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ABSTRACT

Endometriosis may impact many aspects of a person's life including their relationships with romantic and sexual partners. This scoping review examined individual and dyadic impacts of endometriosis on relationship satisfaction from the perspectives of both the person with endometriosis and their partner. Sexual dysfunction, infertility, and psychological distress were found to be significant contributors of lower relationship satisfaction. Relational coping strategies such as effective communication and reframing expectations around sex, intimacy, and needs emerged as strategies that improved satisfaction between couples adversely affected by endometriosis. These findings suggest that multidisciplinary management should target both the affected individual and their partner.

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Endometriosis; relationship satisfaction; sexual satisfaction; infertility

Introduction

Endometriosis is a chronic, systemic, inflammatory disease that is characterized by the presence of endometrial-like tissue found outside of the uterine cavity (Catota et al., 2026; Charatsi et al., 2018; Rathod et al., 2024; Shigesi et al., 2025; Yong et al., 2026). While endometriosis was traditionally thought to only affect persons assigned female at birth at reproductive age, the condition may also be present in premenarchal, postmenopausal, and post-hysterectomy persons, and gender diverse populations (Apelian et al., 2026). The experience of living with endometriosis is highly variable and largely influenced by the presence and severity of symptoms such as chronic pelvic pain, dysmenorrhea, dyspareunia, and gastrointestinal issues contributing to long delays before surgical diagnosis and management (De Graaff et al., 2013; Frayne et al., 2023; Rathod et al., 2024; Taylor et al., 2026). The dynamic and heterogenous nature of these symptoms can have profound and pervasive ramifications on many aspects of an affected person's life, including social and sexual relationships, psychological and emotional wellbeing, work, and study (Culley et al., 2013; De Graaff et al., 2013; Soliman et al., 2017). However, there is limited evidence of a correlation between symptom severity and diagnostic classification of disease severity (Alves et al., 2026; National Guideline Alliance, 2017). Given the interpersonal nature of endometriosis-related challenges, romantic and sexual partners may also be impacted by persistent symptoms, sexual difficulties, and fertility concerns, particularly when these issues are not adequately addressed through clinical management (Norinho et al., 2020).

The increased discussion about endometriosis in recent years has led to a growing body of research on this topic (Deng et al., 2023; Department of Health and Aged Care, 2018; Wu et al., 2025). Despite the proliferation of endometriosis research due to this recent attention, much of research remains focused on the experiences of cis-women with endometriosis, either ignoring the experiences of partners or viewing them in isolation from their counterpart with endometriosis. A dyadic perspective is particularly important in endometriosis research, as symptoms such as dyspareunia and

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complications such as infertility may be experienced as shared stressors that affect both partners and their relationship. Bodenmann's (1997) systemic-transactional model of dyadic coping provides a useful framework for understanding these relational impacts, as the theory posits that stressors affecting one partner can become shared stressors within the relationship, requiring couples to engage in joint coping processes to maintain individual and relational well-being. Reviewing both the individual and dyadic impacts of endometriosis in light of this new research is important to update our integrated understanding of the issues that affect couples managing endometriosis.

Endometriosis and Relationship Satisfaction

Relationship satisfaction refers to an individual's overall assessment of their romantic relationship (Bühler et al., 2021), with greater satisfaction and positive perceptions fostered by partners meeting their supportive needs (Fincham & Rogge, 2010; Taffs et al., 2024). Relational processes have been found to influence dyadic functioning in couples affected by cancer, with higher relational functioning stemming from open and constructive cancer-related communication, supportive behaviors, and joint problem solving, while dysfunctional communication patterns and unsupportive behaviors contributing to lower relational functioning (Traa et al., 2015). This underscores the importance of considering both partners as part of a dyadic system as relationship outcomes are shaped by interdependent processes within couples (Eastwick et al., 2022). In the context of endometriosis, sexual dysfunction, infertility, and emotional distress undermine relationship and sexual satisfaction within the dyad (Aerts et al., 2018; Oppenheimer et al., 2024; Rempert et al., 2024; Shi et al., 2023), while relational processes such as communication, coping, and mutual support, alongside accessibility of professional support systems, play a critical role in how couples collectively navigate these challenges (Facchin et al., 2020; Maulenkul et al., 2024). Understanding how endometriosis shapes dyadic processes is essential for the clinical management of the condition for both members of the dyad.

Sexual satisfaction is strongly related with relationship satisfaction (McNulty et al., 2016). A recent integrative review of systematic reviews found that quality of life was significantly impacted by sexual dysfunction in 60%–70% of persons with endometriosis (Maulenkul et al., 2024). While there is variability in the degree of sexual dysfunction experienced by persons with endometriosis, evidence suggests that for those experiencing sexual distress, dysfunction, or dissatisfaction, the impacts are pervasive across their lives (Van Niekerk et al., 2022). One symptom that is frequently discussed in relation to sexual dysfunction is dyspareunia, which refers to pain experienced during sexual intercourse. The prevalence of dyspareunia amongst women with endometriosis varies from 24%–25% in smaller cohorts to 50–100% in larger studies (Culley et al., 2013; Facchin et al., 2020). For some women, the anticipation of experiencing pain during intimate activities may lead them to avoidance or reducing the frequency of sexual intercourse to reduce the discomfort caused by coitus (Denny & Mann, 2007; Fritzer et al., 2013). The fear avoidance model of chronic pain offers some insight into this behavior, postulating that pain-related fear promotes the avoidances of activities perceived as threatening, thereby reinforcing negative pain expectations and contributing to the persistence of sexual dysfunction (Crombez et al., 2012). As a consequence, the stress associated with painful intercourse may extend beyond the individual to affect the couple as a dyadic unit, potentially undermining effective dyadic coping and contributing to reduced relationship and sexual satisfaction for both partners. Some couples even suggest that endometriosis-related sexual dysfunction is a core driver underlying the dissolution of past relationships (Culley et al., 2013).

Psychological Distress

While sexual and relationship dissatisfaction may be related to sexual dysfunction, psychological distress may also play a part in this narrative. Psychological distress such as feelings of guilt, anxiety, or depression, diminished self-esteem, and a compromised sense of feminine identity are frequently reported by women with endometriosis (Culley et al., 2013; McKay et al., 2022; Pope et al., 2015; Van Niekerk et al., 2022; Zhu et al., 2023). Such psychological distress may arise from the interaction of biological and social factors, with unmet internalized expectations surrounding femininity and

motherhood contributing to ongoing distress. Feminist theory provides insight into this phenomena, suggesting that social constructs and patriarchal norms define womanhood by reproductive capacity, sexual availability, and relational caregiving, and underpin these psychological responses (Ussher, 2006). Furthermore, an intersectional lens (Cole, 2009) posits that the individual experiences of living with endometriosis may be further shaped by the interplay of gender with race, ethnicity, socioeconomic status, and cultural context. In alignment with these theories, to maintain their role as a good partner, women with endometriosis may adopt coping strategies which are incompatible with self-care, such as self-silencing and continuing to have painful sexual intercourse with their partner (Cole et al., 2020). These coping mechanisms may perpetuate sexual distress and dissatisfaction, thus contributing to greater tension between couples affected by endometriosis. In accordance with both the fear avoidance model of chronic pain and the systemic-transactional model, these effects may be cyclical in nature, with psychological strain exacerbating physical symptoms, further contributing to emotional burden and relational conflict.

