

## EPIDEMIOLOGY &amp; RISK FACTORS

## Sexual Functioning After Childhood Abuse: The Influence of Post-Traumatic Stress Disorder and Trauma Exposure

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## ABSTRACT

**Background:** Impairments in sexual functioning and sexual satisfaction are very common in women who have experienced childhood sexual abuse (CSA). A growing body of literature suggests a high prevalence of sexual distress in patients with post-traumatic stress disorder (PTSD). However, the influence of sexual trauma exposure per se and the influence of PTSD symptoms on impairments in sexual functioning remain unclear.

**Aim:** The aim of this study was to investigate the influence of sexual trauma exposure and PTSD on sexual functioning and sexual satisfaction by comparing 3 groups of women.

**Methods:** Women with PTSD after CSA (N = 32), women with a history of CSA and/or physical abuse but without PTSD (trauma controls [TC]; N = 32), and healthy women (N = 32) were compared with regards to self-reported sexual functioning and sexual satisfaction. Trauma exposure was assessed with the Childhood Trauma Questionnaire, and PTSD was assessed with the Clinician-Administered PTSD Scale for *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*.

**Outcomes:** Sexual functioning was assessed with the Sexual Experience and Behavior Questionnaire, and sexual satisfaction was assessed with the questionnaire Resources in Sexuality and Relationship.

**Results:** PTSD patients had significantly lower sexual functioning in some aspects of sexual experience (sexual aversion, sexual pain, and sexual satisfaction) but did not significantly differ in sexual arousal and orgasm from the other 2 groups. TC and healthy women did not significantly differ from each other on the measures of sexual functioning or sexual satisfaction.

**Clinical Translation:** Results suggest that the development of PTSD has a greater impact on sexual functioning than does the experience of a traumatic event. This emphasizes the importance to address possible sexual distress and sexual satisfaction in women with PTSD by administering specific diagnostic instruments and by integrating specific interventions targeting sexual problems into a trauma-specific treatment.

**Conclusions:** The study is the first comparing PTSD patients and TC with healthy women with regards to sexual functioning. Limitations are selection and size of the samples, the assessment of sexual functioning by self-report measures only, and lack of consideration of other potentially relevant factors influencing sexuality. The findings suggest that the experience of sexual abuse does not necessarily lead to sexual impairment, whereas comparably low levels of sexual functioning seem to be prominent in PTSD patients after CSA. Further research is needed on how to improve treatment for this patient group. **Bornefeld-Ettmann P, Steil R, Lieberz KA, et al. Sexual Functioning After Childhood Abuse: The Influence of Post-Traumatic Stress Disorder and Trauma Exposure. J Sex Med 2018;XX:XXX–XXX.**

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**Key Words:** Sexual Abuse; Childhood Abuse; Post-Traumatic Stress Disorder; Sexual Functioning; Sexual Impairments

Received November 2, 2017. Accepted February 17, 2018.

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<https://doi.org/10.1016/j.jsxm.2018.02.016>

## INTRODUCTION

The experience of childhood sexual abuse (CSA) carries a high risk for the development of psychiatric disorders, such as depression, borderline personality disorder (BPD), and post-traumatic stress disorder (PTSD).<sup>1,2</sup> Research furthermore suggests that impairments in sexual functioning and sexual well-being are very common in women who have experienced CSA. The prevalence of sexual dysfunctions (eg, impairments of sexual arousal, orgasm, and sexual pain) in victims of CSA is as high as 59%<sup>2</sup> and is considerably higher in CSA victims than in the general population of women, where the prevalence ranges from 40–45%.<sup>3</sup> Studies commonly find not only high rates of distress concerning sexual functioning itself but also distress that includes sexually related emotional, cognitive, and behavioral factors, such as a negative sexual self-concept, low sexual satisfaction, sexual risk-taking behavior, and relationship distress.<sup>4–6</sup> There are also hints that more severe CSA (eg, penetration and physical violence) is connected with a higher risk for sexual problems.<sup>7</sup> In most studies regarding sexual distress in women with a history of CSA, mental disorders were not assessed.<sup>8</sup> Research suggests that a rather large proportion (45–55%) of CSA victims develop PTSD.<sup>9,10</sup> PTSD is, according to the *Diagnostic and Statistical Manual of Mental Disorders (DSM), Fifth Edition (DSM-5)*,<sup>11</sup> a psychiatric disorder following the exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence (A-criterion). It is further characterized by intrusive symptoms (eg, flashbacks, nightmares [B-criterion]), avoidant behavior (eg, avoidance of trauma-related thoughts or feelings and reminders [C-criterion]), changes in mood and cognition (eg, overly negative thoughts and assumptions about oneself or the world, negative affect [D-criterion]), and hyperarousal (eg, irritability and aggression, difficulty sleeping [E-criterion]). The risk for developing PTSD is especially high if the abuse happened several times and at a young age, was committed by a relative, and included more severe forms of abuse.<sup>9,12–14</sup> Commonly PTSD develops directly after the abuse and, if not treated, the disorder often takes a chronic course.<sup>15</sup> Therefore, a high number of women with CSA assessed in prior studies regarding the experience of sexual difficulties might have PTSD. Thus, it remains unclear whether the previously reported sexual distress is related to trauma exposure or PTSD.

