What Does Premature Ejaculation Mean to the Man, the Woman, and the Couple?

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DOI: 10.1111/j.1743-6109.2011.02426.x

ABSTRACT

Introduction. The relational impact of male and female sexual dysfunction, and specifically premature ejaculation (PE), is an important consideration. Published findings are consistent in identifying the negative psychosocial impact of PE on the man. However, the effect of PE on the female partner, especially in relation to her sexual functioning, has been less well studied.

Aim. Provide an overview of the impact of PE on the man, the woman, and the couple.

Methods. Review of relevant literature.

Results. Female partners of men with PE report significantly greater sexual problems, with reduced satisfaction, increased distress and interpersonal difficulty, and more orgasmic problems than partners of non-PE men. Both men with PE and their partners feel control over ejaculation is the central issue in PE. For both, the lack of control leads to dissatisfaction, a feeling that something is missing from the relationship, and an impaired sense of intimacy. If left untreated, the situation can lead to increased irritability, interpersonal difficulties, and deepening of an emotional divide.

Conclusions. When treating a man with PE, the partner's participation should be encouraged to enable the physician to fully understand the extent of the problem, and consider other relevant factors, from her perspective. Identifying the best approach for the couple requires consultation with each person individually and together. In clinical practice, treatments for PE are likely to include a combination of pharmacological, psychological, sexological, and/or behavioral approaches for both the man and his partner. It is important that physicians regard PE as the couple's problem and endeavor to include the partner in its management where possible. **Graziottin A and Althof S. What does premature ejaculation mean to the man, the woman, and the couple? J Sex Med 2011;8(suppl 4):304–309.**

Key Words. Premature Ejaculation; Relationships; Couple; Partner; Management

Introduction

Each partner has a unique emotional and physical response to the quality of the overall sexual encounter. Clinical experience suggests that the quality of sexual intimacy and erotic performance become increasingly relevant in stable relationships to maintain a high degree of sexual satisfaction and bonding [1]. The evident interpersonal interaction during lovemaking has prompted the investigation of the relational impact of male and female sexual dysfunction, and specifically premature ejaculation (PE) [2]. As with all sexual problems, it is the "meaning" that the symptom has for the man, woman, and couple that is important. Meanings are individually constructed, variable, and influenced by cultural and other factors [3,4].

Definitions of PE include components of perceived lack of control and negative consequences for the man and his partner, in addition to short intravaginal ejaculatory latency time (IELT) [5]. Published findings are consistent in identifying the negative psychosocial impact of PE on the man, despite differences in the definitions of PE and methodologies used [2]. However, the effect of PE on the female partner, especially in relation to her sexual functioning, has been less well studied [2].

In this article, we will consider the impact of PE on both the man and his partner, and approaches to managing the couple with PE.

Impact of PE on the Man

Methodologies that have been used to assess the impact of PE on the man include validated patient-reported rating scales [6–8], qualitative interviews [9], and anonymous surveys [10] (reviewed by Rosen and Althof [2] and Corona et al. [11]). Compared with men without PE, men with PE report worse outcomes on control over ejaculation, satisfaction, distress, and interpersonal difficulty, assessed using the Premature Ejaculation Profile (PEP) (Table 1) [12,13]. The findings were similar in the United States and five European countries [8,13]. In a community-based observational study of 1587 men with and without PE, the 89 men diagnosed with PE had significant reductions in levels of sexual functioning, satisfaction, and overall quality of life, and increased levels of distress and interpersonal difficulty [7].

Both PE and erectile dysfunction (ED) affect the man's sexual enjoyment and quality of life as well as his self-esteem and confidence [2]. Single men report that PE prevents them from seeking out new relationships because they fear embarrassing themselves once again [14]. Additionally, men tend to be reluctant to discuss and raise openly the issue of PE [14]. In the clinical practice setting, men often express concern that there is no effective treatment for PE or have difficulty accepting that there is a problem [2].

