



Psychological Interventions for Premature Ejaculation

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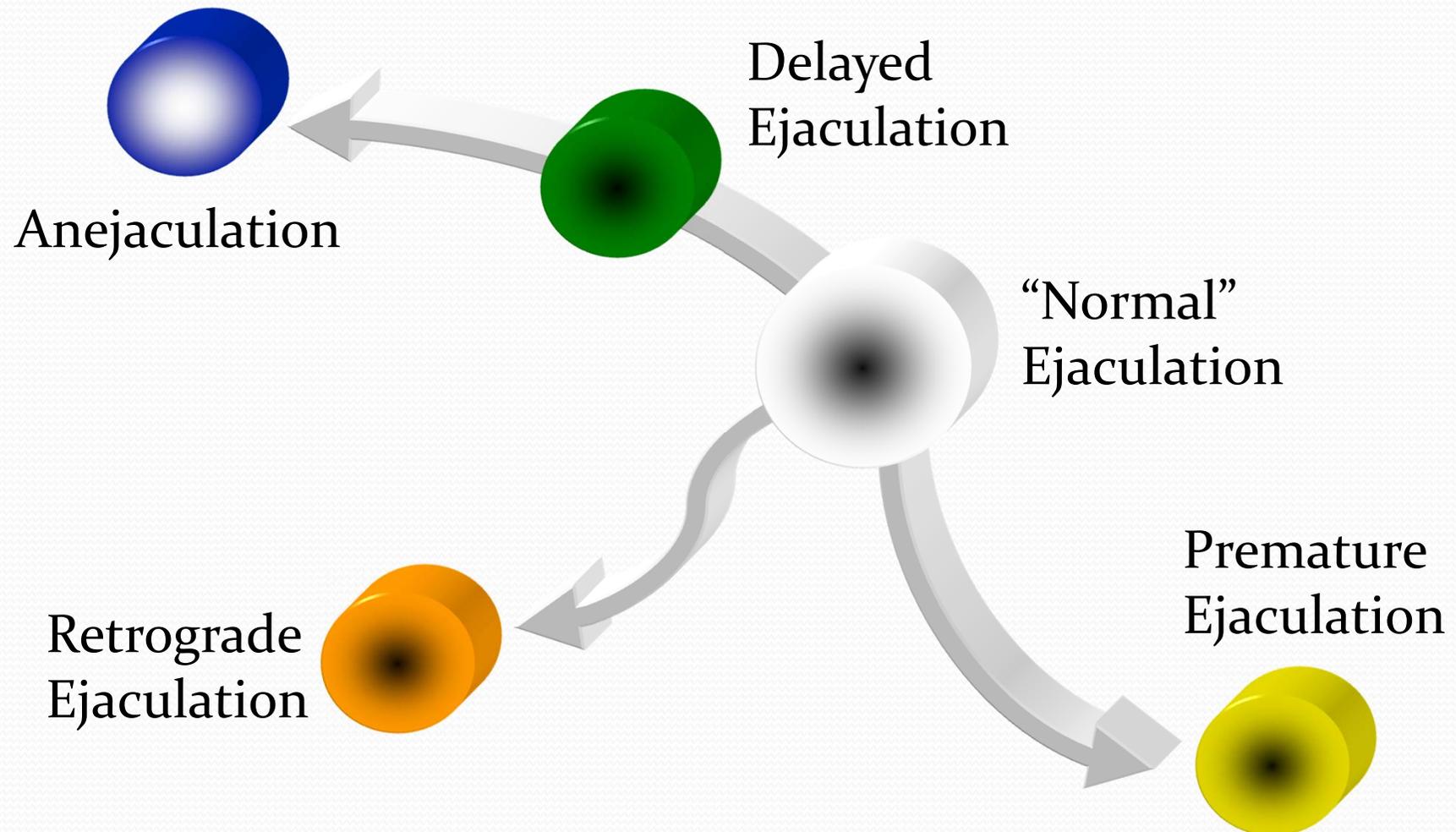
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Disclosures

- Dr. Althof serves as a Principal Investigator, Consultant, Member of the Speaker's Bureau or Advisory Board for:
 - Abvie
 - Allergan
 - Eli Lilly
 - Ixchelsis
 - Menarini
 - Palitan
 - Plethora
 - Promonescent
 - Sprout
 - S1 Pharma
 - SSI
 - Trimel
 - Vyrix



Spectrum of Ejaculatory Disorders



DSM-5 Definition of Premature Ejaculation (302.75)

