



RESEARCH ARTICLE

The relationship of childhood trauma, anxiety, and sexual satisfaction in Turkish men with erectile dysfunction

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ABSTRACT

Objective: Childhood traumas (CT), particularly sexual abuse, are linked with sexual dysfunction and reduced sexual satisfaction. This study explores the association between CT, anxiety, and sexual satisfaction in individuals with erectile dysfunction (ED).

Method: The study cohort consisted of 93 patients with ED and 95 control group volunteers. Participants completed self-report forms on demographic data and sexual histories, along with the Childhood Trauma Questionnaire (CTQ), the State and Trait Anxiety Inventory (STAI), and the Golombok-Rust Inventory of Sexual Satisfaction (GRISS).

Results: Forty participants from the ED groups also had a co-diagnosis of premature ejaculation (PE). Those with co-morbid PE were categorized as a separate group (ED + PE). Physical abuse, sexual abuse, and minimization as measured by the CTQ, along with impotence, infrequency, and dissatisfaction as measured by the GRISS, were significantly lower in the control group compared to the ED and ED + PE groups ($p < 0.001$). Anxiety scores were significantly different between the ED + PE group and both the ED and control groups ($p < 0.001$). A history of childhood sexual abuse was linked to avoidance behavior ($p < 0.05$). Significant correlations were observed between emotional maltreatment and PE ($p < 0.05$), impotence and minimization ($p < 0.001$), impotence and psychical neglect ($p < 0.05$), and tactile avoidance and emotional neglect ($p < 0.01$).

Conclusion: This study highlights the importance of CT, including types other than sexual abuse, in contributing to sexual dysfunction and diminished satisfaction.

Keywords: Childhood trauma, child sexual abuse, anxiety, sexual satisfaction, erectile dysfunction, premature ejaculations

INTRODUCTION

Erectile dysfunction (ED) is a recurrent inability to achieve or maintain an erection during sexual intercourse with a partner. Approximately 30% of men experience at least one type of sexual dysfunction (SD)

(1). Erectile dysfunction is one of the most common male sexual problems, with global prevalence rates ranging from 3% to 76.5%. This variation may be attributed to methodological differences and the diverse ages of study populations (2). The prevalence and incidence of ED tend to increase with age (3). For

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instance, ED affects 2% of men under the age of 40–50 and 40–50% of men older than 60–70 years. In Türkiye, the prevalence of ED is estimated at 33% among men over 40 years of age (4). According to a survey, 59.7% of 2,288 males in Türkiye reported arousal or erectile problems (5).

A normal penile erection is a neurovascular event influenced by psychological factors and regulated by the endocrine system (6). Adult males with ED often experience withdrawal from sexual intimacy, leading to psychosocial issues such as low self-esteem, depression, and anxiety. These challenges can decrease work productivity and diminish the quality of life (QoL) for both the individuals and their female partners (7). Various factors increase the risk of developing ED, including lifestyle choices, genetic predispositions, neurological-psychiatric conditions, substance abuse, and cardiovascular diseases. The risk is particularly pronounced in the presence of comorbidities such as hypertension, obesity, diabetes, lower urinary tract symptoms, cardiovascular disease, neurological disorders, penile injuries, drug use, and pain (8, 9). In a survey, vascular disorders, chronic prostatitis or benign prostatic enlargement, and chronic obstructive pulmonary disease have been identified as significant risk factors for moderate to severe ED. Neurological and endocrinological disorders may affect ED. Limited data are available on the association of ED with endocrinological disorders. Aging is an essential factor contributing to ED. Cardiovascular conditions, hypertension, and other comorbidities become increasingly important as patients age. Some drugs that can cause ED include antidepressants, antihypertensives, diuretics, antipsychotics, non-steroidal anti-inflammatory drugs, opioids, and recreational drugs (4, 10–13).

