From *Principles and Practice of Sex Therapy, Sixth Edition*.
Edited by Kathryn S. K. Hall and Yitzchak M. Binik.

CHAPTER 7

Delayed Ejaculation

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Of the two endpoints on the spectrum of male ejaculatory disorders, premature and delayed ejaculation (DE), DE is much less common, and much less commonly understood. Perelman observes that the "psychological and interpersonal impact of DE is often not appreciated by clinicians, who sometimes misperceive and fail to diagnose this condition." In Chapter 7, Perelman explains the physiology of male orgasm and ejaculation, then, using his own sexual tipping point model, describes and reviews assessment and treatment approaches specific to DE. Accurate diagnosis and effective intervention often rely on both understanding a man's idiosyncratic masturbation patterns and exploring differences between arousing sexual fantasies and the perhaps not so arousing reality of partnered sex. Treatment entails the transfer and translation of effective solo sexual stimulation to partnered sexual activities. Perelman is optimistic that "individually nuanced sex therapy" is the best treatment option for men suffering from DE.

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Delayed ejaculation (DE) is a less common and an often misunderstood male sexual dysfunction. Although this chapter focuses on DE, there is a full spectrum of "male ejaculation/orgasm dysfunctions," ranging from premature ejaculation (PE) through various diminished ejaculatory disorders (DEDs). These other DEDs encompass dimensions of reduced ejaculatory volume, force, subjective sensation, direction, as well as the very rare postorgasmic illness syndrome[1] (Perelman, 2018a; Perelman, McMahon, & Barada, 2004; Waldinger, 2016). Historically, there has been considerable confusion about DE nosology, labeling it "retarded ejaculation," "inhibited ejaculation," "inadequate ejaculation," "idiopathic ejaculation," "anejaculation,"[2] "anorgasmia," "male orgasmic disorder," and so forth. Some of these terms were determined to be pejorative and/or inaccurate among members of the sexual medicine and sex therapy communities. There is current consensus to use "delayed ejaculation" to describe the disorder in which men find it difficult or impossible to ejaculate and/or experience orgasm (Segraves, 2010; Abdel-Hamid & Ali, 2018).

Men with DE usually have no difficulty attaining or maintaining erections, can often ejaculate with masturbation, and frequently present for treatment with a partner-related complaint. Men with DE usually report less coital activity, sexual dissatisfaction, lower subjective arousal, anxiety about their sexual performance, and suffer more general health issues than do sexually functional men. They often report feeling "less of a man," and have higher levels of relationship distress (Abdel-Hamid & Saleh, 2011; Perelman & Rowland, 2006). Some partners initially enjoy the extended intercourse duration. However, they may eventually experience pain, injury, and/or distress, and question their own desirability: "Does he really find me attractive?" Although initially blaming themselves, partners sometimes become angry at the perceived rejection. Finally, men with DE may fake orgasm to avoid negative partner reaction(s).

DE has been considered a clinical rarity since the beginning of sex therapy, with low prevalence rates reported in the literature (rarely exceeding 3%) (Laumann, Paik, & Rosen, 1999; Perelman & Rowland, 2006). However, DE rates will likely rise secondary to demographics, particularly ejaculatory decline secondary to age-related diseases (e.g., prostatic hypertrophy) and the medications used to treat them (Perelman, 2003a; Georgiadis et al., 2007). Despite rates remaining low relative to other male sexual dysfunctions, millions of men worldwide suffer from DE.

[1]Those suffering the postorgasmic illness syndrome (POIS) become ill with flu-like symptoms after ejaculation, whether immediately or within 24 hours, regardless of the type of stimulation triggering the ejaculation.

[2]Anejaculation is the complete absence of ejaculation. Medical approaches, typically employed for infertile men, include the collection of nocturnal emissions, penile vibratory stimulation, probe electroejaculation, sperm retrieval by aspiration from either the vas deferens or the epididymis, and testicular sperm extraction.

