

# Partner Satisfaction and Successful Treatment Outcomes for Men with Erectile Dysfunction (ED)

John Dean, Bert-Jan de Boer, Alessandra Graziottin, Dimitrios Hatzichristou, Jeremy Heaton, Ann Taylor

## Abstract

As first-line treatment for erectile dysfunction (ED), phosphodiesterase type 5 (PDE5) inhibitors are highly effective and well tolerated, making it possible for the majority of men with ED to experience better sex in terms of the restoration or improvement of erection rigidity and durability. Better erectile function can also improve the quality of the couple's relationship and the sexual satisfaction of female partners, yet a high proportion of men discontinue treatment even though the use of a PDE5 inhibitor has restored erection rigidity and durability. In the past, research focused on the influence of the drug regimen and side-effects on noncompliance and premature discontinuation. However, it is apparent that health professionals must also provide pre-treatment education on the impact of drug therapy on the broader sexual experience for men and their partners, rather than limiting themselves to a discussion of erectile function alone. This education should be further reinforced through adequate and timely follow-up to optimise treatment outcome. In addition, any ED treatment plan must consider the context of a man's relationship with his partner, since a partner's encouragement is often crucial in motivating a man to continue with treatment. The partner's motivation to maintain or return to sexual intimacy, her satisfaction with sex, and his perception of that satisfaction are central to the restoration of a satisfactory sexual experience. These beneficial outcomes can best be achieved by adopting a holistic approach that recognises the complexities of ED, and the importance of the partner's central role in the success of treatment and the experience of better sex.

## 1. Introduction

In an earlier review article within this supplement, we proposed three principal factors necessary for men with erectile dysfunction (ED) to experience "better sex":

- Enhanced hardness of erection
- Enhanced perception of partner sexual satisfaction
- Enhanced self-esteem and sexual confidence of the man

In this article, we consider the importance of partner satisfaction to successful treatment outcomes in men with ED. Current European and US clinical guidelines [1,2] advise that any treatment for ED must be integrative, considering the totality of the problem with the man's erectile function at the centre, but also including his relationship with his partner. Indeed, three major factors contribute to sexual function: biologic, psychosexual, and contextual, of which those that are the couple-related factors are prominent. This explains why, although the man is "the patient," his partner's motivation to sexual intimacy, her satisfaction with sex, and his perception of that satisfaction are central to the successful treatment of ED, the aim of which is restoration of satisfactory sexual experience. This approach is even more important in stable relationships.

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## **2. Clinical trials to clinical practice**

Almost all men can receive treatment to improve the hardness of their erection if they are willing to explore both pharmacologic and surgical options. As a first-line treatment for ED in the majority of men, phosphodiesterase type 5 (PDE5) inhibitors are highly effective; they have been shown in randomized controlled trials (RCTs) to improve erectile function, as assessed by the International Index of Erectile Function (IIEF), by two categories (7–10 points) [3]. PDE5 inhibitors have also been demonstrated to be well tolerated, with withdrawal rates attributable to adverse events in RCTs of less than 10% [4,5].

In contrast, discontinuation rates increase in long-term open-label studies [6] and are even higher among men who receive treatment for their ED outside clinical trials. Financial factors probably play some part in the discontinuation rate, as men taking part in clinical trials usually receive adequate supplies of the drug at no cost to themselves.

Outside of clinical trials, there was a clear phenomenon of diminishing returns found amongst men with ED who responded to a recent international survey. Of these men, 28.9% had received a prescription for a PDE5 inhibitor, 25.2% had filled the prescription, and 22.2% had used the treatment more than once, but only 15.7% were still using their PDE5 inhibitor [7]. These findings have been borne out in other studies, which have found that a high proportion of men do not obtain a second prescription for their PDE5 inhibitor even though they have responded physically to the treatment [8,9]. It should therefore be no surprise that only one third of men who consult a physician about ED are satisfied with their treatment [10], and that inadequate explanation and counselling result in poor response rates [11]. Furthermore, data show that inadequate patient instruction regarding treatment administration and insufficient follow-up are common causes of treatment failure [12].

