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The Effects of Childhood Trauma on Sexual Function in Panic Disorder Patients

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ABSTRACT

The effects of childhood trauma on sexual function in panic disorder patients

Objective: The aim of this study is to investigate the relationship between childhood physical/sexual abuse, suicide attempts, self-harming behavior and sexual functioning in patients with panic disorder.

Method: 81 patients with panic disorder were included in the study. Participants were evaluated by using Childhood Trauma Questionnaire, sociodemographic form and Arizona Sexual Experiences Scale (ASEX).

Results: The frequency of physical abuse history was 48.1% and the frequency of sexual abuse was 9.9% in the sample. Female participants with a history of physical abuse had significantly higher scores in the items of sexual desire, arousal, ability to reach orgasm, satisfaction from orgasm and total ASEX scores than those without a history of physical abuse. Female participants with a sexual abuse history also had higher scores in the items of arousal, ability to reach orgasm and total ASEX scores. No significant difference was found between male participants with regard to physical/sexual abuse history. In a regression model, comorbid major depressive disorder rather than abuse history was found to be a predictor of poor sexual functioning.

Conclusion: Female patients with panic disorder who have physical/sexual abuse history have inhibited sexual desire, arousal and orgasm. Sexuality in patients with panic disorder is affected by depression comorbidity as well as sexual and physical abuse history.

Key words: Panic disorder, childhood trauma, suicide, self destructive behaviour, sexual dysfunction

ÖZET

Panik bozukluk hastalarında çocukluk çağı travmatik yaşantılarının cinsel işlev üzerine etkileri

Amaç: Bu araştırmanın amacı, çocukluk çağı cinsel ve fiziksel istismarının (ÇÇCİ/ÇÇFİ), intihar girişimlerinin ve kendine zarar verme davranışlarının, panik bozukluk tanısı almış hastalarda cinsel işlevle ilintisinin incelenmesidir.

Yöntem: 81 panik bozukluk hastası bu çalışmaya alındı. Katılımcılar, Çocukluk Çağı Travma Anketi, sosyodemografik form ve Arizona Cinsel Yaşantılar Ölçeği (ACYÖ) ile değerlendirildi.

Bulgular: Katılımcıların %48.1'inde fiziksel istismar ve %9.9'unda cinsel istismar öyküsü vardı. Fiziksel istismara uğramış olan kadın katılımcıların toplam ACYÖ puanları ile cinsel istek, uyarılma, orgazma ulaşabilme ve orgazm tatmini puanları, fiziksel istismar öyküsü olmayan katılımcıların puanlarından yüksekti. Cinsel istismar öyküsü bulunan kadın katılımcıların puanları; uyarılma, orgazma ulaşabilme ve toplam ACYÖ puanları açısından, cinsel istismar öyküsü bulunmayanların puanlarıyla karşılaştırıldığında, anlamlı olarak daha yüksek bulundu. Erkek katılımcılar için böyle bir farklılık saptanmadı. Regresyon analizine göre, çocukluk çağındaki istismar yaşantılarından ziyade, depresyon komorbiditesi cinsel işlev bozukluğunda yordayıcı olarak belirlendi.

Sonuç: Çocukluk çağı cinsel ve fiziksel istismar öyküsü bulunan panik bozukluk hastalarının cinsel istekleri, uyarılmaları ve orgazmları inhibe olmaktadır. Panik bozukluk hastalarında gözlenen cinsel işlev sorunları, çocukluk çağı taciz yaşantılarının yanı sıra depresyon komorbiditesinden etkilenmektedir.

Anahtar kelimeler: Panik bozukluk, çocukluk çağı travması, intihar, kendine zarar verme davranışı, cinsel işlev bozukluğu

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INTRODUCTION

In recent years, it has been accepted that childhood physical abuse (CPA) and childhood sexual abuse (CSA) can lead to psychiatric disorders in adulthood (1). Epidemiological research also supports the possible association between the childhood physical and sexual abuse (CPSA) and the development of anxiety disorder (2). CPSA is a risk factor for the development of panic disorder; 13% - 54% of patients with panic disorder have a history of abuse (2,3).