- A. A persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within approximately 1 minute following vaginal penetration and before the individual wishes it.
 - B. The symptom in Criterion A must have been present for at least 6 months and must be experienced on almost all or all (approximately 75%-100%) occasions of sexual activity (in identified situation contexts or, if generalized, in all contexts).
 - C. The symptom in Criterion A causes clinically significant distress in the individual.
 - D. The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress or other significant stressors and is not attributable to the effects of a substance/medication or another medical condition
- Specify
 - Lifelong vs. Acquired
 - Generalized vs Situational
 - Severity: Mild, Moderate or Severe



Premature Ejaculation: Psychological Treatment

- Present day psychotherapy for PE is an integration of psychodynamic, behavioral, cognitive and systems approaches within a short-term psychotherapy model
- Harness the power of the mind to teach men a set of skills



Distorted Perceptions of the Psychological Treatment of PE

- Stop\Start and the Squeeze Techniques are NOT the mainstays of psychological intervention
- While behavioral methods are employed, much of the work focuses on the subjective life of the patient and/or partner
 - Meaning of the symptom for that particular patient
 - Relationship dynamics
 - Confidence and performance anxiety



Psychotherapy Harnesses the Power of the Mind to Teach Men a Set of Skills

1. Learn techniques to control and delay ejaculation
2. (Re)gain confidence in their sexual performance
3. Lessen performance anxiety
4. Modify rigid sexual repertoires
5. Surmount barriers to intimacy
6. Resolve interpersonal issues (that cause/maintain PE)
7. Come to terms with interfering feelings and thoughts
8. Increase communication
9. Turn conflict and useless friction into intimacy, fantasy and stimulation
10. Minimize or prevent relapse



Women's Perceptions of Their Partners' Ejaculatory Function

- 1,463 women from 3 countries participated in a web survey to examine their perceptions of their partners' ejaculatory function as well as other aspects of PE that cause distress
- They found a significant correlation between the importance of ejaculatory control and felt distress
- Women with fewer sexual problems considered ejaculatory control more important and reported more PE related distress



Women's Perceptions of Their Partners' Ejaculatory Function

- More importantly, the study highlights that the male's lack of attention and focus on performance was the most frequently reported reason for sexual distress (47.6%), followed by the short time between penetration and ejaculation (39.9%) and the lack of ejaculatory control (24.1%)
- Almost a quarter of women noted that the man's ejaculatory problem had previously led to relationship breakups
 - Women who considered duration to be important were more likely to report breakups



Sexual Excitement Is Not ALL or Nothing!!

- Stop-start technique
 - Semans (1956); Kaplan (1983)
 - Pause sexual stimulation at impending ejaculation
- Graduated behavioral exercises that teach familiarity with intermediate excitement levels
 - Masturbation → Foreplay → Intercourse
 - Resolving interpersonal
 - Resolving intrapsychic issues
 - Addressing cognitive distortions



James Semans MD



Cognitive Restructuring-

Some Negative Thoughts to Avoid

- I'm a complete failure because I come to quickly
- I couldn't control it last time, so I won't this time either
- My partner says it's OK because she doesn't want to hurt my feelings
- I don't need to ask...I know how she feels
- I'm sure it's going to be the same thing this time
- I think I'm a lousy lover, therefore I am
- If I fail again, what's going to happen?
- I should...if only I could...I ought to try...



Early Reported Outcomes-Masters and Johnson - The Challenge to the Field

- Masters and Johnson set a very high bar for sex therapy outcome research
- Never before or since has there been such a highly successful treatment program
 - Based on 186 men the reported failure rates after treatment and at 5 year follow-up was 2.2% and 2.7% respectively
- Thus, few innovations were forthcoming

Masters W, & Johnson V. (1970) *Human Sexual Inadequacy*.



Psychotherapy Outcome for the Treatment of PE

- Post Masters and Johnson the results have been more modest
 - Kaplan reported an 80-90% success rate with primary PE
 - Hawton reported initial success rates 64%
 - Over three years success rate dwindled to 25%
- Relapse prevention strategies would obviate this decline
 - “Booster” sessions for better maintenance

Hawton K, et al. (1986) *Journal of Sex & Marital Therapy*. 27: 665-75

Kaplan H. *How to Overcome Premature Ejaculation*. Bruner/Mazel, New York 1989

McCarthy B (1993) Relapse prevention strategies and techniques in sex therapy. *J Sex Marital Ther* 9:142-147



A Controlled Study of Two Psychological Interventions

Group N = 38	Pre-Treatment Mean IELT- seconds	Post-Treatment Mean IELT seconds	3 Month Follow-up Mean IELT Seconds
Behavioral	57	472	490*
Functional- Sexological	43	468	413*
Waiting List	63	60	

De Carufel F, Trudel G. (2006) Effects of a new functional sexological treatment for premature ejaculation. *Journal of Sex & Marital Therapy*. 32: 97-114.



