0.92; 2.42)

*p<0.05. **p<0.005. ***p<0.0005. in brackets there are values of 95% of confidence intervals estimated for the odds ratios coefficients '---' impossible to assess OR coefficients have been marked

Discussion

The results of the study tally with the literature referenced in the Introduction and also with the results of other analyses [2], which demonstrates the links between traumatic events in childhood and adolescence and sexual dysfunctions in adulthood. In the study they were not discussed by means of symptoms from the symptom questionnaire but the general assessment of the link in the area. Furthermore, more links were observed. They concerned the patients' relationship dysfunctions (probably effects of traumas) which are not communicable through symptoms, at least in a direct manner. The links indicate that some patients experience serious interpersonal dysfunctions, in particular, in their relationships with regards to the perception of their stability, feelings to and from the partner or power division. Such dysfunctions have been discussed for a long time [45, 46, 51]. Sometimes the discussion was related to patients' traumas experienced in the past. However, the literature seems to pay insufficient attention to a formal analysis of the impact of common in clinical observation "less traumatic" circumstances (such as "asexual" way of up-bringing, insufficient sex education from parents or guardians in childhood and adolescence) on later difficulties in close relationships, particularly partner relationships and sexual life.

Obviously, one of the more straightforward explanations for the dysfunctions discussed above is to say that the patients suffer from personality disorders (traumas increase their risks: e.g. [52, 53]) or the presence of social fear or post-traumatic hostility [54]. Elimination of secondary diagnoses or description of intermediary mechanisms in the discussed research on the links goes beyond the scope of the study and is deemed its limitation. Another justification for women who were raped during initiation and demonstrate hostility might be a clinical observation that the perpetrator stayed as the victim's partner or husband. Additionally, the difference in reaction to "mostly undesired" initiation in which men more often felt weaker/worse than their current partners (or wives), whereas women after the same experience felt better/stronger than their partners, might be explained in cultural terms as a forced (not raped but encouraged) woman feels "decent", but a man does not.

Other possible mechanisms, which are worth considering but were not discussed in available analysis results, that cause trauma victims' later relationship dysfunctions might be post-traumatic bounder breaking and its consequent difficulties with their regulation, re-traumatisation caused by dissimilar trauma e.g. family condemnation or incompetent probe (known from clinical practice). Other influences such as incorrect education and up-bringing e.g. a lack of sex education or parents' asexual attitudes can only partly be traced in the current retrospective data encompassing many years.

Cultural and biological differences related to sex as well as the differences in frequency of traumas and their experience [31] seem to correlate with a lower number of male group (typical of psychotherapy patient group in the last few decades), which makes it more difficult to explain the differences in the results of male and female patients.

While observing the links with the frequency of sexual life, the conclusions from meta-analyses should be considered [55]. They suggest that the frequency of sexual contacts is an extremely little accurate and stable parameter of a couple's relationship. It is dependent on many factors such as age, race, continent, length of a relationship, family planning or study methodology.

Among different aspects of aggression and violence in a relationship, police interventions turned out to be a marker of a significant degree of disagreement/violence between partners in a relationship, which tallies with literature [56]. The study confirms the common observation (e.g. [57]) that violence in a partner relationship context substantially decreases the feeling of security related to the future and it also seems to increase the feeling that the relationship is not stable. As demonstrated in clinical practice and research, rape is connected with victims' inadequate feeling of guilt and shame together with the pathological need to avoid demonstrating the trauma and receiving support. It is particularly related to a risk of post-traumatic disorders and, as it can be assumed, it refers particularly to the phenomenon of raping a victim during sexual initiation. In other research on accumulation of different aspects of a trauma it will be possible to specify the link of an accumulated impact of such violence accompanying the initiation with other traumatic circumstances such as young age.

Incest or its attempt also proved its dysfunctional effect on the way patients function later. Parents' punitive attitude to masturbation again turned out to be an unfavourable circumstance.