Psychogenic ED is the primary cause of ED in men under 40 years of age (13). Depression has a stronger association with ED than anxiety, although they often co-occur (10). Various psychological factors, such as stress, general anxiety, and performance anxiety, may influence male sexual difficulties and contribute to their onset and persistence. Anxiety can be a factor in the development of ED, especially during the initial stages of sexual activity. Anxiety can lead to an excessive focus on erection quality, which can negatively affect both arousal and erection. A single instance of sexual failure can lead to anxiety, loss of sexual confidence, and fear, resulting in avoidance of sexual experiences that can perpetuate a vicious cycle of anxiety and ED. Fear of ED during sexual

activity can also lead to decreased sexual desire (13, 14). The presence of SD in the partner, relationship problems such as communication issues between partners, different sexual desires, poor body image perception, a history of sexual or emotional abuse, and psychiatric comorbidities are common factors in the etiology of ED (5). Research suggests that poor mental health, specifically depression and anxiety, are predictive factors for premature ejaculation (PE) and ED in individuals under 40 years of age.

Premature ejaculation stems from the interplay of biological and psychological factors. Disruptions in these processes can lead to PE, which may manifest when one or several of these mechanisms are compromised, highlighting the complex nature of PE that involves both physical and psychological elements (15).

Childhood traumas (CT) expose children to situations that hinder their physical, emotional, mental, and sexual development, and harm their physical or mental health, often inflicted by their parents and other adults. Sexual dysfunctions are higher in individuals with childhood sexual abuse (CSA) compared to the general population (16). Several studies have suggested that men who have experienced CSA are more likely to develop SDs later in life. Adults with a history of CSA are more likely to experience sexual difficulties than those without such a history (17, 18). For both sexes, there is a significant association between CSA and symptoms of SD. Studies suggest that CSA may be reported less frequently by men than women, possibly due to male reluctance to disclose such experiences. Men who have experienced CSA have a higher rate of SD than those who have not (19, 20). Male survivors of CSA are more likely to experience PE, ED, and low sexual desire compared to those without a history of CSA. Specifically, they are reportedly twice as likely to experience PE, three times more likely to encounter ED, and twice as likely to have diminished sexual desire. One-third of abused men have been diagnosed with ED, 15% with PE, and 24% with Hypoactive Sexual Desire Disorder—a condition characterized by persistently or recurrently deficient sexual fantasies or desires, causing distress or interpersonal difficulty (18, 20, 21). Childhood sexual abuse may also be associated with a decrease in sexual satisfaction, an element of sexual well-being; however, some studies indicate no such relationship (18, 19, 22). Childhood sexual abuse may be related to sexual satisfaction in women but not men (23). Studies show a relationship between SD and physical

abuse in women, but data for men are insufficient (24, 25). In one study, cumulative CT, including physical abuse, psychological abuse, and psychological neglect, is indirectly linked to sexual satisfaction (26). In the context of CT and CSA, minimization refers to the tendency of individuals to downplay or diminish the significance of traumatic experiences they may have encountered. This behavior suggests that individuals are less inclined to openly acknowledge or report such traumas, potentially due to factors such as discomfort, stigma, or perceived societal expectations (27).

This study aims to examine the effects of CT and anxiety on sexual dysfunction and sexual satisfaction in people with ED. The study's first hypothesis posits that CT are more frequent and anxiety levels are higher in men with ED. Additionally, it hypothesizes that comorbid PE in people with ED may exacerbate the level of sexual dysfunction. The second hypothesis asserts that CT and anxiety negatively affect sexual satisfaction in those with ED. The null hypothesis for the first hypothesis is that there is no difference in the frequency of CT and anxiety levels between men with ED and men without ED. The null hypothesis, or the second hypothesis, states that there is no relationship between CT, anxiety, and sexual satisfaction among men with ED.

METHODS

The study was conducted in accordance with the Helsinki Declaration (28). The study protocol was approved by the Diskapi Yildirim Beyazit Training and Research Hospital Clinical Research Ethical Committee (approval no: 105/05, date: February 22, 2021).