Self-injurious behavior (SIB) is common in patients with anxiety disorders (4). The frequency of suicide attempts in patients with panic disorder ranges from 13.3% to 29.4% (5.6). The childhood neglect such as CPA and CSA were also found to be associated with a group of the self-injurious behavior in adulthood (7).

The relationship between anxiety disorders and sexual function is controversial. Several studies found the association between the anxiety disorders and sexual dysfunction. The orgasmic disorders were detected in panic disorder and other anxiety disorders as the most common sexual dysfunction (8.9). However, the studies found no association between the anxiety disorder and sexual dysfunction are also available (10). Mercan et al. (10) reported that there are no significant differences in sexual function between the panic disorder patients and healthy controls.

In women with a history of CSA, the prevalence of decreased sexual drive and inhibited orgasm were reported as 29% and 21%, respectively (3). The effects of CPA, childhood neglect, CSA, suicide attempts and self-injurious behavior on sexual function in patients with panic disorder is unknown. The purpose of this research is to examine the association between the CPSA, suicide attempts and self-injurious behavior with sexual function in patients diagnosed as panic disorder.

METHODS

Participants

The study population consists of 81 patients who were admitted to Şisli Etfal Education and Research Hospital, Anxiety Disorders Outpatient Clinic between November 2006 and September 2007 and had panic disorder according to the DSM-IV-TR diagnostic criteria. Participants were 18-65 years of age. Patients with mental retardation, dementia and general medical problems were excluded. Patients with a history of alcohol/drug addiction were excluded because of their effects on sexual function. Patients with comorbid anxiety disorders (such as post-traumatic stress disorder) which may affect sexual function, were also excluded.

Procedure

After explaining the purpose and design of the study, the patients who accepted to participate signed an informed consent form. Research approved by the local ethics committee. Participants were interviewed using the Structured Clinical Interview for DSM-IV-TR, (SCID-I) (11,12) and Arizona Sexual Experiences Scale (ASEX) (13,14), and Childhood Trauma Questionnaire (15,16) were applied.

Demographic data

Demographic data included gender, age, marital status, education level and profession.

Traumatic experience

Childhood traumatic experiences were evaluated by the Childhood Trauma Questionnaire (CTQ) (15). CTQ includes nine questions about physical abuse, neglect, sexual abuse, suicide and self-injurious behaviors. Responders are asked whether he/she had ever sexual contact with a family member or a stranger at least 5 years older than himself/herself when he/she was under the age of 18. CPA is defined as to be a victim of physical violence from someone at least 5 years older or a family member more than 2 years older, before the age of 16 (16). Responders are asked to rate the physical abuse as “one or more times”, “at least five times”, “many times” or “very frequent and severe”. Similarly, sexual abuse and incest are rated as “once”, “multiple times”, “very often” or “often”.

Sexual function

The Arizona Sexual Experiences Scale (ASEX) is a five-item self-rating scale that quantifies sex drive, arousal, vaginal lubrication/penile erection, ability to reach orgasm, and satisfaction from orgasm (13). ASEX quantifies each sexual function from 1 (no disturbance) to 6 (dysfunction) in a Likert type spectrum. Possible total scores range from 5 to 30, with the higher scores indicating more sexual dysfunction. Sexual dysfunction has been associated with total ASEX score ≥19; single item score ≥5 or 3 items score ≥4 (14).

Statistical Analysis

Data was evaluated by using Statistical Package for Social Sciences (SPSS) 13.0 for Windows. Average scores, standard deviations, and frequencies were calculated. Group differences were assessed by chi-square analysis for categorical variables and t test in the independent groups for continuous variables. Regression analysis was used for correlation. For all tests, significance level was <0.05.

RESULTS

The mean age of participants was 35.8±11.6 and 71.6% of the participants were women. Rates of the primary school, secondary school, and high school degree were 42%, 22.2% and 22.2%, respectively. Most of the participants were married (65.4%); 28.4% of them was single and 2 of them (6.2%) were divorced.

