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Parental attitudes recollected by patients and neurotic disorders picture. Sexuality-related and sexuality-unrelated symptoms

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Summary

Objectives. To evaluate the risks associated with non-optimal characteristics of the picture of parents in the patient's memories, concerning the sexuality-related symptoms and other areas of neurotic disorders.

Methods. Coexistence of memories of parental attitudes and the current symptoms were analyzed on the basis of KO"0" Checklist and Life Inventory completed prior to treatment in the day hospital for neurotic disorders.

Results. In questionnaires, obtained from 2582 females and 1347 males between 1980-2002, there was a significant incidence of memories of adverse parental attitudes, the feeling of not being loved, the parent indifference, rejection. Regression analysis showed a significant relationship between the parental attitudes and symptoms, for instance reluctance of men to sexual contacts coexisted (OR=3.41) with hostile mother's attitude, the same association in women was weaker (OR=1.64) but still significant. Also, the absence of mother in childhood was associated with a risk of disruptions in the conduct of intercourse (erectile dysfunction or pain) in women (OR=2.43) and men (OR=3.29). Other analyzed symptoms, also sexuality -unrelated, though weaker and less frequently, were associated with non-optimal pictures of parents, e.g. pessimism in women with the hostile mother (OR=1.97). Higher global severity of symptoms was associated with non-optimal parental attitudes.

Conclusions. The type of recollected attitudes of parents was associated with a higher incidence of symptoms, primarily in the field of sexuality, and with other selected symptoms, as well as with higher global symptom level. The results indicate importance of life circumstances in the development of psychopathology and encourage to further research.

Key words: parental attitudes, sexual problems, symptoms of neurotic disorders

Introduction

The literature discussing the harmfulness of psychological traumas (traumatic events) and adverse life events and circumstances (adversities) focuses on several main

areas: 1) sexual abuse (abuse) in childhood and – to a lesser extent – in adulthood [1], 2) non-sexual crossing of borders of children and adults in the form of physical abuse (physical abuse) [2, 3], and 3) sub-optimal (or recalled as such) upbringing styles (rearing) and parents' attitudes [4]), 4) child neglecting (neglect) [5-8], and psychic abuse of children and adults.

Life events may of course be combined and their impact complex - for instance, greater likelihood of child sexual abuse was indicated in malfunction families, neglecting, using physical violence, characterized by disagreement between the parents [9], dysfunction of mother, distortion of bond between the mother and her mother [10].

The mechanism of impact of particular childhood circumstances, such as the parent feature, on the presence or the image of disorders of an adult is not clear, (e.g., it is difficult to predict when an alcoholic parent will bring up an alcoholic son, when an abstinent suffering from obsessions, and when a healthy person) [11].

As it seems, because of the complexity of the phenomenon, it is also not possible to determine the „degree of harmfulness" of impact of these mentioned types of traumas. In addition, the overlap of the many imperceptible or imperceptibly related, intensifying or reducing their impact circumstances, is another disturbing factor.

Research indicate that more frequent psychological violence (described by patients) from one of the parents, even without accompanying physical or sexual violence, seems to almost equal adverse effects of the latter [12-14], binding, as a consequence, with hostility, anxiety disorders , depression in adulthood.

Review of the literature shows that the effects of disturbances in relationship with parents cover a wide range of disorders: from anxiety disorders, including dissociative disorders, to alexithymia, depression and other serious difficulties in identification and/or regulation of affect [e.g. 15-18], as well as sexual dysfunctions - separately or constituting a component of neurotic disorders [19-22]). Relationship between „sexuality-unrelated" disorders or symptoms and the „sexual" ones, for example in patients with social phobia or somatization disorder, allows to assume their common background and mechanisms that release and sustain them [23, 24].

In turn, Johnson et al, among others, in a number of studies have demonstrated the existence of the relationship between parental behaviors and attitudes, and the risk of personality disorders in the offspring, indicating the importance of, for instance, circumstances such as verbal attacks on the part of mothers, emotional coldness, low protectiveness, lack of parental supervision, physical neglect, severe punishments [25-27].

Relationship of the situation of separation and adverse ways of upbringing by parents with social anxiety turned out to be stronger in the case of experience of sexual abuse in childhood [28], similarly as the links between the physical crossing of the child's borders with the subsequent panic disorder [29, 30]. Physical abuse in childhood, but also conflicts with parents without the possibility of discussing and resolving, more frequently experienced also the patients with psychogenic chronic pain syndromes [31, 32]. Patients suffering from somatization disorders more often reported ancestry from families characterized by coldness, detachment and lack of

support [33]. Being exposed to witnessing psychological violence also turned out to be detrimental [14].

A number of studies have been devoted to the topic of the role and characteristics of the parent's gender and its relationship with the child in the context of later mental health in adulthood. Although many authors since Bowlby have focused on mother -child relationship [34, 35], studies also indicate the importance of the father figure [e.g. 36-38]. Other authors underline the role of both parents [2, 39-42]. Researchers described, inter alia, the relationships of social phobia with overprotection, but also with rejection from the parents, [43], agoraphobia with the assessment of both parents as emotionally cold and mothers as rejecting [44, 45], panic disorder with agoraphobia with memories of parents as less caring and protective [46, 47], obsessive-compulsive disorder with rejection by father [48].

It is worth noting that in the analysis of such data the phenomenon of "overlap" of influences of situations from childhood with current disturbances such as partnerships or professional relationships [1, 49, 50], or the impact of „fresher" traumas [51] should be taken into consideration. Moreover, the image of the family of origin may of course be significantly distorted by the current experiences of the patient and even of the diagnostician [e.g. 52]). Subjective distortions can be considered either a „real circumstances" (father mistakenly remembered as excessively harsh „becomes such"), or for not as common to disturb the picture verified by statistical methods in a large group of patients.

Despite the mentioned difficulties, it is possible to observe in clinical practice relationship: life events – psychopathological symptoms. Among them, the least studied seem to be analysis of the likelihood of individual symptoms among patients with different characteristics of the family of origin. It appears to be possible, according to the theories of psychopathology and pathogenesis, particularly psychoanalysis and developmental psychology, to expect the strongest relationships for the characteristics of relation with mother, disturbances of attachment, parental pair dysfunction [53-56], abandonment [57] or maltreatment, and finally, relation with the father (not without gender-related differences). Probably some circumstances in life can „launch" in total more and some less symptoms or associate with the risk of their different combinations .

Thus, most reasonable seems to be considering the described relations in terms of the probabilities – the risks – of particular symptoms in the presence of certain characteristics of the family of origin.

Both – the carried out literature review (e.g. [7, 58]), as well as clinical observations indicate a higher incidence and greater severity of adverse, traumatic childhood experiences in patients than in healthy adults. This applies not only to severe physical or sexual abuses, but also to other forms of violence (or being a witness of it), including verbal form, neglecting, separation from parents, serious childhood diseases. The effects of distortions of relations with parents include a wide range of disorders and dysfunctions. Although due to the complexity of the phenomenon is difficult to unequivocally define the mechanism of influence of individual circumstances from childhood on the development of particular disorder or symptoms during adulthood,

yet it seems that it is reasonable, in accordance with the theory and clinical experience, to expect relationships between life events and psychopathology – the strongest for the characteristics of the relationship with parents. Therefore assessment of links of such experiences with the occurrence of selected symptoms in the field of sexuality in comparison to other areas of neurotic disorders reported by patients of day hospital seems to be justified, and thus it is the goal of this work.