Moreover, partners of persons with endometriosis may experience emotional distress, frustration, or helplessness when unable to support or connect with their significant other, compounding the overall relational impact (Facchin et al., 2020). A systematic review examining the effects of endometriosis on couple's relationships and sexual functioning highlighted that partners of women with endometriosis are frequently overlooked in both clinical care and research, with few being offered access to sexual or couples therapy to address relational concerns (Norinho et al., 2020). McKay et al. (2022) and Rossi et al. (2020) both suggest that the framing of "endometriosis as a gynecological condition" contributes to the perception that endometriosis is solely a "women's issue," thus neglecting the relational dynamics and emotional burden experienced by partners who support their affected counterparts. However, dyadic coping theories propose for the consideration of the partner's experiences and dyadic impacts due to the inevitable transference of stressors into the dyadic relationship from the person with endometriosis, requiring both partners to engage in collaborative stress appraisal and supportive coping responses to preserve relational functioning (Bodenmann, 1997). Patterns of anxious and avoidant behaviors, such as emotional distancing and communication breakdowns, within a relationship would suggest poor dyadic coping; such behaviors have been found to erode intimacy and mutual understanding within the dyad and contribute to lower relational and sexual satisfaction in dyads (Boudreau et al., 2024). This highlights how sexual challenges posed by endometriosis, and dyspareunia in particular, can reverberate through both the affected individual and their partner, shaping sexual satisfaction as well as emotional connection and well-being for both members of the relationship.

Endometriosis-Related Infertility

Whilst infertility is common among couples affected by endometriosis, its influence on relationship satisfaction remains inconclusive in the current literature. Several meta-analyses and systematic reviews have suggested that emotional distress and uncertainty surrounding future fertility due to endometriosis may cause strain in sexual and intimate relationships (Chaman-Ara et al., 2017; Ferreira et al., 2016; Yang et al., 2021). However, a more recent systematic review found no concrete ties between endometriosis-related infertility among people affected by endometriosis (Maulenkul et al., 2024). In contrast, correlations between relationship satisfaction and infertility show greater consistency in couples without endometriosis seeking fertility treatment. Nakić Radoš et al. (2020) found that greater sexual concerns, namely those associated with difficulties conceiving, were correlated with lower sexual satisfaction. Likewise, Luk and Loke (2018) found that gender-related differences in couples, with women more likely to report concerns that their partner did not understand the effect of infertility on their relationship, which created distance in their relationship, while their male partners were more likely to express concern about the quality of their sex life. Significant differences in psychological well-being between men and women were found in a recent systematic review and meta-analysis of infertile couples, with women experiencing higher anxiety, depression, and stress responses than their male partners in the majority of the literature (Khorasani et al., 2025). These gendered disparities in psychological burden are consistent with an intersectional understanding,

whereby women's heightened distress reflects both the direct physiological impact of endometriosis-associated infertility as well as the compounding weight of socially constructed expectations of femininity and reproductive identity that disproportionately impact women (Cole, 2009). Similarly, Galhardo et al. (2013) found that when faced with infertility-related stress, the mediating role of comparison and judgment on the effects of shame and dyadic adjustment were shaped by the person's gender role in the relationship. When faced with internal shame stemming from infertility-related stress, women were more likely to show compassion toward themselves and the situation, while men displayed self-judgment (Galhardo et al., 2013). These findings suggest that the emotional and relational responses to endometriosis-related infertility are important factors in understanding how both members of the dyad navigate intimacy and how this influences dyadic coping.

The Current Study

Previous reviews have examined how endometriosis impacts psychological, social, and emotional functioning in women with endometriosis and their partners; however, an updated comprehensive understanding that integrates both individual and dyadic experiences is missing. This scoping review aims to synthesize and integrate the individual and dyadic experiences of couples managing endometriosis from a feminist and intersectional perspective to cultivate integrated and holistic understanding of the biological, psychological, and social factors that shape relationship outcomes. While the clinical and psychosocial themes underpinning the experience of living with endometriosis are well established, this review further incorporates relational processes by drawing together existing evidence and theoretical principles to examine how these interrelated factors shape relationship experiences in couples managing endometriosis.

Methods

A scoping review was performed following reporting guidelines detailed by the Joanna Briggs Institute (JBI) methodology for scoping reviews (Peters et al., 2020a, 2020b) and the preferred reporting items for systematic reviews and meta analyses for scoping reviews (PRSIMA-ScR) checklist (Tricco et al., 2018; Supplementary Materials Table S1). Additionally, the methodology was informed by Arksey and O'Malley's (2005) approach to provide a rigorous, structured, and transparent framework to data synthesis and dissemination.

Eligibility Criteria

Eligible studies for inclusion were empirical studies published in English, involving persons with endometriosis and/or the partners of persons with endometriosis. All participants were over the age of 18 years with clinical diagnosis of endometriosis. As the symptoms of endometriosis often overlap with other conditions, such as chronic pelvic pain, which lacks disease morphology and adenomyosis that morphologically define endometriosis, only participants with a known clinical diagnosis of endometriosis were included to maintain relevancy to endometriosis understanding and management. As no existing reviews were identified, no restrictions were imposed based on publication date to ensure a comprehensive search. Articles focusing solely on measuring sexual dysfunction without direct links to impacts on relationship satisfaction were excluded. Additionally, no grey literature was sought to capture only empirical evidence in this review to maintain methodological rigor and reproducibility.

Search Strategy

A comprehensive search was conducted using CINAHL, EMCARE, Medline Ovid, PsycInfo, and Scopus on April 9, 2025. A secondary search using the same search strategy was performed on January 4, 2026, to capture articles published since the primary search was performed prior to

submitting the article. These databases were selected to comprehensively capture the psychological, medical, nursing, and allied health literature relevant to endometriosis and relationship satisfaction from both clinical and psychosocial perspectives. A university librarian was consulted to assist with the development of the search strategy using keyword and MESH terms combined with Boolean operators to comprehensively capture the available literature on the impact of endometriosis on relationship satisfaction across the five databases. The keyword search strategy for Medline OVID can be found in Table S2 (Supplementary Materials).

Study Selection

Title/abstract and full-text screening was performed using Rayyan (Ouzzani et al., 2016), an electronic systematic review management program. Double-blind screening was performed by the first two authors at both screening stages. There was a 99.3% agreement rate during title/abstract screening and 86.1% agreement during full-text screening of candidate articles. Any disagreements that could not be resolved by discussion between these two authors were escalated to the primary supervisor for final review. Following full-text screening, 62 articles met the inclusion criteria for the scoping review.

Data Charting and Analysis

Data was extracted by the primary author using a standardized format. Extracted data included: (1) year of publication, (2) country/countries where study was conducted, (3) study aims, (4) study design, (5) sampling method, (6) where participants were recruited from, (7) ethnicity and race of participants, (8) sample size, (9) participant age (mean, standard deviation, and range where possible), (10) severity classification of endometriosis, (11) population reporting relationship satisfaction (women with endometriosis, partners of women with endometriosis, or women with endometriosis and their partners), (12) psychometric scales used measure sexual, relational, and quality of life outcomes, and (13) main research findings outlining impacts of endometriosis on relationship satisfaction, including illustrative quotations from qualitative sources.