Limitations of Psychotherapy for PE

- Lack immediacy
 - Therapy takes time to be effective
- Efficacy
 - Good initially
 - Tends to diminish over time
- More difficult to treat men not in stable relationships
 - Having a motivated and supportive partner is helpful
- Time consuming and costly

Cochrane Review of Psychosocial Interventions for PE

Authors' conclusions

Overall, there is weak and inconsistent evidence regarding the effectiveness of psychological interventions for the treatment of premature ejaculation. Three of the four included randomised controlled studies of psychotherapy for PE reported our primary outcome (Improvement in IELT), and the majority have a small sample size. The early success reports (97.8%) of Masters and Johnson could not be replicated. One study found a significant improvement from baseline in the duration of intercourse, sexual satisfaction and sexual function with a new functional-sexological treatment and behavior therapy compared to waiting list. One study showed that the combination of chlorpromazine and BT was superior to chlorpromazine alone. Randomised trials with larger group samples are still needed to further confirm or deny the current available evidence for psychological interventions for treating PE.



Combination Therapy- The Essential Premise

- Combination therapy identifies and addresses the psychosocial factors while patients simultaneously make use of and have success with a variety of efficacious medical treatments for sexual problems
 - Is not a long-term sustained intervention
- Combination therapy leads to:
 - Increased efficacy of the medical intervention
 - Increased treatment satisfaction
 - Decreased rates of discontinuation
 - Increased relationship satisfaction

Abdo et al, 2008; Aubin et al, 2009; Bach et al, 2004; Banner et al, 2007; Chen, 2002; Hartmann et al, 1993; Lottman et al, 1998; Melnick et al, 2005; Phelps et al, 2007; Tita et al, 2006; Wylie et al, 2003



PE and Combination Therapy

- Three studies report on combined pharmacological and behavioral treatment for PE
- Each study reported on a different medication- sildenafil, citalopram, clomipramine. Pharmacotherapy was given in conjunction with a behavioral treatment and compared to pharmacotherapy alone
- **In all three studies combination therapy was superior to pharmacotherapy alone on either IELT and/or the Chinese Index of Premature Ejaculation**

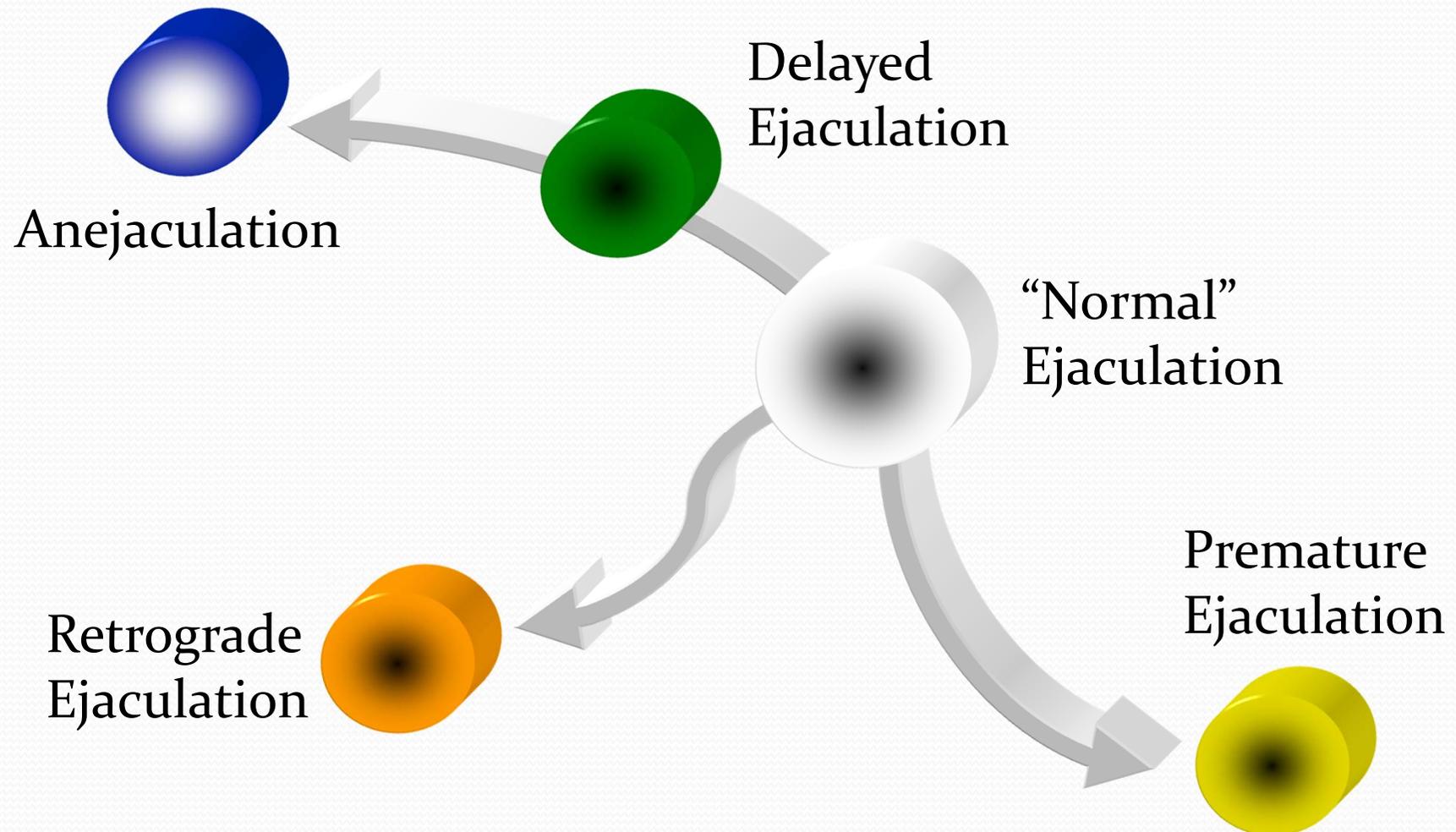
Tang W, et al. *Zhonghua Nan Ke Xue*. 2004;10: 366-67.