To sum up, introducing in psychiatric, psychological and other medical specialisation interviews a greater focus on traumatic events may lessen the burden on post-traumatic patients and non-psychiatric healthcare system as well [58]. It is likely to require a better training of medicine and psychology students in confrontation with sexual problems including sexual traumas that were experiences by themselves and their patients [59].

Conclusions

1. The presence of some life events in the field of sexuality, obtained in an interview from patients qualified for psychotherapy, was related in a statistically significant manner with a higher risk of dysfunctions in their current sexual life and partner relationship or marriage.
2. The events, which were particularly traumatic in relation to the way the patients functioned currently, included sexual initiation by rape, early sexual initiation, incest or its attempt. The same links could also be traced in unfavourable circumstances rather than the ones having the character of a visible trauma such as avoidance of sex education, punishment for masturbation or sex plays or "mostly undesired initiation".
3. The most common areas of dysfunctions which were observed were dysfunctional reasons for forming a relationship or marriage such as social pressure, asymmetry in desires of a relationships, unequal division of power in a relationship, its instability, sub-optimal ways of solving conflicts and often serious dysfunctions in sexual life e.g. low frequency of sexual contacts or insufficient satisfaction.
4. The above-discussed links were different in men and women, which sometimes could be interpreted as the effects of cultural influences.
5. All discussed analysis results were obtained by means of a simple structured interview, which on the one hand allows for the recommendation that it be used in a routine clinical practice and in a medical-psychological interview, but on the other hand, it encourages further exploration through the use of more accumulated and recent tools of clinical scale types.
6. In the light of the obtained results and analysed literature, the impact of accumulated traumatic events and their placement in time needs further analysis.

The results of the study were partially presented at conferences: *Neurotic Disorders. Therapy, Research and Didactics. 30th Anniversary of Psychotherapy Department CM UJ* (Cracow, 10-11th June 2006); 2nd International Scientific Conference *Modern Diagnostics in Psychotherapy. Pharmacotherapy and Psychotherapy. One Aim, Two Paths.* (Wisła, 11-13th December 2008); 40th SPR International Annual Meeting (24-27th June 2009, Santiago de Chile) and during 43rd Convention of Polish Psychiatrists (Poznań, 23-26th June 2010).

Acknowledgements: *Statistical consultations: dr Maciej Sobański. The study was partially funded by grants: K/ZDS/000422 i 501/NKL/270/L (dr J.A.Sobański) K/ZDS/002310 (dr hab. K. Rutkowski) i K/DSC/000018 (Ł.Müldner-Nieckowski, MD).*
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References