Aim

The following study evaluated the relationship of memories about the relationship of patients with parents in childhood and adolescence, with the occurrence of selected symptoms in the field of sexuality in comparison to other areas of neurotic disorders.

Material and method

As a source of information about the subjectively memorized by the patients adverse life circumstances from childhood and adolescence the Life Inventory was used [59], while to obtain data on the symptoms reported by patients referred for psychotherapy the KO „O" Symptom Checklist was applied [60]. Both tools (the instruction and relevant parts of which are quoted in the Annex) are routinely completed before treatment with psychotherapy in the day hospital for neurotic disorders. The currently used version of Life Inventory was modified in 2002 (data collected with its use have not yet reached the necessary number), this study was based on the version of the Inventory version and data from the years 1980-2002. Qualification for treatment included, alongside with questionnaires, usually at least two psychiatric examination, psychological examination and a battery of several questionnaires, allowing to exclude other disorders (such as bipolar, schizophrenic psychoses, exogenous or pseudoneurotic disorders and severe physical illness) that exclude participation in a day hospital [61].

Data concerning patients with diagnoses of neurotic disorders, behavioral and personality disorders (codes F4, F5, F6 according to ICD-10) were obtained with the majority of the 3929 subjects (mean age: females 33 years, males 32) having identified one of the neurotic disorders or personality disorder with the secondary occurring neurotic disorder (Tab. 1 and 2). (see also [62]).

Data obtained from routine diagnostic tests were used with the consent of the patients and were stored and developed in the anonymous form. Estimation of the differences between percentages was performed using two-tailed test for the two stratum weights. Estimation of the odds ratio (OR) for the co-occurrence of two nominal variables (the life circumstances and the symptom encoded in the form of 0-1) was made with logistic regression. Comparisons of distributions of the Global Symptom Levels values (OWK), corresponding to the weighted sum of the points for all the symptoms reported by the patient, was made with ANOVA, with the use of post hoc test for the least significant differences. The licensed statistical package STATISTICA PL was used**.**

Table 1. **Intensity of symptoms and the type of disorders according to ICD-10**

	Females (n=2582)	Males (n=1347)
Global Symptom Levels (OWK) mean ± SD (median)	 394±152 (median 387)	 349±151 (median 336)
Diagnosis (main) F44/45. Dissociative or somatoform disorders F60. Personality disorders F40/F41. Anxiety disorders F48 Neurasthenia F34. Dysthymia F50. Eating disorders F42. Obsessive-compulsive disorder F43. Reaction to severe stress, and adjustment disorders Others Lack of data	 29% 23% 17% 7% 7% 5% 2% 1% 3% 6%	 25% 29% 16% 14% 5% 0% 2% 2% 2% 6%

Table 2. **Sociodemographic characteristics**

	Females (n=2582)	Males (n=1347)
Age in years mean ± SD (median)	 33±9 (33)	 32±9 (28)
Education None / primary Secondary (including students) Higher	 9% 57% 34%	 12% 56% 32%
Employment Working Not working Including pension Students	 59% 41% 10% 23%	 70% 30% 7% 24%

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

	Females (n=2582)	Males (n=1347)
A stable relationship/marriage An unstable relationship/marriage Not in a relationship	43% 26% 31%	47% 21% 32%
Has no sexual contacts Has sexual contacts Longer relationship Short-lived, incidental Short-lived and longer	40% 60% 55% 3% 2%	35% 65% 53% 7% 5%

From among variables included in the KO „O" Symptom Checklist 6 symptoms concerning sexuality dysfunctions and 9 ailments other than sexual ("sexuality-unrelated") were selected (Tab. 4). Selection criteria of items was based on its relative clear formulation, and connection with the core symptom of disorder. The most common sexual health complaint in the studied group was dissatisfaction with sexual life, of which both the presence and significant nuisance were reported by the highest percentages of females and males

Table 4. **The occurrence and intensification of symptoms connected with sexuality**

		Females	Males
		n=2582	n=1347
SYMPTOMS	Percentage of total	66%	34%
Symptoms of sexual dysfunctions			
7. Dissatisfaction with sexual life	maximum intensity	19%	20%
	presence	***53%	***59%
27. Difficulties in sexual intercourses	maximum intensity	**8%	**11%
	presence	***25%	***36%
47. Aversion to heterosexual contacts	maximum intensity	***17%	***9%
	presence	***43%	***33%
67. Significant decrease or loss of sexual drive	maximum intensity	***18%	***9%
	presence	53%	50%
70. Difficulties in contacts with persons of the opposite sex	maximum intensity	9%	8%
	presence	41%	42%
87. Unpleasant feelings related to the practice of masturbation	maximum intensity	**3%	**5%
	presence	***9%	***22%
Sexuality-unrelated symptoms –markers of selected neurotic disorders			
61. Anxiety in an open space	maximum intensity	***9%	***4%
	presence	***27%	***21%
104. Social anxiety	maximum intensity	26%	24%
	presence	72%	74%
44. Panic attacks	maximum intensity	***18%	***10%
	presence	***51%	***41%
12. Compulsive checking	maximum intensity	**22%	**18%
	presence	65%	65%
43. Temporary paresis	maximum intensity	**5%	**3%
	presence	**23%	**19%

table continued on next page

40. Heartache	maximum intensity	*16%	*13%
	presence	*63%	*59%
69. Diarrhea	maximum intensity	6%	5%
	presence	30%	31%
97. Hypochondriacal anxiety	maximum intensity	17%	16%
	presence	***46%	***55%
82. Pessimism	maximum intensity	***36%	***24%
	presence	***81%	***74%

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

The second symptom present in at least half of the respondents was a decline in sexual drive. The least frequently reported symptom was discomfort accompanying masturbation. Men reported significantly more often than women: dissatisfaction with sexual life (59% vs 53%, p <0.05), difficulties in sexual intercourse (36% vs 25%, p <0.05), discomfort accompanying masturbation (22% vs 9%, p <0.05). Females more frequently reported a reluctance to heterosexual contacts (43% vs 33%, p <0.05), also in the maximum intensity (Table 4). Among the 9 most common sexuality-unrelated symptoms, pessimism and social anxiety occurred most often (in more than 70% of respondents).

Results

Table 5 contains the obtained from the studied patients data from the Life Inventory in which the patients selected answers describing the attitudes of their mothers and fathers remembered from childhood and adolescence.