Li P, et al. *Zhonghua Nan Ke Xue* 2006;12: 717-19.

Yuan P, et al. *Chinese Journal of Andrology*. 2008;22: 35-38.



Spectrum of Ejaculatory Disorders



DSM-5 Definition of Delayed Ejaculation (302.74)

- A. Either of the following symptoms must be experienced on almost all or all occasions (approximately 75%-100%) of partnered sexual activity (in identified situational contexts or, if generalized, in all contexts), and without the individual desiring delay:
 1. Marked delay in ejaculation.
 2. Marked infrequency or absence of ejaculation.
 - B. The symptoms in Criterion A have persisted for a minimum duration of approximately 6 months.
 - C. The symptoms in Criterion A cause clinically significant distress in the individuals.
 - D. The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress or other significant stressors and is not attributable to the effects of a substance/medication or another medical condition.
- Specify
 - Lifelong and Acquired
 - Generalized and Situational
 - Severity: Mild, Moderate or Severe



Psychogenic Delayed Ejaculation

- Variability is the hallmark of psychogenic delayed ejaculation
 - Orgasm/ejaculation occurs via masturbation or nocturnal emission but not with a partner
 - May occur with the partner during foreplay but not with intercourse



Four Diverse Psychological Theories All Without Empirical Support

Insufficient Stimulation

Failure to achieve sufficient mental or physical stimulation

Masturbation

High frequency of masturbation
Idiosyncratic masturbatory style
Disparity between fantasy & reality

Delayed Ejaculation

Outgrowth of Psychic Conflict

Loss of self from loss of semen, fear of harm from female genitals, fear that ejaculation may hurt the partner, fear of impregnating the female, fear of defiling the partner with semen, hostility toward partner, not willing to give of oneself, guilt from strict religious upbringing

Disguised and Subtle Desire Disorder Masquerading as an Ejaculatory Dysfunction

Automatic functioning in the absence of genuine arousal, autosexual orientation, partner's touch inhibiting, penis becomes insensate, compulsion to satisfy partner

The Role of Masturbation in Delayed Ejaculation

- Perelman conducted a 5 year retrospective chart review on 80 men diagnosed with Delayed Ejaculation who ranged in age from 19 to 77
 - 25⁰% could not achieve ejaculation under any circumstance
 - 75⁰% could masturbate to orgasm
- Three factors were correlated to DE diagnosis
 - Relatively high frequency of masturbation
 - over 35⁰% reported masturbating at least every other day or more
 - Idiosyncratic style of masturbation
 - Idiosyncratic in the speed, pressure, duration and intensity necessary to produce an orgasm, yet dissimilar to what they experienced with a partner
 - Disparity between the reality of sex with the partner and the use of sexual fantasy during masturbation



Delayed Ejaculation as a Disorder of Sexual Desire

- Apfelbaum believes that delayed ejaculation is a subtle and specific form of a sexual desire disorder.
- The patient's basic sexual orientation is autosexual (masturbatory) rather than partner (heterosexual or homosexual) focused.
 - How could anyone do it (masturbate) better than me, after all I have been doing it for years
- We are accustomed to thinking that any loss of desire or erotic arousal would be reflected by a loss of erection. Not only does the delayed ejaculator not lose his erection, but the erections tend to be prolonged
 - Automatic erections -In the presence of a partner, the DE's penis is relatively insensate or numb because it is out of phase with his level of erotic arousal.
- DE men feel guilty about saying no to intercourse but express it through their symptom
 - Often accompanied by a compulsion to satisfy the partner.