While some RCTs have recruited carefully selected patients who are often extremely well motivated, men seen in clinical practice frequently have several emotional and relationship problems that must be addressed to optimise their response to PDE5 inhibitor treatment [13]. Even then, no therapy is likely to succeed if the patient does not continue to take the treatment. In the past, research focused on the influence of the drug regimen and side-effects on noncompliance and premature discontinuation.

It is increasingly apparent that patients make rational decisions about taking other kinds of medication, not just ED treatments; they weigh possible benefits of treatment against concerns about adverse effects [14]. There have been a series of alarmist, and usually unjustified, reports in the lay media about the alleged dangers of taking PDE5 inhibitors. The sporadic emergence of such reports may be one factor in some men's decision not to take treatment for ED. Health professionals should take the time to seek out and explore any concerns that men might have about the safety of treatment; even if these concerns do not seem rational to the professional, they should be addressed in a respectful manner through evidence-based patient education. Men should be empowered to make rational choices, but they can only do so if they are in possession of that evidence. This approach is borne out in recent studies showing that appropriate education, information, and instruction of patients can play a critical role in treatment success [9,12]. It may be important to educate both the man and his partner if both are available, since the possibility of adverse effects from treatment of ED is a frequently reported concern of female partners [15]. In a recent large survey of men with ED, concern about the potential risks of treatment, together with lack of support from the partner, were key risk factors for the abandonment of treatment [7]. When the partner is not available, the "second-best" approach is to give the man written education about the treatment to share with his partner or, as a last resort, to ask him to tell his partner the verbal information provided to him.

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At the same time, it is important to ensure that the couple has realistic goals for their sex life, as well as realistic expectations of drug treatment. Even the most effective therapy may not restore a 60-year-old man to the sexual function that he enjoyed in his 20s. Both men and their partners should be counselled that he will probably need direct tactile stimulation of the penis to achieve and maintain an erection. Men with severe ED often will benefit from oral therapy and experience improved erections. However, whereas men with milder ED might reasonably expect to achieve rigid erections, men with more severe disease might have erections adequate for penetration but not necessarily erections of the quality they experienced in youth. Every effort should be made to restore optimal erections through the use of an appropriate drug at an appropriate dose; even so the sad fact remains that not all men will be restored to their “pre-ED” state. Professionals should also provide careful education on the correct use of any treatment, including when and how to take the drug, the need for dose titration if the initial dose is ineffective, and the importance of perseverance in taking the drug on several occasions. Verbal advice alone is rarely sufficient and should be supported by written information and reinforced at every follow-up visit [16].

### **3. Influence of the partner**

By adopting the above strategies it is possible to achieve successful outcomes in men who were originally unresponsive to a PDE5 inhibitor [9]. At the same time, it is always important to ensure that any treatment plan takes account of the context of the man's relationship with his partner [17]. A partner's encouragement can be a crucial factor in persuading men to seek treatment for their ED [10], and during the consultation the partner frequently provides information highly relevant to the assessment of ED. This information is particularly helpful in gaining an accurate clinical picture, since partner and patient reports do not always concur [18].

The partner may influence the outcome of treatment in other ways, and these too are often overlooked in clinical practice. ED is probably never purely organic or purely psychogenic in origin; almost all cases have a mixed aetiology. It is particularly important to address issues related to the man's partner and relationship, since these may have predisposed or precipitated, or be maintaining ED [19,20]. Finally, the partner's active support and satisfaction with treatment are important factors in promoting long-term adherence by men with ED. As a result, health professionals should, when possible, include the partner in all aspects of treatment. However, as much as a man wishes to improve his sexual relationship, he is unlikely to continue with treatment for his ED if he has no opportunity to engage in sexual intercourse. For example, in one prospective study [8], 23% of men who abandoned treatment reported that their partners had shown no sexual interest during the 6 months since the PDE5 inhibitor prescription had been filled. Equally, sexual dysfunction or anxiety about treatment in female partners can place a burden on the sexual lives of both partners, resulting in dissatisfaction with treatment [15].

Men most commonly seek professional help for ED in midlife [21]. Consequently, their partners are often also in midlife and may be experiencing age-related physiological changes that might impair their own sexual functioning.

