THE JOURNAL OF
SEXUAL MEDICINE

The Role of Somatic Symptoms in Sexual Medicine: Somatization as Important Contextual Factor in Male Sexual Dysfunction

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ABSTRACT

Introduction: An important feature of somatic symptom disorder is the subjective perception of the physical symptoms and its maladaptive interpretation. Considering that psychological distress is often expressed through somatic symptoms, it is possible that they underlie at least a part of the symptoms in subjects complaining of sexual dysfunction. Nevertheless, studies on the impact of somatoform disorders in sexual dysfunction are scanty.

Aim: To define the psychological, relational, and organic correlates of somatic symptoms in a large sample of patients complaining of sexual problems.

Methods: A consecutive series of 2833 men (mean age 50.2 ± 13.5 years) was retrospectively studied.

Main Outcome Measures: Somatic symptoms were assessed using the "somatized anxiety symptoms" subscale of the Middlesex Hospital Questionnaire (MHQ-S). Several clinical, biochemical, psychological, and relational parameters were studied. Patients were interviewed with the previously validated Structured Interview on Erectile Dysfunction (SIEDY), and ANDROTEST (a structured interview for the screening of hypogonadism in patients with sexual dysfunction).

Results: Among the 2833 patients studied, subjects scoring higher on somatic symptoms were older, more obese, reporting unhealthy lifestyle (current smoking, alcohol consumption), and a lower education (all $P < .05$). Moreover, they reported a general impairment of their sexuality more often, including erectile problems (spontaneous or sexual-related), low sexual desire, decreased frequency of intercourse, and perceived reduction of ejaculate volume (all $P < .005$). Interestingly, we observed a significant association between MHQ-S scoring with a reduced testosterone level and hypogonadism symptoms (both $P < .05$). Finally, we found a significant association between somatic symptoms and both SIEDY Scales 1 (organic domain of ED) and 3 (intrapsychic domain of ED) (both $P < .0001$).

Conclusion: The present study demonstrates that the presence of somatic symptoms can represent an important contextual factor in the determination of or in the exacerbation of male sexual dysfunction. High levels of somatic symptoms in subjects with sexual dysfunction can be related to the sexual symptom itself. The consequences of this pattern have great clinical relevance in a sexual medicine setting, considering their severe impact on sexuality.

J Sex Med 2016;13:1395–1407.

Key Words: Somatic Symptoms; Male Sexual Dysfunction; *Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition*; Sexual Medicine

Received April 14, 2016. Accepted July 5, 2016.

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http://dx.doi.org/10.1016/j.jsxm.2016.07.002

INTRODUCTION

Male sexual behavior is the result of an iterative interaction among psychological (the mind), biological (the body) and relational (the couple) issues, which mutually contribute to satisfactory sexual health. Sexual dysfunction can derive from a simultaneous or, more often, a stepwise problem of all 3 of these domains.[1–4] Hence, considering interactions between the body (including the brain), the mind (including past experience and current intrapsychic conflicts), and the couple (including the quality of their nonsexual and sexual patterns), a respectful

assumption of complexity is imperative for those who practice sexual medicine.[5–7]

As far as intrapsychic issue is concerned, sexual dysfunctions are known to be associated with different psychopathological disorders. In particular, depression,[8–13] and anxiety disorders[14–20] are the usual assumptions of the psychiatric contributions to male sexual dysfunction. Furthermore, it is important to emphasize that not only depressive and anxiety symptoms, but also their pharmacological treatment can impair sexual function.[21–23] However, another diagnostic category often overlooked is somatic symptoms and related disorders (SSD), which involve being distressed or having one's life disrupted by concerns involving physical symptoms when there is no obvious physical or medical cause for the symptoms.[24] Hence, SSD are included in a diagnostic category, recapitulating a multifactorial etiology with complexity interaction between biological and psychological issues.