1. Samelius L, Wijma B, Wingren G, Wijma K. *Somatization in abused women*. J. Womens Health (Larchmt) 2007; 16(6): 909–918.
2. Sobański JA, Klasa K, Müldner-Nieckowski Ł, Dembińska E, Rutkowski K, Cyranka K. *Seksualne wydarzenia urazowe a obraz zaburzeń nerwicowych. Objawy związane i niezwiązane z seksualnością*. Psychiatr. Pol. 2013; 47(3): 411–431.
3. Maniglio R. *The impact of child sexual abuse on health: a systematic review of reviews*. Clin. Psychol. Rev. 2009; 29(7): 647–657.
4. Klanecky AK, McChargue DE. *Vulnerability to alcohol use disorders following early sexual abuse: The role of effortful control*. Addict. Res. Theory 2013; 21(2): 160–180.
5. Warzocha D, Pawełczyk T, Gmitrowicz A. *Associations between deliberate self-harm episodes in psychiatrically hospitalised youth and the type of mental disorders and selected environmental factors*. Arch. Psychiatry Psychother. 2010; 2: 23–29.
6. Kuo JR, Goldin PR, Werner K, Heimberg RG, Gross JJ. *Childhood trauma and current psychological functioning in adults with social anxiety disorder*. J. Anxiety Disord. 2011; 25(4): 467–73.
7. Makara-Studzińska M, Żoga J, Grzywa A. *Zaburzenia odżywiania a doświadczenie wykorzystania seksualnego w dzieciństwie – przegląd badań*. Post. Psychiatr. Neurol. 2006; 15 (4): 297–300.
8. Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V. i wsp. *Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study*. Am. J. Prev. Med. 1998; 14(4): 245–258.
9. Johnson L. *Suggestions for further understanding of mediating factors of sexual arousal dysfunction among women with a history of childhood maltreatment*. J. Sex Marital Ther. 2013; 39(4): 300–302.
10. Kimerling R, Alvarez J, Pavao J, Kaminski A, Baumrind N. *Epidemiology and consequences of women's revictimization*. Womens Health Issues. 2007; 17(2): 101–106.
11. Campbell R, Greeson MR, Bybee D, Raja S. *The co-occurrence of childhood sexual abuse, adult sexual assault, intimate partner violence, and sexual harassment: A mediational model of posttraumatic stress disorder and physical health outcomes*. J. Cons. Clin. Psychol. 2008; 76(2): 194–207.
12. Trickett PK, Noll JG, Putnam FW. *The impact of sexual abuse on female development: Lessons from a multigenerational, longitudinal research study*. Dev. Psychopathol. 2011; 23(2): 453–476.
13. Negriff S, Noll JG, Shenk CE, Putnam FW, Trickett PK. *Associations between nonverbal behaviors and subsequent sexual attitudes and behaviors of sexually abused and comparison girls*. Child Maltreat. 2010; 15(2): 180–189.
14. Kendra R, Bell KM, Guimond, JM. *The impact of child abuse history, PTSD symptoms, and anger arousal on dating violence perpetration among college women*. J. Fam. Violence 2012; 27(3): 165–175.
15. McCartan LM, Gunnison E. *Individual and relationship factors that differentiate female offenders with and without a sexual abuse history*. J. Interpers. Violence 2010; 25(8): 1449–1469.

16. Kobus M, Gromska J, Krzykowski G. *Urazy seksualne w dzieciństwie jako przyczyna późniejszych przestępstw seksualnych*. Psychiatr. Prakt. Ogólnolek. 2002; 2(4): 235–238.
17. Bramsen RH, Lasgaard M, Koss MP, Shevlin M, Elklit A, Banner J. *Testing a multiple mediator model of the effect of childhood sexual abuse on adolescent sexual victimization*. Am. J. Orthopsychiatry 2013; 83(1): 47–54.
18. Schry AR, White SW. *Sexual assertiveness mediates the effect of social interaction anxiety on sexual victimization risk among college women*. Behav. Ther. 2013; 44(1): 125–136.
19. Zwickl S, Merriman G. *The association between childhood sexual abuse and adult female sexual difficulties*. Sex. Relation. Ther. 2011; 26(1): 16–32.
20. Stephenson KR, Hughan CP, Meston CM. *Childhood sexual abuse moderates the association between sexual functioning and sexual distress in women*. Child Abuse Negl. 2012; 36(2): 180–189.
21. Alvarez J, Pavao J, Mack KP, Chow JM, Baumrind N, Kimerling R. *Lifetime interpersonal violence and self-reported chlamydia trachomatis diagnosis among california women*. J. Womens Health 2009; 18(1): 57–63.
22. Busby DM, Walker EC, Holman TB. *The association of childhood trauma with perceptions of self and the partner in adult romantic relationships*. Pers. Relat. 2011; 18(4): 547–561.
23. Larsen CD, Sandberg JG, Harper JM, Bean R. *The effects of childhood abuse on relationship quality: gender differences and clinical implications*. Fam. Relations 2011; 60(4): 435–445.
24. Walker EC, Sheffield R, Larson JH, Holman, TB. *Contempt and defensiveness in couple relationships related to childhood sexual abuse histories for self and partner*. J. Marital Fam. Ther. 2011; 37(1): 37–50.
25. Campbell R, Greeson MR, Bybee D, Raja S. *The co-occurrence of childhood sexual abuse, adult sexual assault, intimate partner violence, and sexual harassment: A mediational model of posttraumatic stress disorder and physical health outcomes*. J. Cons. Clin. Psychol. 2008; 76(2): 194–207.
26. Gobin RL. *Partner preferences among survivors of betrayal trauma*. J. Trauma Dissociation 2012; 13(2): 152–174.
27. Gajowy M, Simon W. *Przemoc, zaniedbanie w dzieciństwie oraz straty ciąży – ich wzajemne powiązania oraz psychologiczne konsekwencje tych powiązań*. Psychiatr. Pol. 2002; 36(6): 911–927.
28. Dennerstein L, Guthrie JR, Alford S. *Childhood abuse and its association with mid-aged women's sexual functioning*. J. Sex Marital Ther. 2004; 30(4): 225–234.
29. Savla JT, Roberto KA, Jaramillo-Sierra AL, Gambrel LE, Karimi H, Butner LM. *Childhood abuse affects emotional closeness with family in mid- and later life*. Child Abuse Negl. 2013; 37(6): 388–399.
30. Ahmad S. *Adult psychosexual dysfunction as a sequela of child sexual abuse*. Sex Relationship Ther. 2006; 21: 405–418.
31. Holmes WC. *Men's self-definitions of abusive childhood sexual experiences, and potentially related risky behavioral and psychiatric outcomes*. Child Abuse & Neglect. 2008; 32(1): 83–97.
32. Walsh K, Galea S, Koenen KC. *Mechanisms underlying sexual violence exposure and psychosocial sequelae: A theoretical and empirical review*. Clin. Psychol. Sci. Pract. 2012; 19(3): 260–275.
33. Sandberg DA, Suess EA, Heaton JL. *Attachment anxiety as a mediator of the relationship between interpersonal trauma and posttraumatic symptomatology among college women*. J. Interpers. Violence. 2010; 25(1): 33-49.
34. Easton SD, Coohey C, O'leary P, Zhang Y, Hua L. *The effect of childhood sexual abuse on psychosexual functioning during adulthood*. J. Fam. Violence 2011; 26(1): 41–50.

