## CHAPTER 6

# Delayed Ejaculation

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"Delayed ejaculation (DE) is probably the least common, and least understood of the male sexual dysfunctions," this chapter begins. In fact, delayed ejaculation is often misdiagnosed or at least misunderstood by clinicians, many of whom do not fully grasp the interpersonal and psychological distress caused by this relatively rare condition. According to Perelman, a key factor for understanding many men with DE is that the reality of partnered sex pales in comparison with the intensity of technique and fantasy occurring during masturbation. This conceptualization highlights the importance of taking a thorough sexual history, including specific questions about the method of masturbation. Improving communication and increasing sexual satisfaction during partnered sex are keys to treatment success. DE may be similar to hypoactive sexual desire in men, in that the sexual problem is a manifestation of a preference for some other type sexual activity rather than partnered sex. In the case of DE, this preference is associated with a style of masturbation and accompanying fantasy with which partnered sex does not compete.

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Delayed ejaculation (DE) is probably the least common and least understood of the male sexual dysfunctions (MSDs). A man diagnosed with DE finds it difficult or impossible to ejaculate *and* experience orgasm. This diagnosis requires distress about the symptom(s), adequate sexual stimulation, and a conscious desire to achieve orgasm. Failure to ejaculate may occur during masturbation or partner manual, coital, or anal stimulation. Men with DE usually have no difficulty attaining or maintaining erections.

Confusion about nosology has been the case historically for the full spectrum of male orgasm and ejaculatory disorders, from premature ejaculation (PE) through various diminished ejaculatory disorders (DEDs; Perelman, McMahon, & Barada, 2004). Nomenclature misunderstanding is in part related to the fact that ejaculation and orgasm usually occur simultaneously, despite being separate physiological phenomena. Orgasm is usually coincident with ejaculation but is a central sensory event that has significant subjective variation. In the fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013), the condition is labeled "delayed ejaculation" instead of the imprecise "male orgasmic disorder" or the pejorative "retarded ejaculation." The definition requires one of two symptoms: either a marked delay in or a marked infrequency or absence of ejaculation on 75–100% of occasions for at least 6 months. The DSM-IV (American Psychiatric Association, 2000) subtype (due to psychological or combined factors) has been eliminated; however, delayed ejaculation is still characterized in DSM-5 as lifelong or acquired and generalized or situational.

Although this chapter focuses on DE, there are other DEDs or alterations of ejaculation and/or orgasm that include anejaculation, painful ejaculation, and retrograde ejaculation. DED also encompasses reductions in volume, force, sensation of ejaculation, and the rarer postorgasmic illness syndrome (POIS; Perelman et al., 2004). These distinctions are important for sex therapists because the specificity of the patient's complaint affects both the treatment provided and the medical understanding needed to coordinate with the patient's physician(s). A man's psychological reaction to real anatomical changes, even when minor, may affect his experience of orgasm. For instance, transurethral procedures causing retrograde ejaculation should not be casually dismissed, whether or not this probable side effect was discussed in advance of surgery—especially if it was not. Finally, even slight changes in semen volume might alter orgasm in a manner that is very "real" for some men. A man taking an antidepressant who is suffering from DE requires a different treatment approach than does a patient whose orgasm and ejaculation are "weaker" when taking a 5-alpha reductase inhibitor (5 αRI) for alopecia.

Men with DE typically report less coital activity, higher levels of relationship distress, sexual dissatisfaction, lower subjective arousal, anxiety about their sexual performance, and were general health issues than sexually functional men (Abdel-Hamid & Saleh, 2011; Rowland, van Diest, Incrocci, & Slob, 2005). The psychological and interpersonal impact of DE is often not

appreciated by clinicians, who sometimes misperceive and fail to diagnose this condition. Some partners enjoy the extended intercourse; however, they eventually may experience pain, injury, and/or distressing questions (e.g., "Does he really find me attractive?"). Although initially blaming themselves, partners might become angry at the often misguidedly perceived rejection. Some men will fake orgasm to avoid an anticipated negative reaction. Distress is often greatest when conception "fails," yet fear of pregnancy leads some men to avoid dating or to avoid sex altogether (Corona et al., 2006; Perelman, 2004).

DE prevalence rates in the literature are low, rarely exceeding 3% (Laumann, Paik, & Rosen, 1999; Rowland, Keeney, & Slob, 2004). The intravaginal ejaculatory latency time (IELT) distribution curves recently used to characterize and define PE can assist in understanding DE prevalence (McMahon et al., 2008). Male IELT exhibits a skewed distribution in PE, with men ejaculating more rapidly than women tend to reach orgasm (Patrick et al., 2005; Waldinger, McIntosh, & Schweitzer, 2009). Segraves (2010) pointed out the difficulty in both diagnosis and the ensuing confusion about prevalence rates when depending *only* on IELT duration data. The concept of "control" does not correlate perfectly with IELT and is, of course, mitigated by volition (Jern, Gunst, Sandqvist, Sandnabba, & Santtila, 2011). Some men with an IELT of 20 minutes may deliberately delay their ejaculation, whereas others might be distressed over not ejaculating after 10 minutes, especially if their partners are "already done."