Participants

The study included 93 ED patients and 95 volunteers from the control group (CG), recruited from the Psychiatry and Urology Clinic at Diskapi Yildirim Beyazit Training and Research Hospital between February 2021 and January 2022. The convenience sampling method was used for its time efficiency. Volunteers aged between 18 and 65, who were literate and capable of filling out the scales, were included in the study. The control group consisted of patients from the Psychiatry and Urology Clinic. Participants in both groups underwent history examinations and laboratory tests in the urology clinic. Individuals not diagnosed with any organic pathology, such as hypogonadism,

neurological diseases, and diabetes mellitus that could cause sexual dysfunction, were included in the study. The patients participating in the study were thoroughly informed, and informed consent was obtained. The study adhered to the principles outlined in the Helsinki Declaration. Both groups were screened for childhood traumas, ED, and PE, according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) by the Structured Clinical Interview for DSM-5 Disorders (SCID-5) in Turkish (29, 30).

Psychometric Measurements Tools

Demographic Data and Sexual History Form: A self-report form that includes questions about age, gender, education, and the psychiatric and medical histories of the volunteers. Additionally, this form evaluates sexual desire, foreplay, frequency, duration, arousal, and satisfaction regarding sexual intercourse.

Childhood Trauma Questionnaire (CTQ)

A 28-item scale developed by Bernstein et al. (31), evaluating abuse and neglect experiences before the age of 20. It comprises six subscales: physical abuse, sexual abuse, emotional abuse, emotional neglect, physical neglect, and minimization. The CTQ was adapted into Turkish by Sar et al. (32).

State and Trait Anxiety Inventory (STAI)

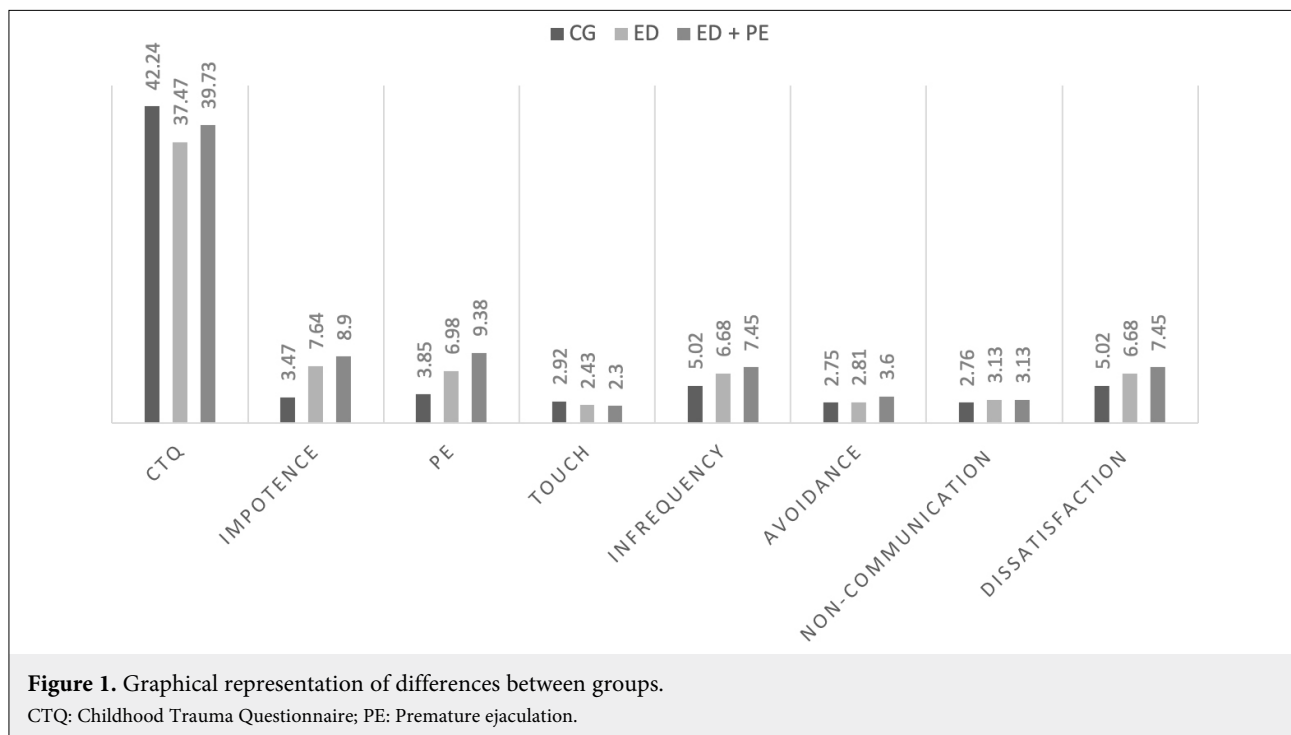
Originally developed by Spielberger et al. (33), the Turkish adaptation was tested by Oner and Le Compte in 1985. The STAI is a 4-point Likert-type self-report scale with two subscales, each containing 20 items that measure state and trait anxiety. Higher scores indicate higher anxiety levels (34).