A narrative approach was employed to comprehensively integrate findings the heterogenous study designs included in this review to present a biopsychosocial recount of how endometriosis affects relationship satisfaction between persons affected by the condition and their partners. As the purpose of a scoping review is to map the current state of the literature, the literature included was not assessed for bias or quality as per the JBI scoping review protocol (Peters et al., 2020a, 2020b).

Reflexivity Statement

The first author of this article was diagnosed with endometriosis during the first screening stage of this project. While the author's lived experiences influenced the direction of the project, standardized methodological frameworks (Peters et al., 2020a, 2020b) were primarily used to mitigate bias during data screening, synthesis, and presentation. Double-blind screening of title/abstracts was performed in batches of 100 by the first and fourth authors to allow discrepancies to be identified and resolved before proceeding to full-text screening. Any discrepancies were discussed and resolved through consensus ensuring that no single author's perspective could unilaterally influence inclusion and exclusion decisions. If consensus could not be reached, a final decision was made through discussion with the three supervisors. Additionally, a documented audit trail of screening decisions was maintained throughout this process to facilitate retrospective verification of decisions. Regular supervisory meetings were held throughout the duration of the project to verify that conclusions were firmly rooted in the literature rather than personal experience. The first author also engaged in ongoing reflective practice to monitor and minimize the inappropriate transference of personal perspectives into the analytical process.

The second reviewer, who independently performed title/abstract and full-text screening, has not been diagnosed with endometriosis but has lived experience of another gynecological condition. Like the first author, this author also engaged in reflective practices throughout the screening process and participated in supervisory discussions to ensure that her experiences did not bias screening or analytical decisions.

Results

The search strategy yielded a total of 4,102 articles; 3,824 from the first search and 278 from the second, with only 62 deemed relevant to the research question after the selection process, as outlined in Figure 1.

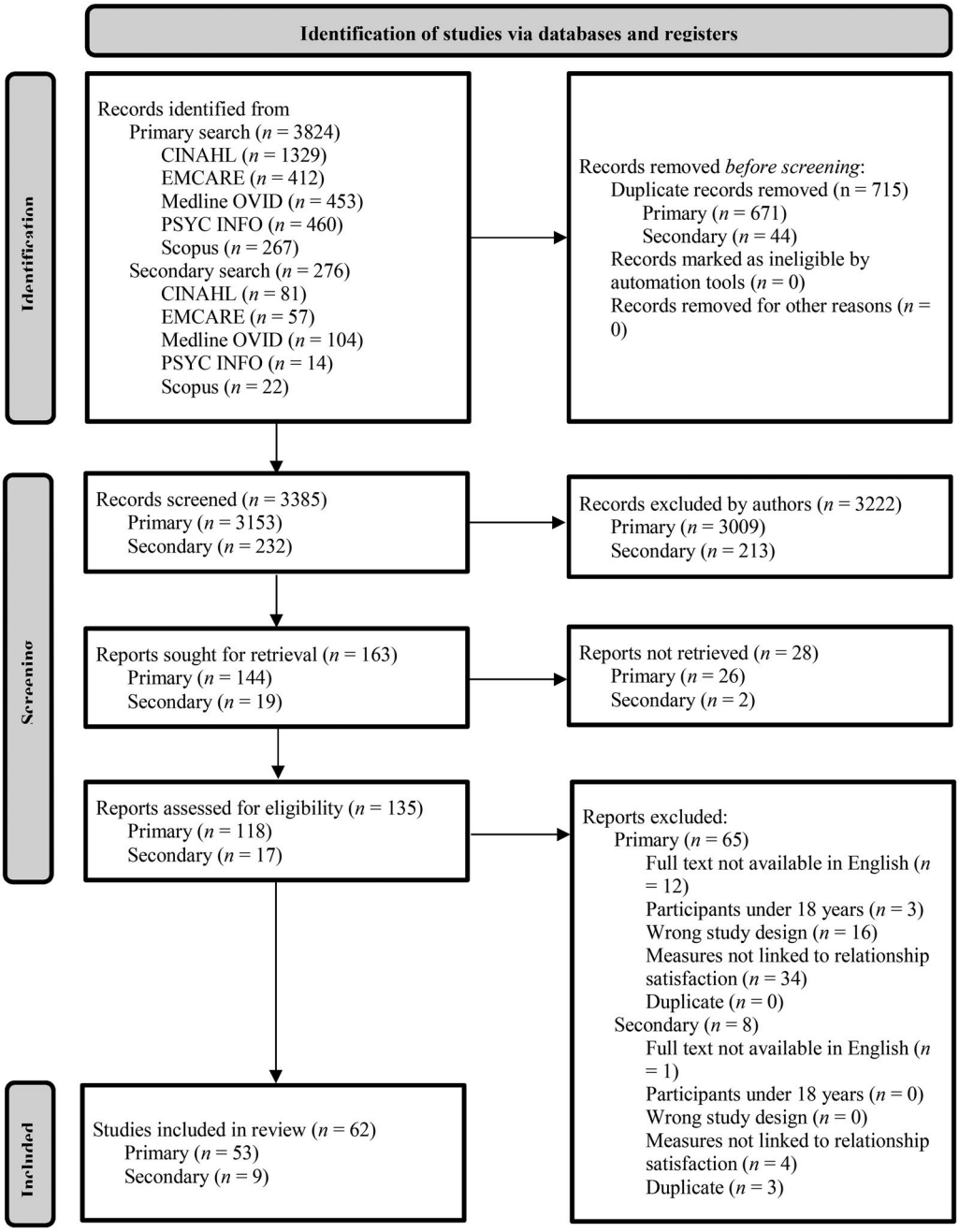


Figure 1. PRISMA flowchart outlining the study selection process.

Study Characteristics

All 62 studies examined how endometriosis affects relationship satisfaction from the perspective of the affected women or the partners of these women. An overview of the included studies can be found in Table S3 in the Supplementary Materials.

Most studies were quantitative in nature ($n = 41$) followed by qualitative ($n = 19$). Only two studies (Fernandez et al., 2006; Rush & Misajon, 2018) employed a mixed-methods approach integrating both qualitative and quantitative methodology. A cross-sectional design was the most common; with 65.9% of quantitative, 47.4% of qualitative, and both mixed-methods studies using this approach. Quotations from participants in qualitative and mixed-methods studies will be included throughout the narrative synthesis to exemplify the themes presented.

The first publication on this topic occurred in 2004, with only eight studies published between this year and 2015. Since 2016, research outputs have steadily increased, with the highest number of publications in 2025 ($n = 13$), followed by 2024 ($n = 9$) and 2023 ($n = 6$).

The largest research outputs were from Germany ($n = 10$) and Australia ($n = 10$), followed by Italy ($n = 8$) and Austria ($n = 7$). Of the 10 studies out of Germany, five were multicenter studies conducted in collaboration with researchers in Austria and Switzerland and two were multicenter studies that in collaboration with researchers in Austria. No other multicenter studies were reported. While there was diversity in geographical locations captured in this review, only a few studies reported racial and ethnic demographics ($n = 12$).

There was a total of 13,438 participants recruited from the 62 studies reviewed. The smallest sample had 10 participants while the largest had 1,586. All studies involved participants over 18 years old. While the majority of studies excluded menopausal women with endometriosis from participating, one study compared differences in relationship satisfaction of pre- and postmenopausal women (Vallée et al., 2025b).

