

Psychological approaches to the treatment of rapid ejaculation

Keywords

Premature ejaculation
Sex therapy
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Abstract

This article reviews the psychological theories and treatment approaches to premature ejaculation. It also describes the potential negative psychological effect of this condition on the man and his partner. Recommendations and guidelines for providing individual and conjoint treatment with the partner are discussed as is the role of combined pharmacological and psychological intervention. The limitations of psychotherapy outcome studies are discussed and the success of psychological interventions for premature ejaculation is assessed from the studies' data. Finally, suggestions for improving the long-term therapeutic efficacy of psychotherapy are offered. Psychological intervention remains a vital alternative in the treatment of premature ejaculation. © 2006 WPMH GmbH. Published by Elsevier Ireland Ltd.

Introduction

Delaying men's ejaculatory latency with off-label selective serotonin reuptake inhibitors (SSRIs) is relatively straightforward, but restoring men's sexual confidence and enhancing sexual relationship satisfaction is more complicated [1]. Pharmacotherapy with SSRIs and clomipramine has eclipsed the use of psychological interventions to become the treatment of choice for this condition [2,3]. However, one of the lessons learned from the "Viagra revolution" for the treatment of erectile dysfunction was that no matter how efficacious and safe the medical intervention, medications alone could not always surmount the psychosocial obstacles that maintained the dysfunction and interfered with sexual life [4].

To date, the cause of rapid ejaculation has not been conclusively determined. Not surprisingly, there are those who advocate for an entirely biological explanation and those who insist that it is a wholly psychological condition. There are also those who believe that rapid ejaculation may be a cluster, or continuum, of disorders, some biologically determined, others psychological in origin. Even if we were able to unequivocally state

that a man's rapid ejaculation is due to biological factors exclusively, he would probably manifest a psychological response that might further worsen the condition. Additionally, his partner may be psychologically affected by the dysfunction, regardless of the underlying cause.

Given that psychological factors can either worsen the condition or in some cases may be responsible for precipitating and maintaining the dysfunction psychotherapy remains a vital intervention to help men and their partners who suffer from rapid ejaculation. The aims of this paper are to review the psychological theories regarding rapid ejaculation and to discuss psychotherapy/sex therapy as the sole intervention for the treatment of rapid ejaculation or, in an updated rendering, as part of a combined or integrated pharmacological/psychological treatment.

Psychological theories

There are multiple psychological explanations as to why men develop rapid ejaculation. Unfortunately, none of the theories evolve from evidenced-based medicine studies. Rather

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they are the products of thoughtful synthesis by clinicians from several schools of thought. Although untested, the theories are thought provoking.

In 1927, a German psychoanalyst speculated that rapid ejaculation is due to a combination of the man's unconscious hostile feelings towards women and his passive pleasure, as a child, in losing control of his urination (passive urethral eroticism) which, as an adult, transforms itself into his passive pleasure in giving up control of ejaculation [5]. Thus, ejaculation into the woman's vagina was equated with "soiling" or "debasement" her. The man took his sexual pleasure, unconsciously soiled her, and in so doing deprived her of sexual pleasure. Simultaneously he gives himself over to the passive pleasure of letting go of his ejaculation without any attempt to control his sexual excitement or delay ejaculation.

A second psychoanalytic explanation focuses on the man's unresolved excessive narcissism during infancy which results in his placing exaggerated importance on his penis. This hypothesis might explain the selfishness observed in some rapid ejaculators who seem unconcerned with pleasuring their partners [6].

In 1943, (Bernard Schaprio) the notion that rapid ejaculation was a psychosomatic disorder was introduced [7]. In his view, early ejaculation is a bodily symptom that expresses the man's psychological conflict, akin to psychosomatic explanations for headache, backache and stomach pain. Schapiro speculated that men with rapid ejaculation had specific "biological organ vulnerabilities" which directed the expression of the person's psychological conflict. In his view, because men with rapid ejaculation had "weakened" genitourinary systems, they became rapid ejaculators rather than expressing their psychological conflict through another organ system, e.g. headache.

Psychodynamic theorists consider anxiety to be the primary causal agent in precipitating rapid ejaculation. However, anxiety is not a singular concept; it is used to characterize at least three different mental phenomena. Anxiety may refer to:

1. a phobic response, like being fearful (i.e. afraid of the dark, wet, unseen vagina)
2. an affect, the end result of conflict resolution where two contradictory urges are at

play (i.e. the man is angry at his partner, but feels guilty about directly expressing his hostility) or

3. anticipatory anxiety commonly referred to as performance anxiety where preoccupation with sexual failures and poor performance leads to deteriorating sexual function and avoidance of future sexual interactions.

