Delayed Ejaculation/Inhibited Orgasm
The Mental Health Perspective

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Definition

- **Professionals differ slightly, but today we will, use the AUA definition:**
- **Delayed ejaculation** is defined as **a consistent, bothersome inability to achieve ejaculation**,
  or as an **excessive latency to ejaculation**,
  despite adequate sexual stimulation and the desire to ejaculate.
- **It can be lifelong or acquired.**
- **Ejaculation and orgasm usually occur simultaneously, despite being separate physiological phenomena.**
- **Orgasm is typically coincident with ejaculation, but is a central sensory event that has significant subjective variation.**
- **They are similar enough that we can use them synonymously.**

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SO, WHAT'S MY MENTAL HEALTH PERSPECTIVE?

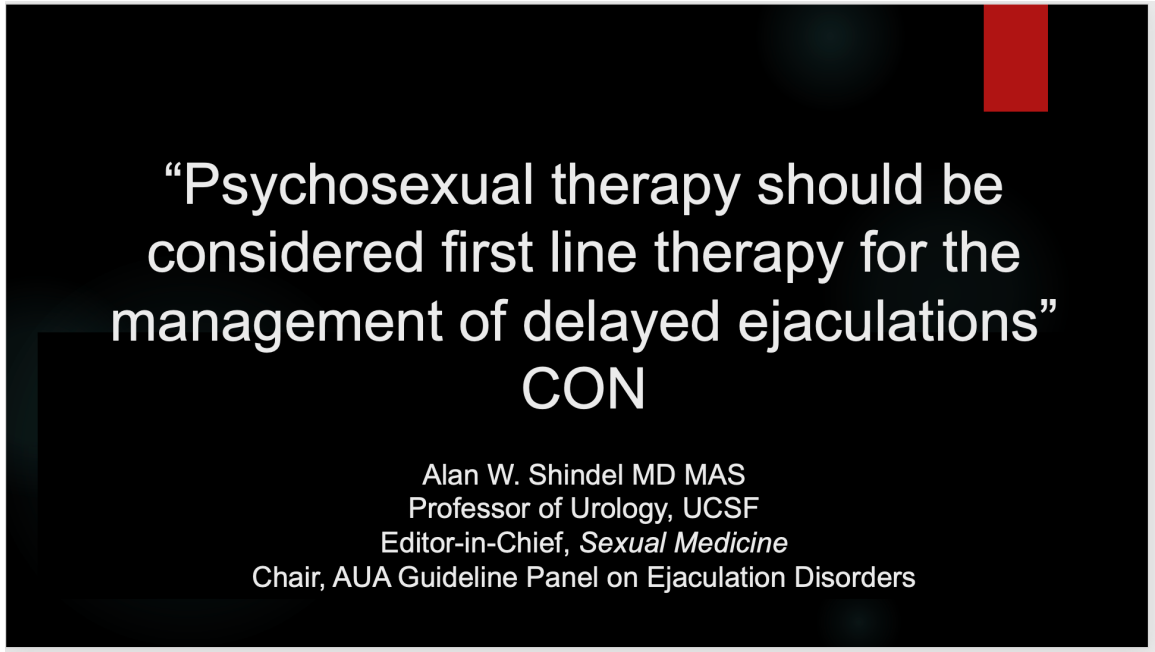
Perelman Disclosures

Company	Position	Financial	Relationship Type		End Date
MAP Education and Research Foundation	Founder & President of this 501(c)(3) public	No	Leadership	8/1/12	present
Springer Publications	Emeritus Editor in Chief, Current Sexual Health Reports	No	Health Publishing	10/1/12	present
Palatin	Self	Yes	Consultant, Advisor, or Investment Interest	2/2/09	present
Roman	Self	Yes	Consultant, Advisor, or Investment Interest	1/3/19	present
Sprout	Self	Yes	Consultant or Advisor, Investment Interest	6/12/13	present

There is one additional disclosure:

Alan Shindel, MD, SMSNA, November 2022

"There are scant data on MAP's approach!"

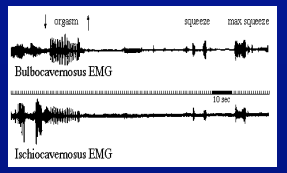


He lost the debate, but he had some good points!