The majority of research was conducted in women with endometriosis ($n = 41$). Six studies focused solely on the perspectives of male partners of women with endometriosis, while 15 studies reviewed the collective experiences of both women with endometriosis and their partners. Only 25 studies explicitly stated that the impacts of endometriosis were investigated in heterosexual relationships. A further 28 studies did not specify the sexuality of participants or the nature of relationship they were in when responding to research questions. Nine studies noted that persons of any sexuality could participate; however, they formed in a minority in all studies.

The majority of studies ($n = 37$) recruited participants from public or private health-care systems such as hospitals, allied health services, or gynecology clinics. Participants were also recruited using social media platforms ($n = 5$), from previous study participation ($n = 6$), endometriosis advocacy groups ($n = 5$), local shopping center (Oehmke et al., 2009), or a combination of strategies ($n = 8$). These recruitment methods may have led to an over-representation of moderate to severe cases of endometriosis, as shown in $n = 24$ studies. Endometriosis classification was not explicitly reported in 38 studies.

Measuring Relationship Satisfaction

Qualitative studies and the qualitative components of mixed-methods research relied heavily on in-depth, semi-structured ($n = 14$) or open-ended ($n = 5$) interviews to explore the perspectives of participants. For quantitative studies that used validated psychometric tools, there was a total of 59 different psychometric measurement tools used. The most common psychometrics were: the Couples Satisfaction Index (Kfoury et al., 2023; Martins et al., 2021; McKay et al., 2022; Pecore et al., 2025; Pereira et al., 2021; Van Niekerk et al., 2021), Endometriosis Health Profile (EHP; Fonseca et al., 2025; Guo et al., 2025; Martins et al., 2022; Matasariu et al., 2017; Rodrigues et al., 2022; Rush & Misajon, 2018; Schick et al., 2022; Vallée et al., 2025b), Female Sexual Functioning Index (FSFI; De Graaff et al., 2013; Fritzer et al., 2013; Pecore et al., 2025; Rao et al., 2023; Rasekh Jahrommi et al., 2025; Rossi et al., 2020; Van Eickels et al., 2024; Vallée et al., 2025a, 2025b; Yang et al., 2021), Hospital Anxiety Depression Scale (De Graaff et al., 2013; Facchin et al., 2017, 2021;

Martins et al., 2022; Pereira et al., 2021), and Visual Analogue Scale (VAS; Namazi et al., 2021; Bernays et al., 2020; Ferrero et al., 2005; Giuliani et al., 2016; Pecore et al., 2025; Rodrigues et al., 2022).

Synthesis of Findings

Predictors of Relationship Satisfaction

Sexual Dysfunction. Disrupted sexual functioning was the most prevalent predictor of sexual and relationship satisfaction for persons with endometriosis and their partners ($n = 49$). Impacts on sexual functioning featured in all studies examining the partner's perspective ($n = 6$) and were prevalent throughout research on persons with endometriosis ($n = 34$) and both members of the dyad ($n = 14$).

Dyspareunia and other pain associated with sexual intercourse were frequently reported as interfering with sexual functioning and pleasure attainment ($n = 42$). The prevalence of dyspareunia was higher in persons with endometriosis; ranging from 29% (Van Den Broeck et al., 2013) to 86% (Law et al., 2025), compared to 1% (Di Donato et al., 2014) to 10% (Hämmerli et al., 2018) in persons without endometriosis. Dyspareunia was associated with reduced sexual quality of life ($n = 4$), psychological distress ($n = 4$), relationship satisfaction ($n = 7$), and sexual dissatisfaction ($n = 14$). Additionally, endometriosis was also linked with dysmenorrhea (Bień et al., 2020; Di Donato et al., 2014; Helfenstein et al., 2023; Jones et al., 2004), dyschezia (Alcalde et al., 2022; Di Donato et al., 2014; Facchin et al., 2021; Fonseca et al., 2025; Martins et al., 2022), and noncyclic chronic pelvic pain (Afifi Araby et al., 2024; Alcalde et al., 2022; Di Donato et al., 2014; Fonseca et al., 2025; Giuliani et al., 2016; Margatho et al., 2022; Namazi et al., 2021; Rodrigues et al., 2022; Taffs et al., 2024). These endometriosis-related pain symptoms were also linked to altered sexual and relationship satisfaction for persons with the disease. Pain was described qualitatively during interviews or open-ended questionnaires ($n = 19$) or quantitatively measured using psychometric measures such as the VAS, FSFI, and EHP. The following quotation describes the experience of abdominal pain associated with endometriosis:

> During sex yes. Not afterwards. It is intense pain at first and then you get a dull pain that goes right across your abdomen. You are sore afterwards but sometimes it will grab you in the night and you can't move, you get this pain in the pelvis area and you are doubled and you try to move and it is such a spasm that you literally can't move. You think no this can't be endometriosis, this has to be something more serious, this can't surely be this painful but then it eases off and it is like cramp, real intense cramp, that is probably what it is I don't know. (Female participant with endometriosis; Jones et al., 2004, p. 127)

Endometriosis was consistently associated with challenges with both sexual and relationship satisfaction for both the person with the condition and their partner ($n = 26$). Broadly speaking, endometriosis had a predominantly negative effect on relationships (Guo et al., 2025; Hunsche et al., 2023; Namazi et al., 2021; Oehmke et al., 2009; Rao et al., 2023), with both persons with endometriosis and their partners experiencing reduced sexual (Di Donato et al., 2014; Fonseca et al., 2025; Giuliani et al., 2016; Guo et al., 2025; Hämmerli et al., 2018; McKay et al., 2022; Netzl et al., 2025; Rasekh Jahroomi et al., 2025; Rossi et al., 2020; Sarvestani et al., 2025; Vallée et al., 2025a, 2025b; Yang et al., 2021) and relationship satisfaction (Margatho et al., 2022; McKay et al., 2022; Sarvestani et al., 2025). Partners of persons with endometriosis reported lower relationship happiness (El Hadad et al., 2024; Hämmerli et al., 2018; Margatho et al., 2022) and sexual satisfaction (Hämmerli et al., 2018; Sarvestani et al., 2025; Schick et al., 2022) in the context of greater symptomatic impairment by their counterpart. The frequency of sexual activity was found to have a positive effect on sexual satisfaction in some studies on persons with endometriosis (Martins et al., 2022; Van Eickels et al., 2024) but not all (Bernays et al., 2020). Quantitative cross-sectional investigations showed that higher relationship and sexual satisfaction in one partner were reciprocated in the other (Martins et al., 2022; McKay et al., 2022; Pecore et al., 2025; Pereira et al., 2021; Van Niekerk et al., 2021). Similarly, signs of psychological distress such as anxiety, depression, and low self-esteem in one partner were associated with reduced relationship and sexual satisfaction for the other partner (De Graaff et al., 2016; Facchin et al., 2017, 2021; Grano et al., 2025; Jones et al., 2024; Kfoury et al., 2023; Pereira et al., 2021; Sarvestani et al., 2025; Van Eickels et al., 2024).