Table 5. **Parents' attitudes recollected by patients**

	Females (n=2582)	Males (n=1347)
Mother's attitude loved very much	46%***	62%***
rather loved	37%**	32%**
indifferent	10%***	3%***
hostile	5%***	2%***
absent, not known	1%	1%
Father's attitude loved very much	37%***	32%***
rather loved	37%***	43%***
indifferent	15%	15%
hostile	6%*	4%*
absent, not known	6%	6%
Mother's reactions to troubles in childhood supported	57%***	69%***
indifferent	17%***	12%***
attacked	25%***	18%***
absent, not known	1%	1%
Mother's reactions to troubles in childhood supported	40%	40%
indifferent	32%	29%
attacked	18%***	23%***
absent, not known	9%	8%

Significance of differences in test for two stratum weights (percentages) was marked **p<0.005, ***p<0.0005

As shown in Table 5, the adverse life circumstances, at least in the patients evaluation which was based on the assessment of the attitudes of parent as other than equivocal unconditional love, were not uncommon. More and more „negative" attitudes of parents - from the ambiguous love through indifference, hostility to the absence (abandonment, inaccessibility), proved to be less and less frequent. Percentages of assessment of mothers behavior in response to the problems of both male and female patients, occurring in childhood and adolescence, were, however, higher than the percentages of indifference. More men than women (62% vs 46%, p <0.0001) marked the answer „mother loved very much ," slightly less „rather loved" (32% vs 37%, p <0.005), and fewer males chose the extreme response options „was indifferent to mother" (3% vs 10%, p <0.0001), „mother hated" (2% vs. 5%, p <0.0001). Deprived of contact with the mother was similar – small – percentage of men and women (1%). More frequent absence of fathers in the question about the problems (8% -9%) than in the question about love (6%) may result from their more common than mothers not living with the family (they could love, but to help in trouble – not so often – not being available). Females more often recollected in mothers attitudes of hostility and indifference, and they were more often ambivalent (more answers with the option 'rather loved') in the evaluation of mothers than men, while men – on the contrary – turned out to be more ambivalent toward their fathers ('rather'). Similar turned out to be the prevalence in recollections of female and male patients about supportive in trouble attitude of their fathers.

Constituting the mainstream of this study logistic regression analyzes were used to estimate statistical significance of the relationship between the analyzed aspects of relationships with parents and symptoms (Tab. 6).

Table 6 contains odds ratio coefficients describing relationships of selected by the patient-woman answers that depict the general affective attitude of parents. Hostility of father during childhood and adolescence has proven to be associated with all sexuality -related symptoms reported by women, except for discomfort connected with masturbation. This phenomenon did not occur for 8 out of 9 „sexuality-unrelated symptoms" (the exception was a pain in the heart area). Recollection of female patient's mothers hostility, although weakly related to the non-sexual area, indicated important „location of impact": pain in the heart area (analogically to male patients), and pessimism

Table 6. **Relationships of the parents' attitudes with the occurrence of sexual problems and the selected sexuality-unrelated symptoms of neurotic disorders. Recollections of female patients**

	Mother's attitude					Father's attitude				
	loved very much	rather loved	indifferent	hostile	absent	loved very much	rather loved	indifferent	hostile	absent
Symptoms of sexual dysfunctions										
7. Dissatisfaction with sexual life	0.71*** (0.61-0.83)	1.27** (1.08-1.50)	1.23 (0.95-1.60)	1.22 (0.86-1.74)	1.25 (0.53-2.93)	0.86 (0.73-1.01)	1.00 (0.84-1.20)	1.10 (0.88-1.37)	1.43* (1.02-2.01)	1.07 (0.77-1.49)
27. Difficulties in sexual intercourse	0.81* (0.67-0.96)	1.09 (0.91-1.31)	1.17 (0.88-1.56)	1.22 (0.83-1.80)	2.43* (1.04-5.65)	0.83 (0.69-1.00)	1.04 (0.87-1.26)	1.03 (0.84-1.22)	1.85*** (1.31-2.61)	0.96 (0.66-1.40)

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47. Aversion to heterosexual contacts	0.71*** (0.60-0.83)	1.23* (1.04-1.44)	1.15 (0.89-1.49)	1.64* (1.16-2.34)	1.56 (0.67-3.63)	0.73*** (0.62-0.86)	1.09 (0.93-1.29)	1.19 (0.96-1.48)	1.95*** (1.39-2.74)	0.94 (0.67-1.31)
67. Significant reduction or loss of sexual desire	0.76** (0.65-0.89)	1.19* (1.01-1.39)	1.26 (0.97-1.63)	1.24 (0.87-1.77)	1.06 (0.45-2.46)	0.81* (0.69-0.95)	1.09 (0.93-1.28)	1.02 (0.83-1.24)	1.65** (1.17-2.34)	0.98 (0.71-1.33)
70. Difficulties in contact with the opposite sex	0.73*** (0.62-0.85)	1.12 (0.96-1.32)	1.52** (1.18-1.97)	1.26 (0.88-1.79)	1.17 (0.50-2.72)	0.77** (0.65-0.90)	1.02 (0.87-1.19)	1.46** (1.17-1.82)	1.58* (1.13-2.21)	0.72 (0.51-1.01)
87. Discomfort connected with masturbation	1.06 (0.82-1.38)	0.78 (0.59-1.03)	1.12 (0.74-1.70)	1.48 (0.88-2.48)	2.05 (0.69-6.12)	0.91 (0.69-1.19)	1.18 (0.91-1.54)	1.16 (0.82-1.65)	0.73 (0.39-1.37)	0.49 (0.24-1.02)
Sexuality-unrelated symptoms – "markers" of selected neurotic disorders										
61. Anxiety in an open space	0.92 (0.78-1.10)	0.98 (0.81-1.17)	1.19 (0.90-1.57)	1.30 (0.90-1.90)	1.00 (0.84-1.19)	0.91 (0.76-1.10)	1.02 (0.85-1.22)	1.03 (0.82-1.30)	1.19 (0.83-1.70)	1.05 (0.73-1.51)
104. Social anxiety	0.88 (0.67-1.16)	0.97 (0.74-1.28)	1.20 (0.74-1.94)	1.56 (0.75-3.23)	2.08 (0.28-15.5)	0.89 (0.67-1.17)	1.04 (0.76-1.41)	1.41 (0.92-2.15)	0.80 (0.47-1.36)	0.90 (0.52-1.56)
44. Panic attacks	0.82* (0.70-0.96)	1.16 (0.95-1.42)	1.25 (0.96-1.61)	0.99 (0.68-1.43)	1.69 (0.70-4.03)	0.99 (0.81-1.22)	0.96 (0.82-1.12)	1.10 (0.88-1.36)	1.34 (0.95-1.87)	0.72 (0.52-1.00)
12. Compulsive checking	0.96 (0.81-1.14)	0.92 (0.78-1.09)	1.25 (0.95-1.66)	1.06 (0.73-1.53)	1.41 (0.55-3.63)	0.95 (0.81-1.13)	1.01 (0.89-1.14)	1.04 (0.82-1.31)	1.03 (0.72-1.47)	1.05 (0.74-1.49)
43. Temporary paresis	0.89 (0.74-1.07)	1.02 (0.83-1.24)	1.23 (0.92-1.65)	1.19 (0.80-1.77)	0.72 (0.24-2.15)	0.97 (0.80-1.18)	1.06 (0.88-1.28)	0.96 (0.74-1.25)	1.06 (0.72-1.56)	0.86 (0.58-1.29)
40. Heartache	0.89 (0.76-1.05)	1.10 (0.93-1.30)	0.82 (0.63-1.07)	1.59* (1.07-2.35)	0.70 (0.30-1.62)	1.01 (0.77-1.33)	0.88 (0.74-1.03)	1.04 (0.83-1.32)	1.54* (1.06-2.23)	0.97 (0.69-1.37)
69. Diarrhea	1.01 (0.80-1.27)	1.00 (0.94-1.06)	1.03 (0.78-1.38)	0.86 (0.58-1.27)	1.08 (0.44-2.65)	1.02 (0.87-1.20)	0.88 (0.74-1.05)	1.18 (0.94-1.49)	0.95 (0.66-1.38)	1.14 (0.80-1.62)
97. Hypochondriacal anxiety	0.99 (0.89-1.11)	1.04 (0.88-1.23)	0.90 (0.70-1.17)	1.11 (0.78-1.58)	0.81 (0.35-1.91)	1.05 (0.90-1.24)	1.01 (0.88-1.15)	0.87 (0.70-1.08)	1.04 (0.75-1.44)	0.98 (0.88-1.15)
82. Pessimism	0.80* (0.65-0.97)	1.15 (0.93-1.42)	0.87 (0.63-1.20)	1.97* (1.12-3.47)	4.82 (0.65-35.9)	0.89 (0.73-1.10)	0.92 (0.75-1.13)	1.35 (1.00-1.82)	1.18 (0.75-1.85)	1.11 (0.72-1.72)