Few studies systematically examined the impact of the type of trauma on sexual dysfunction in patients with PTSD. In a study on somatoform disorders in PTSD patients, sexual symptoms (eg, sexual disinterest) were significantly more prevalent in patients who had experienced interpersonal trauma than in patients who had experienced other types of trauma, such as accidents.<sup>16</sup> In a second study on women with PTSD, sexually traumatized patients had a 3.8 times higher risk of developing sexual dysfunctions than non-sexually traumatized patients, even when controlling for depression.<sup>17</sup> These results suggest a higher probability of sexual dysfunctions in sexually abused PTSD patients than in non-sexually abused PTSD patients. However,

more recently, studies on sexual functioning suggested a high impact of PTSD-specific symptoms on sexual dysfunctions (eg, erectile dysfunction, vaginal pain).<sup>18–20</sup> The assumption that PTSD rather than the experience of sexual violence is crucial for impairments in sexual functioning is supported by a high prevalence of sexual dysfunctions in PTSD patients who experienced other forms of traumatic events, such as war-related trauma.<sup>19–21</sup>

Looking more closely at PTSD symptoms, the notion that PTSD symptoms might impact sexual functioning seems reasonable.<sup>8</sup> For example, intrusive symptoms (B-criterion) might interfere with sexuality because trauma-related stimuli might evoke aversive emotions and physical reactions during sexual interactions.<sup>22</sup> If the traumatization was sexual, sexual situations themselves might elicit intrusions and lead to sexually avoidant behavior.<sup>23</sup> However, painful body-related memories after physical violence might also elicit intrusive symptoms and strong emotions that interfere with sexual functioning.<sup>24,25</sup> Avoidant behavior (C-criterion) can be related to external as well as internal stimuli. Thus, sexual situations might not only act as external stimuli but also as internal stimuli such that symptoms of sexual arousal (breathing faster, higher frequency of heartbeat) might be perceived as aversive when they are related to trauma.<sup>18</sup> Avoidance of internal stimuli might lead to emotional numbing such that pleasant experiences such as closeness to a partner cannot be perceived. Changes in cognition and mood (D-criterion) have a very large impact on psychological functioning<sup>26</sup> and likely also on sexual functioning. Changes in cognition might result in dysfunctional beliefs not only about oneself in general (eg, “I cannot trust anyone”; “I have to stay in control all the time”) but also about one’s sexuality (eg, “Sex is always violent and dangerous”).<sup>27</sup> Strong emotions, such as anger and shame, that are related to these dysfunctional beliefs hinder normal sexual functioning directly but also indirectly through potential relationship distress, ie, following strong mood swings.<sup>28</sup> Lastly, changes in arousal and reactivity (E-criterion) might directly affect normal sexual functioning because biological processes such as an optimal activation of the sympathetic nervous system are impaired, and thus, fear is incompatible with sexual arousal.<sup>18</sup>

## AIMS

Considering the results of previous studies, it remains unclear whether the occurrence of PTSD symptoms or the experience of a traumatic event itself has a greater impact on the development of sexual impairments. The literature suggests not only a negative impact of CSA on sexuality<sup>1,4</sup> but also a negative impact of PTSD symptoms on sexuality.<sup>17,18</sup> To better understand the unique influence of both CSA and PTSD on sexual distress, we compared 3 groups of women with regard to aspects of sexual functioning and sexual satisfaction: women who had experienced CSA and developed PTSD afterward (trauma group [TG]), women who had experienced CSA and/or childhood physical abuse and did not develop any psychopathology (trauma controls

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