DE has been seen as a clinical rarity since the beginning of sex therapy. Yet DE rates will likely rise secondary to demographics and our male population's age-related ejaculatory decline (Perelman, 2003a). DE rates will also rise due to increased use of 5 αRI (Rowland, 2006) and the widespread use of selective serotonin reuptake inhibitors (SSRIs; Georgiadis, Reinders, Van der Graaf, Paans, & Kortekaas, 2007). Despite rates remaining low relative to other MSDs, many men do suffer from DE.

## ETIOLOGY

Neither pathophysiology nor psychogenic etiology should be assumed without both medical investigation and a focused psychosexual history. Of course, biogenic and psychogenic etiologies are neither independent nor mutually exclusive. Genetically predetermined ejaculatory thresholds have a prodigious impact on ejaculatory ease and latency time and are distributed in a manner similar to a number of other human characteristics (Perelman, 2009; Waldinger, 2011). However, human experience is better explained when one postulates that such thresholds predetermine a range of response, a "scattercloud" rather than a "trigger point." The timing of a particular ejaculation would be the result of a variety of psychosocial, cultural, and behavioral (PSCB) factors that influence the biologically predetermined range (Perelman & Rowland, 2006). This integrated biological and PSCB model would

account for the variation in latencies between men and the intraindividual range of each man. This multilayered conceptualization is different from current animal models that postulate an exclusive neurobiological threshold model, as well as different from the early "psychological" theories described next (Olivier et al., 2011). A bio-psychosocial-cultural model explains the variation, both between and within given individuals, and provides a better theoretical model (Perelman & Rowland, 2006).

## PSYCHOLOGICAL AND BEHAVIORAL MODELS

Early psychodynamic explanations saw DE as an outgrowth of psychic conflicts suggesting malingering, unconscious, and unexpressed anger, whereas other theorists suggested that men with DE are "unwilling" to receive pleasure. Some dynamic theorists ascribe fear: of semen loss; of female genitals; of hurting the partner through ejaculation; and of "defiling" the partner. Clinicians from various theoretical persuasions note pregnancy concerns among men with DE and also observe how referrals may be tied to a female partner's wish to conceive (Althof, 2012; Perelman & Rowland, 2006). Masters and Johnson (1970) first suggested an association between DE and religion; for a few men, orthodox beliefs limit the experience needed to learn how to ejaculate and thus normal function is inhibited.

Other factors associated with partnered sex that contribute to DE include anxiety, lack of confidence, and poor body image (Perelman & Rowland, 2006). Anxiety draws the man's attention away from erotic cues that enhance arousal and can interfere with genital stimulation sensation, resulting in insufficient excitement for climax, even if erection is maintained. Apfelbaum (2000) considers DE to be a desire disorder specific to partnered sex, believing that these men prefer sex with themselves rather than partnered sex. Apfelbaum suggests that a couple may interpret the man's erectile response as erroneous evidence that he is sufficiently aroused to attain orgasm (Apfelbaum, 2000). Perelman later posited that inadequate arousal was probably responsible for increased anecdotal reports of DE when men used oral medications for erectile dysfunction (ED) (Perelman, 2003a). Those men did not experience sufficient erotic excitement before and during coitus to reach orgasm, believing their erections indicated sexual arousal when they primarily indicated vasocongestive success.

Perelman identifies three factors highly associated with DE: higher frequency of masturbation (more than three times per week); idiosyncratic masturbatory style, and a disparity between the reality of sex with a partner compared with preferred sexual fantasies during masturbation (Perelman, 2002, 2005). While preparing this chapter, I reviewed 175 records from my practice of men ages 18–90 diagnosed with DE over the last 20 years. Almost 90% of these men could orgasm relatively easily with masturbation, and coital anorgasmia was almost exclusively the primary diagnosis. Although DE is

correlated with high-frequency masturbation, the most frequent behavioral factor causing DE is an "idiosyncratic masturbatory style," which I define as a technique not easily duplicated by the partner's hand, mouth, or vagina. Specifically, many men with DE engage in self-stimulation that is striking in terms of the speed, pressure, intensity, duration, and the "spot" focused upon to produce an orgasm (Perelman, 2005). In fact, some of these men will report penile irritation and erythema secondary to their masturbatory pattern (Abdel-Hamid & Saleh, 2011; Perelman, 2001). Almost universally, these men fail to communicate their stimulation preferences to their partners (or to previous doctors) because of shame or embarrassment. The disparity between the reality of sex with their partners and the sexual fantasies (whether or not unconventional) they prefer to use during masturbation is another cause of DE (Perelman, 2001). That disparity takes many forms, such as partner attractiveness, body type, sexual orientation, and the specific sex activity performed (Perelman, 2002; Rowland et al., 2004).