During the consultation, health professionals should take the opportunity to explore the partner's attitudes towards the resumption of sexual activity: key points include her motivation for sex (which is more related to emotional, affective, and relational factors) and her drive for sex (which perhaps is more dependent on endocrine factors). This assessment of problems affecting women's sexual function should address both biomedical and psycho-sociocultural factors.

It is beyond the scope of this paper to describe in detail the assessment of women's sexual function and its problems. Several questionnaire instruments designed to allocate women's sexual symptoms to diagnostic categories of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, have been developed and validated;

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these questionnaires are of questionable utility in clinical practice and are not a substitute for an appropriate clinical assessment. Some of the important issues involved in the assessment and diagnostic processes are explored in a recent article by Basson [22] in the New England Journal of Medicine (2006).

Sensitive enquiry about the couple's general relationship is important, since this will reflect positively or adversely on their sexual relationship. Similarly, it is essential to explore any conflict between the partners about ED – resulting, for example, from the man's unwillingness to face up to and deal with his erectile problems or his partner having a negative attitude towards sexual activity. The latter may be due to reduced enjoyment of sexual intercourse (or the enhanced intimacy associated with it) attributable to his lack of erection hardness, a personal lack of motivation for pleasure in sex attributable to a female dysfunction diagnosis, or some other health problem. Indeed, studies suggest that the presence of sexual dysfunction in partners can significantly impact satisfaction with treatment [23].

#### **4. Partner satisfaction**

If the above barriers are addressed, successful treatment of ED has been shown to improve the quality of a couple's relationship. For example, in an observational study, improvements in erectile function after treatment of ED positively correlated in both men and their partners on the "tenderness" and "togetherness" subscales of a partnership evaluation questionnaire used in German-speaking countries [24]. Other studies have shown that successful treatment with sildenafil citrate increases men's desire for hugs, kisses, and cuddles [25].

ED has a negative impact on the sexual life of female partners, specifically on their sexual satisfaction and sexual drive [26]. Conversely, improvement in the quality of a man's erections after treatment may improve female partners' sexual function in terms of improved arousal, orgasm, and sexual satisfaction, and reduced pain during intercourse [27], provided that the woman is still motivated to have sex with that partner. In this study there was a strong, positive correlation between reduced pain and increased lubrication during intercourse. Since there were no changes in the female partners' sexual desire, it seems likely that the positive changes in the couple's emotional well-being and relationship were responsible for the increased sexual satisfaction reported by the female partners (Figs. 1 and 2). These findings have been further borne out in a recent study [28] suggesting that improvements in women partners' sexual function relate significantly and consistently to treatment-related improvements in men's erectile function.

Other studies have also found an association between successful treatment for ED and satisfaction in both the man and his partner that is based on the Erectile Dysfunction Inventory of Treatment Satisfaction (EDITS), a validated psychometric instruments with versions for men and their female partners, including 11 patient items and 5 partner items [29]. For example, a recent analysis of partner responses to treatment in 14 clinical trials of PDE5 inhibitor treatment found that, compared with the placebo group, two to three times as many partners of men receiving active treatment with sildenafil were satisfied with treatment [30]. Partner satisfaction corroborated the male patients' satisfaction with ED treatment, suggesting a "virtuous cycle" in which improvements in each partners' satisfaction reinforce the positive effects of successful treatment on the other and on the intimacy of their relationship. However, partner satisfaction scores did tend to be lower than those for patients, and the authors considered that this finding emphasised the importance of a holistic approach to the treatment of ED [30].

Such a strategy may need to include both an appropriate hormonal treatment of women's sexual function problems, more specifically related to the menopausal status [31,32], and/or counselling or psychosexual therapy to resolve complex issues within the relationship. Since many men with ED delay seeking medical help, partners may become accustomed to a lack of sexual intercourse and/or develop secondary female sexual dysfunction, such as low desire

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and/or arousal and orgasmic difficulties. Furthermore, ED often leads to cessation of all sexual activity, including demonstrations of affection and intimacy that, in turn, may result in diminished sexual desire on the part of both partners and the compounding of any distance or conflict that already existed in the relationship.