The psychological and interpersonal impact of DE is often not appreciated by clinicians, who sometimes misperceive and fail to diagnose this condition. There are no U.S. Food and Drug Administration (FDA)-approved treatments for DE; physicians often report finding it difficult to treat, and when attempting to do so, generally report poor results (Perelman & Rowland, 2006). Yet, four decades of clinical research and practice by myself and others suggest that many of these men can gain the necessary skills to overcome their suffering from this disorder (Perelman, 2016a; Blair, 2017). To be sure, not all therapists have found this to be the case, as suggested by a reader's response to the blog: "Why Delayed Ejaculation Is More Common Than Folks Realize."

> "I (55) have suffered from the inability to ejaculate with a partner all my life. . . . Most if not all my partners would freak out and start asking questions like 'don't you find me attractive?' or 'don't I turn you on?' To say this has caused sexual unhappiness is an understatement. . . . When having 'one off' sex with a stranger or paid sex I didn't suffer with the inability to ejaculate . . . only when having sex for the 2nd or 3rd time with the same woman that the sexual dysfunctions would crop up. . . . Married in my late 30s, sexual functioning with my wife was very bad and it caused a lot of friction. . . . We spent a few years going from Sex Therapist to Sex Therapist. . . . Finally, my wife told me we were wasting out [*sic*] money and that we just have to learn to live with the situation. . . . the marriage has been sexless now for 15 years. I never had any problem when masturbating . . . my only way to get sexual release. I wouldn't wish this terrible sexual dysfunction on my worst enemy." Signed, Al Q.[3]

Both implicit and explicit information contained in Al's "response" could lead to treatment strategies that would improve the situation for Al and his wife. My purpose in this chapter is to offer therapists reading this chapter enough understanding of DE's assessment and treatment to enable them to provide successful assistance when confronted with a similar patient themselves.

The Physiology of Ejaculation and Orgasm

Ejaculation is a reflex that can be anticipated through recognition of premonitory sensations that often include but are not limited to increased heart rate, breathing, muscle tension, and pleasure. Ejaculation itself is a process that involves emission, bladder neck closure, and expulsion of fluid (often erroneously presumed to be the only indication of ejaculation). During emission, seminal fluid is delivered to the posterior urethra. Sympathetic innervation controls the emission, as well as contraction of the bladder neck to prevent retrograde ejaculation. During expulsion, the bulbocavernosus muscle and

[3]Posted to the *Psychology Today* "Sexual Tipping Point" blog, February 27, 2019 (*www.psychologytoday.com/us/blog/sexual-tipping-point/201812/why-delayed-ejaculation-is-more-common-folks-realize*).

pelvic floor muscles contract to expel semen in an antegrade fashion through the urethra. In general, this reflex is mediated by both sympathetic and somatic neural inputs, as well as sensory inputs. Many neurotransmitters such as dopamine, norepinephrine, and especially serotonin are known to have roles in ejaculatory physiology. Genetically predetermined ejaculatory thresholds have a prodigious impact on ejaculatory ease and latency time, and are distributed in a manner similar to a number of other human characteristics (Abdel-Hamid & Ali, 2018; Perelman, 2009; Waldinger, 2011). The timing of a particular ejaculation is the result of a multitude of medical, psychosocial, behavioral, and cultural factors that influence the biologically predetermined range (Perelman & Rowland, 2006).

As noted earlier, male orgasmic disorder and anorgasmia are distinct but related conditions to DE, as ejaculation and orgasm usually occur simultaneously, despite being separate physiological phenomena. Orgasm is usually coincident with ejaculation, but is a central sensory event that has significant subjective variation, most often characterized as very pleasurable sensations followed by feelings of well-being and lessened tension. While I focus in this chapter on DE, both arousal and ejaculation have other subjective components independent of orgasm, and some patients do need to increase awareness of their sensations during preejaculatory stimulation (arousal), ejaculation itself, and orgasm. There are numerous parallels between male and female orgasmic disorders, with controversy over varying emphases when discussing their respective subjective and physiological processes.[4] There are some men who report orgasm (sometimes "multiple") without ejaculation. Many of these individuals are typically pleased with that capability, cultivated (often rehearsed during masturbation) using an "edging" process.[5] Both men who attempt "edging" and/or those men who misunderstand "stop–start" PE treatment methods may seek professional help when they fail to properly distinguish between premonitory sensations and emission. Their attempts to "stop" and interrupt stimulation are "too late." Both situations result in a "partially retarded ejaculation," in which fluid dribbles from the urethral tip and orgasmic sensations are diminished (Perelman, 2017).