## BIOLOGICAL MODELS

In some instances, a somatic condition accounts for DE, as any procedure or disease that disrupts sympathetic or somatic innervation to the genital region has the potential to interfere with ejaculation and orgasm. Thus spinal cord injury, multiple sclerosis, pelvic-region surgery, severe diabetes, alcoholic neuropathies, hormonal abnormalities, and medications that inhibit $\alpha$-adrenergic innervation of the ejaculatory system are associated with DE (Master & Turek, 2001; Vale, 1999; Witt & Grantmyre, 1993). Comprehensive lists of agents causing ejaculatory delay are available and include many antihypertensive antiadrenergic agents and antidepressants, as well as antipsychotic drugs (Segraves, 2010; Perelman et al., 2004).

Low penile sensitivity, often associated with aging (Paick, Jeong, & Park, 1998; Rowland, 1998) may exacerbate difficulty reaching orgasm, but it is not usually a primary cause. Variability in the sensitivity of the ejaculatory reflex may be a factor. Recently, Waldinger and Schweitzer (2005) advocated for an etiology based on appreciating orgasmic disorders as neurobiological variants of a "normal" ejaculatory distribution curve. This view is derived from animal studies (primarily male rat latencies; Pattij et al., 2005), as well as studies demonstrating similar (albeit skewed) distribution curves for a random population of men from different countries (Waldinger et al., 2009). IELT reflects genetic biological variability, and diagnosable orgasmic disorders are primarily deviations from "normal" behavior. However, ejaculatory latency is an endpoint consequence that is also determined by a range of PSCB factors, not just a genetically determined biological set point.

Dichotomizing etiology, diagnosis, and treatment into classifications such as psychogenic and biological are too categorical. Genetic predispositions

affect the typical speed and ease of ejaculation for any particular organism; however, many of these components are influenced by past experiences and present context (Perelman, 2006b). The most useful approach to understanding human responses is to integrate—rather than isolate—the biological and PSCB components. The goal is identifying peripheral and/or central orgasmic elements that contribute to each man's varied response.

Our understanding of the biology of male orgasmic processes is increasing markedly but remains limited; for instance, even the male refractory period is poorly characterized (Paduch, Bolyakov, Beardsworth, & Watts, 2010). "Normal" male orgasm is refractory subsequent to the previous ejaculation, yet refractory latency increases for men secondary to surgical, medical, or pharmaceutical complications. Given new data showing that cognitive processes can affect neurotransmitters, distinctions between psychology and biology are clearly less binary than many previously presumed (Etkin, Pittenger, Polan, & Kandel, 2005). Delayed ejaculation is best understood as an endpoint response that represents the interaction of biological, psychological, social, and cultural factors.

## EVALUATION AND DIAGNOSIS

The evaluation of DE focuses on uncovering potential physical and learned causes of the disorder. The Sexual Tipping Point® (STP) model offers a clinically useful heuristic for conceptualizing the role both biogenic and PSCB factors play in determining the etiology of MSDs generally, and DE in particular (Perelman, 2009). The STP is the characteristic threshold for an expression of a sexual response for any individual, which may vary dynamically within and between sexual experiences. The specific threshold for the sexual response is determined by these multiple factors for any given moment or circumstance, with one factor or another dominating as others recede in importance. Every man, whether he experiences a "normal" ejaculatory latency or delayed ejaculation, has a multidimensional, predetermined "ejaculatory tipping point" (EjTP; Perelman, 2006a). Appropriate assessment appreciates the interdependent influence of these factors on the endpoint dysfunction for each man (see Figures 6.1 and 6.2).

It is frequently useful for a urologist to conduct a genitourinary examination and medical history that may identify physical anomalies, as well as contributory neurological and endocrinological (especially androgen levels) factors (Corona et al., 2012). Attention should be given to identifying reversible urethral, prostatic, epididymal, and testicular infections. Finally, with secondary DE in particular, adverse pharmaceutical side effects—most commonly from serotonin-based prescriptions—should be ruled out.

A focused psychosexual evaluation is critical and typically begins by differentiating this MSD from other sexual problems and reviewing the