Table 1 Patient-reported outcomes included in the Premature Ejaculation Profile [12,13]

Measure	Question	5 possible responses
Control over ejaculation	Over the past month, was your control over ejaculation during sexual intercourse. . .	0: Very poor 1: Poor 2: Fair 3: Good 4: Very good
Satisfaction with sexual intercourse	Over the past month, was your satisfaction with sexual intercourse. . .	0: Very poor 1: Poor 2: Fair 3: Good 4: Very good
Personal distress related to ejaculation	How distressed were you by how fast you ejaculated during sexual intercourse?	0: Not at all 1: A little bit 2: Moderately 3: Quite a bit 4: Extremely
Interpersonal difficulty related to ejaculation	To what extent did how fast you ejaculated during sexual intercourse cause difficulty in your sexual relationship with your partner?	0: Not at all 1: A little bit 2: Moderately 3: Quite a bit 4: Extremely

Acquired PE sometimes includes a man presenting with both PE and ED. In such cases, the fear of losing erection may accelerate the ejaculatory reflex. Careful clinical history and patient evaluation should help the clinician to differentiate lifelong PE from the acquired form that requires ED to be investigated and addressed first [4,15]. On the opposite end of the clinical spectrum, patients with lifelong PE may develop ED both on psychogenic grounds (when performance anxiety and the correlated adrenaline increase contribute to maintenance ED) and/or with an organic etiology (when different biological factors, such as aging, smoking, diabetes, cardiovascular diseases, low testosterone, and high prolactin to name a few, contribute to impair quality of erection). Comorbidity between PE and ED, and concomitant loss of desire, if reported, should therefore be carefully investigated to define the accurate dimension of PE in the context of the sexual experience and performance of the consulting patient and couple.

Impact of PE on the Woman

Female partners of men with PE reported worse outcomes on the partner version of the PEP scale compared with partners of men without PE [8,13]. In addition, female partners of men with PE in a community-based observational study reported significantly greater sexual problems, with reduced satisfaction and increased distress and interpersonal difficulty than partners of non-PE men [7]. Moreover, data from other studies show that all sexual domains—including desire, arousal, lubrication, and orgasm—are significantly worse in partners of men with PE [16]: Fifty-two percent of the partners of men with PE report orgasmic problems vs. only 23% of the partners of non-PE men ($P < 0.0001$) [17]. There is some evidence to suggest that partnered-orgasm frequency is associated with duration of penile-vaginal intercourse [18], rather than, as is often written, correlating with duration of foreplay. However, it is important to note that frequency of intercourse-related orgasm is not the only concern for female partners of men with PE. The majority of women, no matter the duration of lovemaking, do not always achieve orgasm with intercourse [19]. Accordingly, the main concern for many partners is the abrupt

break in intimacy and/or sexual pleasure caused by the man ejaculating too soon [20].

Clinical experience shows that the response of the woman to symptoms of PE in her partner changes over time [1]. A woman may initially avoid raising the problem for fear of hurting the man's feelings and/or of increasing his feeling of inadequacy. This can lead to a "collusion of silence," where neither partner is willing to talk about the problem. Later, she may raise the issue but finds the man denying that there is a problem or reluctant to discuss the issue of PE, which can result in feelings of frustration, anger, and contempt toward the man. If left untreated, the situation can lead to increased irritability, interpersonal difficulties, and deepening of emotional fracture.

In our clinical experience, the natural history of the impact of PE on the female partner typically comprises a number of stages. As discussed previously, the initial complaint may be lack of coital orgasm or a broader complaint about the abrupt cessation of intimacy or sexual pleasure caused by the man's PE. Over time, untreated PE can cause the female partner to lose sexual desire and can lead to inadequate central and genital arousal, vaginal dryness, and an inability to climax. These sexual problems can bring about emotional and physical dissatisfaction for the partner and the couple as a whole [1].

The impact of another sexual dysfunction, ED, on female partners has been studied in some detail. An interesting dichotomy is revealed when the responses of partners of men with PE and ED are compared (Table 2); partners of men with ED tend to blame themselves, whereas partners of men with PE tend to blame the man for their problems. In the case of PE, the partner's anger and frustration that the man has not done anything to address the problem often provides the impetus for the couple to seek help [2].

Table 2 Differing perceptions of partner's of men with PE or ED [1]

Partners' perception of PE:	Partners' perception of ED:
• "What is wrong with him?" — "Why can't he control himself?" — "Why does he let me down every time?" — "Why doesn't he care for me?"	• "What is wrong with me?" — "Am I not attractive enough?" — "Am I not beautiful enough?" — "Am I not sexy enough?" — "He must have another woman"

Information taken from presentation by A. Graziottin "Out of the shadow: How to manage the couple with PE" at the 12th Congress of the European Society of Sexual Medicine. Lyon, France; November 15–18, 2009.
PE = premature ejaculation; ED = erectile dysfunction.