Statistical significance of the OR coefficients (odds ratios, together with their estimated confidence intervals) were marked: * $p<0.05$, ** $p<0.005$, *** $p<0.0005$

In male patients, there were no significant relationships found indicating the risk of comorbidity of 9 sexuality-unrelated neurotic symptoms with the attitude of father. However, the most strong and statistically significant relationships were found for the attitude of mother and the symptoms associated with sexuality (upper left quadrant in Tab. 7), and successively for attitudes of patient's father and sexual symptoms, and the least for the sexuality-unrelated symptoms. Doubts, ambivalence expressed in the description of attitude of mother as „rather" loving were associated with the occurrence of several symptoms of sexual dysfunctions for both sexes, but such experiencing of father – only in men. In terms of sexuality-unrelated symptoms in women, there was no associations with "rather" loving, in men they concerned „only" social anxiety disorder (OR=1.91). Table 7 – *next page*.

Beyond the information about relationships denoting the risk of symptoms, Table 7 also shows coefficients indicating smaller likelihood of symptom of intrusive checking in men who remembered their mother's attitude as hostile, and recollecting fathers as hostile was associated with hypochondriacal anxiety.

Father was remembered more often as a supportive in trouble in childhood (understanding, helpful) in patients reporting fewer symptoms and sexual problems, while father indifferent, or – especially – attacking in trouble – on the contrary (Tab. 9).

Table 7. **Relationships of the parents' attitudes with the occurrence of sexual problems and the selected sexuality-unrelated symptoms of neurotic disorders. Recollections of male patients**

	Mother's attitude					Father's attitude				
	loved very much	rather loved	indifferent	hostile	absent	loved very much	rather loved	indifferent	hostile	absent
Symptoms of sexual dysfunctions										
7. Dissatisfaction with sexual life	0.77* (0.62-0.97)	1.20 (0.95-1.51)	1.31 (0.71-2.43)	1.74 (0.67-4.53)	0.69 (0.24-1.98)	0.81 (0.64-1.03)	1.31* (1.05-1.64)	0.95 (0.70-1.30)	1.44 (0.82-2.53)	0.50** (0.31-0.79)
27. Difficulties in sexual intercourse	0.71** (0.56-0.89)	1.28* (1.01-1.63)	1.28 (0.70-2.33)	1.36 (0.57-3.26)	3.29* (1.10-9.90)	0.90 (0.71-1.15)	1.15 (0.92-1.44)	0.96 (0.70-1.32)	1.39 (0.82-2.37)	0.71 (0.43-1.18)
47. Aversion to heterosexual contacts	0.67** (0.53-0.84)	1.35* (1.06-1.71)	1.21 (0.66-2.23)	3.41* (1.40-8.29)	0.82 (0.26-2.63)	0.71* (0.55-0.91)	1.29* (1.02-1.62)	1.09 (0.79-1.49)	1.37 (0.80-2.35)	0.71 (0.42-1.19)
67. Significant reduction or loss of sexual desire	0.80* (0.64-0.99)	1.09 (0.86-1.38)	1.43 (0.79-2.58)	2.52 (0.97-6.55)	1.80 (0.60-5.38)	0.85 (0.68-1.07)	1.26* (1.01-1.56)	0.90 (0.67-1.22)	0.94 (0.47-2.01)	0.77 (0.49-1.23)
70. Difficulties in contact with the opposite sex	0.56*** (0.44-0.70)	1.44** (1.14-1.81)	2.40** (1.30-4.41)	4.46** (1.62-12.3)	1.37 (0.48-3.93)	0.78* (0.62-0.99)	0.93 (0.75-1.16)	1.34 (0.99-1.81)	1.99* (1.17-3.40)	1.02 (0.65-1.61)
87. Discomfort connected with masturbation	0.71* (0.55-0.92)	1.11 (0.85-1.46)	2.58** (1.41-4.71)	2.69* (1.12-6.45)	0.96 (0.26-3.53)	0.94 (0.71-1.24)	0.98 (0.74-1.28)	1.19 (0.84-1.69)	2.24** (1.30-3.88)	0.39* (0.19-0.82)
Sexuality-unrelated symptoms – "markers" of selected neurotic disorders										
61. Anxiety in an open space	0.98 (0.77-1.25)	0.97 (0.74-1.28)	1.02 (0.51-2.06)	0.86 (0.29-2.59)	2.06 (0.68-6.20)	1.02 (0.74-1.40)	0.96 (0.74-1.26)	1.02 (0.72-1.46)	1.07 (0.57-2.00)	0.81 (0.45-1.46)
104. Social anxiety	0.46*** (0.32-0.68)	1.91** (1.28-2.86)	6.18 (0.84-45.2)	1.27 (0.29-5.50)	0.80 (0.18-3.59)	0.73 (0.51-1.03)	1.14 (0.82-1.61)	1.60 (0.93-2.76)	0.82 (0.38-1.77)	0.88 (0.44-1.76)
44. Panic attacks	0.83 (0.66-1.04)	1.14 (0.91-1.44)	1.11 (0.61-2.01)	1.08 (0.45-2.58)	1.93 (0.66-5.59)	0.91 (0.72-1.15)	0.87 (0.69-1.08)	1.33 (0.98-1.80)	1.26 (0.75-2.14)	1.02 (0.62-1.68)
12. Compulsive checking	0.89 (0.71-1.12)	1.27 (1.00-1.63)	0.82 (0.45-1.50)	0.39* (0.16-0.94)	1.33 (0.41-4.27)	0.94 (0.74-1.19)	1.05 (0.84-1.32)	1.02 (0.72-1.43)	1.09 (0.62-1.92)	0.98 (0.60-1.61)
43. Temporary paresis	0.77 (0.58-1.01)	1.09 (0.81-1.46)	2.36* (1.26-4.40)	0.71 (0.21-2.42)	3.25* (1.12-9.46)	0.81 (0.60-1.10)	0.97 (0.74-1.28)	1.26 (0.87-1.82)	1.12 (0.58-2.14)	1.22 (0.70-2.13)
40. Heartache	0.94 (0.75-1.17)	1.08 (0.86-1.37)	1.09 (0.60-1.99)	0.52 (0.22-1.24)	1.76 (0.55-5.63)	0.86 (0.68-1.08)	1.16 (0.93-1.45)	1.04 (0.76-1.41)	0.99 (0.56-1.74)	1.10 (0.69-1.76)
69. Diarrhea	0.76* (0.60-0.97)	1.22 (0.95-1.56)	1.21 (0.65-2.25)	2.08 (0.88-4.95)	1.26 (0.42-3.79)	0.81 (0.63-1.05)	1.05 (0.83-1.33)	1.32 (0.96-1.81)	0.94 (0.53-1.67)	0.90 (0.54-1.50)
97. Hypochondriacal anxiety	1.13 (0.91-1.41)	0.98 (0.79-1.23)	0.57 (0.31-1.03)	0.61 (0.26-1.46)	2.07 (0.64-6.62)	1.01 (0.81-1.27)	1.20 (0.96-1.49)	0.96 (0.71-1.30)	0.56* (0.33-0.96)	0.79 (0.50-1.25)
82. Pessimism	0.84 (0.65-1.08)	1.19 (0.92-1.56)	1.47 (0.70-3.08)	1.51 (0.51-4.53)	0.47 (0.16-1.36)	0.83 (0.64-1.07)	1.07 (0.84-1.37)	1.37 (0.95-1.98)	1.37 (0.72-2.62)	0.77 (0.47-1.27)