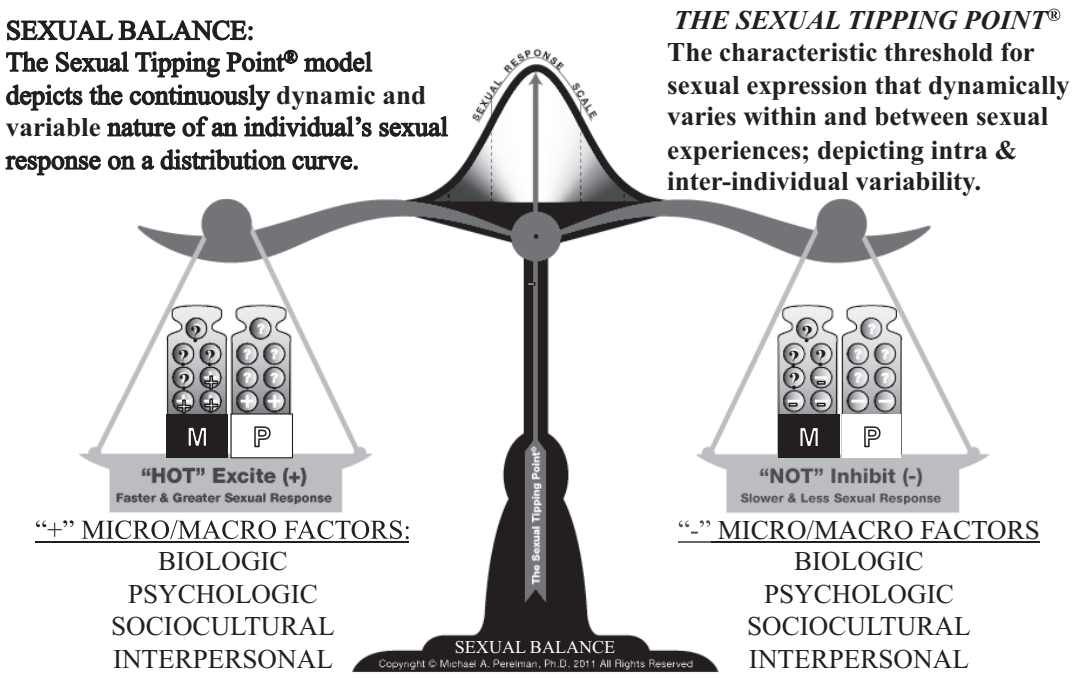


**FIGURE 6.1.** The multifactorial etiology of sexual function and dysfunction: Sex is always both mental and physical; the mental factors can turn you on as well as turn you off, and the same is true of physical factors. Copyright 2013 MAP Educational Fund and adapted for use with permission.

conditions under which the man is able to ejaculate. The problem's developmental course should be noted, including variables that improve or worsen performance (particularly those related to psychosexual arousal). What distinguishes sex therapists from all other health care providers is our comfort using highly detailed and specific sexual language. Perceived partner attractiveness, the use of fantasy during sex, anxiety surrounding coitus, and masturbatory patterns all require exploration. For instance, the patient should be asked: (1) "What is the frequency of your masturbation?"; (2) "How do you masturbate?"; (3) "In what way does the stimulation you provide yourself differ from your partner's stimulation style, in terms of speed, pressure, etc.?"; (4) "Have you communicated your preference to your partner(s), and if so, what was their response?" Additional questions can be asked to give greater specificity to the putative role of masturbation in the disorder and to clarify other relevant etiological factors. If orgasmic attainment was possible previously, life events and circumstances temporally related to orgasmic cessation should be reviewed. Events in question may include pharmaceuticals, illness, or a variety of psychological stressors. A therapist should investigate previous treatment approaches, including the use of herbal therapies, home remedies, and so forth. Information regarding the partner's perception of the problem

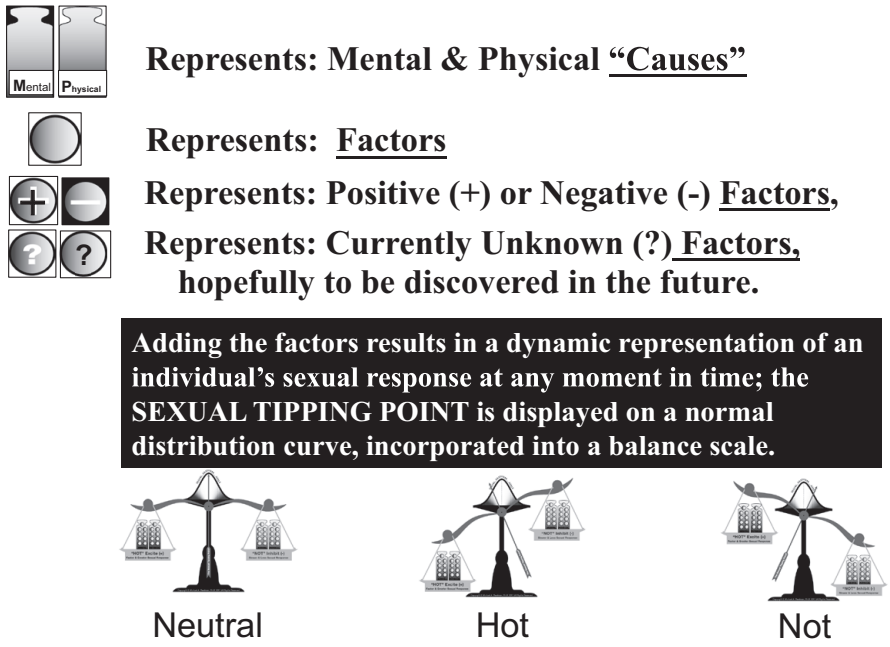


**FIGURE 6.2.** Key to the Sexual Tipping Point model. Copyright 2013 MAP Educational Fund and adapted for use with permission.

and her satisfaction with the relationship may help. Sexual and relationship inventories in general, and even ones specific to ejaculation, such as the Male Sexual Health Questionnaire (MSHQ), improve research methodology but provide only limited diagnostic enhancement (Rosen et al., 2004; Wei, Dunn, Litwin, Sandler, & Sanda, 2000).