Case Examples

Insufficient Stimulation

Failure to achieve sufficient mental or physical stimulation

79 year old married ♂ with a 5 yr history of being unable to achieve orgasm/ejaculation under any circumstance. BCG treatment for same period of time. Good marriage, intercourse 1x/10days, good sexual desire.

Masturbation

31 year old healthy married ♂ who ejaculates with masturbation yet unable to ejaculate with partner. Couple trying to conceive. High frequency and idiosyncratic style of masturbating. Some disparity in fantasy as well.

Delayed Ejaculation

Outgrowth of Psychic Conflict

61 year old ♂, divorced 1 yr ago had been married 35 years. Has mild ED and low T (220 ng/dl), able to ejaculate by self. Long distance relationship with 43 year old ♀ and unable to ejaculate. Finds her self centered, histrionic, and demanding.

Disguised and Subtle Desire Disorder Masquerading as an Ejaculatory Dysfunction

38 year old, engaged, healthy ♂ unable to have coital ejaculation. Increasing awareness of lack of arousal toward partner, wanted to please her, significant performance anxiety

Treatment Based Upon Etiology

Insufficient Stimulation

Failure to achieve sufficient mental or physical stimulation

Treatment

Vibrator stimulation
Enhancing mental arousal
Demanding pelvic thrusting

Masturbation

High frequency of masturbation
Idiosyncratic masturbatory style
Disparity between fantasy & reality

Treatment

Masturbatory retraining
Realignment of sexual fantasies

Delayed Ejaculation

Outgrowth of Psychic Conflict

Loss of self from loss of semen, fear of harm from female genitals, fear that ejaculation may hurt the partner, fear of impregnating the female, fear of defiling the partner with semen, hostility toward partner, performance anxiety, unwillingness to give oneself, guilt from strict religious upbringing

Treatment

Psychotherapy targeting areas of conflict
Sensate Focus

Disguised and Subtle Desire Disorder Masquerading as an Ejaculatory Dysfunction

Treatment

Change orientation from self to partner
Less focus on pleasing partner

Conclusion

- Need for an agreed upon nosology
- Need for a definition or criterion set that is objective, evidence-based and properly integrates biological and psychological data
 - Separate disorders of ejaculation and orgasm
- Need for more rigorous, controlled outcome studies
- Need for combination therapy studies
 - Development of protocols
 - Validated outcome measures
- Much work remains to be done!!





Inconsistent Nomenclature

- All these terms describe a delay or absence of ejaculation/orgasm
 - Anejaculation
 - Delayed ejaculation
 - Difficult ejaculation
 - Ejaculatio retardata
 - Ejaculatio deficiens or nulla
 - Ejaculatory incompetence
 - Idiopathic anejaculation
 - Impotentia ejaculandi
 - Inhibited ejaculation
 - Inadequate ejaculation
 - Late ejaculation
 - Male orgasmic disorder
 - Partner anorgasmia
 - Primary impotentia ejaculations
 - Psychogenic anejaculation
 - Retarded ejaculation



It is axiomatic that the more names we have for a dysfunction the less we know about it!!!



Orgasm and Ejaculation are Not Synonymous

- Often times, the terms orgasm and ejaculation are used synonymously, yet they are two distinct events
 - Orgasm is a pleasurable mental experience resulting from sensations from the pudendal nerve sensory stimuli resulting from increased pressure in the posterior urethra, sensory stimuli arising from the verumontanum and contraction of the urethral bulb and accessory sexual organs
 - anorgasmia
 - Ejaculation is the rhythmic expulsion of fluid from the penis which can be further subdivided into an emission and ejection phase
 - Delayed ejaculation
 - Premature ejaculation
 - Retrograde ejaculation
 - Painful ejaculation



Anejaculation in Elderly Males

<u>Ejaculatory/Orgasmic Disorder</u>	AGE		
	57– 65 years	65 – 74 years	75–85 years
Anejaculation	16.2 %	22.7 %	33.2%

