World J Urol (2005) 23: 89–92
DOI 10.1007/s00345-004-0489-6

TOPIC PAPER

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Psychological treatment strategies for rapid ejaculation: rationale, practical aspects, and outcome

Received: 16 November 2004 / Accepted: 8 December 2004 / Published online: 1 June 2005

Abstract The landscape has dramatically changed for patients seeking treatment for rapid ejaculation. Previously, psychotherapy or behavioral treatment was considered to be the treatment of choice for this troubling sexual dysfunction. Since the early 1990s, an efficacious alternative treatment has emerged—the off-label administration of SSRI medications. Currently, several short-acting SSRI compounds are in phase III clinical trials and are likely to receive approval as the first medical treatment for rapid ejaculation. Given the presumed efficacy of these new compounds and the off-label use of the current SSRIs, one might conclude that psychotherapy\behavior therapy for rapid ejaculation is an obsolete and antiquated intervention. On the contrary, psychotherapy is now more relevant than ever. The two aims of this paper are to review psychological/behavioral therapies for rapid ejaculation and to discuss the important role of combined psychological and medical treatment. In the new age of SSRI treatment for rapid ejaculation, some form of psychological/behavioral intervention is essential to help patients/couples make better use of medical therapies, to learn skills to delay ejaculation once off medication, to bolster sexual confidence, and to enhance patient and partner sexual satisfaction.

Keywords Sexual dysfunction · Treatment strategies · Ejaculation

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Introduction

The landscape has dramatically changed for patients seeking treatment for rapid ejaculation. Previously, psychotherapy or behavioral treatment were considered to be the treatment of choice for this troubling sexual dysfunction. In the early 1990s, clinicians began successfully experimenting with the off-label administration of selective serotonergic reuptake inhibitors (SSRIs) to delay ejaculatory latency [27]. Presently, several novel, short-acting SSRI compounds are in phase III clinical trials and are likely to receive approval as the first medical treatments for rapid ejaculation.

Thus, physicians may soon have an approved, simple, efficacious and safe intervention that delays ejaculatory latency. Given the efficacy of SSRIs, one might conclude that psychotherapy\behavior therapy for rapid ejaculation is an obsolete and antiquated intervention. On the contrary, psychotherapy is now more relevant than ever.

These days, delaying men's ejaculatory latency is relatively straightforward, restoring their sexual confidence and reversing the impact on the relationships is more complicated [26]. One of the lessons learned from the PDE5 revolution for the treatment of ejaculatory dysfunction (ED) was that no matter how efficacious and safe the medical intervention, by itself, medication could not surmount all the psychosocial obstacles that maintained the dysfunction and interfered with sexual life [3, 4].

In the new age of SSRI treatment for rapid ejaculation, some adjunctive form of psychological/behavioral intervention is essential to help patients/couples make better use of medical therapies and to lessen the high discontinuation rates due to psychosocial factors. Psychotherapy is useful either in its traditional form as the sole intervention for men or couples with rapid ejaculation or, in an updated rendering, as an integral aspect of a combined or integrated biopsychosocial intervention [2]. Psychotherapy in the context of an integrated treatment is often short-term, directive, educational and

targeted at helping couples overcome their resistances to making use of a medical treatment.

The two aims of this paper are to review psychological/behavioral therapies for rapid ejaculation and to discuss the important role of combined psychological and medical treatment.

The goals of traditional psychotherapy

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 [1, 2].

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.

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 (4) helping them to modify maladaptive sexual scripts.

What makes therapy work?

Donahey and Miller [7] report that regardless of the therapeutic modality (individual, couple or group therapy). or the specific therapy goals, there are several common factors that make psychotherapy effective.

1. Empowering the patient to experience themselves as having the ability to create change and impact contextual factors.
2. The patient/therapist relationship is critical to successful therapeutic outcome. The therapist must be able to assess and accommodate to the patient's readiness for change and provide a safe and empathic environment where the patient can explore obstacles, choices and meanings of his psychological and behavioral dilemmas.
3. The role of hopefulness and realistic expectancy should be provided in psychotherapy.

Psychotherapy for rapid ejaculation

Present day psychotherapy for rapid ejaculation is an integration of psychodynamic, systems, behavioral, and cognitive approaches within a short-term psychotherapy model [13, 15, 18, 20, 28]. 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.