Several studies explored the functionality of orgasms as a measure of sexual pleasure in person with endometriosis ($n = 13$). Persons with endometriosis experienced an impairment in their ability to orgasm (Di Donato et al., 2014; Ferrero et al., 2005; Sarvestani et al., 2025) or pain associated with orgasm (Ferrero et al., 2005; Howard et al., 2024), with greater impairment occurring following menopause (Vallée et al., 2025b). Less frequent and satisfying orgasms were associated with lower sexual and relationship satisfaction in persons with endometriosis (Rossi et al., 2020; Vallée et al., 2025b; Van Den Broeck et al., 2013). One woman described how "the pain has reduced my sexual pleasure, and reaching orgasm has become less frequent; sometimes I fail to reach orgasm entirely" (Sarvestani et al., 2025, p. 9). Two studies reported no significant impacts on achieving pleasurable orgasms during sex (Rasekh Jahroomi et al., 2025; Yang et al., 2021). Orgasm functionality in persons with endometriosis was measured using several psychometric tools, such as the Derogatis Sexual Functioning Inventory (Ferrero et al., 2005), FSFI (Rossi et al., 2020; Vallée et al., 2025a, 2025b; Yang et al., 2021), Global Sexual Satisfaction Index (Ferrero et al., 2004), McCoy Female Sexuality Questionnaire (Rossi et al., 2020), Sexual Health Outcomes in Women questionnaire (Di Donato et al., 2014), and Short Sexual Functioning Index (Van Den Broeck et al., 2013), or described qualitatively (Howard et al., 2024; Sarvestani et al., 2025). There was no quantitative evidence of self-reported sexual dysfunction in male partners (Amza et al., 2025) or measured by the International Index of Erectile Function (De Graaff et al., 2016; Pecore et al., 2025). However, some partners qualitatively reported experiencing erectile dysfunction. Partners described themselves as experiencing slowness to ejaculate (Keany et al., 2025) or were described as prematurely ejaculating by their counterparts with endometriosis; for example, "as soon as penetration occurs, my husband ejaculates—sometimes even without penetration, just from foreplay. He says he can't enjoy it the way he wants because I'm in pain" (Sarvestani et al., 2025, p. 9).

Infertility. Fertility concerns featured consistently throughout the literature ($n = 25$), with studies on persons with endometriosis ($n = 15$), their partners ($n = 4$), and within couples ($n = 6$) experiencing infertility. Primary infertility due to endometriosis affected between 25% (Facchin et al., 2017; Hämmerli et al., 2018) and 82% (Hudson et al., 2016) of persons with endometriosis, with around 42% (De Graaff et al., 2013) to 50% (Hudson et al., 2016) seeking medical assistance to conceive.

Fertility concerns caused greater distress in persons and dyads that did not already have children (Facchin et al., 2017; Rodrigues et al., 2022; Van Eickels et al., 2024) and promoted some couples to reassess when and how many children they would have (Culley et al., 2017; Hudson et al., 2016). The desire to conceive and start a family led some persons with endometriosis to persist with painful intercourse (Fritzer et al., 2013; Law et al., 2025; Sarvestani et al., 2025). This is illustrated by a quotation from a female study participant with endometriosis: "All my sexual relations have become about having a baby—it's no longer for pleasure or comfort … I'm only thinking about the baby" (Sarvestani et al., 2025, p. 7). This was largely driven by the notion that having children was a fundamental aspect of the female identity, and their "wifely" duties and life would be unfulfilled in the absence of children (Girard et al., 2023; Hudson et al., 2016; Jaeger et al., 2024; Jones et al., 2004; Matasariu et al., 2017; Peterson et al., 2023; Sarvestani et al., 2025; Shinan-Altman et al., 2024). This is illustrated by another female participant with endometriosis: "The thought of not having a baby, that was the biggest thing because … get married by 21, 22, have my first baby at 24, have my second baby at 26 … obviously it didn't work out" (Hudson et al., 2016, p. 726).

Both persons with endometriosis (Girard et al., 2023; Hudson et al., 2016; Jones et al., 2004; Kfoury et al., 2023; Mastrangelo & Turnbull, 2022; Matasariu et al., 2017; Namazi et al., 2021; Pereira et al., 2021; Rush & Misajon, 2018; Van Eickels et al., 2024) and their partners (Culley et al., 2017; Fernandez et al., 2006; Guo et al., 2025; Law et al., 2025; Sarvestani et al., 2025; Van Eickels et al., 2024) experienced emotional and psychological distress from fertility issues and invasive fertility treatments. The consequences of both the physical and psychological distress stemming from endometriosis-associated infertility were responsible for relationship strain (Jones et al., 2004), conflict (El Hadad et al., 2024), miscommunications (Jaeger et al., 2024; Matasariu et al., 2017), and unhappiness (Bernays et al., 2020) in relationships. However, some partners sought to overcome this by prioritizing their affected counterpart's well-being over their desires to conceive (Culley et al., 2017; Margatho et al., 2022).

Impact on Relationship Satisfaction

Sexual Dysfunction. Intercourse avoidance was a common pain avoidance strategy used by members of the dyad to mitigate experiencing or inflicting pain during intercourse ($n = 12$), with up to 82% of persons with endometriosis using this strategy (Armour et al., 2020). Persons with endometriosis recounted how pain was prevalent during intercourse (Armour et al., 2020; De Graaff et al., 2016; Fritzer et al., 2013; Hunsche et al., 2023; Peterson et al., 2023; Rodrigues et al., 2022) and sometimes lingered long after intercourse had finished (Armour et al., 2020; Fritzer et al., 2013; Girard et al., 2023; Law et al., 2025; Rodrigues et al., 2022). This experienced is described by a woman with endometriosis:

> Over the last two years [we've] probably [had sex] once or twice a month because I just couldn't bear the pain of having sex … it was the sheer agony; it was like somebody putting a knife in me, like every time he penetrates the bowel pain would send electric shocks down my legs. (Law et al., 2025, p. 148–49)

Some partners likened the experience of engaging in intercourse that hurt their counterparts with endometriosis to abuse; "You almost feel … like you're abusing that person, almost like a sort of rape, you know" (male participant; Law et al., 2025, p. 150). However, only one study quantified this, finding that a recent diagnosis of endometriosis was a risk factor for intimate partner violence (East et al., 2025).

For both members of the dyad, the apprehension of experiencing or inflicting pain during future intimate encounters led to a conditioned fear response and further intercourse avoidance. One woman with endometriosis described how her "husband tries not to ask for sex because of the pain I go through" (Sarvestani et al., 2025, p. 6). Although intercourse avoidance served as a physically protective response to dyspareunia, it risked being interpreted by partners as diminished sexual desire, contributing to dyadic conflict (Girard et al., 2023; Keany et al., 2025; Law et al., 2025; Sarvestani et al., 2025) and fostered feelings of guilt in the person with endometriosis surrounding their perceived inadequacy as a sexual partner (Fritzer et al., 2013; Jones et al., 2004; Law et al., 2025).