General prevalence

The prevalence of physical/verbal abuse and physical/emotional neglect was 48.1%; 9.9% of participants had a history of CSA. The prevalence of suicide attempts and self-injurious behavior was 19.8%. ASEX scores of participants who had CPA were higher than those who have no CPA. ASEX scores differences between those had CPA or not were significant in sexual drive (p=0.04), arousal (p=0.002), reaching orgasm (p=0.005), orgasm satisfaction (p=0.008) and total ASEX scores (p=0.003); there was no significant differences in scores of lubrication / erection. Table 1 shows the association between trauma, suicide attempts, self-injurious behavior and sexual function in study population (Table 1).

ASEX scores differences between those had CSA or not were significant in arousal (p=0.045), reaching orgasm (p=0.025) and total ASEX scores (p=0.03); there was no significant differences in scores of lubrication / erection. ASEX scores of participants who had suicide attempts, self-injurious behavior were higher than those who have no history. The differences between the groups in drive (p=0.03), reaching orgasm (p=0.04) and total ASEX scores (p=0.03) were significant; there was no significant differences in scores of arousal and vaginal lubrication / erection.

49.6% of the participants had comorbid depression. There were no significant differences between those having CPA, CSA, suicide attempts, and self-injurious behavior or not in the presence of comorbid depression. ASEX scores of participants having comorbid depression were higher than those have no depression (Table 2).

Table 1: The association between trauma, suicide attempts, self-injurious behavior, and sexual function in study population (with or without history of abuse)

ASEX item	PA/N+ n=39	PA/N- n=42	t	p	SA+ n=8	SA- n=73	t	p	SA/SIB+ n=16	SA/SIB- n=65	t	p
Sexual drive	3.90	3.36	1.73	0.04	4.5	3.52	1.88	0.053	4.25	3.46	2.02	0.03
Sexual arousal	3.97	2.93	3.17	0.002	4.5	3.32	2.07	0.045	3.94	3.31	1.45	0.13
Lubrication/ Erection	3.28	2.79	1.62	0.07	3.75	2.95	1.57	0.14	3.31	2.95	0.92	0.45
Orgasm	4.05	3.29	2.70	0.005	4.63	3.55	2.23	0.025	4.25	3.51	2.04	0.04
Orgasm satisfaction	3.58	2.74	2.64	0.008	4.0	3.05	1.71	0.18	3.94	2.95	2.04	0.04
ASEX total	18.87	15.00	2.76	0.003	21.38	16.37	2.25	0.03	19.88	16.12	2,02	0.03

t: Student t test, PA: physical abuse, N: neglect, SA: sexual abuse, SA: suicide attempt, SIB: self-injurious behavior, ASEX: Arizona Sexual Experiences Scale, +: present; -: absent

When ASEX scores were assessed by regression analysis according to the presence of childhood physical and sexual trauma, suicide attempts, self-injurious behavior, and comorbidity, the presence of comorbidity was determined as a predictive factor for the level of sexual dysfunction (data not shown).

Female gender

In regard of the association between ASEX score and CPA/ CSA history in female patients, women with a history of CPA had higher ASEX scores than women with no history of CPA. While there was significant difference between the two groups in sexual arousal (p=0.01), reaching orgasm (p=0.009), orgasm satisfaction (p = 0.008) and total ASEX scores, sexual drive and vaginal lubrication / penile erection scores had no difference. There was no significant difference in ASEX scores between the groups having CSA or not.

ASEX scores of the participants with a history of suicide attempts and self-injurious behavior were significantly higher than those have no similar history. There was significant difference between the two groups in orgasm satisfaction (p=0.03) and ASEX total scores (p=0.04); no significant differences was found in sexual drive, arousal, vaginal lubrication and reaching orgasm. Results are shown in Table 3 (Table 3).