Golombok-Rust Sexual Satisfaction Scale (GRISS)

Developed by Golombok and Rust in 1986 (35), the GRISS is a tool for evaluating the quality of sexual intercourse and SDs. It has separate forms for men and women, each containing 28 questions. The male form includes subscales for frequency, communication, satisfaction, avoidance, touch, impotence, and PE. High scores indicate a deterioration in sexual functions and the quality of the relationship. The GRISS was adapted into Turkish by Tugrul et al. (36).

Statistical Analysis

Data were analyzed using Jamovi (Version 2.3.21.0). Demographic and clinical characteristics were presented descriptively, with mean and standard deviation for continuous variables, and



frequency and percentage for categorical variables. Relationships among continuous variables were examined through Pearson correlation analysis. Given that concurrent PE may influence outcomes, individuals with both ED and comorbid PE were treated as a distinct subgroup for analysis. Data were divided into three groups for statistical purposes: ED only, ED with comorbid PE, and the CG. Differences between groups were evaluated using one-way Analysis of Variance (ANOVA) with a post hoc test. Confidence intervals of 95% were considered statistically significant. A power analysis conducted with G*Power (37) for an alpha error at 0.05 and an effect size at 0.5 suggested a sample size of 88 per group to compare the two groups.

RESULTS

Descriptive Statistics for Demographic and Clinical Data, Differences in Scales Among Groups

The study included 93 patients with ED and 95 healthy volunteers in the control group. Forty (43%) of the patient sample were diagnosed with comorbid PE (ED + PD). There was no significant difference in age among the groups according to one-way ANOVA analyses ($p=0.084$). Marriage rates also showed no significant difference across all groups according to a 2 x 3 contingency table ($\chi^2=4.45$, $p=0.108$).

According to ANOVA analyses, physical abuse, sexual abuse, and minimization scores were significantly different between the CG and both the ED and ED + PE groups ($p<0.05$). However, there was no difference between the ED and ED + PE groups ($p>0.05$). Childhood Trauma Questionnaire scores were measured higher in the CG than in other groups, but the difference was not statistically significant ($p=0.064$), suggesting that this result might be random and not significant. For the GRISS, the scores for impotence, infrequency, and dissatisfaction were significantly different in the ED and ED + PE groups compared to the CG ($p<0.05$). However, there was no difference between the ED and ED + PE groups ($p>0.05$). ANOVA analysis revealed significant differences in PE scores across all three groups ($p<0.05$). For anxiety, trait anxiety scores were significantly different between the ED + PE group and both the ED and control groups ($p<0.05$). However, there was no difference between the ED and control groups ($p>0.05$). Participant data and differences among groups are detailed in Table 1 (Fig. 1).

Correlations Among Scales in ED and ED + PE Groups

Statistically significant correlations were identified between some scales by Pearson correlation analyses for 93 individuals with ED. Pearson correlation coefficients and level of significance are presented in Table 2.