In contrast to intercourse avoidance, the literature also documented instances where persons with endometriosis pursued sexual intercourse despite pain ($n = 14$). This included to satisfy their partner's sexual needs (Fritzer et al., 2013; Law et al., 2025), mitigate relational conflicts (Fritzer et al., 2013; Peterson et al., 2023), maintain a sense of normalcy in the relationship (Hudson et al., 2016; Rush & Misajon, 2018; Taffs et al., 2024), maintain a sexual identity (Fritzer et al., 2013; Girard et al., 2023), out of fear of relationship breakdown as experienced in past relationships (Armour et al., 2020; El Hadad et al., 2024; Facchin et al., 2021; Fritzer et al., 2013; Girard et al., 2023; Mastrangelo & Turnbull, 2022), to conceive offspring (Guo et al., 2025; Law et al., 2025; Mastrangelo & Turnbull, 2022; Sarvestani et al., 2025), or due to a normalization of painful intercourse (Howard et al., 2024; Law et al., 2025; Peterson et al., 2023; Sarvestani et al., 2025). Such behaviors were sometimes recognized by the partner (Hämmerli et al., 2018; Law et al., 2025) and negatively impacted sexual satisfaction for both members of the dyad (Fritzer et al., 2013; Pecore et al., 2025).

Dyadic Coping. Navigating the impacts of endometriosis on their relationship was a difficult activity for many couples ($n = 15$). Poor communication and misunderstandings between couples often led to tension and arguments (Culley et al., 2017; El Hadad et al., 2024; Ferrero et al., 2005; Fritzer et al., 2013; Girard et al., 2023; Howard et al., 2024; Law et al., 2025; Margatho et al., 2022; Sarvestani et al., 2025), with persons with endometriosis twice as likely to experience partner-related conflicts than controls without endometriosis (El Hadad et al., 2024). Conflicts sometimes arose due to a misconception that partners did not offer enough support or understanding regarding their infertility or sexual issues (Matasariu et al., 2017). While partners sometimes experienced negative feelings toward their counterpart due to their endometriosis (Culley et al., 2017; El Hadad et al., 2024; Santulli et al., 2024; Vallée et al., 2025b), for the most part, they experienced concern and compassion toward their partners and the impacts that endometriosis had on them (Culley et al., 2017; Fernandez et al., 2006; Hudson et al., 2016; Margatho et al., 2022; Santulli et al., 2024). Partners often felt frustrated and helpless from being unable to ease their partner's pain (Culley et al., 2017; El Hadad et al., 2024; Fernandez et al., 2006; Girard et al., 2023; Hämmerli et al., 2018; Hudson et al., 2016; Margatho

et al., 2022; Shinan-Altman et al., 2024) and struggled to articulate these feelings without attributing blame onto their partners (Law et al., 2025; Santulli et al., 2024). Such attributions often coincided with feelings of guilt due to an awareness that endometriosis was the issue, rather than their partner (Culley et al., 2017; Santulli et al., 2024; Shinan-Altman et al., 2024). The following quotation highlights how "Ben" recounts how he hid his feelings about his partner's endometriosis from her.

> The doctor spoke, and I felt pressure, I didn't know what would happen, how she would manage with it, how I would manage with it, how we would manage with it together. … I was thinking about her, about me, about us, … however, the truth is that I didn't feel comfortable revealing my feelings, I'm not used to talking about feelings, I usually hide them. (Shinan-Altman et al., 2024, p. 6)

Social Isolation. The unpredictability of endometriosis symptoms shaped a greater reliance on the partner for social support and isolation from external social contacts ($n = 8$). Persons with endometriosis sometimes feared their pain or symptoms would be unmanageable or poorly perceived by their partner, friends, and family (Jones et al., 2004; Namazi et al., 2021; Sarvestani et al., 2025), leading to a tendency to avoid social engagements (Hudson et al., 2024; Jones et al., 2004; Mastrangelo & Turnbull, 2022; Namazi et al., 2021; Peterson et al., 2023; Sarvestani et al., 2025). South Asian women described that cultural expectations contributed to their feelings of guilt and failure over their symptoms and infertility issues as there was a lack of awareness of their situation by their extended family and community (Hudson et al., 2016). The following quotation highlights how cultural expectations led this woman to attend a social engagement despite her severe symptoms:

> Like, when my cousin got married … I have no choice but to go to the wedding whether I was fit enough or not fit enough, I had to go basically and he [partner] was like, "No if you're not well, you're not going." I was like, "If I don't go it's going to cause a problem between dad and his brother" … just to keep the peace I went to the wedding. But I didn't do any work and I think other people like guests were gossiping. (South Asian woman with endometriosis; Hudson et al., 2016, p. 728)

Instability in their external social relationships, created a sense of guilt in some persons with endometriosis and an over-reliance on their partner for social connection, as many partners may already be disproportionately contributing to home and work responsibilities (Culley et al., 2017; Hudson et al., 2016; Jones et al., 2004; Mastrangelo & Turnbull, 2022; Peterson et al., 2023; Rea et al., 2020).

Coping Strategies

Dyadic Approaches. Qualitative studies provided rich insight into dyadic coping strategies of couples when navigating endometriosis adversities ($n = 2$). Some persons with endometriosis sought to cope with their symptoms alone, not wishing to burden their partners with their distress while they navigated appointments and symptoms alone (Shinan-Altman et al., 2024; Strzempko Butt & Chesla, 2007). Whilst partners showed support by respecting this need for space, they wished they could be more involved with treatment (Shinan-Altman et al., 2024). Other couples addressed endometriosis together, relying on one another for reciprocal care and support as they navigated day to day variability with endometriosis (Shinan-Altman et al., 2024; Strzempko Butt & Chesla, 2007).

Role of a Partner. Partners have a crucial role in supporting and stabilizing their partner with endometriosis when their symptoms impacted their everyday life ($n = 8$). For persons with endometriosis, their partner was the first avenue for emotional support and need fulfillment (Culley et al., 2017; Sechi et al., 2024). The presence of a partner had a positive effect on quality of life (De Graaff et al., 2013) and reduced psychological distress in persons with endometriosis (Facchin et al., 2017, 2021). During symptom flares, partners described themselves performing disproportionate household chores to allow their partners to rest and recover (Hudson et al., 2016; Margatho et al., 2022). Additionally, persons with endometriosis felt more secure and satisfied in their relationship if their partner accompanied them to medical appointments and were actively involved in treatment decision making (Culley et al., 2017; Facchin et al., 2021). However, in some dyads, traditional gender roles reemerged,

with the male partner assuming primary financial responsibilities to compensate for their partner's inability to maintain full time work (Culley et al., 2017; Hudson et al., 2016; Peterson et al., 2023), which hindered some partners from attending medical appointments even if they wanted to Margatho et al. (2022).