Statistical significance of the OR coefficients (odds ratios, together with their estimated confidence intervals) were marked: * $p<0.05$, ** $p<0.005$, *** $p<0.0005$

Mother was more often recollected by men as supportive in trouble in childhood in connection with fewer sexual (majority) symptoms, while mother experienced as indifferent or attacking in trouble – on the contrary. There was no correlation found between discomfort concerning masturbation in women and the support or its lack on the part of either mother or father (Tab. 8 and 9 – *next pages*). In men (Tab. 9) such relationships indicate indifference of at least one parent as a risk factor. The risk of

occurrence of few sexuality-unrelated symptoms was significantly associated in men with memories of being attacked in trouble situations (patients) in childhood or adolescence while these connections were different depending on the gender of the parent „attacker": on the part of mother with pain in the heart area and social anxiety, on the part of father with panic attacks. Recollection of attacking father or mother was associated with the risk of diarrhea.

Table 8. **Relationships of the parents' reactions to the troubles of female patients in childhood with the occurrence of sexual problems and the selected sexuality-unrelated symptoms of neurotic disorders**

	During the female patient troubles in childhood, the mother			During the female patient troubles in childhood, the father		
	supported	was indifferent	attacked	supported	was indifferent	attacked
Symptoms of sexual dysfunctions						
7. Dissatisfaction with sexual life	0.64*** (0.55-0.75)	1.40** (1.14-1.73)	1.34** (1.12-1.61)	0.74*** (0.63-0.87)	1.02 (0.86-1.21)	1.50*** (1.22-1.85)
27. Difficulties in sexual intercourse	0.72*** (0.60-0.86)	1.28* (1.02-1.61)	1.20 (0.98-1.47)	0.82* (0.68-0.99)	1.04 (0.85-1.27)	1.24 (0.99-1.55)
47. Aversion to heterosexual contacts	0.69*** (0.59-0.81)	1.18 (0.96-1.45)	1.40*** (1.17-1.68)	0.69*** (0.59-0.81)	1.16 (0.98-1.37)	1.41** (1.15-1.72)
67. Significant reduction or loss of sexual desire	0.74*** (0.63-0.87)	1.26* (1.03-1.56)	1.26* (1.05-1.51)	0.81* (0.69-0.95)	1.03 (0.84-1.22)	1.34* (1.09-1.64)
70. Difficulties in contact with the opposite sex	0.72*** (0.61-0.84)	1.39** (1.13-1.71)	1.19 (0.99-1.42)	0.71*** (0.61-0.84)	1.18 (1.00-1.40)	1.38** (1.13-1.69)
87. Discomfort connected with masturbation	0.87 (0.67-1.12)	1.05 (0.87-1.39)	1.16 (0.87-1.56)	0.93 (0.71-1.21)	0.90 (0.67-1.19)	1.31 (0.96-1.80)
Sexuality-unrelated symptoms – "markers" of selected neurotic disorders						
61. Anxiety in an open space	0.81* (0.68-0.97)	1.29* (1.03-1.61)	1.09 (0.89-1.33)	0.88 (0.74-1.06)	1.00 (0.98-1.02)	1.15 (0.92-1.43)
104. Social anxiety	0.80 (0.61-1.06)	1.20 (0.82-1.76)	1.17 (0.85-1.62)	0.80 (0.61-1.05)	1.08 (0.81-1.44)	1.32 (0.91-1.93)
44. Panic attacks	0.81** (0.69-0.94)	---	1.05 (0.87-1.25)	0.98 (0.83-1.12)	1.02 (0.86-1.21)	1.16 (0.95-1.42)
12. Compulsive checking	0.90 (0.76-1.06)	1.20 (0.96-1.50)	1.02 (0.86-1.21)	0.97 (0.82-1.15)	0.85 (0.71-1.01)	1.15 (0.93-1.43)
43. Temporary paresis	0.91 (0.76-1.09)	1.12 (0.89-1.42)	1.06 (0.86-1.31)	1.06 (0.88-1.27)	0.92 (0.75-1.12)	1.04 (0.83-1.31)
40. Heartache	0.94 (0.80-1.12)	1.09 (0.88-1.35)	0.99 (0.80-1.23)	0.98 (0.80-1.20)	0.97 (0.81-1.15)	1.10 (0.89-1.36)
69. Diarrhea	0.87 p<0.1 (0.73-1.03)	1.05 (0.85-1.31)	1.19 (0.99-1.45)	0.96 (0.82-1.14)	1.01 (0.88-1.15)	1.05 (0.84-1.31)
97. Hypochondriacal anxiety	0.99 (0.87-1.12)	1.20 (0.98-1.48)	0.90 (0.75-1.08)	1.19* (1.02-1.40	0.93 (0.79-1.10)	0.88 (0.72-1.08)
82. Pessimism	0.89 (0.73-1.09)	0.90 (0.69-1.16)	1.23 (0.97-1.57)	0.86 (0.70-1.05)	0.97 (0.80-1.18)	1.55** (1.16-2.06)

Statistical significance of the OR coefficients (odds ratios, together with their estimated confidence intervals) were marked: * $p<0.05$, ** $p<0.005$, *** $p<0.0005$

Table 9. **Relationship of the parents' reactions to the troubles of male patients in childhood with the occurrence of sexual problems and the selected sexuality-unrelated symptoms of neurotic disorders**