For a long time, revisions of SSD have been requested, as the current diagnostic criteria are insufficient for both therapeutic and scientific uses.[25–29] "Somatoform Disorders" were described for the first time in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), Third Edition[30] as the experience of physical complaints *without* an apparent organic explanation. The DSM, fourth edition (DSM-IV) essentially accepted the previous definition.[31,32] At that time, the exclusion of organic disorders as a potential explanation of symptoms was one of the unsolved problems in studies of somatoform disorders and a substantial burden in diagnosing them. DSM, fifth edition (DSM-5) substantially modified these diagnostic criteria and revised the nosographic term from "Somatoform Disorders" to "Somatic Symptoms and Related Disorders." As compared with DSM-IV, the new DSM introduces 2 major modifications. First, the somatic symptoms should no longer be limited to medically unexplained conditions, thus eliminating the implicit mind-body dualism (Criterion A).[24] Second, positive psychological diagnostic criteria have been added to the diagnosis in criterion B, which covers excessive thoughts, feelings, and behaviors related to these somatic symptoms or associated health concerns. Therefore, a characterizing feature of individuals with SSD is not the presence of somatic symptoms per se but the subjective perception of the physical symptoms and its maladaptive interpretation.

The exact prevalence of somatic symptoms has yet to be established in the general population as well as in primary care settings. Some studies reported a 5% to 7% prevalence,[24] whereas other suggested a prevalence of 10% to 15%.[33,34] Considering that psychological distress often is expressed through somatic symptoms, patients suffering from somatic symptoms commonly refer to primary care and other medical settings, including that of sexual medicine. It is important to note that both depression and anxiety could be expressed either through somatic symptoms, encompassing gastrointestinal, respiratory, as well as urogenital dimensions.[35] However, in a primary care setting, somatizing subjects express significant distress and subsequent functional impairment[34,36] and are often dissatisfied with their care.[37]

Sexual dysfunctions are often the result of a profound uneasiness and are associated with different expressions of depression and anxiety.[1–4,8,20,38] It is therefore possible that somatoform symptoms underlie at least a part of the symptoms in subjects complaining of sexual dysfunction. Therefore, their study is of crucial relevance in a sexual medicine setting, yet studies on the impact of somatoform symptoms in sexual dysfunction are scanty.

There are several reasons for the little attention given in psychosomatic medicine to sexual dysfunctions. Originally, doctors have long ignored them. Afterwards, their treatment generally was considered to be in the province of urology. In 1970, sexual dysfunction became an entity apart and "sexual medicine" was popularized.[39] Since then psychiatrists took care of these problems; before they generally did not.

Considering the above evidence and the high prevalence of somatoform symptoms in clinical practice, few studies have specifically taken into consideration their relationship with sexual dysfunction. Hence, the aim of this study is to define the psychological, relational, and organic correlates of somatic symptoms in a large sample of patients complaining of sexual problems. Our hypothesis was that excessive worry about dysfunction can be thought of as part of the pathogenesis of what causes dysfunction and/or maintains it after other forces establish its presence. For this purpose, we have used the subscale "somatic symptoms" of the Middlesex Hospital Questionnaire,[40] an instrument developed to evaluate psychiatric symptoms in a nonpsychiatric setting.

MATERIALS AND METHODS

A consecutive series of 2833 male patients, attending an andrology outpatient clinic for sexual dysfunction for the first time between January 2002 and June 2015 was retrospectively studied. Data reported in this study have been collected during routine clinical procedures according to a "Day Service" standard protocol for males with erectile dysfunction, encoded by PACC L-99 (D/903/ 110; Azienda Ospedaliera-Universitaria Careggi [AOUC], Florence, Italy) and approved by the Regional Health Care Service (§ DGRT n. 1045; § DGRT n. 722; § DGRT n. 867). The exclusion criteria were based on the presence of illiteracy and intellectual disability based on the formal diagnostic criteria of the DSM-5.[24] In addition, at the time of the first visit, all patients gave their written informed consent to have their clinical records included in a dedicated database and they were aware that their data, after having been made anonymous, would be used for clinical research purposes.

Medical History Assessment

Patients were interviewed prior to beginning any treatment and before any specific diagnostic procedures using the Structured Interview on Erectile Dysfunction (SIEDY)[41] and ANDROTEST.[42]