Reframing Sexual Expectations. In contrast to the communication difficulties outlined above, some couples drew on open and adaptive communication strategies as a foundation for reframing their intimate relationship. Couples were found to adopt several different strategies to reframe their understanding of intimacy in their relationship ($n = 10$). Regarding their sex life, many couples found new ways of obtaining pleasure from each another by introducing sex toys to minimize the degree of penetration or stimulate external erogenous areas (Howard et al., 2024; Rea et al., 2020), relaxation strategies (Howard et al., 2024; Law et al., 2025), and avoiding painful positions such as "vaginally from behind" or "woman on top" (Hudson et al., 2016; Keany et al., 2025; Law et al., 2025; Rea et al., 2020). The success of such strategies was contingent on open communication of needs, as opposed to avoidance of such conversations and intercourse (Hämmerli et al., 2018; Howard et al., 2024). This contributed to both personal growth and closeness in the relationship as the couple sought to understand and accommodate one another's needs (Culley et al., 2017; Hudson et al., 2016; Shinan-Altman et al., 2024; Strzempko Butt & Chesla, 2007). The following quotation provides insight from a male partner into how intimacy was reframed in their relationship:

> We … went through the stage of realizing that this is gonna be something we have to deal with and so now we need to make a plan to make sure that we can still have a functioning relationship and life around the problem … and you know I guess we sort of have been connecting more on the couch, you know … cuddling and kissing and that sort of thing … without it actually being a precursor to any intercourse. (Male partner; Keany et al., 2025, p. 5)

Access to Appropriate Care. The impact of endometriosis on the partner was rarely considered in clinical management of the condition ($n = 5$). Partners tended to internalize and conceal their emotional responses from their counterpart because they did not want to cause additional distress or attribute blame to their partner (Culley et al., 2017; Fernandez et al., 2006; Keany et al., 2025; Law et al., 2025). Qualitative interviews were often the first opportunity for partners to express their feelings and many encountered difficulties articulating their concerns (Culley et al., 2017; Margatho et al., 2022). While, some men received external clinical or personal psychological support, this was often inadequate due to limited clinical understanding about the systemic effects of endometriosis on the individual and partnership (Culley et al., 2017; Fernandez et al., 2006; Margatho et al., 2022), highlighting a need for improved clinical and general awareness of endometriosis to better support both persons with endometriosis and their partners (Culley et al., 2017; Fernandez et al., 2006; Shinan-Altman et al., 2024).

The need for greater multidisciplinary clinical management was also mirrored by persons with endometriosis ($n = 4$). Very few individuals were informed by their health-care providers about the impacts of endometriosis on their sexual functioning and the implications these may have on intimacy, well-being, and the relationship, and were reliant on their partners for such information (Law et al., 2025; Taffs et al., 2024). For individuals and couples that were referred to generic psychological or counseling services, these services were often poorly received and nonspecific to endometriosis concerns (Helfenstein et al., 2023; Law et al., 2024). More specialized services, such as pain psychologists and pelvic physiotherapists, were more favorably perceived, yet underutilized (Howard et al., 2024; Taffs et al., 2024).

Discussion

This scoping review utilized narrative synthesis to map the findings from 62 studies to examine the impact of endometriosis on relationship and sexual satisfaction between persons with the condition

and their romantic partners. Primarily these relationships were examined in heterosexual relationships between cis-women and cis-men.

Endometriosis was found to have a negative effect on relationship satisfaction in couples. Sexual dysfunction, stemming from pain associated with sexual activities and difficulties experiencing sexual pleasure, was one notable driver for lower relationship and sexual satisfaction at both an individual and dyadic level. These findings align with and integrate the findings of previous systematic reviews on endometriosis that sought to view female sexual dysfunction (Zhu et al., 2023) and the partner's perspectives on sexuality (Facchin et al., 2018) in isolation. Sexual and relationship satisfaction were influenced by how the couple addressed issues in their relationships. While some persons sought to reduce the frequency of intercourse to minimize the pain experienced during coitus, if this was poorly communicated to their counterpart, it may be incorrectly perceived as a desire rather than functionality issue and contribute to dyadic conflict and distress. This pattern is consistent with the fear-avoidance model of pain, where negative or exaggerated interpretations of pain precipitate fear of reexperiencing pain lead to avoidance behaviors, such as reducing coitus. Within a dyadic context, these avoidance responses may be misinterpreted by the partner, thereby reinforcing maladaptive cognitive-affective cycles and contributing to heightened relational distress of both individuals. However, constructive communication between couples about developing strategies to address sexual and relational needs was found to precipitate better relationship satisfaction, thus disrupting maladaptive cognitive-affective cycles. Such findings corroborate that relationship satisfaction in dyads is closely related with relationship satisfaction, with one partner reflecting that experienced by the other (Eastwick et al., 2023).

While sexual dysfunction was most notable, another impact on relationship satisfaction was the repercussions of endometriosis-related infertility. Infertility appeared to be more of a concern for persons with endometriosis than their partners due to their loss of choice of when or if they could have children as this interfered with their identity as women and mothers. This is consistent with a feminist theoretical understanding of how patriarchal norms define womanhood by reproductive capacity and maternal identity, and that infertility poses a profound threat to this socially normalized identity (Ussher, 2007). An intersectional lens suggests this burden may not uniformly fall across all women, with some women experiencing amplified distress due to cultural factors (Cole, 2009). This aligns with previous research that suggests sexual functionality, rather than infertility, is more of a concern to male partners (Luk & Loke, 2019), reflecting broader gendered scripts whereby men's relational and sexual identities are less contingent on reproductive outcomes than those of their female partners.

Limitations

While this scoping review provides a valuable synthesis of existing literature on the relational impacts of endometriosis, there were several limitations to the approach.

First, in alignment with the JBI approach for scoping reviews (Peters et al., 2020a), there were no quality or bias assessments conducted on the included studies as the overall aim was for a descriptive literary summary rather than assessment of research quality. Future research is encouraged to build upon the breadth of evidence mapped in this scoping review through a systemic review and formal quality appraisal to provide a more rigorous evaluation of the strength, consistency, and risk of bias in the current literature. Additionally, we did not examine any grey literature, including non–peered reviewed articles, pre-publications, organizational resources, and conference abstracts available through online sources. The decision to exclude grey literature was grounded in methodological limitations in accessing and analyzing this data, including difficulties reproducing grey literature searches and the potential for inadequately reviewed sources to introduce bias and reduce the validity of synthesized findings (Paez, 2017). A secondary literature search was conducted 8 months after the initial search to identify newly published studies and publications missed in the previous search to ensure the scoping review broadly captured the empirical literature on this topic. This decision was informed by the rapidly expanding bibliometric landscape of endometriosis research (Deng et al., 2023; Wu et al., 2025). Additionally, forward and backward citation searching was not undertaken because broad

inclusion criteria were intended to capture the breadth of the literature on this topic across the two searches. Nevertheless, future reviews on this topic are encouraged to systematically incorporate grey literature and citation searches alongside formal quality appraisal to increase the robustness and mapping of findings.

Second, the exclusion criteria applied meant that research that did not concretely link sexual dysfunction measures to relationship outcomes were excluded, which may have failed to capture the full breadth of sexual dysfunction experienced by persons with endometriosis. It would be important to have an overview of these studies to understand patterns in sexual dysfunction accompanying endometriosis; however, a meta-analysis may be a more appropriate methodology to quantify the degree of sexual dysfunction in women with endometriosis, especially in relation to treatment outcomes.

Future Research

Gender-neutral terminology was used at times throughout this review to reflect the current understanding that ectopic endometrial-like tissue may arise and cause complications in premenarchal, pre- and postmenopausal, and gender diverse populations (Apelian et al., 2026). Chronic pelvic pain has been shown to affect between 51% and 72% of trans- and gender-diverse people presumed female at birth (Ferrando et al., 2021; Shim et al., 2020). While endometriosis is a common cause of chronic pelvic pain, there was no research captured by this review that explored the experiences of trans- and gender-diverse persons with endometriosis. These populations should be considered in future research as their experiences with how endometriosis affects romantic relationships may differ from the experiences of cis-women with endometriosis and their cis-male partners. Furthermore, there was limited examination of the individual and dyadic effects of endometriosis in the few studies that allowed LGBTIQA+ individuals to participate. While several studies allowed individuals of any sexual orientation to participate, there was limited exploration of any deviations from traditional heteronormative sexual and relational scripts. Small sample sizes were provided as an explanation for this in one quantitative study (Howard et al., 2024), while qualitative studies did not explore LGBTIQA+ participants as a distinct subgroup, precluding any meaningful examination of how sexual orientation and relationship structure may shape the dyadic impact of endometriosis beyond heteronormative frameworks.