Conceptualizing rapid ejaculation in more of a behavioral/learning perspective, Masters and Johnson [8] emphasized the concept of "early learned experience." By reviewing the case histories of men with rapid ejaculation, Masters and Johnson noted that many men described first sexual experiences characterized by haste and nervousness, for example making love in the backseat of an automobile or during an encounter with a prostitute. Masters and Johnson speculated that the men became conditioned to ejaculate rapidly. It is not known whether these early conditioning experiences are unique to men with rapid ejaculation [9].

Kaplan [10] considered "lack of sexual sensory awareness" to be the immediate cause of rapid ejaculation. She believed that men fail to develop sufficient feedback regarding their level of sexual arousal. Such men experience themselves as going from low levels of arousal to ejaculation without any awareness.

Absent from any of these theories are compelling notions differentiating the lifelong and acquired forms of rapid ejaculation. Obviously more work remains to be done in clarifying the psychological contributions to their problem.

The role of performance anxiety

Performance anxiety per se does not generally cause the initial episode of rapid ejaculation; however, it is pernicious in maintaining the dysfunction. By the time patients present for treatment the initial precipitating event is often obscured because of the intensity of the man's performance anxiety. Performance anxiety distracts the man from focusing on his level of arousal, rendering him helpless in exerting voluntary control over his sexual arousal and ejaculation. With each failure performance anxiety heightens, further worsening sexual performance resulting in sexual avoidance behaviors.

Effect on the man and couple

Rapid ejaculation affects both individual and relationship quality of life (QOL). Men report a decrease in sexual self-confidence [11]. Moreover, single men or uncommitted men are reluctant to establish new relationships, and men in relationships are distressed at not satisfying their partner, with some worrying that their partner would be unfaithful to them because of their sexual dysfunction.

Hartmann et al. [12] characterize men with rapid ejaculation as preoccupied with thoughts about controlling their orgasm, with anxious anticipation of a possible failure, thoughts about embarrassment and thoughts about keeping their erection. In contrast, they found that functional men focused on sexual arousal and sexual satisfaction.

Intimacy is also negatively affected. Men with premature ejaculation scored lower on all aspects of intimacy (emotional, social, sexual, recreational, and intellectual) and had lower QOL (lower levels of satisfaction in all areas) than sexually functional men [13].

Premature ejaculation also has a negative effect on the partner's quality of life. Lower partner sexual satisfaction in heterosexual couples was found where the man had rapid ejaculation than where the man did not have the condition [14]. Partners are not just distressed because of the quality of the man's sexual performance; they are also upset because the condition and the man's associated distress often lead to a rapid and unwanted interruption of intimacy. Women are also angry with their premature ejaculation partners because they do not feel that their concerns have been genuinely "heard" by the man or that he is unwilling "to fix" the problem. Men overcompensating to "give their partners orgasm" through manual or oral stimulation is sometimes felt to be a burden which produces performance anxiety and further diminishes the partner's sexual satisfaction. Women feel ambivalence between expressing their concerns to their partner because they fear injuring the man's already fragile self-esteem and suffering in silence. Men likewise believe that their partners do not understand the degree of frustration and humiliation that they routinely experience. This disconnection between the men and their partners is the basis for considerable relation-

ship tension. Thus, for men in stable relationships, premature ejaculation should be recognized as a couple's issue. All these studies suggest that the psychosocial effect of premature ejaculation on most patients and partners has profound psychosocial consequences.

When to offer what

Psychotherapy alone is best reserved for men/couples where the precipitating and maintaining factors are clearly psychological and/or the psychosocial obstacles are too great to overcome with pharmacotherapy alone. Examples of these psychosocial obstacles include:

1. patient variables such as the degree of performance anxiety or presence of depression
2. partner issues such as how the partner copes with the rapid ejaculation or how the dysfunction obscures the woman's sexual dysfunction (e.g. anorgasmia)
3. interpersonal non-sexual variables such as a chronically unsatisfying relationship
4. contextual variables including lack of privacy and
5. partner's expectations from treatment (e.g. he should last 20 minutes because it takes me that long to have an orgasm).

Individual psychotherapy is the default choice for single men not in relationships. In addition to treating the sexual dysfunction, therapy must address these men's reluctance to enter into new relationships for fear of humiliating themselves and/or disappointing the woman. Psychotherapy for rapid ejaculation can only go so far without the presence of a partner. Obviously, without a partner, the patient cannot sexually practice what he has learned nor work through salient interpersonal dynamics. For these men, treatment is sometimes divided into two phases, treatment when there is no partner and later resumption of treatment when he establishes a new relationship.

