ORIGINAL RESEARCH

Conflicts Within the Family and Within the Couple as Contextual Factors in the Determinism of Male Sexual Dysfunction

Valentina Boddi, MD,* Egidia Fanni, BA,* Giovanni Castellini, MD,† Alessandra Daphne Fisher, MD,* Giovanni Corona, MD,‡ and Mario Maggi, MD*

*Andrology Unit, Department of Experimental and Clinical Biomedical Sciences, University of Florence, Florence, Italy; †Psychiatry Unit, Department of Neurological and Psychiatric Sciences, Florence, Italy; ‡Endocrinology Unit, Maggiore-Bellaria Hospital, Bologna, Italy

DOI: 10.1111/jsm.13042

ABSTRACT

Introduction. The deterioration of a couple's relationship has been previously associated with impairment in male sexual function. Besides a couple's dystonic relationship, other stressors can unfavorably influence dyadic intimacy. A largely neglected etiopathogenetic factor affecting couple sexuality is the frustration caused by conflicts within the family.

Aim. To evaluate the possible associations between male sexual dysfunction (SD) and conflictual relationships within the couple or the family.

Methods. A consecutive series of 3,975 men, attending the Outpatient Clinic for SD for the first time, was retrospectively studied. Conflicts within the family and within the couple were assessed using two standard questions: "Are there any conflicts at home," and "Do you have a difficult relationship with your partner?" respectively, rating 0 = normal relationships, 1 = occasional quarrels, and 2 = frequent quarrels or always.

Main Outcome Measures. Several clinical, biochemical, and psychological (Middlesex Hospital Questionnaire) parameters were studied.

Results. Among the 3,975 patients studied, we observed a high prevalence of conflicts within the family and within the couple (32% vs. 21.2%). When compared with the rest of the sample, subjects reporting both type of conflicts showed a higher prevalence of psychiatric comorbidities. Hence, all data were adjusted for this parameter and for age. Family and couple conflicts were significantly associated with free floating anxiety, depression symptoms, and with a higher risk of subjective (self-reported) and objective (peak systolic velocity at the penile color Doppler ultrasound <35 mm/sec2) erectile dysfunction and hypoactive sexual desire. Female sexual function parameters, as reported by the patient, retained a significant association with both type of conflicts.

Conclusions. This study indicates that the presence of often unexplored issues, like conflicts within the family or within the couple, can represent an important contextual factor in the determinism of male SD. **Boddi V, Fanni E, Castellini G, Fisher AD, Corona G, and Maggi M. Conflicts within the family and within the couple as contextual factors in the determinism of male sexual dysfunction. J Sex Med 2015;12:2425–2435.**

Key Words. Family; Conflict; Sexual Dysfunction

Introduction

The human sexual response involves a complex interaction among biological, sociocultural, and psychological factors. Thus, sexual dysfunction must be considered a multidimensional disorder in which the perturbation of one component, eventually, will involve all the others in a stepwise manner, with negative effects on quality of life, interpersonal relationships, and mood [1–4]. The deterioration of a couple's relationship has also been reported as being associated with impairment in male sexual function [5]. In particular, different degrees of disturbance in the relational domain of erectile dysfunction (ED), such as long, hostile,

Valentina Boddi and Egidia Fanni equally contributed to the article.

and dissatisfying couple bonding, are associated with the most severe form of ED [6]. Furthermore, data suggest that a reduction of sexual activity because of a hostile and dissatisfactory relationship could contribute to an impairment of penile vascular flow and to a reduction in testosterone levels [5]. In other words, a good relationship is the cornerstone for successful and happy sexual activity in a couple, which can then even be associated with higher testosterone levels. Hence, the couple's functioning and in particular the syntonic feelings of the dyad should be accurately evaluated in subjects with ED.

Besides a couple's dystonic relationship, other stressors can unfavorably influence dyadic intimacy. Everyday stressors such as work, children, and money, or physical issues, can leave couples worn out and uninterested [5]. A lack of sexual privacy can drive a wedge between partners, causing them to drift apart [7]. Similarly, different types of relational issues could be associated with an impairment of sexual performance, among them, a largely neglected etiopathogenetic factor affecting couple sexuality is the frustration caused by conflicts within the family.

Family conflict has been defined as a focus on physical and verbal aggression, frequent criticism, displays of anger, and recurring arguments that occur across multiple relationships in the family, even though this definition is not widely accepted [8–11]. A variety of issues can alter the overall family climate and cause concerns, including extramarital affairs, financial difficulties, poor communication and child-related hardships such as disabilities or opposing parenting styles or even couple infertility [12]. Family theorists suggest that conflicts within the family interact to create the overall climate of the family environment [9,13]. The presence of worrisome family conflicts has been related to psychological distress and risky behaviors [14,15]. To the best of our knowledge, few studies have taken into consideration the association between conflicts within the family and sexual dysfunction.

Therefore, the aim of our study was to evaluate the possible associations between male sexual dysfunction and conflictual relationships within the couple or the family. Differences between these two constructs were also evaluated.

Methods

A consecutive series of 3,975 male patients, attending the outpatient clinic for sexual dysfunction for the first time, was retrospectively studied. All enrolled patients underwent the usual diagnostic protocol applied to newly referred subjects at the Andrology Outpatient Clinic. All the data were collected as part of the routine clinical procedure. An informed consent for the study was obtained from all patients. Patients were interviewed prior to beginning any treatment and before any specific diagnostic procedure using the Structured Interview on Erectile Dysfunction (SIEDY) [1]. SIEDY is a 13-item structured interview made up of three scales, which identify and quantify components concurring with ED [1]. Scale 1 deals with organic disorders, and it consists of questions 4, 13, and 15, concerning medical history, morning/nocturnal erection, and ejaculate volume, respectively. Scale 2 deals with disturbances in the relationship with the primary partner, and it is made up of questions 7, 8, 9, and 10, concerning reported presence of disease in the primary partner, primary partner's climax and desire, and menopausal symptoms, respectively [5,6,16]. The patient's answer is codified on a 0–3 Likert scale by the interviewer. Scale 1 score ranges between 0 and 12 and Scale 2 score ranges between 0 and 12 [1]. Validation studies confirmed that SIEDY subscales have good sensitivity and specificity in detecting the biological and psychological components of sexual dysfunction [1].

Conflicts within the family and within the couple were assessed using two standard questions, "Are there any conflicts at home (with children, or other persons living with you?)", and "Do you have a difficult relationship with your partner? Do you quarrel often? Do you avoid each other?", respectively. Both questions were rated 0 = *normal relationships*, 1 = *occasional quarrels*, and 2 = *frequent quarrels or always*. The socio-demographic and clinical characteristics of the sample are summarized in Tables 1 and 2.

The characteristics of ED were assessed using SIEDY Appendix A as previously described [1]. In particular, severe ED was defined when a patient reported an erection not sufficient for penetration in >75% of occasions as previously reported [1,17,18]. Patient's hypoactive sexual desire (HSD) was explored with question #14 of SIEDY ("Did you have more or less desire to make love in the last three months?") rating 0 = *unmodified or increased desire*, 1 = *reduced or never present desire*.

Patients were also asked to complete the modified Middlesex Hospital Questionnaire (MHQ) [19], a brief self-reported questionnaire for the screening of the symptoms of mental disorders in a non-