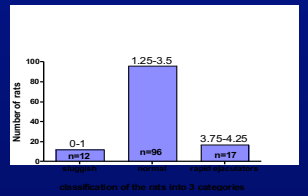
BIOLOGICAL FACTORS

A SLUGGISH REFLEX?

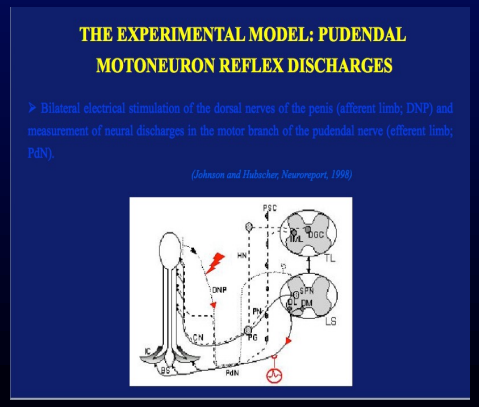
Genetic latency variations



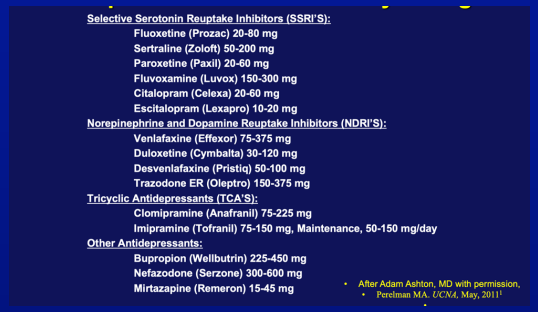
WISTER RATS



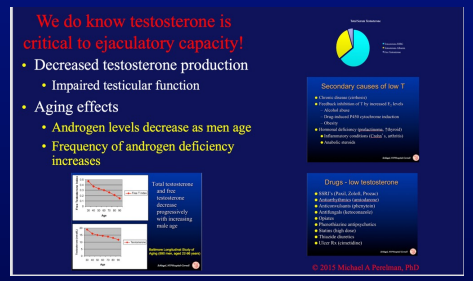
PUDENDAL NERVE RESPOSNE VARIATIONS

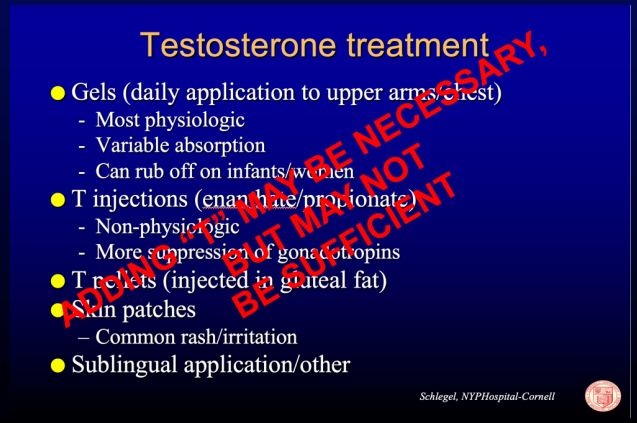


ANTIDEPRESSANT SIDE EFFECTS

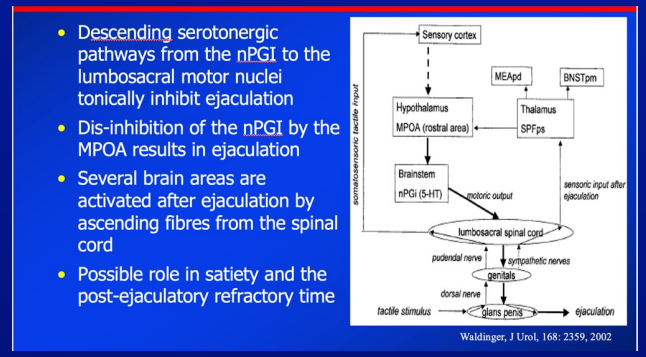


ANDROGENS

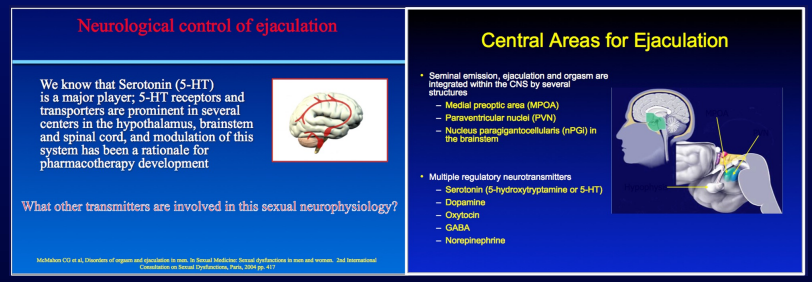




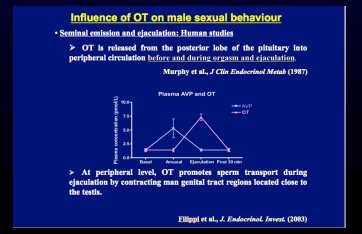
CENTRAL FACTORS CAN BE INVOLVED



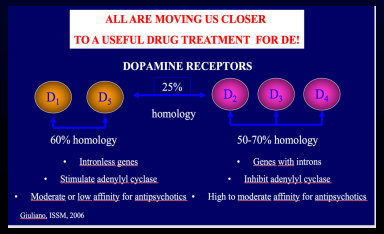
There are predispositions that may be caused by by 5-ht sensitivity, or be related to other neurotransmitters



OXYTOCIN?



DOPAMINE?



"Antidotes" For Sexual AE's Found In The Literature[1]

Frequently Suggested Antidotes, based on limited evidence:

Amantadine (Symmetrel) 100-200 mg
Buspirone (Buspar) 20-60 mg