Lindau, S.T. et al, NEJM 2007, 357, 762-774



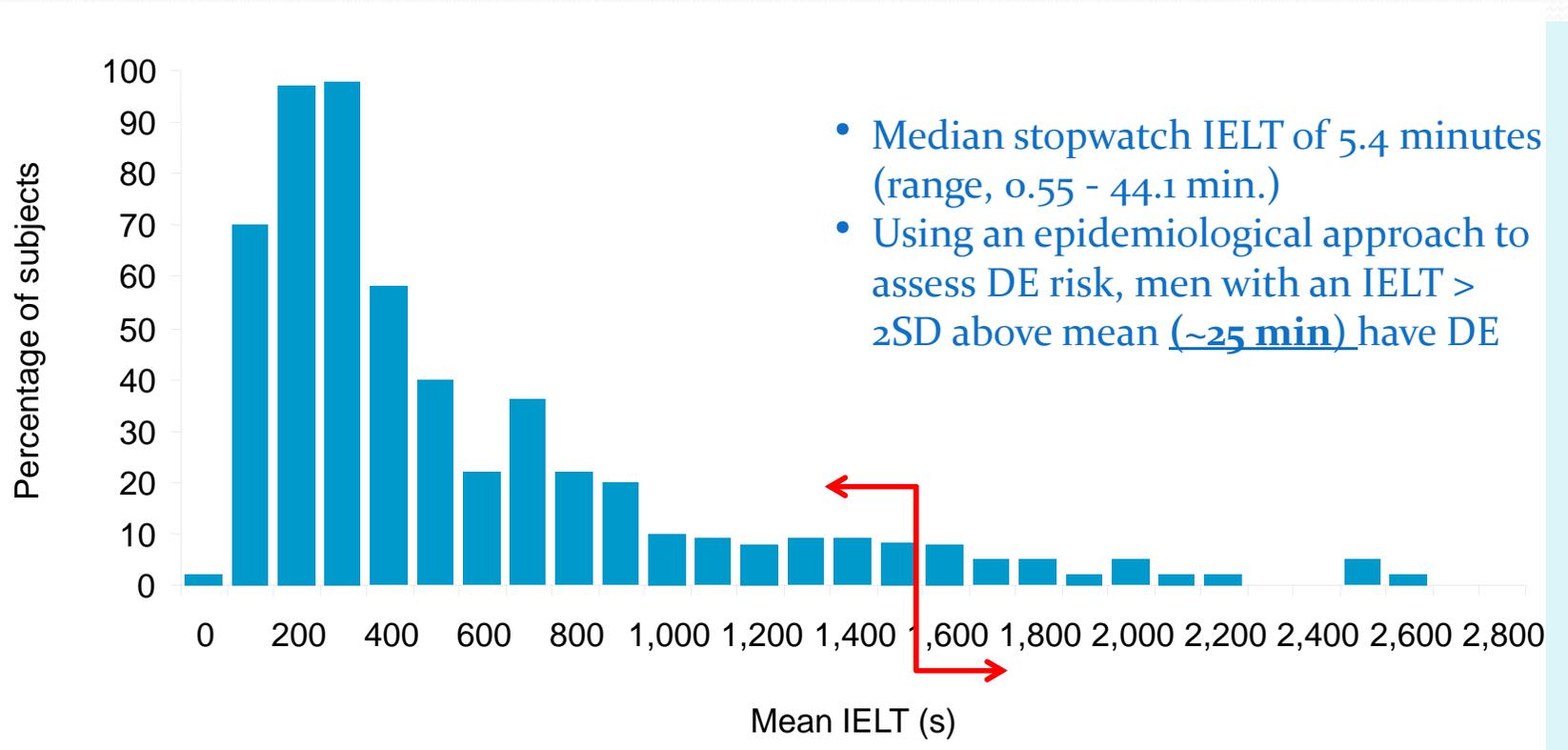
Better Defining Delayed/Anejaculation

- The revised DSM-5 remains vague and subjective
 - Does not objectively or precisely define what marked delay or marked infrequency or absence refers to
- Experts have suggested that an ejaculatory delay \geq 2 standard deviations above the mean may serve as an objective IELT threshold for delayed ejaculation
 - The diagnosis should also include the presence of negative personal psychological effects i.e. distress, bother, frustration, sexual avoidance, suspension of coitus due to fatigue, partner request



Normative IELT Data

Population based study of 500 heterosexual couples in the Netherlands, United Kingdom, Turkey and Spain. Subjects used a stopwatch to time their intravaginal ejaculatory latency time (IELT)



Negative Psychological Consequences of Delayed Ejaculation

- Impact of DE on the patient and partner is often not fully appreciated
 - Some perceive DE to be a positive attribute that allows the man to “bestow multiple coital orgasms to his partner”
 - DE is involuntary and causes distress for both the man and the partner
 - Partners believe they are not attractive enough for the patient. They feel unneeded and rejected.
 - Extended coitus causes pain for the patient and partner
 - Anejaculation results in a failure to conceive