For some couples, ED may even serve an important function in maintaining the relationship by providing a focus for concern and enabling the couple to avoid facing underlying conflicts. When such dynamics exist, simply restoring the man's erectile function will not result in sexual or relationship satisfaction; indeed, in some cases, the couple will, consciously or unconsciously, find some way to sabotage the treatment or minimise the success of therapy to avoid having to confront the true reasons for their dissatisfaction with their relationship. Even when the relationship is sound, a couple may have difficulty in reintegrating intimacy and sexual activity into their lives. Both partners will have many other roles beyond their sexual partnership – as parents, friends, and workers – and women in particular may find that these other responsibilities compromise their role as a lover. In this situation, the couple will need to be helped to become lovers again.

## **5. Conclusions**

Currently available treatments make it possible for men with ED to achieve better sex in terms of restoration or improvement of erection hardness. Improvement in erectile function can also improve the quality of the couple's relationship and improve sexual satisfaction in female partners. However, these beneficial outcomes can best be achieved by adopting a holistic approach that recognises the complexities of ED, and the importance of recognising the needs of the partner and her central role in the success of treatment. A multidisciplinary team approach, involving a sexual medicine practitioner experienced in managing women's sexual health and function issues, offers the best possibility of a successful treatment outcome – which should at least be a “satisfactory sexual experience” for both partners.

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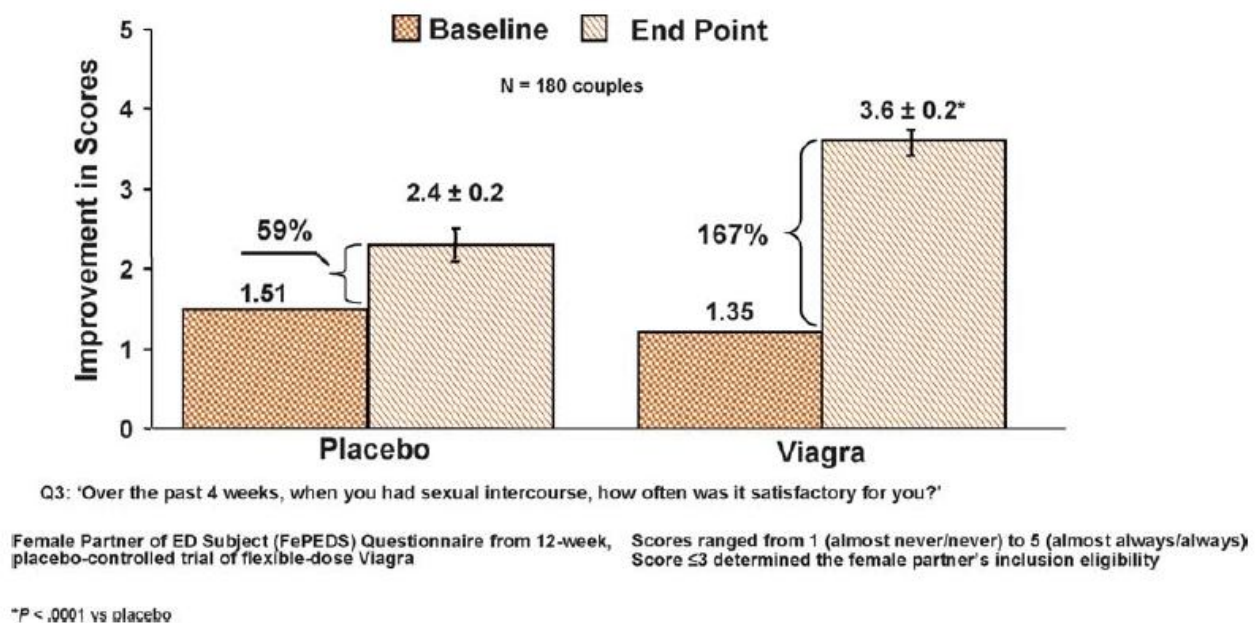
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**Fig. 1** – Rates of partner satisfaction during intercourse in men treated with sildenafil versus men treated with placebo [McCullough A. Tseng L. Siegel RL. *J Sex Med* 2006; 3 (suppl. 3): 258]



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**Fig. 2** – Rates of partner satisfaction during intercourse in men treated with sildenafil versus men treated with placebo (the higher the pain score, the less the pain experienced) [McCullough A. Tseng L. Siegel RL. J Sex Med 2006; 3 (suppl. 3): 258]