	During the male patient troubles in childhood, the mother			During the male patient troubles in childhood, the father		
	supported	was indifferent	attacked	supported	was indifferent	attacked
Symptoms of sexual dysfunctions						
7. Dissatisfaction with sexual life	0.70** (0.55-0.89)	1.41 (0.99-2.01)	1.32 (0.99-1.76)	0.85 (0.68-1.06)	1.08 (0.84-1.37)	1.35* (1.04-1.76)
27. Difficulties in sexual intercourse	0.79* (0.62-1.00)	1.36 (0.97-1.91)	1.02 (0.77-1.34)	0.84 (0.67-1.06)	1.04 (0.82-1.32)	1.27 (0.98-1.65)
47. Aversion to heterosexual contacts	0.63*** (0.49-0.80)	1.78** (1.27-2.49)	1.24 (0.93-1.66)	0.70** (0.55-0.88)	1.31* (1.02-1.68)	1.19 (0.91-1.55)
67. Significant reduction or loss of sexual desire	0.80 (0.63-1.00)	1.16 (0.83-1.63)	1.17 (0.89-1.55)	0.83 (0.67-1.04)	1.06 (0.84-1.34)	1.21 (0.94-1.57)
70. Difficulties in contact with the opposite sex	0.66*** (0.53-0.83)	1.72** (1.23-2.40)	1.18 (0.90-1.56)	0.82 (0.65-1.02)	1.21 (0.95-1.53)	1.01 (0.74-1.38)
87. Discomfort connected with masturbation	0.65** (0.50-0.86)	1.54* (1.06-2.24)	1.31 (0.95-1.81)	0.83 (0.64-1.09)	1.43* (1.09-1.88)	1.10 (0.81-1.48)
Sexuality-unrelated symptoms – "markers" of selected neurotic disorders						
61. Anxiety in an open space	0.99 (0.63-1.57)	1.11 (0.74-1.65)	0.93 (0.66-1.31)	1.05 (0.81-1.38)	0.83 (0.62-1.11)	1.28 (0.95-1.72)
104. Social anxiety	0.60* (0.40-0.88)	1.29 (0.74-2.27)	1.72* (1.04-2.83)	0.75 (0.53-1.04)	1.12 (0.77-1.64)	1.30 (0.86-1.98)
44. Panic attacks	0.78* (0.62-0.98)	1.49* (1.06-2.08)	1.03 (0.78-1.36)	0.59*** (0.47-0.74)	1.19 (0.94-1.51)	1.55** (1.20-2.00)
12. Compulsive checking	0.90 (0.71-1.15)	1.05 (0.74-1.48)	1.09 (0.81-1.46)	0.88 (0.70-1.10)	0.98 (0.90-1.21)	1.28 (0.97-1.68)
43. Temporary paresis	0.67* (0.51-0.89)	1.60* (1.09-2.36)	1.19 (0.84-1.67)	0.88 (0.66-1.16)	0.92 (0.68-1.25)	1.22 (0.89-1.67)
40. Heartache	0.80 (0.63-1.02)	0.99 (0.71-1.37)	1.34* (1.00-1.78)	0.84 (0.67-1.05)	1.03 (0.81-1.31)	1.19 (0.91-1.54)
69. Diarrhea	0.70** (0.55-0.90)	1.38 (0.97-1.95)	1.34* (1.00-1.79)	0.79 (0.62-1.00)	0.99 (0.88-1.27)	1.57** (1.20-2.04)
97. Hypochondriacal anxiety	1.14 (0.91-1.44)	0.94 (0.67-1.31)	0.81 (0.61-1.07)	1.06 (0.85-1.31)	1.04 (0.82-1.33)	0.93 (0.72-1.20)
82. Pessimism	0.82 (0.63-1.07)	1.27 (0.85-1.88)	1.21 (0.87-1.67)	0.69** (0.54-0.88)	1.39* (1.05-1.84)	1.33 (0.98-1.80)

Statistical significance of the OR coefficients (odds ratios, together with their estimated confidence intervals) were marked: * $p<0.05$, ** $p<0.005$, *** $p<0.0005$

The final result of the analysis (shown in Tab. 10 below) is the link of the Symptom Checklist KO „O" result, accounting for the information about the global intensity of all the symptoms included in it, with the recollected parents' attitudes .

Among all comparisons contained in Table 10 (below), it turned out that significantly lower global symptom levels (OWK) were found in groups of persons recollecting parents more as loving very much than hostile or indifferent, and as helpful and supportive rather than indifferent or attacking in trouble.

Table 10. **Relationship of Global Symptom Levels (OWK) with the recollected by the patients attitudes of parents**

	n	Mean±SD	Median and quartiles	ANOVA Kruskal-Wallis main effect	post hoc tests
Mother's attitude recollected by females					
Loved very much	1195	371±152	359 (257; 470)	p<0.0001	①②③
Rather loved	963	400±150	393 (295; 497)		① p<0.0001
Indifferent	259	428±154	424 (312; 538)		② p<0.0001
Hostile	132	435±142	421 (317; 527)		③ p<0.0001
Absent	22	428±182	390 (340; 539)		
Mother's attitude recollected by males					
Loved very much	827	335±155	318 (224; 435)	p<0.0005	①②
Rather loved	432	357±142	348 (264; 458)		① p<0.05
Indifferent	46	391±149	385 (265; 505)		
Hostile	21	437±122	455 (363; 521)		② p<0.01
Absent	14	399±190	384 (280; 534)		
Father's attitude recollected by females					
Loved very much	947	378±154	372 (264; 478)	p<0.0005	①②
Rather loved	945	391±154	378 (277; 498)		
Indifferent	381	409±149	395 (311; 507)		①p<0.05
Hostile	147	432±144	433 (326; 526)		② p<0.0005
Absent	152	386±144	380 (285; 473)		
Father's attitudes recollected by males					
Loved very much	426	329±154	313 (224; 423)	p<0.001	①
Rather loved	576	347±147	332 (244; 454)		
Indifferent	198	378±148	369 (280; 488)		① p<0.0005
Hostile	58	370±154	344 (273; 484)		
Absent	77	335±167	328 (223; 415)		
Support from mothers recollected by females					
Helped	1455	370±149	359 (259; 467)	p<0.0001	①②
Indifferent	436	418±159	400 (306; 532)		①p<0.0001
Attacked	634	419±147	416 (311; 515)		② p<0.0001
Absent	35	426±157	404 (333; 539)		

table continued on next page

Support from mothers recollected by males					
Helped	918	331±152	317 (224; 435)	p<0.0001	①②
Indifferent	157	381±142	369 (283; 479)		① p<0.0005
Attacked	245	375±149	365 (276; 466)		② p<0.0005
Absent	20	398±165	366 (294; 519)		
Support from fathers recollected by females					
Helped	1018	373±156	363 (256; 478)	p<0.0001	①②
Indifferent	817	397±148	384 (284; 492)		① p<0.05
Attacked	469	419±153	407 (306; 523)		② p<0.0001
Absent	238	396±147	391 (294; 488)		
Support from fathers recollected by males					
Helped	529	320±147	308 (216; 413)	p<0.0001	①②
Indifferent	386	355±149	345 (254; 447)		① p<0.005
Attacked	308	384±154	377 (268; 492)		② p<0.0001, ③ <0.05
Absent	108	338±158	324 (230; 451)		③

①②③ was marked statistical significance of post hoc test for pairwise comparisons

Discussion

The discussed analyses were performed separately for men and women, because of numerous evidences of sex-related differences in experiencing and/or reporting symptoms, resulting in, among others, setting different cut-off point values for global symptom level index [60].