To summarize, men who describe themselves as suffering from DE may also experience diminished orgasmic sensations or report a complete lack of orgasm. The workup for all these conditions is quite similar in terms of the initial diagnostic procedures, and treatment is primarily a consequence of the data gained from history taking. I intermittently discuss male orgasmic disorders in the context of the subjective elements associated with ejaculation, but for simplicity's sake, I focus in this chapter on the etiology, diagnosis, and

[4]For some men who suffer from male orgasmic disorder and/or DE the "mindfulness" techniques can be integrated with this chapter's treatment recommendations, but describing the variability and specifics of such integration is beyond this chapter's scope.

[5]Stimulation that brings one to the "edge" of an orgasm with interruptions to that stimulation (often several) before finally achieving orgasm; meant to intensify orgasm, volume of ejaculate, and force of ejaculation.

treatment of DE, as this is the complaint of the preponderance of men seeking assistance for DEDs.

Definition and Diagnosis

The third International Consultation on Sexual Medicine (ICSM) defined DE as an intravaginal ejaculatory latency time (IELT) threshold beyond 20–25 minutes of sexual activity, accompanied by negative personal consequences such as bother or distress (Althof & McMahon, 2016; McCabe, Althof, Assalian, Chevret-Measson, Leiblum, et al., 2010). The 20–25 minutes IELT criterion was chosen because it represented greater than two standard deviations above the mean found in the "worldwide" normative studies. That research, with heterosexual males in stable relationships (the only large studies available to date), found an approximate 5–6 minutes median IELT (Patrick et al., 2005; Waldinger, McIntosh, & Schweitzer, 2009). Those IELT population studies had helped form the basis for the earlier ISSM ejaculation disorder definitions (McCabe et al., 2016; Serefoglu et al., 2014; Waldinger et al., 2005, 2009).

Perelman (2016b), disagreeing with those groups' conclusions, observed how overemphasizing limited quantitative evidence led to artificial narrowing of diagnostic classifications. Since male ejaculatory latency data display a very large range, too restricted a focus on a temporal criterion may limit access to care. Current quantitative evidence only documented a global average heterosexual IELT; many men have sexual experiences that are not limited to heterosexual penile/vaginal thrusting (e.g., noncoital heterosexual and homosexual sexual acts), which should also be incorporated into DE definitions.

Perelman (2016b) emphasized the substantial evidence that satisfactory sexual experiences and the distress related to both PE and DE are probably mediated more by perceived control over an ejaculation (including manual, oral, coital, and anal stimulation regardless of the partner's gender) than by its latency time (Gagnon, Rosen, McMahon, Niederberger, Broderick, et al., 2007; Perelman, 2016a, 2016b). For those requiring a quantitative metric for global research and regulatory requirements, Perelman suggested an approximate, bilateral one standard deviation from the male majority's average IELT be used as one of three criteria in defining either PE or DE, thus providing consistent criteria for these two most commonly treated ejaculatory disorders (Jern, Gunst, Sandqvist, Sandnabba, & Santtila, 2011; Perelman, 2016a, 2016b).[6] DE can be diagnosed when a patient reports either an inability to achieve ejaculation or a prolonged ejaculatory latency (IELT greater than 10 minutes) *as long*

[6]This suggestion served as a compromise to those researchers who believed, correctly or otherwise, that a quantitative temporal metric was necessary for global studies, clinical trials, and government regulatory agencies. Such a compromise avoids negating or minimizing what clinical research and practice teaches about the more important factors of control and distress.

as the patient also indicates a perceived "lack of control" and "distress." For instance, a man who ejaculates in 15 minutes, who is not distressed, would not be diagnosed with DE. However, a man who is unable to ejaculate during coitus within 10 minutes, who desires to do so (consistent with the majority of other men, i.e., ~65%), and subjectively experiences "no choice" (control) and is distressed, could be diagnosed as suffering from DE.

The fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; 2013) does not have a quantitative latency metric, and the condition is labeled "delayed ejaculation" instead of the previous DSM manual's "male orgasmic disorder." Despite the diagnostic label, the DSM-5 definition also includes those cases in which male ejaculation is not only delayed but also does not occur at all or occurs only infrequently. As is true with all the DSM diagnoses of sexual dysfunction, the problem must be distressing to the individual and be fairly stable, manifesting during the majority of occasions over a significant duration of time (at least 6 months). The DSM diagnostic criteria encourage the exploration of the context in which DE manifests, including sociocultural, relational and medical factors (American Psychiatric Association, 2013).

The World Health Organization's (2019) recently approved *International Classification of Diseases* (ICD-11) also does not require an IELT temporal criterion as part of its definition of DE. ICD-11 defines DE as an inability to achieve ejaculation or an excessive or increased latency of ejaculation, despite adequate sexual stimulation and the desire to ejaculate. The pattern of delayed ejaculation needs to have occurred episodically or persistently over a period at least several months and be associated with clinically significant distress (World Health Organization, 2019). Whereas DSM labels them "Specifiers" and ICD-11 offers temporal, situational, and etiological "Qualifiers," both manuals allow for further subcategorization based on assessed etiology (i.e., medical, psychosocial, drug sequela, relationship, cultural, and other unspecified factors).

In conclusion, although debate continues over how much emphasis should be placed on both quantitative and qualitative evidence, most sex therapists and a growing number of urologists support the view that the personal impact of the disorder on a man and his partner, in terms of control and distress rather than time, should be considered the more important parameters when diagnosing both PE and DE (Patrick, Rowland, & Rothman, 2007; Perelman, 2016b; Perelman & Rowland, 2006; Althof & McMahon, 2016; Waldinger et al., 2009). Sex therapists will also recognize that men who seek treatment, even when their latency complaint does not meet the previously discussed standards to be formally diagnosed with DE, are still deserving of compassionate and empathic care.

Etiology

Psychological Factors

Early psychoanalytic explanations saw DE as an outgrowth of psychic conflicts suggesting malingering, unconscious, and unexpressed anger, whereas

other theories suggested that men with DE are "unwilling" to receive pleasure. Some dynamic theorists attributed DE to fear of semen loss, of the female genitalia, or of hurting the partner through ejaculation. Other factors historically discussed as contributing to DE include anxiety, depression, lack of confidence, and poor body image (Perelman & Rowland, 2006). Alternatively, Apfelbaum (1989) considered DE to be a desire disorder specific to partnered sex, believing that these men prefer sex with themselves rather than partnered sex. From a cognitive-behavioral perspective, pejorative and distracting cognitions (negative "self-talk") interfere with the positive subjective pairing of thoughts and entrancement with pleasurable genital stimulation sensation, thus resulting in insufficient excitement for climax even when an erection is maintained. All of the these dynamics may play a contributory etiological role (Perelman, 2014) and examples of how these factors contribute to DE are incorporated into the case study presented later in this chapter.

Social/Cultural Factors

Masters and Johnson (1970) suggested that some men's DE is associated with orthodoxy of religious belief. Sociocultural and/or religious beliefs may limit the sexual experience necessary for learning to ejaculate (e.g., masturbatory prohibitions) and may result in DE (Perelman, 2014).

