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Delayed Ejaculation in Couple and Family Therapy

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Name of the Concept

Delayed ejaculation in couple and family therapy

Synonyms

Retarded ejaculation; Inhibited ejaculation; Inhibited male orgasm

Introduction

Delayed ejaculation (DE) is a type of diminished ejaculation disorder (DED), which includes all subtypes manifesting ejaculatory delay/absence (Perelman et al. 2004). Many clinicians may find DE difficult to treat and may not grasp the psychosocial distress it causes. Assessment requires a thorough sexual history including inquiry into masturbatory methods to ascertain the information needed for proper diagnosis and treatment. This entry describes a transdisciplinary approach to the etiology, diagnosis, and treatment of men with DE based on the Sexual Tipping Point® model (Perelman 2009, 2016).

DE remains an uncommon disorder, with prevalence rates in 1–4% of males (Rowland and Perelman 2006). Rates are increasing due to greater use of pharmacotherapy [5-alpha reductase inhibitors (5αRIs), serotonin reuptake inhibitors (SRIs), etc.] and an aging population's declining ejaculatory capacity (Perelman 2016). A man with DE usually has intact erectile capacity but find ejaculating during partnered sex extremely difficult or impossible. Ejaculatory difficulty may occur in all situations (generalized) or be limited to certain experiences (situational). It may be lifelong (primary) or acquired (secondary). A man typically is unable to ejaculate in the presence of a partner (especially during coitus) but is able to orgasm and ejaculate during solo masturbation. Nomenclature confusion arises over ejaculation and orgasm usually occurring simultaneously, despite being separate physiological phenomena. Orgasm is typically coincident with ejaculation but is a central sensory event with significant subjective variation.

Men with DE typically report less coital activity, lower subjective arousal, and often report feeling "less of a man." Some partners enjoy extended intercourse, but eventually many

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experience some annoyance, pain, and the distressing question: "Does he really find me attractive?" Initially blaming themselves, partners frequently become angry at the perceived rejection. Men with DE may fake orgasm to avoid negative partner reaction. Finally, distress is extreme when conception "fails," while fear of pregnancy leads other men to avoid sex (Perelman 2016).

Theoretical Context for Concept

The Diagnostic and Statistical Manual of Mental Disorders defines DE as marked delay in ejaculation and/or marked infrequency or absence of ejaculation. Five additional factors must be considered during assessment: (1) partner issues, (2) relationship quality, (3) individual vulnerability, (4) cultural/religious influences, and (5) medical diagnoses relevant to prognosis (American Psychiatric Association 2013). "Worldwide" normative studies indicate that heterosexual males in stable relationships have a median coital duration of approximately 5–6 min (Waldinger 2009, p. 2888; Patrick et al. 2005). Influenced by those studies, the International Society of Sexual Medicine's ejaculation disorder definitions invoke a concept of percentage (0.5% and 2.5%), often used in medicine. The 3rd International Consultation On Sexual Medicine defines DE as a threshold beyond 20–25 min of coital activity, as well as negative personal consequences such as distress (McMahon et al. 2009). Perelman has recommended that any bilateral deviation from the majority of men's ~4–10 min coital range would meet the temporal criterion, but a licensed healthcare clinician must also assess for "lack of control" and "distress" to diagnose either premature or delayed ejaculation (Perelman 2016). He also recommended qualifying lifelong (primary) or acquired (secondary), global or situational, and then specifying: mild, moderate, or severe.

A man's inability to ejaculate in response to coital stimulation may be due to biological and/or a range of psychosocial and cultural factors. Typically, medical examination, laboratory testing, and sexual history are all used to rule out anatomical, hormonal, and neurological abnormalities as well as pharmaceutical causes. However, clinicians should also be alert to the numerous potential psychological and behavioral causes of DE. These can include ineffective sexual communication, cultural and religious prohibitions, mood disorders, anxiety, fatigue, trauma, and psychodynamic issues such as abandonment/rejection concerns, emotional intimacy conflicts, and unwanted pregnancy. Additionally, hostility toward the partner and paraphilic inclinations/interests also may play an etiological role (Masters and Johnson 1970; Rowland and Perelman 2006).

Regardless of the degree of organic etiology, DE is exacerbated by insufficient stimulation: an inadequate combination of "friction and fantasy" (Perelman 2016)**.** Fantasy refers to any erotic thought associated with a given sexual experience. High frequency negative thoughts may neutralize/override erotic cognitions (fantasy) and subsequently delay, ameliorate, or completely inhibit ejaculation, while inadequate partner physical stimulation (friction) may lessen response.