Scores of sexual drive (p=0.005), arousal (p=0.003),

Table 2: Sexual function in comorbid depression

ASEX item	Comorbidity (+) n=39	Comorbidity (-) n=42	t	p
Sexual drive	4.32±1.09	3.00±1.43	-4.72	<0.001
Sexual arousal	4.11±1.35	2.81±1.54	-4.21	<0.001
Lubrication/erection	3.53±1.33	2.54±1.31	-3.24	0.001
Orgasm	4.18±1.21	3.17±1.28	-3.58	0.001
Orgasm satisfaction	3.79±1.44	2.56±1.36	-3.90	<0.001
ASEX total	19.89±5.42	14.07±5.91	-3.90	<0.001

t: Student t test, ASEX: Arizona Sexual Experiences Scale

Table 3: The association between the trauma, suicide, self-injurious behavior and sexual function in female patients with or without abuse history

ASEX item	PA/N+ n=29	PA/N- n=29	t	p	SA+ n=7	SA- n=51	t	p	SA/SIB+ n=13	SA/SIB- n=45	t	p
Sexual drive	4.28	3.69	2.30	0.07	4.57	3.90	1.38	0.23	4.46	3.84	1.20	0.14
Sexual arousal	4.31	3.34	3.12	0.01	4.57	3.72	1.60	0.14	4.30	3.68	1.21	0.18
Lubrication	3.59	3.14	1.68	0.14	3.86	3.29	1.18	0.22	3.61	3.28	0.68	0.46
Orgasm	4.45	3.66	2.71	0.009	4.71	3.96	1.65	0.73	4.53	3.91	1.29	0.06
Orgasm satisfaction	4.03	3.07	2.86	0.008	4.14	3.47	1.23	0.40	4.38	3.31	2.12	0.03
ASEX total	20.76	16.76	2.93	0.007	21.86	18.33	1.72	0.11	21.53	17.95	1.91	0.04

t: Student t test, PA: physical abuse, N: neglect, SA: sexual abuse, SA: suicide attempt, SIB: self-injurious behavior, ASEX: Arizona Sexual Experiences Scale, +: present; -: absent

Table 4: The association between the comorbid depression and sexual function in female/male patients with panic disorder

ASEX item	♀ Comorbidity (+) n=31	♀ Comorbidity (-) n=27	t	p	♂ Comorbidity (+) n=8	♂ Comorbidity (-) n=15	t	p
Sexual drive	4.50±1.07	3.46±1.50	-2.94	0.005	3.63±0.92	2.20±0.86	-3.78	0.001
Sexual arousal	4.40±1.16	3.19±1.67	-3.45	0.003	3.00±1.51	2.13±0.991	-1.56	0.173
Lubrication/ Erection	3.77±1.28	2.89±1.37	-2.23	0.016	2.63±1.19	93±0.962.40	-1.64	0.182
Orgasm	4.47±1.17	3.62±1.24	-2.84	0.011	3.13±0.64	±0.99	-1,25	0.046
Orgasm satisfaction	4.10±1.27	2.96±1.48	-3.13	0.003	2.63±1.51	1.87±0.74	-1.43	0.117
ASEX total	21.20±4.86	16.12±6.04	-2.69	<0.001	15.00±4.81	10.53±3.64	-2.35	0.041

t: Student t test, ASEX: Arizona Sexual Experiences Scale

vaginal lubrication ($p=0.016$), reaching orgasm ($p=0.011$), orgasm satisfaction ($p=0.003$) and ASEX total scores ($p<0.001$) of women with comorbid depression were higher than women without comorbid depression. The association between comorbid depression and sexual function in women are shown in Table 4 (Table 4).

Male gender

No significant difference was found between the men with or without history of CPA/CSA in sexual drive, arousal, erection, orgasm, orgasm satisfaction scores. Similarly, ASEX scores were not different between the men with or without suicide / self-injurious behavior. Scores of sexual drive ($p<0.001$), reaching orgasm ($p=0.046$) and ASEX total ($p=0.041$) were higher in men with comorbid depression than those without depression. The association between the comorbid depression and sexual function by gender are shown in Table 4 (Table 4).

The scores of sexual drive ($p<0.001$), arousal ($p<0.001$), vaginal lubrication / penile erection ($p<0.001$), reaching orgasm ($p<0,001$), orgasm satisfaction ($p<0.001$) and total ASEX ($p<0.001$) in panic disorder patients with comorbid depression were found higher than those without comorbid depression.

DISCUSSION

In recent years, the increasing interest was emerged about the sexual dysfunction in panic disorder and CPSA. This research including 81 patients with panic disorder is a step to examine the relationship between the aforementioned issues.