Cyproheptadine (Periactin) 4-12 mg
Gingko Biloba 120-240 mg
Granisetron (Kytril) 2 mg
Yohimbine (Yocon, Aphrodyne) 5.4-32.4 mg

Larry Levine & Irwin Goldstein

- Cabergoline/Dostinex:
- potent dopamine receptor agonist
- direct inhibitory effect on prolactin
- higher affinity for D_2 receptor sites

Stimulants:

Methylphenidate (Ritalin, Concerta, Focalin and others) 15-60 mg
Mixed Amphetamine Salts (Adderall) 15-60 mg
Dextroamphetamine (Dexedrine) 10-60 mg

Phosphodiesterase Type 5 Inhibitors:

Sildenafil (Viagra) 50-100 mg
Tadalafil (Cialis for use as needed) 10-20 mg, (Cialis for daily use) 2.5 mg and 5 mg
Vardenafil (Levitra) 10-20 mg

* After Adam Ashton, MD with permission, Perelman MA. *UCNA,* May, 2011[1]

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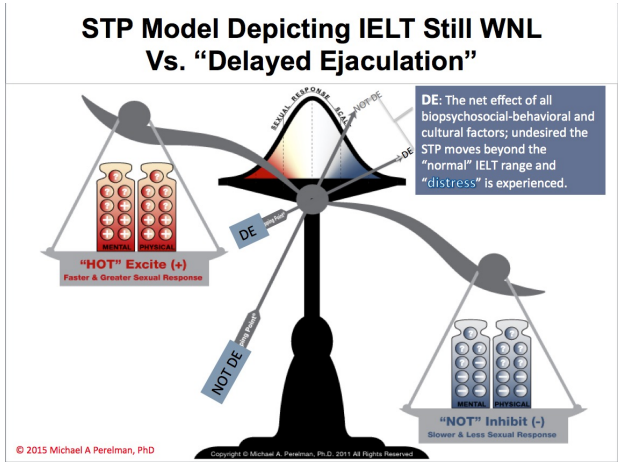
BOTTOMLINE:
THERE IS NO FDA APPROVED DRUG TREATMENT FOR DE!

