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# The role of the partner in erectile dysfunction and its treatment

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**Advances in pharmacological, mechanical, and surgical treatment for erectile dysfunction (ED) now allow erectile function to be re-established in most men who experience this problem. However, re-establishing erectile function and re-establishing a satisfying sexual interaction with a partner are totally different objectives, and when the latter is not met, the man may re-present with treatment failure or withdraw from treatment altogether. All nontalking therapies focus on the penis as the dysfunctional element, and all too often clinicians fail to appreciate that ED can result from problems in the patient's partner and/or difficulties in their relationship. This article examines the role of the partner in the etiology, assessment, and treatment of ED.**
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## Introduction

Most men who seek treatment for erectile dysfunction (ED) are in established heterosexual relationships. As long ago as 1970, Masters and Johnson[1] noted that there is no such thing as an uninvolved partner in any marriage in which there is some form of sexual inadequacy. Partners may be involved in the etiology and maintenance of sexual problems apparent in the second partner and should be involved in the therapeutic processes used. A partner who has normal sexual function and is involved in a relationship with a sexually dysfunctional partner has been termed the 'invested partner'.[2] Partner issues in the etiology, maintenance, assessment management, and prognosis of ED have not been extensively studied. Studies and observations that have been reported have focused mainly on female partners. Research on male partners of homosexual men who present with ED has been neglected.

Although the importance of interviewing the sexual partner for diagnostic and therapeutic purposes is well recognized,[3] it is by no means a universal occurrence. Since the introduction of safe, effective, and user-friendly pharmacological approaches to the management of ED, whether formally stated or not, it has been considered a male medical problem. This attitude leads to men with ED being managed in the clinic in isolation of their partners. Men tend to present in medical settings alone,[4] and even when they are invited to bring their partners to the clinic, only a few partners attend. Many clinics to which partners are invited are environmentally unsuitable for conjoint consultation.

## Partner's role in etiology and maintenance of ED

Keeping sex alive within a relationship requires more than just physiological competency. Important requirements are positive reinforcing feedback from one partner to the other and novelty of sexual behavior within that relationship. When these requirements are not met, one or both partners may lose interest in the sexual side of the relationship and, as a result, develop or induce in the other partner physiological sexual impairment, including ED. Derogatis *et al*,[2] for example, found female partners of men who present with sexual dysfunction had significantly lower sex drive and were more restricted in their range of sexual activities than other women. Absence of sexual interest in the partner of the older man can lead to ED simply by the man not receiving sufficient direct penile stimulation.

A high prevalence (62%) of sexual difficulties in female partners of men who present with ED was found by Renshaw.[5] The problems included primary and secondary orgasmic dysfunction, vaginismus, dyspareunia, and reduced sexual interest.

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Interestingly, in only 8% of cases did the female sexual dysfunction precede the onset of the ED, suggesting that these problems probably contributed to the maintenance of ED rather than caused it. In contrast, in another study of partners of men with ED, vaginismus and dyspareunia were more frequent in the period before the onset of presumed nonorganic ED than in men with organic causes for their ED, suggesting a causal relationship in the former group.[6] This study also showed a higher prevalence of relationship problems in men with presumed nonorganic ED than in men with organic ED.

## Partner's role in assessment of men with ED

The origin of ED is often multifactorial, with organic, psychological, and behavioral factors interacting either to cause the problem in the first place or to maintain it once it has occurred. Successful treatment depends on identifying and addressing all the factors operating in a particular case. Unless this is done, the man and his partner may not be able to (re-)establish a meaningful and mutually satisfying sexual relationship, even though he may be given erectogenic pharmacological treatment. It is regrettable that many physicians are too focused on identifying organic factors and, having done so, attribute the ED to the factors found without assessing whether they are, in fact, the cause of the ED. A man with diabetes may develop ED as a consequence of the vascular or neurological complications of this disease, but his ED may be totally unrelated to diabetes and be caused by psychological or relationship difficulties.[7]

It is known, only too well, that it is rarely possible to identify and address all the etiological and maintaining factors by talking with only one of the partners. Ideally, each partner should be seen separately and then together to resolve the high number of discrepancies in their accounts of the problem and its history, the partner's sexual adequacy and interest, and the quality of their relationship,[8,9] but this takes time and is not always possible in a busy andrology clinic.