The presence of sexual dysfunction in panic disorder is controversial; while several studies reported sexual dysfunction in these patients (8.9), others not (10). Weissman et al. (5), found that anxiety disorder has an important role in the pathophysiology of reduced sexual drive. The sexual dysfunction was observed in 50% and 64% of OCD and GAD patients, respectively (17). Freund and Steketee (18) reported that sexual dysfunction in patients with OCD is relatively less common and over 73% of patients experience dissatisfaction rather than sexual dysfunction.

The prevalence of CSA/CPA in panic disorder patients have been reported between 13% and 54% (2,3). Similarly, we found the prevalence of CSA/CPA as 48.1%. In line with these results, in our study, 12.1% of female patients and 4.3% of male patients reported CSA. In our study, it has been observed that in patients with a history of childhood physical abuse and neglect had decreased sexual drive and inhibited arousal and orgasm. In addition, female patients with a history of physical abuse and neglect had inhibition in arousal, orgasm and orgasm satisfaction. A previous study found no association between the CPA/CSA history and sexual dysfunction in male patients (19). The same study reported that there was significant individual differences in terms of sexual drive among men (20.6% of men reported increased sexual drive when they are anxious or stressed). Several reviews suggested that one-third of individuals exposed to childhood abuse would not develop adult psychiatric problems (20). Women are more likely to be victims of violence and sexual harassment (21) and also they are more likely to develop anxiety disorders (22). Although this suggests that women suffer from CPSA more than men, in samples including predominantly male gender it would be better to examine the sexual function.

In previous studies, the long-term effects of abuse on sexual function have been observed especially in women. Although there are the studies suggesting that childhood sexual abuse was not a predictor for sexual dysfunction in men (3), other studies demonstrated an association between the sexual dysfunction and sexual abuse (23). Large clinical studies are needed to reveal the influence of abuse on sexual function in men and women.

Studies suggest that there is an association between the suicide attempts / self-injurious behavior and physical/sexual abuse, and depression and anxiety disorders (1). Although it has been reported that exposure to childhood abuse could cause suicidal behavior and sexual problems in adult life (24), no detailed data showing the association between the suicide attempts/self-injurious behavior and sexual function are available. In our study, those with a history

of suicide attempts/self-injurious behavior had higher ASEX total, sexual drive, orgasm and orgasm satisfaction scores than those have no similar history. In female patients with a history of suicide attempts and self-injurious behavior, the orgasmic satisfaction was lower than those have no similar history.

In our study, prevalence of the comorbid depression was 46.9% and it was in line with previous studies reporting prevalence from 20% to 75% (25,26). The prevalence of the comorbid depression was not different between the groups with or without physical / sexual abuse and history of suicide attempts.

It has been reported that almost all areas of sexual function are affected in depression, (27). In our study, female patients with comorbid depression had higher scores in sexual drive, arousal, vaginal lubrication, orgasm, reaching orgasm, satisfaction, and ASEX total than those without depression; suggesting that they have more sexual dysfunction. However, Nofzinger et al. (21) reported that depressed patients were no different from controls in terms of sexual drive. In male patients with comorbid depression, the scores of sexual desire, reaching orgasm and total ASEX were higher than non-depressed women with panic disorder. Comorbid depression in panic disorder increases sexual dysfunction.

This study has limitations. Traumatic patients could have tendency to hide their trauma and also they could be amnesic. This might have caused the underestimation. In addition, sexual function was assessed with only ASEX. The other limitation was that the drugs (antidepressant and anxiolytic) receiving by the patients also affect sexual functions. For this reason, it is suitable to assess the sexual function in patients not using antidepressants. Moreover, small sample and women predominancy also hinder the findings to generalize. Because the patients with similar sexual experiences and similar intellectual capacities could express themselves better, it is thought to obtain more meaningful results. Exclusion criteria should include those with previous sexual dysfunction and necessary preliminary investigations should be performed.

In this study, the association between the childhood physical abuse/neglect, sexual abuse, suicide attempts and self-injurious behavior, and sexual function were examined. The sexual function should be questioned especially in panic disorder patients having comorbid depression; childhood abuse and suicide attempts should be evaluated in patients with sexual dysfunction. Similarly, the patients with a history of abuse and suicide attempts should be examined in terms of sexual function.

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