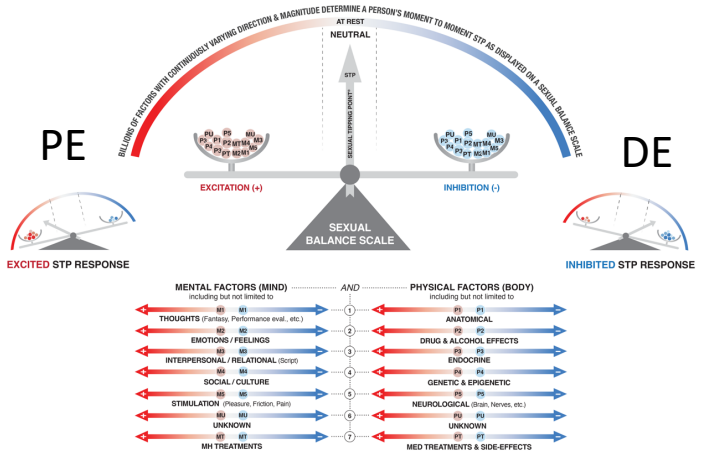
* After Adam Ashton, MD with permission, Perelman MA. *UCNA*, May, 2011

Besides those biomedical factors, for years I have tried explaining that your DE patients also have psychosocial, behavioral, cognitive and cultural, predisposing, precipitating, maintaining, and contextual factors which trigger, reinforce, or worsen DE probability.

Why some men and not others?

- Ejaculatory thresholds vary across men and across situations as do other sexual disorder thresholds, all described by my Foundation's Sexual Tipping Point Model.
- I have tried teaching everyone how the STP & sex coaching could be used in a transdisciplinary manner to treat all sex disorders!





ELSEVIER
The Journal of Sexual Medicine
Volume 15, Issue 12, December 2018, Pages 1667-1672

Invited Commentary

Sex Coaching for Non-Sexologist Physicians: How to Use the Sexual Tipping Point Model

Michael A. Perelman PhD

BUT TO BE HONEST, NOT ALL OF YOU HAVE BOUGHT INTO IT!

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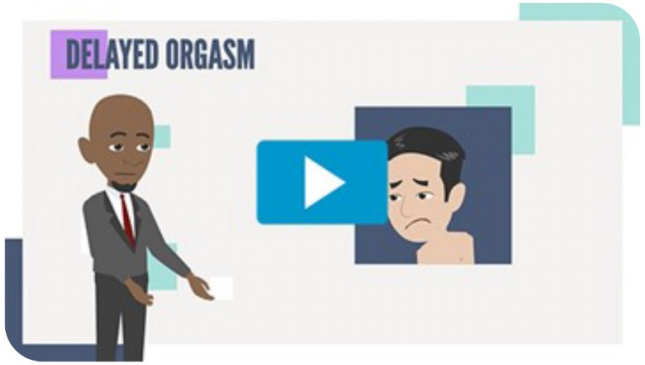
SO THIS YEAR, I AM UPPING MY GAME, BY REFERRING TO A RECENT, SMSNA, DE VIDEO BY OUR PROGRAM CHAIR, DR. JENKINS!



DR. JENKINS WISELY SUGGESTS YOU ASK ALOT OF QUESTIONS WHEN TREATING DE!

- HAVE YOU ALWAYS STRUGGLED TO REACH ORGASM DURING SEXUAL ACTIVITY?
- IF NOT, WHEN DID YOU START EXPERIENCING DIFFICULTIES?
- DO YOU HAVE TROUBLE REACHING ORGASM ALL THE TIME, OR ONLY IN CERTAIN SITUATIONS?
- CAN YOU GIVE ME AN ESTIMATE OF THE TIME IT TAKES FOR YOU TO EJACULATE FROM THE START OF SEXUAL STIMULATION?
- DOES THIS HAPPEN ONLY WITH A PARTNER OR ARE YOU ABLE TO ORGASM WITH MASTURBATION?

He has some good ones, but here is another way to think about it.

Patient Education Videos / February 10, 2023

WHAT TO DO FIRST?

- Take a. focused sex history or a "sex status," as it will expose psychosocial-behavioral & cognitive reason(s) for DE such as: insufficient penile or psychological stimulation, high frequency and/or idiosyncratic masturbation, preference for masturbation over partnered sex, and psychological conflict regarding ejaculation, e.g. pregnancy concerns.
- These issues often combine and overlap.