In taking the history from both partners, it is important to identify three sets of factors: those that may make the man more susceptible to develop ED (predisposing factors), those that triggered the onset of the problem (precipitating factors), and factors that maintain the problem (maintaining factors).[10]

## Partner's role in treatment and prognosis of ED

Involving partners in discussions on treatment options and the choice of therapeutic modality to be tried probably increases treatment compliance, but obviously this can only happen when both partners attend the clinic. Partner's attendance at the clinic is also important so that she/he can learn about the treatment and how it should be used. In a personal series of 101 men who had been prescribed products for home intracavernosal injections elsewhere, but had not used them, 51% attributed their nonuse to their partners' refusal to cooperate with this treatment (unpublished observations). Subsequently, with more detailed discussion and concomitant sex therapy, all but eight women agreed to their partners using injection therapy.

Men with ED and their female partners appear to overestimate the importance their respective partners put on sexual intercourse. Although only 20.2% of women considered sexual intercourse to be somewhat or very important to them, 47.6% of their male partners considered this to be the case.[9] A partner may be less interested in helping the man achieve sexual intercourse if she is not really interested in this activity. She may be reluctant to offer adequate sexual stimulation and positive reinforcing feedback, an important consideration when the man uses a treatment that requires sexual stimulation for its full erectogenic effect (for example, sildenafil and apomorphine).

Partners may also be less enthusiastic in providing sexual stimulation if they feel that they are unlikely to get out of the sexual interaction what they really would like and what is important for them in contributing to their sexual satisfaction. Although a man with ED seeks a means to have an erection to enable him to have sexual intercourse, his partner may have a totally different agenda. Carroll and Bagley[11] asked female partners of men with ED, 'What is your favorite part of sexual behavior?' Only 37% reported sexual intercourse, whereas most (60%) reported foreplay. This finding is supported by a study of nonclinical women in nondistressed marriages in which 58.2% of women considered foreplay to be the most satisfying component of partner-related sexual activities, whereas only 11.2% considered sexual intercourse to be the most satisfying component; 65.3% of the women in this study reported wanting more foreplay.[12] Unless the partner of a man with ED sees that her own sexual needs are likely to be met, she may not be as cooperative in helping the man regain his erectile function and may even sabotage the treatment.

Involving the partner in the actual treatment process appears to improve compliance with it. Women often express the feeling that they want to be involved in the initiation of their partner's erection. When a man has a pharmacologically induced erection, such as with intracavernosal injection therapy, his partner may have feelings of resentment that he achieved it without her involvement, and such feelings lead her to consider the

erectile process as being unnatural. This can be overcome by encouraging the partner to be involved; in the case of intracavernosal injection therapy, she may do anything from opening the pack to actually giving the injection.

A series of psychosocial reactions frequently follows the onset of ED. The reactions arise from the man's fear of failure and progress to fear of initiating intimate behavior, leading to physical distancing between the partners in a relationship. The female partner may feel both guilty ('Am I the cause of the ED?') and rejected ('He never approaches me; he can no longer love me'). In a retrospective study of men with ED and their female partners, it was found that couples had not had any form of intimate contact for up to 15 y before the man presented with ED[9] (Table 1). In such a situation, simply giving these men the means to have an erection may not result in sexual intercourse unless steps are first taken to help the couple re-establish intimate contact.

The association of sexual problems in the partner and ED has already been alluded to. The presence of such sexual problems may hinder the re-establishment of intimacy and sexual activity during treatment of ED. Studies of patients and couples treated by sex therapy have confirmed the prognostic importance of the general relationship[13] and good pretreatment communication between the partners.[14] Wylie[15] noted that poor prognosis (drop out from couple therapy for ED) was associated with either poor relationship adjustment reported by the male partner or good adjustment reported by the female partner, but not within the same couple. Such problems should be identified and treated before treatment of ED by a pharmacological approach is initiated so that they can be addressed by appropriate sex or couple therapy.

Physical problems in the partner that may make intercourse impossible or difficult must also be considered. In a series of men presenting with ED where their partners were also examined, clinical evidence of urogenital atrophy was found in 33.3% of the women older than 46 y.[9] Most of these women had not had sexual intercourse for many years, and dyspareunia would be expected on coital resumption. Ideally, urogenital atrophy, and other genital pathological conditions, should be treated before treating the ED to reduce obstacles to successful penile-vaginal penetration.