Men fear focusing on their sexual excitement, believing it will cause them to ejaculate even more quickly. They attempt to diminish or limit their sexual excitement by resorting to wearing multiple condoms, applying desensitization ointment to the penis, repeatedly masturbating prior to 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.

These men typically describe themselves as having two points on their subjective excitement scale—no excitement and the point of ejaculatory inevitability. They fail to focus on their arousal and are unable to perceive or linger in mid-range sexual excitement.

In treatment, men are instructed to focus on their sexual arousal. By utilizing 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 the 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. [23] list 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 [8]. 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.

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. The majority of psychotherapy treatment outcome studies can be characterized as uncontrolled, unblinded trials; 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 to placebo, control or wait list groups. These studies are summarized below.

Since the early 1970s, an array of individual, conjoint, and group therapy approaches employing behavioral strategies such as stop-start [16] or squeeze techniques [24] have been used to treat rapid ejaculation [11, 13, 15, 18].

Masters and Johnson [16] reported on 186 men who were seen in their quasi-residential model utilizing 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 [10, 12, 14, 25]. For example, only 64% of men in Hawton et al.'s [10] study were characterized as successful in overcoming rapid ejaculation immediately post-therapy [5, 6, 10].

All studies with long-term follow-up noted a tendency for men to suffer relapses. In writing about the problem of relapse in treating all forms of sexual dysfunction, Hawton et al. [9] reported that recurrence of or continuing difficulty with the presenting sexual problem was commonly being 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.

The concept of relapse prevention has begun to be incorporated into sex therapy. McCarthy [17], in discussing relapse prevention, 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 out any ''glitches'' that have interfered with their progress.

Combined therapy-coaching

The concept of integrating a talking therapy with a medical treatment seems like a radical departure from the traditional treatment of rapid ejaculation. Typically, patients come either to the urologist's or the mental health clinician's office, but not both. However, in other specialties, psychiatry for example, combined therapy is the most efficacious treatment for a variety of disorders and is often performed by two therapists [21].

One of the misconceptions regarding combined therapy or coaching is that it would require a mental health clinician to come to the urologist's office or the patient to make a separate appointment with the sex therapist. While this would be ideal, it is not practical and is unlikely to occur. However, coaching can be conducted by the physician or his/her nurse. It requires someone who has time, interest, interpersonal sensitivity, minimal training in sex therapy (i.e. teaching techniques to delay ejaculation), and an appreciation of the relevant psychosocial issues that may interfere with medical treatment.

There is growing support for the paradigm of combined treatment. McMahon and colleagues [19] in their recommendations from the 2nd International Consultation on Sexual Dysfunction in Men and Women, list combination therapy as a first line intervention for lifelong or acquired rapid ejaculation. Independently, Althof [2] and Perelman [22] have also written about this intervention.

There are several cogent reasons to consider coaching as a vital aspect of the treatment of rapid ejaculation. First, men want to be able to delay ejaculation by themselves (without medication) but have not learned the skills to do so. Coaching would teach men the behavioral skills of ejaculatory delay as they are weaned from pharmacotherapy. Second, some couples will have a difficult time surmounting the barriers built in response to the psychosocial consequences of the dysfunction. With the caring support and direction of a neutral party these difficulties can often be overcome. Third, combination therapy would help to establish or restore sexual self-confidence as well as diminish

performance anxiety. Fourth, partners will feel freer to engage in extended foreplay or to broaden their sexual repertoire leading to greater satisfaction for both.

Conclusion

To be effective in enabling patients to make love, clinicians need to broaden their perspective from genital function to appreciating the context in which couples live. Outcomes conceived solely in terms of ejaculatory delay or control are far too narrow and mechanistic. Successful sexuality outcomes require attending to the complex interplay between the biological, psychological and relational components of individuals' and couples' lives.

While clinicians will soon have safe, effective pharmaceutical interventions available to delay ejaculation, the couples formidable psychosocial barriers may diminish the treatment outcome. By providing patients with an integrated medical/psychological treatment aimed at overcoming these barriers clinicians are likely to significantly increase the effectiveness of their treatment interventions. Psychotherapy in its traditional form remains a viable alternative for men who do not wish pharmacotherapy. Combined therapy is likely to improve treatment satisfaction, compliance, and help couples make better use of an effective medical intervention.