## TREATMENT

Discussion of a potential biological predisposition is helpful in reducing patient and partner anxiety and mutual recriminations while improving therapeutic alliance (Perelman, 2004, 2005). Masters and Johnson (1970) first advocated specific exercises when treating DE. Current approaches usually emphasize integrating a behavioral masturbatory retraining within a nuanced sex therapy (Apfelbaum, 2000; Masters & Johnson, 1970; Perelman, 2003b, 2006a; Sank, 1998). Masturbation can serve as rehearsal for partnered sex. By informing the patient how his masturbation conditioned his response, stigma is minimized and partner cooperation can be evoked. Of course, masturbation retraining is only a means to an end; the goal of therapy for DE is evoking higher levels of psychosexual arousal within a mutually satisfying experience.

It is useful to help men with primary DE identify their sexual arousal preferences through self-exploration and stimulation. Masturbation training is similar to models described for women, but the use of vibrators, often recommended by urologists, is rarely needed (Perelman, 2006a). Masturbation exercises progressing from neutral to pleasurable sensations (without orgasm) remove the "demand" aspects of performance (Apfelbaum, 2000). Fantasizing can help block thoughts that might otherwise interfere with arousal. Some men with DE manifest an overeagerness to "please" that must be addressed. In general, a clinician should validate (not encourage) an autosexual orientation when encountering it in a man, as this helps remove the stigma that DE is a form of withholding from a partner. General anxiety-reduction techniques may also be helpful in treating some men with DE. Finally, couple therapy, when appropriate, involves encouraging the man and his partner to share their sexual preferences so that both their needs are met.

Lack of adequate stimulation was the salient variable for the first couple I treated for DE over 30 years ago. A very young and sexually naïve Orthodox Jewish couple presented with a symptom of primary DE, which interfered with their religiously mandated desire for a large family. The cause was a complete lack of stimulation, as the couple would lie quietly together during coitus, waiting for his ejaculation to occur. Once informed of the need for friction and the benefit of movement, a pregnancy soon ensued, and they now have eight children (Perelman, 1994). Although education is a necessary part of therapy, it is almost never sufficient in and of itself.

Therapy for secondary DE shares similarities with treatment for primary DE. However, the patients with secondary DE should be counseled to suspend masturbatory activity temporarily and limit orgasmic release to their desired goal activity, that is, coital orgasm. Reducing or discontinuing both masturbation (typically 14–60 days) and (usually) noncoital orgasm evokes patient resistance. The clinician needs to provide support to ensure adherence to this suspension. Depending on motivation level, masturbation interruption must sometimes be compromised and negotiated. A man continuing to masturbate might be encouraged to alter style ("switch hands") and to approximate the stimulation likely to be experienced through manual, oral, or vaginal stimulation by his partner (Perelman & Rowland, 2006). In addition to suspending noncoital orgasmic release, the patient should use fantasy and bodily movements during coitus that approximate the thoughts and sensations experienced in masturbation. Single men should use condoms during masturbation to rehearse "safe sex." Sexual fantasies may be realigned so that thoughts experienced during masturbation better match those occurring during coitus. Efforts to increase the arousing capacity of the partner by reducing the disparity between the man's fantasy and the actuality of sex with his partner may be useful. Significant disparity tends to characterize more severe and recalcitrant DE and relationship problems, with consequently poorer prognosis (Perelman, 2001).

## TREATMENT OUTCOME

To date there is no evidence for a pharmaceutical demonstrating anything beyond anecdotal success in decreasing ejaculatory latency, and there is no approved drug treatment for DE. Researchers have explored "antidotes" such as yohimbine, cyproheptadine, and bupropion, among others; however, this research was typically confined to animal experiments (Carro-Juareza & Rodriguez-Manzo, 2003) or focused on antidepressant-induced DE (Clayton et al., 2004; McCormick, Olin, & Brotman, 1990). There is some limited support for the use of bupropion, but a recent study concludes that the drug seems to be of only limited benefit (Abdel-Hamid & Saleh, 2011). Clearly further trials are needed.

Unlike urologists, some sex therapists report good success rates when treating DE (Masters & Johnson, 1970; Perelman & Rowland, 2006); yet these results should be viewed as exploratory, albeit encouraging. Althof (2012) notes the difficulty in evaluating sex therapy treatment outcomes, because the published studies use small samples, uncontrolled, nonrandomized methodologies, and lack validated outcome measures. Disparity between the results of different professionals may well reflect clinically different treatment populations. Only well-designed multicenter clinical trials will establish an answer. In the meantime, the two cases that follow demonstrate how a sex therapist can effectively support mutual sexual harmony and satisfaction with couples suffering from DE.