Causes of Delayed Ejaculation, Anejaculation and Anorgasmia

Male Aging	Degeneration of afferent neurons and paccinian corpuscles
Psychological	Insufficient stimulation, atypical masturbation, conflict and disguised desire disorder
Congenital	Mullerian duct cyst, Wolfian duct abnormality, Prune belly syndrome
Anatomic	TURP, bladder neck incision
Neurogenic	Diabetic autonomic neuropathy, SCI, RP, proctocolectomy, Bilateral sympathectomy, abdominal aortic aneurysmectomy, para-aortic lymphadenectomy
Infective	Urethritis, genitourinary TB, schistosomiasis
Endocrine	Hypogonadism, hypothyroidism, hypothyroidism
Medication	Alpha-methyl dopa, thiazides, α -blockers, SSRIs, SNRIs, phenothiazines, alcohol



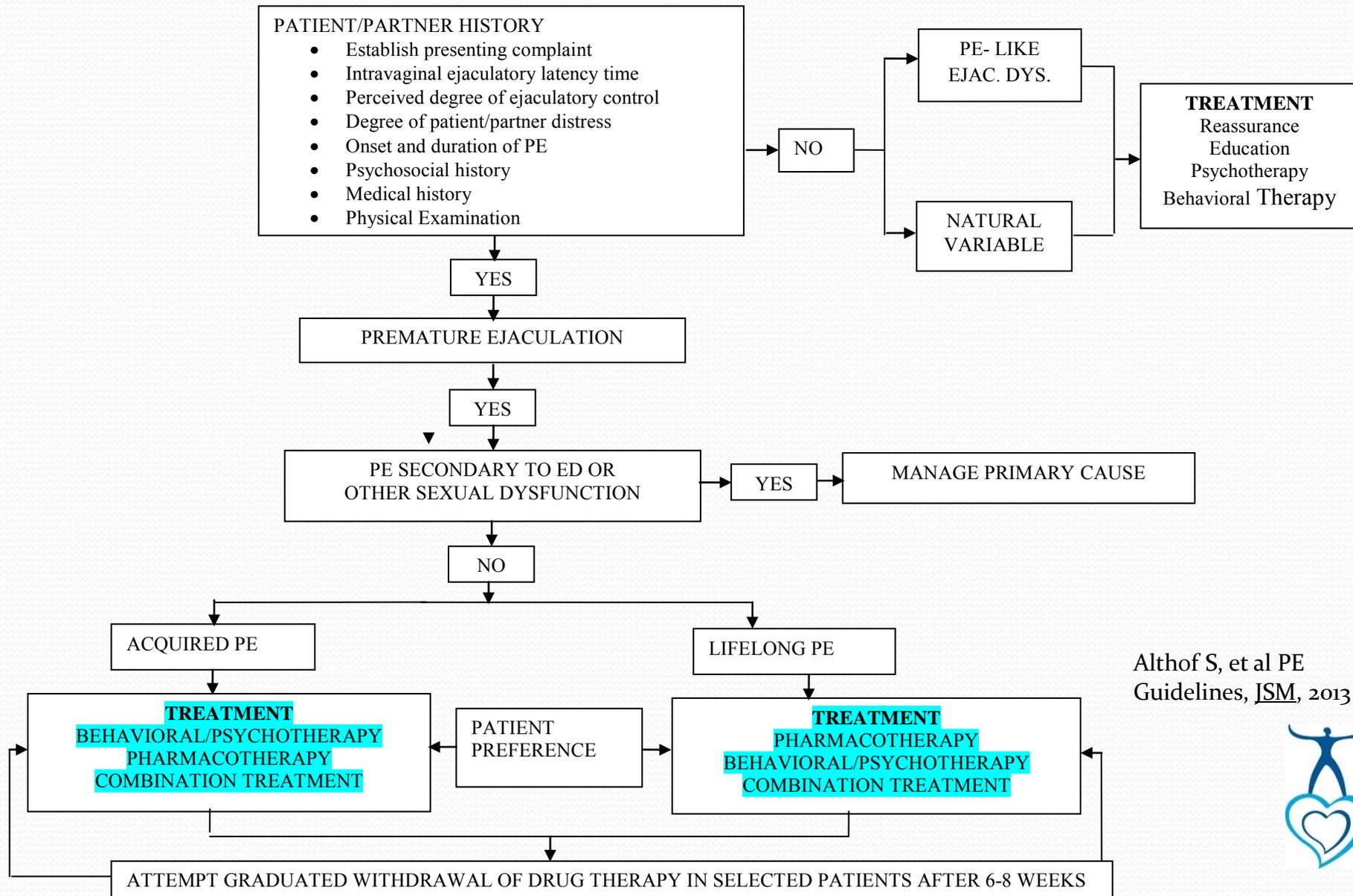
Combination Therapy

- The essential premise of combination therapy is to either simultaneously or sequentially address all relevant medical/biological, psychological and interpersonal aspects that contribute to the onset and continuation of the symptom
 - Drugs may facilitate ejaculation by either a central dopaminergic, or an anti-serotonergic, or oxytocinergic mechanism of action, or a peripheral adrenergic mechanism of action
 - Psychological intervention addresses the interpersonal and intrapsychic factors that precipitate and maintain the symptom

Althof S, (2006) Sexual therapy in the age of pharmacotherapy. *Annual Review of Sex Research*, 116-132.



Recommended Treatment Algorithm for Premature Ejaculation

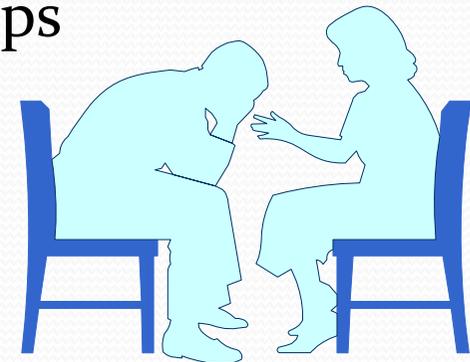


Althof S, et al PE Guidelines, *JSM*, 2013



Impact of PE

- PE is associated with diminished sexual satisfaction for the patient and partner
- PE negatively impacts on self-esteem, sexual confidence, and intimacy
- Men with PE are significantly bothered by the dysfunction
- Partners of PE men are likewise significantly bothered
- PE has detrimental effects upon relationships
- PE interferes with single men beginning new relationships



Behavioral Therapy of PE

- Squeeze technique
 - Masters & Johnson (1970)
 - Withdrawal and squeeze of the glans penis
- Factors influencing success
 - Heightened male awareness of sexual sensations
 - Decreased emphasis on coitus



Factors that Contribute to Successful Treatment Outcome

- Quality of couple's general relationship, specifically the female partner's relationship satisfaction
- Motivation of the partners, particularly the male