References

1. Althof S, Wieder M (2004) Psychotherapy for erectile dysfunction: now more relevant than ever. Endocrine
2. Althof S (2003) Therapeutic weaving: the integration of treatment techniques. In: Levine S, Risen C, Althof S (eds) Handbook of clinical sexuality for mental health professionals. Bruner-Routledge, New York, pp 359–376
3. Althof SE (2002) When an erection alone is not enough: biopsychosocial obstacles to lovemaking. Int J Impot Res 4 [Suppl 1]:S99–104
4. Althof S (2000) Erectile dysfunction: treatment of men and couples. In: Lieblum S, Rosen R (eds) Principles and practices of sex therapy, 3rd edn. Guilford Press, New York, pp 242–275
5. Bancroft J, Coles L (1976) Three years experience in a sexual problems clinic. Br Med J 1:1575–1577
6. DeAmicus L, Goldberg DC, LoPiccolo J, Friedman J, Davies L (1985) Clinical follow-up of couples treated for sexual dysfunction. ArchSex Behav 14:467–489
7. Donahey K, Miller S (2001) What works in sex therapy: a common factors perspective. New directions. In: Kleinplatz P (ed) Sex therapy innovations and alternatives. Bruner Routledge, Philadelphia, pp 210–233
8. Gagnon J, Rosen R, Leiblum S (1982) Cognitive and social aspects of sexual dysfunction: sexual scripts in sex therapy. J Sex Marital Ther 8:44–56
9. Hawton K, Catalan J, Faff J (1992) Sex therapy for erectile dysfunction: characteristics of couples, treatment outcome, and prognostic factors. Arch Sex Behav 21:161–175
10. Hawton K, Catalan J, Martin P, Fagg J (1986) Long-term outcome of sex therapy. Behav Res Ther 24:665–675
11. Hawton K (1998) Integration of treatments for male erectile dysfunction. Lancet 351:728
12. Heiman JR, LoPiccolo J (1983) Clinical outcome of sex therapy. Arch Gen Psychiatry 40:443–449
13. Kaplan HS (1989) PE: how to overcome premature ejaculation. Brunner/Mazel, New York
14. Kilman P, Auerbach R (1979) Treatments of premature ejacuation and psychogenic impotence: a critical review of the literature. Arch Sex Behav 8:81–100
15. Levine S (1992) Sexual life, a clinicians guide. Plenum, New York
16. Masters W, Johnson V (1970) Human sexual inadequacy. Little Brown, Boston
17. McCarthy B (1993) Relapse prevention strategies and techniques in sex therapy. J Sex Marital Ther 19:142–147
18. McCarthy B (1990) Cognitive-behavioral strategies and techniques in the treatment of early ejaculation. In: Leiblum SR, Rosen RC (eds) Principles and practice of sex therapy: update for the 90s. Guilford Press, New York, pp 141–167
19. McMahon CG, Meston C, Abdo C, Hull E, Incrocci L et al. (2004) Disorders of orgasm in men and women, ejaculatory disorders in men. In: Lue TF, Basson R, Rosen R, Giuliano F, Khoury S, Montorsi F (eds) Sexual medicine: sexual dysfunctions in men and women. Health Publications, (in press)
20. Metz M, McCarthy B (2003) Coping with premature ejaculation: how to overcome PE, please your partner and have great sex. New Harbinger, Oakland
21. Nathan PE, Gorman JM (eds). (2002). A guide to treatments that work, 2nd edn. Oxford, New York
22. Perelman M (2003) Sex coaching for physicians: combination treatment for patient and partner. Int J Impot Res 15 [Suppl 5]:s67–s74
23. Rosen R, Leiblum S, Spector I (1994) Psychologically based treatment for male erectile disorder: A cognitive-interpersonal model. J Sex Marital Ther 20:67–85
24. Semans J (1956) Premature ejaculation. Southern MedJ 49:352–358
25. St. Lawrence J, Madakasira S (1992) Evaluation and treatment of premature ejaculation: a critical review. Int J Psychiatry 22:77–97
26. Symonds T, Roblin D, Hart K, Althof S (2003) How does premature ejaculation effect a man's life. J Sex Marital Ther 29:361–370
27. Waldinger MD, Zwinderman AH, Schweitzer DH, Oliver B (2004) Relevance of methodological design for the interpretation of efficacy of drug treatment of premature ejaculation: a systematic review and meta-analysis. Int J Impot Res 1–13
28. Zilbergeld B (1999) The new male sexuality. Bantam, New York