  - Ask specific questions like:

    " Tell me what you mean by DE."

    " What do you think is causing this problem?"

  - Listen & question further based on your available time.

https://www.auanet.org/guidelines/guidelines/disorders-of-ejaculation, accessed 2021.10.15

Perelman, M, Invited Commentary: Sex Coaching for Non-Sexologist Physicians: How to Use the Sexual Tipping Point Model. *The Journal of Sexual Medicine*, Vol.15, Issue 12. Dec. 2018.

Althof SE, Rosen RC, Perelman MA, Rubio-Aurioles, E. "Standard Operating Procedures For Taking a Sexual History." Journal of Sexual Medicine, September 2012;

Best Possible Practice: DE

- **Your approach will vary with new patients versus established patients who have been with you for years.**

WHAT YOU WILL FIND

- Overwhelmingly, the DE cases you see are SITUATIONAL DE:
  - "Only occurring with certain types of stimulation, situations, or partners."
  - The vast majority of DE patients are complaining about DE during coitus and can ejaculate with self-stimulation.
  - The following information will allow you to help many men with DE, often without the need for drugs and may also negate the need for a mental health referral!

Perelman, TAU, 2016

Perelman MA. *Int J Impot Res.* 2005;15(suppl 50:S67-S

Perelman, In Balon & Segraves, 2005

Perelman, In Goldstein, FSD, 2005

Office Management Of Delayed Ejaculation

- Obtain a “masturbation status” with questions regarding his self-stimulation including frequency and technique:

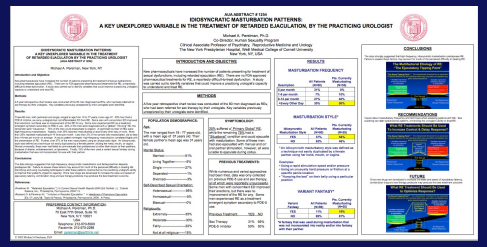
  - Ask about: speed, pressure, teasing, “special spot”
    - how does his technique change as orgasm approaches.

You can get even more specific:

- Does he use lubricant, is it a dry… an object, e.g. cloth?
- Time to ejaculation once he begins stimulating himself?
- Can he speed it up and reduce that time? How?
- Has anything about it changed over time?
- Location & body position, e.g. lying down, standing, sitting
- Atypical techniques, e.g. grinding forcefully against the bed.

If You, Or Your Patient Are Uncomfortable With These Questions

RECOGNIZE FOR YOURSELF, AND TELL HIM:



IIUA ABSTRACT # 5330

IDIOSYNCRATIC MASTURBATION PATTERNS:
A KEY UNEXPLORED VARIABLE IN THE TREATMENT OF RETARDED EJACULATION, BY THE PRACTICING UROLOGIST

Michael A. Perelman, Ph.D.
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Clinical Associate Professor, Department of Medicine and Urology
The New York Presbyterian Hospital, Weill Medical College of Cornell University
New York, NY, USA

INTRODUCTION AND OBJECTIVES

METHODS

RESULTS

MASTURBATION FREQUENCY

MASTURBATION STYLE*

CONCLUSIONS

RECOMMENDATIONS

"Accumulating evidence indicates men suffering from DE, masturbate in a manner that is different from how their partner's hand, mouth, vagina or anus feels."

"Understanding how you stimulate yourself and how it differs from your partnered experience will help me assist you."

If still uncomfortable, use my brief Psychology Today Blog that summarizes "idiosyncratic masturbation's" role in the etiology of DE called:

"Why Delayed Ejaculation Is More Common Than Folks Realize."

URL: https://www.psychologytoday.com/us/blog/sexual-tipping-point/201812/why-delayed-ejaculation-is-more-common-folks-realize

Two Questions About His Masturbation Are Critical

Most important questions:

1. " What feels different when you self-stimulate yourself vs how it feels when your partner stimulates you?
2. "Specifically what physical sensations and thoughts are different?"

You are wondering if there are "arousing" thoughts during masturbation

versus his thoughts before, & during coitus:

*erotic vs anti-erotic intrusive thoughts:

"It's taking too long!" "it's not going to work.'