## CASE DISCUSSIONS

### Case 1

George (53) had become less attracted to Janice (52) but wanted the coitus with orgasm that once characterized their sex life. He did not wish to "hurt" Janice by discussing his diminished attraction. He suffered from "metabolic syndrome" and was hypogonadal. Coital activity had gradually disappeared. He had masturbated to "help fall asleep" at least two to three times per week since adolescence. He now needed greater pressure, speed, and focused attention on "sensitive parts" to orgasm with masturbation. His physician, presuming he had ED, took a brief sex history and obtained a testosterone level. The doctor gave sildenafil samples (with limited instruction) and told George not to worry. Returning for follow-up, George said, "The pills I took 15 minutes before sex did not work; soon after penetration, I lost my erection." When he lost his erection, the couple argued. The physician attributed George's remaining problems to his low testosterone level and prescribed a topical androgen gel. George telephoned the physician 4 weeks later and indicated that "the gel had not helped," and the physician reportedly told him it was "in his head" and suggested a sex therapist, referring him to me. George wanted treatment

and had "no patience for lengthy 'shrinking' or touchy-feely stuff." Problems with the patient's sexual script and the earlier treatment were apparent. Coital intercourse with his spouse was no longer arousing. George reported, "It felt like work." Detailed inquiry revealed that his wife's vagina felt "slack." Was the sildenafil ineffective, or was his hypogonadal status the key factor, despite the gel normalizing his T levels? These and other issues were not likely to become clear, even with the most exact testing. Problems with his physician's treatment plan were summarized in a manner to generate hope. George was enlisted in developing a new plan. He agreed to stop masturbating until he was able to have coitus with orgasm on three successive occasions with his wife. This goal was arbitrary but generated by the patient himself and therefore useful, as discontinuing masturbation is difficult to motivate. He continued using both the sildenafil and the testosterone his physician prescribed. Proper instructions for using the PDE5 were given, and George was educated about men's need for greater stimulation with aging. He asked for more direct penile touching from his wife and complimented her improved technique. George preferred a coital position different from the female-superior posture they previously used. Conveniently, Janice agreed, as the earlier position was uncomfortable after her recent knee surgery. Male-superior coitus allowed him to control the angle and pace of thrusting. George was instructed to close his eyes and fantasize about whatever "worked best." Initially guilty for thinking of someone other than Janice, he was reassured that he could open his eyes at the moment of orgasm, and that could become his new fantasy. He was instructed to move inside her in a manner that duplicated (as closely as possible) the sensations he preferred during masturbation. He was reassured that once his capacity was restored, if Janice had any concerns, the couple could be seen together, and he could learn additional techniques. Earlier he declined couple counseling, as reportedly they both felt "it was his problem." The whole notion of treatment format is complex, but couple cooperation is the key to good treatment, not necessarily the couple's mutual attendance in the clinician's office (Perelman, 2003b). It took 10 weekly sessions for him to reach his goal of three successive coital experiences. Before reintroducing masturbation, he was weaned from sildenafil. For a couple of months, he split the sildenafil into smaller pieces, until he "forgot" to take it at all! The couple experienced a "second honeymoon," and Janice was thrilled with his increased interest in sex with her. George was advised to use the sildenafil as needed during future periods of either physical or emotional stress. With his physician's guidance he could wean himself on and off the drug as the situation warranted. He was advised about the possibility of age-associated symptoms and offered coping strategies. George began masturbating again but limited the speed and pressure to what he experienced inside his wife's vagina. Suggestions were provided to help him relax in advance of bedtime. He declined a referral to a sleep specialist. At 2-year follow-up he was still masturbating as a soporific periodically; however, the frequency was self-titrated to monthly to ensure that it would not interfere with the now again preferred coitus.

Partner issues 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 woman—and often the man—usually resist(s) intrusions on their plan to conceive. If the therapist suspects the patient's DE is related to fear of conception, he or she should inquire about the patient's ability to experience ejaculation with contraception but not during "unprotected" sex. Such a "test" serves as a powerful diagnostic indicator. If the DE occurs only during "unprotected" sex, the therapist can assume that conception is a primary concern. The therapist must then find an acceptable way to refocus the treatment temporarily on the issues responsible for the patient's ambivalence. Resolving those issues typically requires individual work with the man and occasionally with the partner. Fortunately, the high levels of motivation that usually characterize fertility-related cases improve prognosis.