Table 1: Clinical variables and differences among groups

	Groups			p	Post-hoc analysis differences b		
	CG	ED	ED+PE		CG-ED	CG-ED+PE	ED-ED+PE
N	95	53	40				
Age, Mean (SD)	40.9 (9.06)	41.6 (11.67)	44.7 (8.97)	0.084 ^a			
Marital status, n (%) for married	64 (67.4%)	39 (73.6%)	34 (85.0%)	0.108 ^b			
CTQ, Mean (SD)	42.24 (16.62)	37.47 (8.20)	39.73 (9.17)	0.064 ^a			
Physical abuse	7.61 (4.36)	5.43 (1.08)	5.97 (2.19)	<0.001^a	<0.001	0.026	
Sexual abuse	6.83 (3.52)	5.34 (0.68)	5.60 (1.52)	<0.001^a	0.003	0.037	
Emotional abuse	7.42 (3.64)	6.53 (2.20)	7.35 (2.49)	0.112 ^a			
Emotional neglect	11.19 (4.63)	12.23 (4.77)	12.60 (4.72)	0.119 ^a			
Physical neglect	9.19 (4.46)	7.94 (3.05)	8.20 (2.82)	0.203 ^a			
Minimization	7.76 (2.77)	9.19 (2.31)	9.65 (2.21)	<0.001^a	0.003	<0.001	
GRISS							
Impotence	3.47 (2.86)	7.64 (3.50)	8.90 (2.95)	<0.001^a	<0.001	<0.001	
PE	3.85 (2.60)	6.98 (3.28)	9.38 (3.21)	<0.001^a	<0.001	<0.001	<0.001
Touch	2.92 (3.31)	2.43 (2.14)	2.30 (2.83)	0.440 ^a			
Infrequency	5.02 (3.17)	6.68 (2.55)	7.45 (3.51)	<0.001^a	<0.001	<0.001	
Avoidance	2.75 (3.22)	2.81 (2.27)	3.60 (2.89)	0.280 ^a			
Non-communication	2.76 (1.83)	3.13 (2.24)	3.13 (2.44)	0.482 ^a			
Dissatisfaction	5.02 (3.166)	6.68 (2.548)	7.45 (3.508)	<0.001^a	0.006	<0.001	
STAI							
State anxiety	39.24 (10.25)	38.25 (9.76)	40.23 (7.94)	0.617 ^a			
Trait anxiety	38.99 (8.42)	42.28 (7.97)	46.35 (7.97)	<0.001^a	<0.001		0.049

CG: Control group; ED: Erectile dysfunction; PE: Premature ejaculation; SD: Standard deviation; CTQ: Childhood Trauma Questionnaire; GRISS: Golombok-Rust Sexual Satisfaction Scale; STAI: State and Trait Anxiety Inventory; a: One-way Analysis of Variance (ANOVA); b: Tukey test. In post hoc comparisons, only statistically significant results are shown in the table (p<0.05).

DISCUSSION

In both the ED group and the ED + PE group, scores for physical abuse, sexual abuse, and minimization from the CTQ were significantly different from those of the control group. While some research suggests that CTs affect sexual functions, other studies find no relationship. Male CSA does not predict SD among men, supporting the notion that sexual abuse does not impair adult sexual functioning as much in men as it does in women (38). Some studies indicate no relationship between CSA and male SD (19, 22, 39). However, consistent with our results, multiple articles state that SD is more common in those with CSA (17, 18, 20). The higher minimization scores in the patient group may suggest that individuals with ED are less likely to report trauma and have a greater tendency to downplay or minimize the impact of traumatic experiences. This tendency may be attributed to the fact that men do not easily express experiences of sexual and physical abuse. Traumatic experiences

involving male abusers may be underreported due to fears of stigmatization, with victims concerned about being labeled as homosexual (40, 41). The higher Childhood Trauma Questionnaire scores observed in the control group, compared to the patient groups, along with an insignificant p-value, suggest that this difference is likely due to random variation rather than a true difference. The insignificant p-value indicates that there is no statistically significant difference between the groups, implying that the higher trauma scores observed in the control group may be attributable to chance.

While there was no difference between the groups in state anxiety scale scores, trait anxiety scale scores were higher in those with PE compared to both the control group and those with only ED. When examining men with both PE and ED in terms of anxiety, one study found significantly higher levels of state anxiety in these groups compared to healthy controls; however, there was no significant difference in state anxiety scores between the ED and PE groups.