Perelman identified three masturbatory factors associated with DE: frequency of masturbation, idiosyncratic masturbatory style, and unsettling disparity between masturbatory fantasy and reality (Perelman 2005). Although correlated with high frequency masturbation, the primary causative factor for many men was an "idiosyncratic masturbatory style," which Perelman defined as masturbation technique not easily duplicated with the partner's body, i.e., hand, mouth, or vagina. These men engaged in patterns of self-stimulation notable for one or more of the following idiosyncrasies: speed, pressure, duration, body posture/position, and specificity of focus on a particular "spot" in order to produce orgasm/ejaculation. Disparity between the reality of sex with their partner and their preferred sexual fantasy used during masturbation is another cause. That disparity takes many forms, such as partner attractiveness, body type, sexual orientation, and the sex activity performed (Perelman 2016).

A focused sexual history or *sex status* is critical (Perelman 2003). A *sex status* begins by

differentiating DE from other sexual problems and reviewing the conditions under which the man can ejaculate. Perceived partner attractiveness, the use of fantasy during sex, anxiety-surrounding coitus, and masturbatory patterns all require meticulous exploration. Identify important causes of DE by juxtaposing the patient's cognitions and the sexual stimulation he experiences during masturbation versus a partnered experience.

Application of Concept in Couple and Family Therapy

Consider asking clients: "In what way does the stimulation you provide yourself differ from your partner's stimulation style, in terms of speed, pressure, etc.?" "Have you communicated your preference to your partner and if so, what was their response?" Some patients might balk at these personal questions, but once assured that research has shown such information is critical to successful outcome, refusal to answer is rare.

Assess for the degree of immersion and focus on "arousing" thoughts and sensations during masturbation versus partnered sex including: fantasy, watching/reading pornography, sexy versus antierotic intrusive thoughts, e.g., "It's taking too long!" How do his thoughts/feelings during sex with a partner differ from those during solo masturbation? Additional questions will identify other etiological factors that improve or worsen performance. Obtain the disorder's development history and if orgasm was ever previously possible. Review life events/circumstances temporally related to orgasmic cessation. Investigate previous treatment approaches, including the use of herbal therapies, home remedies, etc., and if there was benefit. Information regarding the partners' perception of the problem and their satisfaction with the relationship may assist treatment planning.

There are no pharmaceuticals proven to treat DE, but numerous techniques can be combined to treat DE including and not limited to sex education, cognitive-behavioral therapy, mindfulness, psychodynamic exploration of underlying conflicts, and/or couples' therapy. Patient and partner (when present) education should be integrated into the history taking process to the extent it does not interfere with rapport building or obtaining needed information. Before the evaluation concludes, offer the patient a formulation that highlights the immediate cause of his problem and how it can be alleviated. The Sexual Tipping Point® model can provide a useful frame for helping the patient (and partner) understand etiology and treatment planning. Explain how the mental and physical erotic stimulation he is receiving is insufficient for him to ejaculate in the manner he desires. Successful treatment will depend on the patient's willingness to follow therapeutic recommendations, which will be influenced by the extent of organicity, relational issues, and potentially deeper patient/partner psychodynamic problems.

Behavioral masturbatory retraining within a nuanced sex therapy serves as a frequent primary or adjunctive treatment (Apfelbaum 2000; Perelman 2003, 2016). Masturbation can serve as rehearsal for partnered sex. By informing the patient how masturbation conditioned his response, stigma is minimized and partner cooperation is evoked. Masturbation retraining is only a means to an end; the goal of therapy is higher levels of arousal within mutually satisfying experiences.

For both primary and secondary DE (when therapeutically possible), obtain an agreement from the patient to temporarily refrain from ejaculating alone. If he will not stop, negotiate a reduction in his masturbatory frequency with a minimum commitment of no ejaculation within 72 hours (experience based) of his next partnered experience. The clinician must provide support to ensure adherence to this suspension. The patient who continues to masturbate alone must do so in a manner different from his normal routine. Limit his orgasmic outlet from his easiest current capacity (usually a specific style) and progressively "shaping" it closer to his likely partnered experience. This can vary from changing hands or the position he uses during self-stimulation to masturbating in his partner's presence. Transitioning from manual to oral and to coital stimulation is typical, each providing progressively less friction.

The patient's coital bodily movements and fantasies should approximate the thoughts and sensations experienced in masturbation. Single men should use condoms during masturbation to rehearse "safe sex" (Perelman 2016).