A further limitation of the reviewed literature was the widespread absence of key demographic data, including the ethnicity and racial profiles of participants and their geographic proximity to tertiary health-care infrastructure. Mapping the country of publication revealed an overrepresentation of the Global North and limited representation of the Global Majority World. While this may suggest a greater representation of Caucasian individuals in this review, without ethnicity and racial data this cannot be confirmed, nor can the role of culture on the individual and dyadic experiences of living with endometriosis be inferred. This highlights a gap in our current knowledge and research strategy, particularly given that cultural factors are known to meaningfully shape how individuals and couples experience and manage endometriosis (Culley et al., 2017; Hudson et al., 2016). Evidence from a 35-nation cross-sectional study demonstrated that the associations between dyadic coping behaviors and relationship satisfaction vary significantly both between and within nations (Hilpert et al., 2016). This suggests that the transactional stress and coping processes central to Bodenmann's (1997) systemic-transactional model may not operate uniformly across cultural contexts; instead, culturally specific norms around communication, stress disclosure, and partner support shape the extent to which dyadic coping translates into relational satisfaction. Thus, future research should therefore prioritize the inclusion of ethnically, racially, and culturally diverse samples in addition to systematic collection and reporting on relevant demographic data to ensure that findings are culturally appropriate. Furthermore, the publication bias toward the Global North may be explained by provision of government funding to improve health and well-being outcomes for persons with endometriosis, such as The Australian National Action Plan for Endometriosis (Department of Health and Aged Care, 2018) and national strategies in France and Denmark (Endometriosis.org, 2023). Bibliometric research has observed an increase in publications on endometriosis since 2020 (Deng et al., 2023; Wu et al., 2025), a trend that was also observed in this review, with increased research output from 2016 to

2025. These bibliometric findings suggest that such government initiatives have had a positive effect on increasing research to understand globally endometriosis from biological, psychological, and social perspectives; however, a publication bias toward the Global North remains. While endometriosis research continues to be a global concern, future research should seek to actively explore the dyadic perspectives of members of the Global Majority World. Moreover, the majority of participants in this review were recruited through tertiary healthcare services or media sites linked to endometriosis societies. While there is lack of consensus on association between disease severity and symptom severity (Pašalić et al., 2023), persons with more severe endometriosis symptoms may be more likely to seek medical investigations for their symptoms and be geographically favored to do so. For persons in metropolitan areas, there may be greater provision and availability of these services (Rural Doctors Foundation, 2025) which would account for the absence of research captured in geographically isolated areas, such as research skewed toward metropolitan over rural Australia. This review captured only Australian study that had geographical representation from metropolitan, regional, and remote Australia (Taffs et al., 2024), however there was greater representation of metropolitan dwelling participants and limited exploration on geographical barriers to accessing support. Future research should seek to examine the geographical barriers to care both in the Global North and Global Majority World.

Finally, improving endometriosis awareness in both clinical and general settings is essential to increase awareness of the impacts of endometriosis in the person with the condition and the flow-on implications on their partner and romantic partnership. To facilitate this, health-care professionals may benefit from a universal endometriosis-specific screening tool that captures all domains of functioning that can be affected by endometriosis. This tool can be used in primary care settings to quickly identify areas most significantly impacted by endometriosis, such as sexual functioning and relationship with partner, and direct patients to appropriate care. Moreover, this review has highlighted the significant heterogeneity of psychometric measurement tools used in research to measure elements of relationship satisfaction in women with endometriosis and their partners. While the EHP has been specifically designed to capture the experiences of living with endometriosis with five core and six additional subscales (Jones et al., 2024), this questionnaire does not specifically measure how the condition impacts romantic relationships. And while other questionnaires can screen for relationship satisfaction outcomes, they are not tailored to measuring these outcomes in persons with endometriosis. Research on the clinical applications of preexisting tools, such as the EHP, is needed to ascertain their suitability for such purposes or to direct the development of new psychometrics to serve this purpose.

Implications for Policy and Practice

This scoping review has revealed several implications for policy and practice. Surprisingly, very few participants reported that they had been directed to counseling services by health-care providers or sought out these services themselves to address relational concerns stemming from issues related to endometriosis. For those that accessed such services, very few found the experience to be helpful. Additionally, many partners wished they had been directed to psychological services to discuss how their counterpart's endometriosis had affected them and develop strategies to assist them with coping. This suggests that the current provision of psychological services for persons with endometriosis and their partners are not meeting their needs. While psychologists have an important role in the management and treatment of psychological issues, these need to be tailored toward endometriosis-specific issues, such as sexual dysfunction and chronic pain. Such services should be targeted toward both members of the dyad to assist with developing strategies to improve communication, navigate intimacy and infertility challenges, manage shared stress, and foster mutual understanding and support in the face of endometriosis-related difficulties. This should be pursued in conjunction with multidisciplinary care services, such as sexologists and pelvic floor physiotherapists, to help individuals regain their sexual identity by learning how intimacy can be achieved through nontraditional means.

To facilitate this, access to educational resources for both persons with endometriosis, their partners, and healthcare professionals should be a key priority in the care of those affected by endometriosis. This review highlighted how many partners rely on their partners for endometriosis information,

suggesting a lack of societal awareness of endometriosis and the impacts it can have on individual and dyadic functioning. Increasing awareness may foster greater support and empathy for those with the condition from friends and family and reduce social isolation and reliance on the partner for those with endometriosis. Furthermore, a significant proportion of partners suggested that they wanted more information about endometriosis and the effects it would have on their partner and partnership while pursuing treatment, but their information seeking was limited by their clinician's expertise. This highlights a critical gap in clinician knowledge which may inadvertently leave partners feeling excluded from the care process or unprepared to support their partner. Improving training and resources for clinicians is paramount to negate strain in romantic relationships caused by the inaccessibility of clinical information to persons with endometriosis and their partners.

Conclusion

This scoping review highlights the complexity of how endometriosis can affect relationship satisfaction between those affected by the condition and their romantic or sexual partners. Sexual dysfunction and distress driven by endometriosis-related pain, infertility, psychological distress, and partner dynamics were found to be crucial drivers in the perception of relationship satisfaction in couples affected by endometriosis. The literature showed that the perception and burden of endometriosis on the relationship dynamic differed between the person with the condition and their partner. Such differences could lead to conflict if individuals were unable to articulate their needs. There was limited evidence of appropriate clinical management that involved both physical and psychological support for both members of the dyad. The absence of questions targeting relationship impacts, in isolation from sexual functionality, may contribute to this. Despite the highly evolving nature of the endometriosis research, driven by increased awareness of the disease by government bodies around the world, there remains a clear need for more research into and implementation of more comprehensive, multidisciplinary, and partner-inclusive approaches that address both the physical and psychological dimensions of the condition. Additionally, as these findings were largely reported in heterosexual couples where the person with endometriosis was born with a uterus, future research should seek to capture the needs of other persons with endometriosis and those in nonheterosexual relationships.

Third-Party Materials

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Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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