Impact of PE on the Couple

Both men with PE and their partners feel control over ejaculation is the central issue in PE [9,13]. For both men with PE and their partners, a lack of control leads to dissatisfaction, a feeling that something is missing from the relationship, and an impaired sense of intimacy. A typical scenario after the man ejaculates is that he feels ashamed and embarrassed and she is frustrated and angry. He goes to his side of the bed and she goes to hers; at this point, they are separate and silent and whatever intimacy existed has been badly terminated. In couples with PE, communication about sexual intimacy can be a major issue; therefore, early diagnosis and treatment are essential [1].

Some self-help treatments that men use in an attempt to manage their PE may actually make the situation worse [10]. For example, focusing attention elsewhere in an attempt to delay ejaculation decreases the sense of intimacy between the couple. It also diverts the man's attention away from his level of arousal resulting in his having little awareness of his excitement resulting in diminishing ejaculatory control. In addition, interrupted stimulation such as "stop-start" techniques [21–23] affects the woman's sexual satisfaction. In one study, up to 40% of men reported that they had used alcohol in an attempt to reduce their anxiety and another 17% had used other recreational drugs [10]. Use of alcohol and recreational drugs should be explored as part of the clinical history because it touches on other clinical risks and comorbidities.

Managing the Couple with PE

Practical approaches to the diagnosis, pharmacological management, and sexual counselling of PE are considered in other articles in this supplement [24–26]. Physicians may not ask patients about their sexual life, leaving patients uncertain where to seek treatment. By asking about PE, the physician gives the patient permission to raise the issue during the consultation or at a later date [4]. The recent International Society for Sexual Medicine (ISSM) guidelines for the diagnosis and treatment of PE [4] propose a number of recommended and optional questions to ask men who are complaining of PE (Table 3). The recommended questions establish the diagnosis of PE based on the patient's IELT, control over ejaculation, and the impact of the condition. The optional questions provide information relevant to the treatment strategy, including the differentiation between lifelong and

Table 3 International Society for Sexual Medicine (ISSM) guidelines; recommended and optional questions to establish diagnosis of PE and inform treatment decisions [4]

Recommended questions *For diagnosis*	What is the time between penetration and ejaculation (cumming)? Can you delay ejaculation? Do you feel bothered, annoyed, and/or frustrated by your premature ejaculation?
Optional questions *Differentiate lifelong and acquired PE*	When did you first experience premature ejaculation? Have you experienced premature ejaculation since your first sexual experience on every or almost every attempt and with every partner?
Optional questions Assess erectile function	Is your erection hard enough to penetrate? Do you have difficulty in maintaining your erection until you ejaculate during intercourse? Do you ever rush intercourse to prevent loss of your erection?
Optional questions *Assess relationship impact*	How upset is your partner with your premature ejaculation? Does your partner avoid sexual intercourse? Is your premature ejaculation affecting your overall relationship?
Optional question *Previous treatment*	Have you received any treatment for your premature ejaculation previously?
Optional questions *Impact on quality of life*	Do you avoid sexual intercourse because of embarrassment? Do you feel anxious, depressed, or embarrassed because of your premature ejaculation?

PE = premature ejaculation.

acquired PE, any comorbid ED, and the impact on their relationship and quality of life.

These ISSM guidelines reinforce the importance of involving the partner in the treatment of PE [4]. However, in practice, the vast majority of men who are present for treatment do not involve their partners and may not appreciate the importance of involving them. In general, physicians do not invite the partners to participate in the treatment. The physician may feel awkward in doing so or believe that the problem can be managed without consulting the partner (e.g., it is the man's problem). Even if invited, partners can be reluctant to participate. Nevertheless, the partner's participation should be encouraged to enable the physician to fully understand the extent of the problem, and consider other relevant factors, from their perspective [4].