For men in relationships, individual psychotherapy is recommended when the psychological variables supporting the dysfunction are thought to be more intrapsychic rather than interpersonal, e.g. fear of penetrating a dark, wet, warm vagina or excessive fear of or hostility to women. These are generally products of unresolved childhood issues that continue to interfere in the man's adult sexual life.

Individual psychotherapy may also be the treatment of choice when the relationship is deemed too chaotic or unworkable, or when the partner refuses to participate. Individual treatment in these situations is, of course, limited given the limitations of the interpersonal environment.

Conjoint psychotherapy is recommended for men with either lifelong or acquired forms of premature ejaculation where both partners are relatively psychologically healthy and motivated to pursue treatment. Ideally, the precipitating and maintaining factors can be explained, the effect of the dysfunction on both partners can be clarified and interventions directed at him, her and them can be initiated.

Combined pharmacological and psychological therapy is a new untested paradigm that may offer the best of both interventions [1,15,16]. Pharmacotherapy will rapidly delay ejaculation and allow the man to regain some sexual confidence. Psychological intervention will help the man/couple maximize gains from pharmacotherapy. It seeks to help men/couples overcome the psychosocial obstacles that interfere with making effective use of the pharmacological intervention. The man can be taught to attend to sensations rather than fear his arousal. He can learn to better pace himself and expand his sexual repertoire. In time, he can be weaned from pharmacotherapy and he can implement what he has learned in therapy. Not all men will be able to give up the pharmacological intervention. Some, however, will be pleased that “on their own” they have triumphed over adversity.

Psychotherapy alone

Present day psychotherapy for rapid ejaculation is an integration of psychodynamic, systems, behavioral, and cognitive approaches within a short-term psychotherapy model [1,8,10,17–21]. The guiding principles of treatment are to learn to control ejaculation while understanding the meaning of the symptom and the context in which it occurs. Psychotherapy/behavioral interventions improve ejaculatory control by helping men/couples to:

1. learn techniques to control and/or delay ejaculation
2. 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 precipitate and maintain the dysfunction
7. come to terms with feelings/thoughts that interfere with sexual function, and
8. increase communication.

Psychodynamically oriented therapists view the dysfunction as a metaphor in which the man/couple are trying to simultaneously conceal and express conflicting aspects of themselves or the relationship. In symbolic terms, the dysfunction contains a compromised solution to one of life's dilemmas.

Alternatively, behavior therapists understand the dysfunction as a conditioned response or a maladaptive response to interpersonal or environmental occurrences. They provide exercises or homework to help the man comfortably attend to his sensations and learn to pace his arousal.

Men fear that by focusing on their sexual excitement it will cause them to ejaculate even more quickly. They attempt to diminish or limit their sexual excitement by wearing multiple condoms, applying desensitization ointment, repeatedly masturbating before intercourse, not allowing partners to stimulate them, or distracting themselves by performing complex mathematical computations while making love. These tactics, however creative, curtail the pleasures of lovemaking and are generally unsuccessful.

Men with rapid ejaculation typically describe two points on their subjective excitement scale, no excitement and the point of ejaculatory inevitability. They are unable to perceive or linger in mid-range sexual excitement levels. In treatment, men are instructed to focus on their sexual arousal. By using graduated behavioral exercises, they are taught to identify and become familiar with intermediate levels of sexual excitement. Successively, beginning with masturbation and moving progressively through foreplay and intercourse, they master the ability to linger in this range, thereby delaying ejaculation.

In addition to teaching men sexual skills and resolving the interpersonal and intrapsychic issues related to rapid ejaculation, it

is also helpful to address the cognitive distortions that help maintain the dysfunction. Rosen et al. [22] lists eight forms of cognitive distortions that may interfere with sexual function. These include:

1. all or nothing thinking, e.g. “I am a complete failure because I come quickly”
2. overgeneralization, e.g. “If I had trouble controlling my ejaculation last night, I won’t be able to this morning”
3. disqualifying the positive, e.g. “My partner says our lovemaking is satisfying because she doesn’t want to hurt my feelings”
4. mind reading, e.g. “I don’t need to ask, I know how she felt about last night”
5. fortune telling, e.g. “I am sure things will go badly tonight”
6. emotional reasoning, e.g. “Because a man feels something is true, it must be”
7. categorical imperatives, i.e. ‘shoulds’, ‘ought to’ and ‘musts’ dominate the man’s cognitive processes, and
8. catastrophizing, e.g. “If I fail tonight my girlfriend will dump me”.