## Case 2

James, a 34-year-old lawyer, was referred to his urologist for infertility treatment by his wife's gynecologist. James and Joan (32) had been married 4 years, had failed to conceive, and did not want to wait to pursue infertility treatment. James reported difficulty with ED and DE over the previous months. His urologist diagnosed a testicular transposition, noting that James's right testis was behind the left. Also observing James's severely scarred frenulum, the urologist recommended circumcision, as well as correction of the transposition. Surgery was scheduled in 3 months, during James's upcoming vacation. A varicocelectomy was also discussed due to a palpable varicocele. Another urologist reconfirmed the surgical recommendations. The varicocelectomy recovery period would have delayed potential conception by approximately 6 months. The urologist prescribed tadalafil and, in his referral note, suggested that couple treatment might help minimize the impact of the delays caused by the surgery.

The couple was first evaluated individually, followed by a conjoint session. They were in love and eager for a child. Each feared he or she had "caused the infertility." James suggested that his ED might be related to both work stress and the performance pressure he felt when Joan was ovulating.

Although these issues exacerbated the problem, it was clear from the history that there was another reason for James's DE. He preferred masturbation to coitus, and he did this at high frequency and in an idiosyncratic manner (due to early injury). He had torn the frenulum of his penis (secondary to penile adhesions of his uncircumcised penis) during an adolescent coital experience. Subsequently, any time he attempted coitus, his penis would bleed, and he had pain. He developed an intense fear of hurting himself during coitus and avoided it. Unfortunately, he never discussed this with any of his physicians, nor did they ask him direct questions about his sexual response. These critical facts emerged in his first session. The challenge was helping

him feel safe sharing this information with his wife, as he felt ashamed. Based on her first consultation, it was clear that she would be supportive. She was relieved to understand why this man she loved seemed to avoid sex. He was a gentle and generous lover, and she was content with their sex life but wanted a baby.

The sex therapy expanded his repertoire of orgasmic variability, and within 90 days of beginning treatment Joan became pregnant. James would have willingly suffered to impregnate her, but of course that was not necessary. General sex education, counseling, and some sex therapy exercises were provided. He first stopped masturbating and later altered his style and frequency. He was instructed to move his body during coitus in a manner as to not hurt himself and instead enhance both his own and his partner's pleasure. After the pregnancy, the urologist performed a circumcision so that James would not have to be so precise in his movements and the likelihood of pain could be reduced. Finally, after the birth of their child, the urologist performed the varicocelectomy, which did benefit the quality, quantity, and motility of James's sperm (which were indeed subnormal despite the successful pregnancy). E-mail follow-up included thanks and the baby's first-birthday photo! A recent follow-up 2 years later informed me that Joan was pregnant with their second child.

Fertility-related or not, anger toward the partner is an important causal factor and must be ameliorated through individual and/or conjoint consultation. Anger acts as a powerful anti-aphrodisiac, and although 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 therapist should also remain sensitive and responsive to the impact of change on the partner, as well as to alterations in the couple's equilibrium.

As treatment progresses, interventions may be experienced as mechanistic and insensitive to the partner's needs and goals. In particular, many women respond negatively to an impression that the man is essentially masturbating himself with her body, as opposed to engaging in connected lovemaking. This perception is exacerbated when men need pornography to distract themselves from negative thoughts in order to function. Indeed, because these men are sometimes disconnected emotionally from their partners, the therapist must help the partner become comfortable with the idea of postponing greater intimacy. Once the patient is functional, the therapist can encourage a man toward greater sensitivity. Alternatively, both partners may be disconnected from each other but otherwise in a valued stable relationship. The therapist must support the patient's goals but not push the man (or couple) unnecessarily toward a preordained concept of success. Here, the concept of "good enough sex" provides guidance (Metz & McCarthy, 2007).

Not all cases treated resolve themselves so easily. Often, an orgasm with coitus is obtained but is not preferred in reality. These men will frequently need support from the therapist to express their preference for noncoital orgasms, especially when their coital orgasms were less satisfactory and obtained only by painstaking effort. However, therapists who readily negotiate compromises with a couple whose female partner prefers noncoital stimulation should recognize the parallel with men suffering from coital DE. Therapists must assess their own prejudices and assist couples in identifying workable sexual scripts regardless of gender. Yet for some men with DE, partner psychopathology, values regarding pornography, and relationship issues may predetermine failure.

Often the most difficult cases are men suffering sexual sequelae subsequent to prostate cancer, whether treated surgically, medically, or with radiation. In these cases vibratory devices become desirable, as greater stimulation is required secondary to the damage caused by the cancer treatments. Devices for this purpose are being evaluated by urologists (Nelson, Ahmed, Valenzuela, Parker, & Mulhall, 2007; Tajkarimi & Burnett, 2011). Sex therapists should focus on the many patients who are often disheartened by their sexual side effects secondary to prostate cancer treatments, even when the patient received proper informed consent guidance from their physician in advance of that treatment (Perelman, 2008). Yet sex therapists may find themselves humbled when rehabilitating a response that is severely anatomically limited. As one man treated for post-prostatectomy orgasmic change said, "it used to feel like a jet engine . . . it became a 'paperclip' after surgery. You've got me back to a prop plane, and that is what I need to live with." Certainly, the greater the anatomical damage, the more psychotherapy facilitates adjustment to the loss rather than restoration of function. Of course, when less information has been provided to the patient regarding potential adverse side effects of treatment, the matter becomes even more complex and difficult to manage.