For both women and men smaller risk of occurrence of majority of sexual dysfunctions and some „sexuality-unrelated" symptoms was associated with a feeling of being loving very much by the mother, and to a lesser extent, by father. Different relationship in the group of symptoms and sexual problems – and more specifically the lack of it – was found only in women for the symptom of discomfort connected with masturbation as well as pains and other genital dysfunctions. In addition, experiencing mother as hostile towards the patient was associated in men with the presence of many sexual problems. Slightly more similar in women and men was the link of the feeling of incomplete to some extent mother's love („rather loved"). In men strong correlation of the symptom 'difficulty in contacts with the opposite sex' with the perceived deficit of love from mother was indicated.

Limitation of the obtained results can be the method of assessing the parents attitudes on the basis of entirely subjective recollections of adult patients reported in period of mental crisis – applying for psychotherapy treatment. In view of the common beliefs about the "toxicity" of relationship with parents, it can be a source of artifacts. On the other hand, such are almost all data derived from patient's provided interview. Furthermore, the current conflict experiencing may interfere with the memories of similar problems as pointed out by Peter and colleagues [63] in relation to the retrospective

measurement of childhood separation anxiety – disrupted by situations of separations in adulthood. Similar concerns were also expressed by Dube et al [64] in relation to the difficulties with determining cause and effect relationships based on retrospective data. On the other hand, many authors emphasize the relevance and objectivity of memories concerning parents [46], and even the greater importance of the subjective beliefs of the patients about the reality rather than of the attempts of its objectification (at least for non-psychotic disorder where the verification of reality is the basis for diagnosis including, inter alia, the productive symptoms). Numerous reports in the literature also indicate the importance of parents' attitudes recollected and evaluated by adult patients, and emphasize their relationship to psychopathological picture [25].

Another limitation of conclusions is inaccessibility of control group – resulting from retrospective aspect of our research, based, among others, on broad biographical interview (Life Inventory), not administered in those decades neither in control nor comparative groups. Also diagnostic labels approximated only (because of re-translation into main ICD-10 codes) made the analyses of disorder's influence on the connections researched impossible.

Another possible limitation of validity of conclusions may be time distribution of data acquisition over 20 years, e.g. considering culture transformation and other reasons of neurotic disorders' symptom reporting frequencies [65, 66]. An attempt to analyze relevant connections between symptoms and parental attitudes in time-related subgroups, evaluated before and after 1990 year, showed that some results are partly consistent with results commented for total group, and partly not verifiable statistically, probably because of approximately twice smaller numbers of subgroups.

Attitudes of parents were often evaluated using tools much more complicated than the fragment of the Life Inventory, such as the *Parental Bonding Instrument* [46, 47], or the *Childhood Trauma Questionnaire*, or *Trauma History Questionnaire* [5, 6, 13, 17] or *Verbal Abuse Questionnaire* [14] and EMBU questionnaire [44].

The results of this study, though obtained through much simpler method (it seems to be one of its merits), confirm first of all, the essential meaning of the relationships with parents for the proper conduct of psychosexual development (and vice versa, its disturbances associated with the appearance of symptoms), as well as the special importance of a good relationship with mother (understood as memory of unambiguous love and of providing support and understanding in trouble), and smaller though significant - relationship with father. Another explanation for „inherited risk" of various dysfunctions can be that the disorders manifested by the parents are partially „trained" by patients, especially from mother, as shown by the risk factors for instance for somatization disorders (OR=16.0 if the children suffered from functional abdominal pain), although these relationships are often not „precise" (among the above mentioned mothers more frequent than in the control group were also other problems such as anxiety and depression OR=6.1) [67].

Due to, inter alia, the properties of the material derived from retrospective analyzes, doubts concerning the various subjective meaning of the content of variables can never be unequivocally resolved. Similar objections exchanged Kendler et al [68] in relation to the interview of the patient (as dependent from the accuracy of self-observation), not always objective interview from the family members, or data about its history.

At the same time, however, Rogers [69] considers information from genogram to be reliable data to the analyzes of risk of occurrence of disorders.

Bandelow et al [30], using a retrospective life inventory of a similarly wide range of questions about traumatic events in childhood, parental attitudes, the occurrence of mental disorders in the family, etc. received confirmation (in the group of 115 patients) of higher incidence of: the death of father, separation from parents, childhood illness, parental alcohol abuse, domestic violence, sexual abuses in patients with panic disorder. They also described the parents of patients recollected as providing less support, care and attention - which was also confirmed in this study.

Deficit a good relationship with father (or such intra-psychic representation of father) seems to be much less frequently associated, in the males group, with the occurrence of the analyzed problems, „sexuality-unrelated" symptoms.

As particularly interesting should be considered the very explicit link between symptom 'difficulty in contacts with the opposite sex' – in the group of men – with the perceived shortage of love from mother, according to data from the literature and clinical practice.

The results of this study are consistent with reports suggesting link between a number of factors of poorer quality of relationships with parents with traumas in childhood (e.g., sexual abuse), which is consistent with theories about multifactorial etiology [50]. Also the disagreement between teenager and parents (interacting through internalization disorder) is considered to be the risk factor for anxiety disorders [70].

The results of studies with the use of multidimensional questionnaires of post-traumatic reactions, such as the Trauma Symptom Checklist, suggest sexualization of neutral in content (non-sexual but physically threatening) early childhood traumas. This suggests overestimation of the sexual abuses scale results, with exclusion of such experiences [71].

Although Harlow [19] indicated a very strong (and statistically significant) relationship of vulvodynia with deficiency of support in childhood (OR=2.6), and even stronger with frequent physical (OR=4.1), or sexual (OR=6.5) abuse by the closest relative (physical OR=3.6 or sexual OR=4.4), probably for less „sexual" or „less traumatic" life circumstances, such as the perceived attitude of the parents, different results (i.e. weaker connections) may be expected

Although results of this study are partially confirmation of relationships clinically observed and described in the literature, they do seem to be important because of the large studied group as well as, still rarely encountered in Polish literature, analysis of occurrence of sexuality-related symptoms.

Conclusions

1. Attitudes of parents recollected by patients in adulthood are associated with the occurrence of symptoms – especially in the field of sexuality, as well as with some of the selected symptoms of neurotic disorders from other areas.
2. Probably dysfunctional relationships with parents – experiencing their care as incomplete („rather loved"), lack of support from them, indifference in trouble, or even hostility (attacking), were associated with a significantly higher global symptom levels (OWK) as well as with incidence of most of the analyzed sexual problems.

3 Significantly lower values of global symptom levels (OWK) were found in groups of people recollecting parents as very loving than hostile or indifferent, and as helpful and supportive rather than indifferent or attacking in trouble.
4 In this study, based on retrospective material and concerning only patients, it was not possible to obtain information on similar relationships or their lack in the non -clinical population, which should be the subject of further research.
5 This study emphasizes the need to disclose and reduce the damage caused by dysfunctional relationships with parents and the need to prevent them by shaping the desired parental attitudes favorable to the future functioning of children.