Table 2: Correlations among scales in erectile dysfunction (ED) and erectile dysfunction with comorbid premature ejaculation (ED + PE) groups

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1 CTQ															
2 PA	0.591***														
3 SA	0.257*	-0.023													
4 EA	0.574***	0.529***	0.207*												
5 EN	0.661***	0.208*	0.085	0.032											
6 PN	0.866***	0.343***	0.086	0.298**	0.478***										
7 Min.	0.534***	0.101	0.072	0.172	0.368***	0.610***									
8 Imp.	0.258*	0.056	0.118	0.191	0.125	0.252*	0.353***								
9 PE	0.199	0.118	0.072	0.229*	0.118	0.119	0.191	0.154							
10 Touch	0.113	-0.017	-0.051	-0.181	0.290**	0.135	0.144	0.290**	-0.260*						
11 Inf.	0.050	-0.102	0.004	0.038	0.108	0.041	0.016	0.316**	-0.132	0.270**					
12 Avo.	0.094	0.103	0.211*	0.098	0.123	-0.039	0.005	0.343***	0.085	0.362***	0.083				
13 NS	0.095	-0.082	0.002	0.009	0.189	0.080	0.081	0.208	-0.023	0.427	0.258	0.275			
14 Dis.	0.119	-0.006	0.128	0.037	0.212	0.039	0.109	0.345	0.059	0.400	0.403	0.409***	0.119		
15 SAN	0.387***	0.109	0.098	0.222*	0.215*	0.403***	0.375***	0.291**	0.099	0.182	0.025	0.083	0.141	0.145	
16 TA	0.307**	0.194	0.025	0.337***	0.153	0.226*	0.291**	0.346***	0.322**	0.048	0.141	0.238*	0.039	0.253*	0.662***

CTQ: Childhood Trauma Questionnaire; PE: Premature ejaculation; PA: Physical abuse; SA: Sexual abuse; EA: Emotional abuse; EN: Emotional neglect; PN: Physical neglect; Min.: Minimization; Imp.: Impotence; Inf: Infrequency; Avo.: Avoidance; NS: Non-sensuality; Dis.: Dissatisfaction; SAN: State anxiety; TA: Trait anxiety; *: p<0.05; **: p<0.01; ***: p<0.001. The values in the table represent Pearson correlation coefficients between the variables.

In terms of trait anxiety scores, there were substantial differences between the healthy controls and the ED group, but no difference between the controls and the PE group. In men, distracting thoughts can hinder sexual arousal, and sexual performance anxiety is a leading cause of acquired PE (42–44).

Men with anxiety are more likely to develop ED (45), although this study did not find a similar result for ED. It is suggested that long-standing issues may explain the high level of trait anxiety observed in the patient group. From another perspective, the patient group may exhibit high levels of trait anxiety, which could be indicative of underlying psychopathology. The high level of trait anxiety in the PE group may be due to the chronic nature of the problem. The patient group may exhibit high levels of trait anxiety, which could be a contributing factor in psychopathology (43). A study examining the relationship between anxiety and sexual dysfunction reported that individuals experiencing ED and PE have higher levels of state anxiety compared to healthy controls.

Meanwhile, the ED group scored higher on trait anxiety than the controls, but the PE group showed no difference from healthy controls in trait anxiety (46). Although the results mentioned above suggest that anxiety is generally related to sexual dysfunction, anxiety appeared to differ in terms of trait and state anxiety compared to the current study. Studies evaluating the possible link between performance anxiety, ED, and PE, which may also relate to trait and state anxiety, have shown various results. State anxiety, as measured by the STAI, may give inaccurate results because it focuses on participants' anxiety at the time the form is applied. More research is needed to examine these hypotheses.

Childhood trauma was associated with an increased likelihood of developing anxiety and depressive disorders, with the highest risk found in those with both conditions. Additionally, CT predicted the onset, recurrence, and poorer outcomes of these disorders (47). Similarly, this study found that CT and anxiety are related. Childhood sexual abuse was linked to sexual anxiety, decreased sexual satisfaction, and involvement in difficult interpersonal relationships (26, 48).