## CONCLUSIONS

In summary, high-frequency idiosyncratic masturbation, combined with fantasy–partner disparity, often predisposes men to experience problems with arousal and ejaculation. An integrated and individually nuanced sex therapy that is derived from an appreciation of multidimensional etiology and supports multidisciplinary cooperation is the optimal treatment today (see Figure 6.3). Should a safe and effective drug become available, a major paradigm shift toward combining drugs and sex therapy when treating DE will occur, as happened when PDE5's became available to treat ED. Better understanding of the ejaculatory process may lead to pro-ejaculatory drugs (most likely dopaminergic), but there will always be a role for sex therapy.

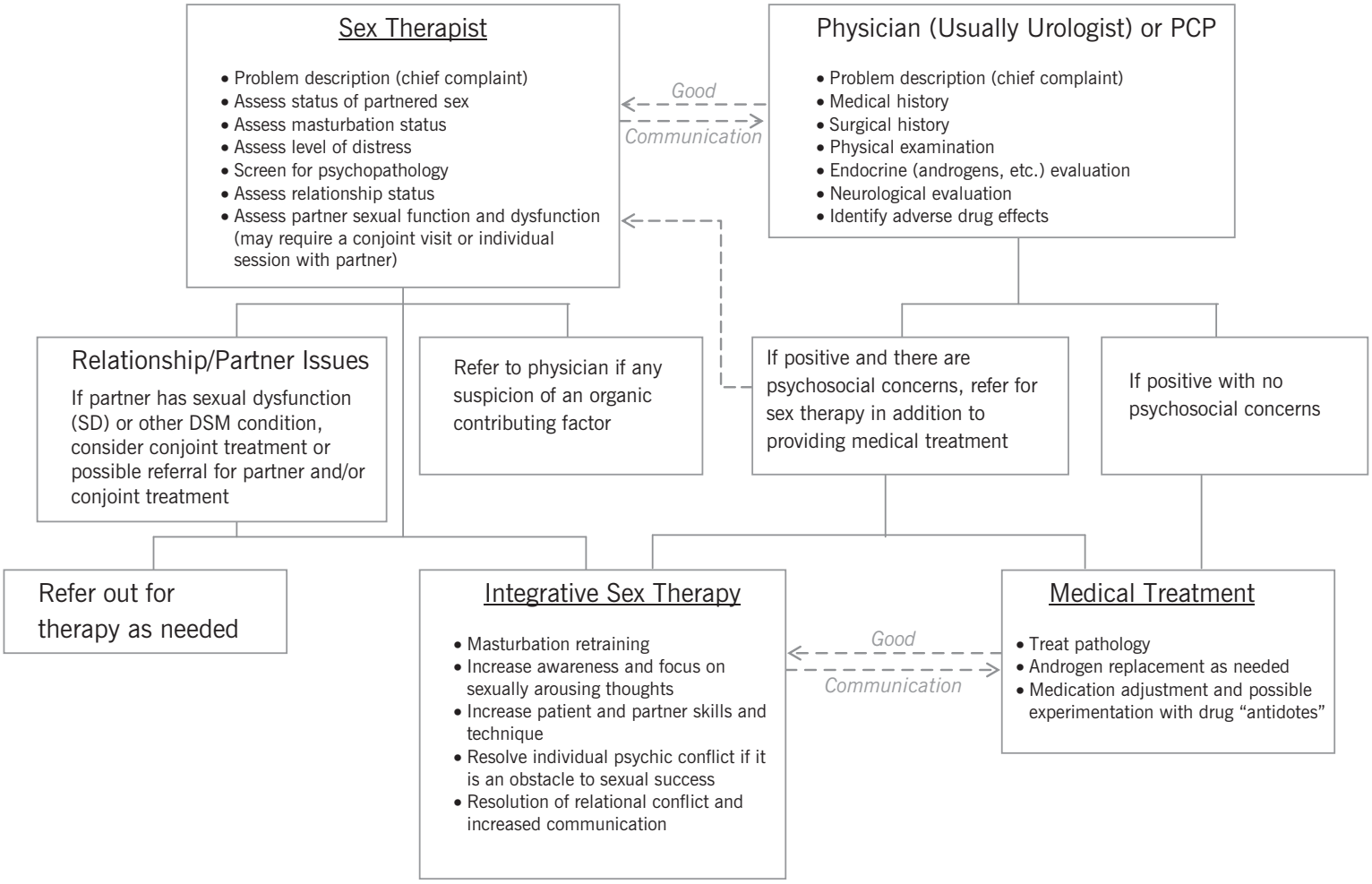


**FIGURE 6.3.** DE treatment algorithm.

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