High Frequency & Idiosyncratic Masturbation

BTW, The AUA Guidelines chaired by Dr.Shindel notes:

- "some men report ….high-frequency masturbation, and/or an
  - idiosyncratic masturbation style (i.e., referring to speed, pressure, and intensity that do not mimic sensations during intercourse),

- BTW: Ejaculation frequency can be a primary cause of DE especially as men age.
- With age, some men used to higher masturbation frequency can no longer sustain it, with out losing the ability to ejaculate with their partner.

https://www.auanet.org/guidelines/guidelines/disorders-of-ejaculation, accessed 2021.10.15

Treatment of DE: Frequency, Friction, Fantasy!

If you have time?

- Has he communicated his preferences to his partner?
  and if so, what was their response?

- You're likely to identiy:
  - **A disparity is too great between his masturbation fantasy or porn preference(s), and the reality of partnered sex?**
    - **Is he attracted to his partner at this time**
    - **Does he actually want to have sex with his partner**
- Is there:
  -Insufficient partner stimulation…OR…
  - An over-rehearsed masturbation pattern? "She doesn't do it right!"
  TIP " Which hand do you use… OK, can you O using the other one?"

Office Management Of Delayed Ejaculation

IF GIVES THE PREDICTED ANSWER “NO”, THEN WHAT?

Whether you are a urologist with 5 minutes
or a sex therapist with 45 minutes,

YOU CAN TELL HIM:

1. “Regrettably, your masturbation conditioned you to respond to very specific stimuli.”
2. “No wonder you have this problem, anyone might!”
3. “Do you know the most important step to help solve your problem?”

TELL HIM THE ANSWER:

- **"You need to temporarily stop masturbating, and not have an orgasm unless it is with your partner"**
- **OR, " If you insist on continuing to masturbate, only do so if your partner is present."**

- Help him agree to decrease ejaculatory frequency while finding ways to increase the quality of friction and erotic thought.
-Typically, he must temporarily suspend masturbatory activity and limit ejaculatory release to his/their goal activity: Usually coitus.

THEN ASK: " Can you do that… are you willing ?

THE EVENTUAL SOLUTION: Adjusting his body and mind when he's with his partner so sensation and erotic thoughts become as stimulating as when he masturbates."

This may not suffice to solve the problem entirely .

But partnered sex now has increased probability of success.

Office Management Of Delayed Ejaculation

HERE ARE SOME COACHING RESPONSES I HAVE USED:

- "What would help you get more lost in the moment, be in the zone." – provide a sports or race car analogy-speed…?
- "OK to be more aggressive… position yourself and move in a way to maximize your own pleasure. Do not S/S!
- " Be more selfish and do not worry about her. She will take care of herself and/or you can learn how later!"
- "Not allowing your partner to experience you having an orgasm is more selfish, then not focusing your lovemaking on her!"

- If he won't stop masturbating temporarily; negotiate a frequency reduction with no orgasm allowed within 72 hours of partnered sex.
- When he does masturbate, he must change technique (e.g. switch hands) OR AGAIN: ONLY MASTURBATE IN HIS PARTNER'S PRESENCE!

Exception

- The exception to the above are the limited number of primary DE cases.
- Psychosocial factors still contribute, but biological causation risk is higher.

- Then AUA guidelines recommending a physical exam and/or laboratory testing, must be added to the always necessary focused sex history.

- Etiological factors including but not limited to anatomic, hormonal, neurologic, iatrogenic, and pharmaceutical factors must then be ruled out.

But even with primary DE it is not always biological:
CASE: “Do you ever move?”

https://www.auanet.org/guidelines/guidelines/disorders-of-ejaculation, accessed 2021.10.15

THANK YOU FOR LISTENING!

And thanks to my friend Dr. Shindel for his good sense of humor
and for Chairing the AUA Committee
" Guidelines On Ejaculation Disorders," which recommended:

"Clinicians should consider referring men diagnosed with lifelong or acquired delayed orgasm to a mental health professional with expertise in sexual health."

Complete guidance on tx DE can be found at mapedfund.org, which offers free download of all materials needed under the PRESENTATIONS & PUBLICATIONS drop down MENU.

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