## Partner's role in assessing outcome of treatment

The results from many studies have shown good concordance between patients and their partners in their assessment of outcome of treatment for ED in terms of erectile function.[16–18] However, couples who participate in such research may not be representative of those seen in clinical practice, where, as alluded to herein, partners rarely attend the clinic. Any therapist who reviews patient's progress by interviewing both partners of a relationship will recall many instances where there are major inconsistencies in the assessments of outcome by the individual partners. This may be because the individual partners have different criteria on which to base successful outcome. For the ED patient, the most important measure of outcome is his renewed ability to have an erection sufficiently rigid to enable him to have penetrative sexual intercourse. For his partner, success might be judged more in terms of the quality of their sexual interaction and emotional elements. In so doing, she may take into account, either consciously or subconsciously, her personal expectations and aspirations, which may be different from those of her partner. Salonia *et al*,[19] for example, found that whereas oral sildenafil provided a high satisfaction outcome rate among patients with vasculogenic ED, a significantly smaller number of female partners reported satisfaction with the treatment. Of the 29% of partners who were not satisfied with the treatment outcome, 75%

**Table 1** Partner-related sexual activities during the 4 weeks before consultation in heterosexual couples where the man presents with erectile disorder[a]

| *Activity* | *Experienced in past 4 weeks (%)* | *When last experienced* | |
|---|---|---|---|
| | | *Range* | *Median (months)* |
| Nonsexual kissing | 55.2 | 1 d–4 y | 3 |
| Sexual kissing | 10.1 | 1 d–15 y | 30 |
| Caressing | 9.3 | 1 d–15 y | 30 |
| Manual genital stimulation | | | |
| Male to female | 8.2 | 1 d–15 y | 31 |
| Female to male | 8.6 | 1 d–10 y | 26 |
| Orogenital contact[b] | | | |
| Cunnilingus | 1.6 | 1 d–15 y | 32 |
| Fellatio | 2.3 | 1 d–10 y | 26 |

[a]Reprinted from Riley and Riley[9] with permission from the publisher.
[b]A total of 47.7% and 57.8% of the study population had experienced cunnilingus and fellatio, respectively, in their present relationship.

reported some abnormalities of their own sexual function, including hypoactive sexual desire and reduced arousal.

## Future practice

Health care professionals should recognize the role partners have in the etiology and management of erectile disorder and should be prepared to offer advice and therapy to those partners who have their own problems that affect sexual behavior. Such management would be best provided in multidisciplinary clinics, where urologists, gynecologists, sex therapists, psychologists, and specialist physicians could provide comprehensive and holistic management to couples in which one or both partners have sexual problems. A greater understanding of female sexual dysfunction and improved therapies are required, and the role of partners in the etiology and management of ED in homosexual relationships should be addressed by appropriate research.

## Conclusion

Although ED is failure to attain or maintain an erection in the male, it is a problem that affects those around him, especially his sexual partner. Sexual problems and relationship conflict are common among female partners of men who present with ED. These problems may cause or contribute to the cause and maintenance of the ED and can negatively affect the treatment process and prognosis. Partners' problems may be psychological or physical but unless she/he is assessed along with the presenting man, the problem(s) will go unrecognized and the patient's prognosis in terms of re-establishing satisfying sexual intercourse will be compromised. It is regrettable that, in the UK (and probably in other countries), the environment and staff attitudes at most ED clinics are not conducive to partner attendance. ED must be considered in terms that go beyond simply a failure of erection, and greater emphasis must be given to involving the partner in all stages of the management of this all too common sexual difficulty.

## Appendix

*Open discussion following Dr Riley's presentation*

*Dr Porst:* What I have learned from my patients is that many women in the older age groups are never touching the penis of the partner and that the males are needing this for getting an erection.

*Dr Riley:* I see this as an important cause for failure to get an erection.

*Dr Hedlund:* I think these presentations point out how important it is that we treat the couple and a relationship disturbance and not just erectile dysfunction.

*Dr Nehra:* That's something that we as clinicians traditionally don't take into account.

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*Dr Riley:* I think the other problem we have in the UK, and it might be true in other areas, is that urology clinics are not always partner friendly and the partners often feel that the environment is hostile for discussing the problem.