- Absence of serious psychiatric disorder in either
- Physical attraction between the partners
- Early compliance with the treatment program

Hawton K et al. *Behav Res. & Therapy*. 1986, 24: 655-675

Hawton K et al. *Arch Sex Behav* 1992, 21: 161-175



Landscape Has Dramatically Changed for the Treatment of PE

- Prior to 1990 psychotherapy was considered the treatment of choice for men suffering from PE
- After 1990 clinicians began experimenting with off-label administration of SSRIs
- After 2006 Dapoxetine was approved for the treatment of PE in over 50 countries
- In the future there is likely to be an FDA approved medication for this indication
 - New trials with different mechanisms of action are ongoing
- Ideal treatment would be combined psychological and pharmacological intervention



The Burden of PE on the Relationship

- Strain on relationship
 - Mistrust of partner
 - Perceived selfishness of man
- Difficulty initiating and maintaining relationships
- Dissatisfaction with sexual relationship
- Inability or lack of desire to communicate
 - Partner has not raised the problem
 - Fears hurting man's feelings
 - Does not know how to discuss
 - Some think it is a normal condition
 - Many think there is no solution



Combination Therapy

- Also known as “coaching” or “integrated therapy”
- Not a novel concept
- Successfully employed in the treatment of depression and PTSD
- Important aspect of treatment of diabetes and breast cancer because psychosocial support is a crucial aspect of care giving

Althof, S. E. (1998). New roles for mental health clinicians in the treatment of erectile dysfunction. *Journal of Sex Education and Therapy*, 23, 229–231.

Althof, S. E., (2003). *Handbook of clinical sexuality for mental health professionals* (359–376). New York: Bruner-Routledge.

Perelman M. In: Balon R, Segraves R, eds. *Handbook of sexual dysfunction*. New York: Marcel Dekker, Inc.; 2005:13–41

Rosen RC. Medical and psychological interventions for erectile dysfunction: toward a combined treatment approach.

In : Leiblum SR, Rosen RC, editors. *Principles and Practice of Sex Therapy*. New York: Guilford Press; 2000



Conclusions

- Psychotherapy for PE remains a viable treatment alternative
- Can modify feelings and behaviors that are not accessible by pharmacotherapy alone
- Combined with pharmacotherapy likely to offer patients/partners the best result