35. Roemmele M, Messman-Moore TL. *Child abuse, early maladaptive schemas, and risky sexual behavior in college women*. J. Child Sex. Abuse 2011; 20(3): 264–283.
36. Lacelle C, Hebert M, Lavoie F, Vitaro F, Tremblay RE. *Sexual health in women reporting a history of child sexual abuse*. Child Abuse Negl. 2012; 36(3): 247–259.
37. Waller G. *Perceived control in eating disorders: relationship with reported sexual abuse*. Int. J. Eat. Disord. 1998; 23(2): 213–216.
38. Sobański JA, Klasa K, Rutkowski K, Dembińska E, Müldner-Nieckowski Ł, Cyranka K. *Zapamiętane postawy rodziców pacjenta a obraz zaburzeń nerwicowych. Objawy związane i niezwiązane z seksualnością*. Psychiatr. Pol. 2013; 47(4): 827–851.
39. Scott-Storey K. *Cumulative abuse: Do things add up? An evaluation of the conceptualization, operationalization, and methodological approaches in the study of the phenomenon of cumulative abuse*. Trauma Violence Abuse 2011; 12(3): 135–150.
40. Lacelle C, Hebert M, Lavoie F, Vitaro F, Tremblay RE. *Child sexual abuse and women's sexual health: The contribution of CSA severity and exposure to multiple forms of childhood victimization*. J. Child Sex. Abuse 2012; 21(5): 571–592.
41. Fassler IR, Amodeo M, Griffin ML, Clay CM, Ellis MA. *Predicting long-term outcomes for women sexually abused in childhood: Contribution of abuse severity versus family environment*. Child Abuse Negl. 2005; 29(3): 269–284.
42. Bifulco A, Moran PM, Ball C. *Childhood adversity, parental vulnerability and disorder: Examining inter-generational transmission of risk*. J. Child Psychol. Psychiatry 2002; 43: 1075–1086.
43. Young EA, Abelson JL, Curtis GC, Nesse RM. *Childhood adversity and vulnerability to mood and anxiety disorders*. Depress. Anxiety 1997; 5(2): 66–72.
44. Arboleda MRC, Canton-Cortes D, Duarte JC. *Long term consequences of child sexual abuse: the role of the nature and continuity of abuse and family environment*. Behav. Psychol. 2011; 19(1): 41–56.
45. Makara-Studzińska M, Rudnicka-Drozak E, Kulik TB. *The type of relationship in marriages of patients with neurosis disorders*. Ann. Univ. Mariae Curie Sklodowska Med. 2004; 59(1): 292–296.
46. Makara-Studzińska M. *Zaburzenia nerwicowe a relacje małżeńskie*. Lublin: Wydawnictwo UMCS: 2000.
47. Montesi JL, Conner BT, Gordon EA, Fauber RL, Kim KH, Heimberg RG. *On the relationship among social anxiety, intimacy, sexual communication, and sexual satisfaction in young couples*. Arch. Sex. Behav. 2013; 42(1): 81–91.
48. Czyżkowska A. *Zaburzenia seksualne z perspektywy terapii systemowej*. Przegl. Seksuol. 2009; 18: 28–35.
49. Sobański JA, Müldner-Nieckowski Ł, Klasa K, Rutkowski K, Dembińska E. *Objawy i problemy z zakresu zdrowia seksualnego w populacji pacjentów dziennego oddziału leczenia zaburzeń nerwicowych*. Psychiatr. Pol. 2012; 46: 35–49.
50. Sobański JA, Klasa K, Rutkowski K, Dembińska E, Müldner-Nieckowski Ł. *Kwalifikacja do intensywnej psychoterapii w dziennym oddziale leczenia nerwic*. Psychiatr. Psychoter. 2011; 7(4): 20–34.
51. Ożarowska M. *Wykorzystywanie seksualne dziecka: istota zjawiska, objawy, skutki*. Horyz. Psychol. 2011; 1(1): 89–100.
52. Bierer LM, Yehuda R, Schmeidler J, Mitropoulou V, New AS, Silverman JM. i wsp. *Abuse and neglect in childhood: relationship to personality disorder diagnoses*. CNS Spectr. 2003; 8(10): 737–754.