Success rates for treatment by a skilled sex therapist are greater than 75% (Perelman 2016). Yet, not all cases resolve themselves easily. Naturally, more complex cases require more time for treatment. The longest latency a DE patient in this author's practice who limited masturbation but eventually reached coital orgasm was 8 months. That couple required management of numerous relational problems before he was willing to stop masturbating and be truly motivated to experience a coital orgasm with his wife. Often coital orgasms are obtained but no longer remain the preferred choice. Despite being the patient/partner's initial preference, coital orgasms may be less pleasurable and intense than masturbatory orgasms. Nonetheless, for many men and their partners, it is often subjectively the most satisfying for a variety of psychosocial-cultural reasons. This potential conundrum is best resolved when the clinician allows the choice of posttreatment orgasmic preference to remain the decision of the man/couple. Sometimes these men will need clinician support to express their preference for noncoital orgasms, especially when their coital orgasms were less satisfactory and only obtained by painstaking effort. However, clinicians who readily negotiate compromise with a couple whose female partner prefers noncoital stimulation should recognize the parallel with men suffering from coital DE. Finally, for some men with DE, failure is predetermined secondary to partner psychopathology, values regarding pornography and their relationship issues, etc.

Couples' therapists will readily notice that many partner issues may affect males' ejaculatory interest and capacity, but two require special attention: fertility and resentment. The pressure of a woman's "biological clock" is often an initial treatment driver. The women – and often the man – usually resist anything delaying their plan to conceive. However, the clinician suspecting the patient's DE is related to conception fears should note any disparity during sex with contraception versus "unprotected" sex. If the DE only occurs during "unprotected" sex, the clinician can assume that impregnation reluctance is a primary variable. Resolution typically requires individual work with the man and occasionally with the partner.

Fertility related or not, patient/partner anger is an important causational factor and must be ameliorated through individual and/or conjoint consultation. Anger acts as a powerful anti-aphrodisiac. While some men avoid sexual contact entirely when angry, others attempt to perform, only to find themselves modestly aroused and unable to function. The man's assertiveness should be encouraged, but the clinician should also remain sensitive and responsive to the impact of change on the partner, as well as alterations in the couple's equilibrium (Perelman 2016).

As treatment progresses, interventions may be experienced as mechanistic and insensitive to the partner's needs and goals. Understandably, partners' respond negatively to the impression he is essentially masturbating with her body, as opposed to engaging in connected lovemaking. Indeed, some men are disconnected emotionally from their partners. The clinician must empathically help the partner become comfortable with the idea of temporarily postponing desired intimacy. Once the patient is functional, the clinician can encourage a man/couple toward greater intimacy. Alternatively, both partners may be disconnected from each other but otherwise in a valued stable relationship. Support the patient's goals, but do not push the man (couple) toward the clinician's own preordained concept of a relationship. Instead, embrace McCarthy's "good enough" sex model (Metz and McCarthy 2007). The more relationship strife, the less likely treatment will succeed. Clinicians should practice to their level of comfort but should not hesitate to refer as needed to an expert sex therapist (Perelman 2016).

Clinical Example

David (34) worked as a lawyer and was recently living together with his girlfriend Judy (28), who

he has dated for 18 months. They shared values and enjoyed each other's company. He planned to propose marriage, but she recently indicated her reluctance to commit in light of their sexual difficulties. They were extremely distressed by his coital anorgasmia, causing a crisis as they questioned his attraction toward her despite his assurances of her desirability. Subsequently, he consulted his urologist, who referred to this author.

The decision to meet alone with David or meet with them conjointly was left to David when he first called. Be sensitive to patient preference regarding partner participation, as patient and partner cooperation is more critical to successful treatment than partner attendance at all office visits (Perelman 2003). A focused sex history was obtained from David during the first session. He reported that she usually initiated sex, had high desire, and was easily aroused and was orgasmic with manual, oral, and coital stimulation. The critical issue was his ability to orgasm on masturbation, but not with partnered sex. That was lifelong. He described an idiosyncratic masturbation technique, and his masturbation frequency was high. He reported first masturbating using his right hand, but when he broke it at athletic camp at age 15, he switched to lying on his belly and pressing his penis into the bed until he ejaculated. He continued doing so until the present more than four times per week, plus having sex (nonorgasmic) with Judy. His current sexual fantasy was, "making love to Judy," which was not contributing to his delayed ejaculation.

Other dynamic issues may have caught a counselor's attention. For instance, his shyness and passivity contributed to his not communicating to Judy about his sexual preferences or how he pleasured himself. Although that type of character issue could be addressed, a direct symptomatic focus is preferred unless individual or relational dynamics require doing otherwise. David was instructed to stop masturbating and to limit his attempts to reach orgasm during coitus only to those times when he was initiating sex because he wanted it, independent of who initiated. That suggestion which he followed religiously until follow-up 2 weeks later was sufficient for David to experience his first coital orgasm. Both Judy and David were exuberant. Judy and David married and 2 years later had their first child. Their case is not offered to suggest that DE can always be treated so easily and rapidly but to emphasize the importance of a counselor obtaining specific sexual experience data as part of the history taking because of its profound ability to influence both treatment and outcome.

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