Запомненные поведения родителей пациентов и картина невротических нарушений – симптомы, связанные и не связанные с сексуальностью

Содержание

Задание. Оценка риска, связанного с неоптимальными чертами картины родителей в воспиминаниях пациента из периода его детства и юношества, относящаяся к симптомам сексуальности и иных невпротических нарушений.

Метод. Сосуществование воспоминаний относящихся к поведениям родителей пациента и актульных симптомов были оценены при помощи глоссрий КО „0", а также анамнестических анкет, заполняемых перед лечением в Дневном отделении неврозов.

Результаты. В анкетных, полученных от 2582 женщин и 1347 мужчин, леченных в 1980–2002 годах отмечена значительное число данных о негативных типах поведения родителей: чувство отсутствия любви родителей, равнодушие или по-просту отверженность. Анализы регрессии показали статистичкски существенные связи между анализированными поведениями родителей и симптомами, как нп. нежелание мужчин к сексуальным контактам во взрослом возрасте, которое сосуществовала (OP = 3,4I) с оценкой поведения матери вражески настроенной к ребенку в детстве.Такое же поведение и связь была меньшей (OP = 1,64), однако оставались существенными. Также отсутствие матери в детстве связывалась с большим риском нарушений течения отношений между ними (нарушениями эррекции или болью) у женщин (OP = 2,43) и мужчин (OP = 3,29). Иные анализированные симптомы – „не сексуальные" также, хотя слабее и реже, связывались с неоптимальными картинами родителя, нп. пессимизм у женщин с оценкой матери как враждебной личности (OP = 1,97). Более высокое общее утяжеление симптомов связывалось с неоптимальными поведениями родителей.

Выводы. Тип запомненных пациентами поведений родителей связывется с более частым появлением симптомов в области сексуальности так иных симптомов невротических нарушений, как и более высоким общим утяжелением болезненных ощущений. Полученные результаты указывают на значение отягчающих жизненных ситуаций в формировании психопатологической картины и требует последующих наблюдений над более точными аспектамии взаимоотношений детей с родителями.

Ключевые слова: симптомы невротических нарушений, поведения родителей пациента, сексуальные проблемы

Haltungen der Eltern in Erinnerung des Patienten und das Bild der Nervenstörungen – mit der Sexualität verbundene und nicht verbundene Symptome

Zusammenfassung

Ziel. Die Einschätzung vom Risiko, das mit den nicht optimalen Eigenschaften des Elternbildes in der Erinnerung des Patienten aus der Kindheit und Adoleszenz zu den Symptomen aus dem Bereich der Sexualität und anderer Bereichen der Nervenstörungen.

Methode. Komorbidität von Erinnerungen zu den Haltungen der Eltern des Patienten und der aktuell auftretenden Symptomen analysierte man aufgrund der KO „0“ - Fragebogen und Lebenslauf – Umfragen, die vor der Behandlung in der Tagesabteilung für Nervenbehandlung ausgefüllt wurden.

Ergebnisse. In den Umfragen – Interviews, die von der Gruppe der 2 582 Frauen und 1 347 Männern gesammelt wurden, die in den Jahren 1980 – 2002 behandelt wurden, wurden häufige Erinnerungen an die negativen Haltungen der Eltern nachgewiesen: Gefühl, nicht ohne Vorbehalte geliebt zu sein; Gleichgültigkeit eines Elternteils oder Ablehnung. Die Regressionsanalysen zeigten statistisch signifikante Zusammenhänge zwischen den analysierten Haltungen der Eltern und den Symptomen, z.B. Abneigung der Männer gegenüber den sexuellen Kontakten im Erwachsenenalter war komorbid (OR=3,41) mit der Bewertung der Haltung der Mutter als feindlich gegenüber sie im Kindesalter; dieselbe Bindung bei den Frauen war schwächer (OR=1,64), aber immer noch signifikant. Auch die Abwesenheit der Mutter in der Kindheit hing mit einem höheren Risiko der Störungen beim Geschlechtsverkehr (Dysfunktionen der Erektion oder Schmerz) bei den Frauen (OR=2,43) und bei den Männern (OR=3,29). Andere analysierten Symptome - „nicht sexuellen“ hingen auch, obwohl schwächer, mit dem nicht optimalen Bild der Eltern zusammen, z.B. Pessimismus bei den Frauen mit der Wahrnehmung der Mutter als feindlich (OR=1,97). Eine global höhere Intensität der Symptome hing mit den nicht optimalen Haltungen der Eltern zusammen.

Schlussfolgerungen. Die Art der Haltungen der Eltern in den Erinnerungen der Patienten hängt mit dem häufigeren Auftreten vor allem der Symptome aus dem Bereich der Sexualität und anderer Nervenstörungen zusammen. Es ist auch mit der höheren globalen Intensität der Beschwerden verbunden. Die erzielten Ergebnisse zeigen auf die Bedeutung der belastenden Lebensumstände in der Gestaltung des psychopathologischen Bildes und regen zu weiteren Studien an den Aspekten der Beziehungen zu den Eltern an.

Schlüsselwörter: Symptome der Nervenstörungen, Haltungen der Eltern des Patienten, sexuelle Probleme

Les attitudes des parents gardées dans la mémoire des patients et l’image des troubles névrotiques – symptômes liés et non liés avec la sexualité

Résumé

Objectif. Evaluer le risque lié avec non optimales caractéristiques de l’image des parents dans les souvenirs des patients venant de leur enfance et de leur adolescence et concernant les symptômes liés avec la sexualité et d’autres dimensions des troubles névrotiques.

Méthodes. On analyse la coexistence des souvenirs des patients concernant les attitudes des parents et les symptômes actuels des troubles avec les questionnaires KO « 0 » Checklist and Life Inventory, complétés avant l’hospitalisation.

Résultats. Dans les questionnaires, complétés par 2582 femmes et 1347 hommes, traités durant les années 1980-2002, on note la signifiante fréquence des souvenirs défavorables concernant les attitudes des parents : sentiment d’être rejeté, manque d’amour sans conditions, indifférence des parents. Les analyses des régressions démontrent l’existence de fortes corrélations de ces attitudes analysées et des symptômes par ex. l’aversion pour les contacts sexuels des hommes adultes corrèle (OR=3,41) avec les attitudes hostiles de la mère durant l’enfance ; la même corrélation chez les femmes est plus faible (OR=1,64), pourtant encore importante. Et encore l’absence de la mère pendant l’enfance se lie avec le plus grand risque au cours de l’acte sexuel (troubles de l’érection, douleur) – (OR=2,43 – femmes, OR=3,29 – hommes). Les autres symptômes analysés – non sexuels – corrèlent aussi, bien que rarement et faiblement, avec les images défavorables des parents par ex. le pessimisme (des femmes) se lie avec la perception de la mère comme hostile (OR=1,97). En général les symptômes plus sévères corrèlent avec les attitudes défavorables des parents.

Conclusions. Le type des attitudes des parents gardées dans la mémoire des patients se lie avant tout avec la plus grande fréquence des symptômes du champ de la sexualité, avec aussi d’autres symptômes choisis ainsi qu’avec leur plus grande sévérité. Ces résultats soulignent aussi l’importance

des circonstances dans le développement de la psychopathologie et ils encouragent aux recherches futures en question.

Mots clés : symptômes des troubles névrotiques, attitudes des parents, problèmes sexuels

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