53. Klatkiewicz A. *Traumatyczne zdarzenia w dzieciństwie a rozwój zaburzenia osobowości borderline*. Now. Lek. 2011; 80(6): 484–492.
54. Roy A. *Childhood trauma and hostility as an adult: relevance to suicidal behavior. Brief report*. Psychiatry Res. 2001; 102(1): 97–101.
55. Schneidewind-Skibbe A, Hayes RD, Koochaki PE, Meyer J, Dennerstein L. *The frequency of sexual intercourse reported by women: A review of community-based studies and factors limiting their conclusions*. J. Sex. Med. 2008; 5(2): 301–335.
56. Wilson JS, West JF, Messing JT, Brown S, Patchell B, Campbell JC. *Factors related to posttraumatic stress symptoms in women experiencing police-involved intimate partner violence*. ANS Adv. Nurs. Sci. 2011; 34(3): E14–E28.
57. Perez S, Johnson DM. *PTSD compromises battered women's future safety*. J. Interpers. Violence 2008; 23(5): 635–651.
58. Fiddler M, Jackson J, Kapur N, Wells A, Creed F. *Childhood adversity and frequent medical consultations*. Gen. Hosp. Psychiatry 2004; 265: 367–377.
59. Müldner-Nieckowski Ł, Klasa K, Sobański JA, Rutkowski K, Dembińska E. *Seksualność studentów medycyny – rozwój i realizacja potrzeb seksualnych*. Psychiatr. Pol. 2012; 46(1): 35–49.

ANNEX

Table 15. **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 not aware	26%	28%
65.4. Totally 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%
72.0. Has not had sex yet	**14%	**18%
72.1. Initiation before13 year of age	1%	1%
72.2. Initiation at the age 14-6	*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 rape	***4%	***1%
Incest of an attempt of incest		
74.2. An incest or its attempt did occur	4%	3%

***p<0.0005, **p<0.005, *p<0.05 two-tailed test for two stratum weights (percentages) see [49]