Sexual satisfaction is negatively correlated with CT. Childhood traumas, particularly exposure to multiple forms of maltreatment, are associated with negative emotional states and a reduced capacity to regulate those states. This may affect the quality of adult sexual experiences. Individuals with a history of CT can develop negative assumptions and expectations for intimate relationships, along with high sexual

anxiety. Such individuals may find sexuality particularly challenging as it involves relational intimacy and can trigger unprocessed and trauma-related memories (26). The possible association of CTs with impotence supports this hypothesis in the current study's sample. Additionally, various levels of correlation were found between emotional abuse and PE, impotence and minimization, impotence and psychical neglect, and touch and emotional neglect. The results of this study indicate that CTs other than sexual trauma might also be associated with sexual dysfunction and decreased sexual satisfaction. As previously mentioned, individuals who have experienced CSA may face difficulties with sexuality because it involves emotional intimacy and can trigger unprocessed memories of their trauma. A study suggests that abuse could induce feelings of vulnerability in men, consequently making it challenging for them to establish a sense of safety within an intimate relationship (41). Another study indicates that CSA might diminish self-awareness and cause relational confusion, hindering the ability to consent to sexual activity freely, communicate effectively in intimate relationships, and cope with negative sexual memories. Childhood sexual abuse survivors may struggle to understand, relate to others, and fulfill their sexual needs (48). The results of the current study also indicated an association between avoidance of intimacy and sexual acts and having a history of CSA.

One limitation of this study is that it did not address the etiology of ED. Subgroup analyses evaluating the etiology could provide a better interpretation of the relationship between psychological variables and ED. According to correlation analyses, the two types of traumas associated with impotence are physical abuse and physical neglect. However, the sample size in the subclusters was considered insufficient and the correlation coefficients were low, so further analyses such as linear regression were not performed. Another limitation is the small sample size, which may restrict the generalizability of the findings. Additionally, due to time constraints, the randomization method employed may not fully mitigate potential biases, impacting the validity of the results. Another limitation is that the CTQ used in this study was not a structured interview but a self-administered questionnaire based on statements, increasing the likelihood of individuals hiding their experiences of sexual or physical abuse. Therefore, future studies should employ more comprehensive and objective assessment methods to better understand the relationship between CTs and sexual health. The high level of anxiety in the PE

group may be related to the duration of symptoms; however, this hypothesis could not be tested as the duration of PE and ED was not measured in this study. The link between CSA and SD is established, but the specific mechanisms are unclear (20), and there was no detailed evaluation in this study. Future research may focus on uncovering possible mechanisms.

CONCLUSION

This study is significant as it underscores that a history of CT, beyond CSA, can contribute to sexual dysfunction and decreased sexual satisfaction. The results suggest that CT, in general, can have profound impacts on an individual's sexual health. Several studies have shown that men with ED have a lower QoL than those without ED. They report lower mental and physical health scores and reduced satisfaction with sexual activity (7, 49). Exploring the potential link between SD, CT, and QoL in future research could enhance our understanding of SD's impact on QoL. It is crucial to recognize that individuals with a history of CT can develop negative assumptions and expectations regarding intimate relationships and sexuality. This can lead to high levels of sexual anxiety and a reduced tolerance for negative emotions, complicating the management of sexual health issues. Therefore, healthcare providers must create a safe and non-judgmental environment to enable patients to discuss their experiences and concerns related to sexual health and CSA openly.

Contribution Categories		Author Initials
Category 1	Concept/Design	Y.S., S.K.
	Data acquisition	S.K.
	Data analysis/Interpretation	S.K., H.S.B.
Category 2	Drafting manuscript	S.K., H.S.B.
	Critical revision of manuscript	Y.S.
Category 3	Final approval and accountability	Y.S., H.S.B.
Other	Technical or material support	S.K.
	Supervision	Y.S.

Ethical Approval: The Diskapi Yildirim Beyazit Training and Research Hospital Clinical Research Ethics Committee granted approval for this study (date: 22.02.2021, number: 105/05).

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