In situations where the couple present for treatment, identifying the best approach for the couple requires consultation with each person individually and together based on a series of clinically relevant questions (Table 4) [1]. For the man with lifelong PE, questions should address the fre-

Table 4 Clinically relevant sexual questions to ask the man, woman, and couple [1]

Clinically relevant sexual questions to him individually	Clinically relevant sexual questions to her individually	Clinically relevant sexual questions to the couple together
For the man with lifelong PE • How frequently do you have intercourse per week? *Many men report a worsening of their IELT when they reduce the frequency of intercourse* • How often do you ejaculate per week? *Establishes "ejaculatory rhythm"* • How would you describe your current sexual desire: physical (the urge to have sex) and emotional (the desire to make love)? *This question addresses the quality of the relationship with the partner* • What motivates you to have treatment now? For the man with acquired PE • What in your opinion is causing or worsening PE?	• How would you describe your sexual desire/arousal in the last month? • Do you have vaginal dryness or pain? • Do you have orgasm during intercourse? Or under any circumstances? • Are you currently sexually satisfied/ dissatisfied? • Which are your most frequent feelings/ emotions when you think about your sexual life? *Does the partner wish to help him, or does she have feelings of helplessness, frustration, anger, sexual indifference/ avoidance?* • Are you personally motivated to start couple treatment? • If this is not your first sexual relationship, how was sex before? • If you have any personal sexual problem, would you like to be evaluated/ examined as well as treated?	• How would you describe the quality of your relationship? • What place does sex currently have in your life? Marginal or central? • Which contraceptive method do you use? Or do you want children? • *Key qualitative questions to help set the motivational scenario for effective treatment:* • What do you currently miss the most in your relationship? • Which one of you was more motivated to ask for treatment?

Information taken from presentation by A. Graziottin "Out of the shadow: How to manage the couple with PE." At the 12th Congress of the European Society of Sexual Medicine. Lyon, France; November 15–18, 2009.
IELTs = intravaginal ejaculatory latency times; PE = premature ejaculation.

quency of intercourse and "ejaculatory rhythm" to distinguish between men with low desire and/or low biological drive and men with higher desire who are likely to respond better to treatment [1]. For men with acquired PE, it is important to explore their perception of the cause of their condition [1] as well as exclude or identify potential underlying causes. For the partner, questions should explore whether she has a sexual dysfunction or other problem and also assess her current attitude to her partner [1]. Both the man and his partner should be asked individually what their motivation is for seeking treatment. It is also important to question the couple together to help determine whether there is a "symptom inducer" and a "symptom carrier." If the patient is consulting with the partner (either a she or he), it may be helpful to ask the partner if he or she is happy with his or her own sexuality, if there was any problem antecedent to the current relationship, or if the current PE is causing changes/problems in their personal sexual satisfaction. In the authors' experience, PE patients usually consult the uroandrologist alone, while they are more likely to consult in couple when they consult the psychosexologist.

In clinical practice, treatments for PE should ideally include a combination of pharmacological, psychological, sexological, and/or behavioral approaches for both the man and his partner [4,27,28]. However, the treatment patients receive is likely to depend on who they see, (e.g., physician vs. sex therapist). It is important to address any underlying conditions (e.g., prostatitis) [15]. If the female partner has an independent or preexisting sexual dysfunction (e.g., vestibulitis), then treating the couple is a valid approach to complement the man's PE treatment [29].

Conclusions

PE has a significant negative impact on both the man and his female partner and, therefore, has implications for the couple as a whole. PE may deeply affect the quality of their relationship: erotically and emotionally. The female partner is often under-evaluated in the clinical practice setting. When the patient is in a stable relationship and the partner is willing to collaborate, it is important that physicians regard PE as the couple's problem and endeavor to include the partner in its management where possible. The optimal treatment often includes both a pharmacologic, psychological, and sexological approach to improve not only the "symptom" of PE, but also the quality of the erotic intimacy, the variety of the sexual repertoire and, ultimately, the erotic satisfaction of both partners. Combining a medical and psychological approach may be particularly useful in men with acquired PE where there is a clear psychosocial precipitant, or lifelong cases where the individual or couple's issues interfere in the medical treatment and success of therapy.

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Conflict of Interest: Dr. Graziottin is a member of speakers' bureaux for Bayer, Janssen-Cilag, Pantarhei, Sanofi-Aventis, Theramex, and Valeas. She has participated in advisory boards for Bayer, Janssen-Cilag, Theramex, and Valeas, and is a consultant for Bayer, Epitech, and Theramex. Dr. Althof is a Principal Investigator for Boehringer Ingelheim, Johnson and Johnson, and United Biosource. He is also a Consultant to Johnson and Johnson, Eli Lilly, Palitan, and Shionogi. He serves on Advisory Boards for Boehringer Ingelheim, Neuohealing, and Shionogi. He is a speaker for Boehringer Ingelheim and Shionogi.

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