Psychoeducational interventions also aim to rework the behavioral repertoire of the man or couple, referred to as their sexual script [23]. Men with rapid ejaculation limit foreplay because they fear becoming too excited. Sex becomes very mechanical and rigid, yet these solutions do not help the man to delay ejaculation. By modifying rigid and narrow scripts, therapists may help couples establish a more satisfying sexual life.

Resistance

No therapy ever progresses without some resistance on the part of the patient or couple. It is to be expected. Resistances seek to maintain the status quo. It is not easy for patients/couples to give up comfortable, yet maladaptive behaviors. By using confrontation, interpretation, and gentle humor patients can be encouraged to relinquish resistances and “try on” new behavioral and interpersonal routines.

Levine [17] posits four sources of resistance:

1. when the rapid ejaculation and associated problems maintain a sexual equilibrium and cover up the female partners sexual disorder or concern

2. when the individual or couples harbor unrealistic expectations about sexual performance
3. when there are major relationship problems
4. when male or female deceit is present.

Psychotherapy outcome studies

Evidenced-based medicine has become the gold standard for judging the efficacy of psychological or medical interventions. Studies at the highest level of evidence-based medicine require moderate to large sample sizes with designs being randomized, placebo controlled and double blinded. Sex therapy treatment outcome studies are uncontrolled and unblinded; none meet the requirements for high level evidenced-based studies. What exists in the literature are reports on small to moderately sized cohorts of subjects who received different forms of psychological interventions with limited or no follow-up. In most studies, active treatment was not compared with placebo, control or wait list groups.

An exception to this standard of small sample sizes and lack of follow-up is Masters and Johnson’s [8] report on 186 men who were seen in their quasi-residential model using multiple treatment techniques including the squeeze technique sensate focus, individual and conjoint therapy as well as sexual skills and communication training. They reported “failure rates” of 2.2% and 2.7% immediately post-therapy and at a 5-year follow-up respectively. Never before, or since has any clinical center been able to replicate either the initial, or post-treatment, efficacy rates reported by Masters and Johnson. For example, only 64% of men in Hawton et al.’s [24] study and 80% of Kaplan’s cohort [25] were characterized as successful in overcoming rapid ejaculation immediately post-therapy.

All studies with long-term follow-up noted a tendency for men to suffer relapses. In writing about relapse, Hawton et al. [26] noted that recurrence of or continuing difficulty with the presenting sexual problem was commonly reported by 75% of couples. This caused little to no concern for 34%. Patients indicated that they discussed the difficulty with the partner, practiced the techniques learned during therapy, accepted that difficulties were likely to recur, and read books about sexuality. In spite

of the decrease in intravaginal ejaculatory latency time (IELT) over time, patients sexual satisfaction remained very high.

The concept of relapse prevention has begun to be incorporated into sex therapy. McCarthy [27], suggests that therapists schedule periodic “booster or maintenance” sessions following termination. Patients remark that knowing that they will be seen again in 6 months keeps them on target because they know they will have “to report” on their progress. The follow-up sessions can also be used to work on any “glitches” that have interfered with their progress.

Combined treatment coaching

The psychological aspects of a combined medical/psychological treatment are different from psychotherapy alone and are generally referred to as coaching. Such interventions are more directive, advice giving, educational and technique oriented. They target the psychosocial obstacles created after the onset of the dysfunction such as avoidance of foreplay, restrictive sexual patterns that are resented by partners, unwillingness to discuss the problem which itself creates a barrier, etc. The goals of coaching include:

1. identifying and working through the resistances to medical interventions that lead to premature discontinuation
2. reducing or eliminating performance anxiety
3. gaining sexual confidence
4. understanding the context in which men/couples make love, and
5. helping them to modify maladaptive sexual scripts.

Combined treatment may be especially helpful when the treatment effects of pharmacotherapy are modest. By lessening the psychosocial obstacles that interfere with treatment and offering the men/couples methods to delay ejaculation the effect of pharmacotherapy can be enhanced.

Conclusion

Psychological intervention remains relevant to treating men and couples with rapid ejaculation. The effect of this dysfunction on the man, partner and couple are generally profound and distressing. Psychological intervention in its traditional form, or in its updated rendering as combined therapy, offers couples a method to improve sexual satisfaction, emotional intimacy and relationship satisfaction.

This article is the second in a series of articles on premature ejaculation. Further articles in the series will be published in future issues of the journal.

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