Masturbation

Perelman (1994) recognized the very important role that both insufficient stimulation and masturbation played in the etiology of DE. An update of an earlier review of over 300 charts from my clients with a DE diagnosis (45 years of practice) continued revealing three masturbatory factors associated with DE (Perelman, 2005).[7] Sometimes the unsettling disparity between a man's sex with his partner and his sexual fantasies (whether or not unconventional) used during masturbation resulted in DE secondary to insufficient arousal (Perelman, 2003b, 2014, 2016a, 2018a). That disparity took many forms, such as body type, sexual orientation, the specific sex activity performed, and partner attractiveness (Perelman, 2003b; Perelman & Rowland, 2006). The second most common association was high-frequency masturbation, which, of course, is a relative metric. A masturbatory frequency that impedes ejaculatory capacity via male refractory mechanisms will vary between men as a function of both innate biological capacity and age. To date, there are no definitive evidence-based data to help guide the clinician's judgment beyond expert opinion and the clinician's own experience.

DE is correlated with high-frequency masturbation, a factor particularly relevant when aging men erroneously presume they can engage in partnered

[7]Some clients in the last 20 years, despite using oral erectile medications that produced adequate erections for coitus, were still unable to ejaculate, as they remained insufficiently erotically aroused (Perelman, 2014).

sex successfully while simultaneously maintaining the masturbatory frequency they did when younger. However, the most common behavioral factor causing DE was an "idiosyncratic masturbatory style," an expression I coined in 1994 and defined as a sexual stimulation technique not easily duplicated by the partner's hand, mouth, or vagina (Perelman, 1994). Such men engage in patterns of self-stimulation notable for one or more of the following idiosyncrasies: speed, pressure, duration, body posture/position, and specificity of focus on a particular "spot" in order to produce orgasm/ejaculation (Perelman, 2016b; Perelman & Rowland, 2006). Learning theory readily explains how such patterns may have conditioned these men and subsequently raised the probability that alternative forms of stimulation would be inadequate to produce an ejaculatory response (Bandura, 1969). In fact, it is surprising that despite a chief complaint of DE and clinical manifestations of penile irritation and erythema, men's masturbation patterns remain unexplored by so many clinicians (Abdel-Hamid & Saleh, 2011; Perelman, 2018a). It is important to note that, almost universally, these men fail to communicate their stimulation preferences to their partners (or to professionals) because of shame or embarrassment (Perelman, 1994, 2005, 2016a, 2017). Sex therapists should be certain to avoid the error of not inquiring about masturbation habits.

Interpersonal Issues

Numerous other communication/relational conflicts that can result in DE are discussed more fully in the section on assessment. However, two particularly noteworthy partner issues deserve specific mention: fertility and anger/resentment. Clinicians from various theoretical persuasions have correctly noted pregnancy concerns among men with DE, and have also observed how treatment seeking is often tied to a female partner's wish to conceive (Perelman & Rowland, 2006). Distress is often greatest when conception "fails," yet fear of pregnancy leads some men to avoid dating or to avoid sex altogether (Perelman, 2018a).

Fertility related or not, patient–partner anger is an important factor that can be both a direct cause and a maintainer of sexual dysfunction. Anger acts as a powerful anti-aphrodisiac. While some men avoid sexual contact entirely when angry, others attempt to perform, only to find themselves insufficiently aroused and unable to function. Besides perceiving rejection, some partners suspect men with DE of infidelity. These trust issues evoke pejorative consequences for both partners. Misguided accusations and questions regarding the man's sexual orientation can also be especially pernicious. Such tensions often lead to avoidance of partnered sex entirely as feelings of disconnection increase (Perelman, 2016a).

Biomedical Factors

A number of somatic conditions other than those causing infertility can account for DE, as any procedure or disease that disrupts sympathetic or

somatic innervation to the genital region has the potential to interfere with ejaculation and orgasm. Neurological and endocrine disorders, including spinal cord injury, stroke, multiple sclerosis, pelvic-region surgery (including but not limited to prostatectomy), severe diabetes, alcoholic neuropathies, and hormonal abnormalities, can all cause DE (Sullivan, Stember, Deveci, Akin-Olugbade, & Mulhall, 2013; Abdel-Hamid & Ali, 2018). Consequences of aging (whether organic and/or psychosocial) are significant risk factors for many sexual disorders, and DE is no exception (Lindau et al., 2010). Medications (tamsulosin, alfuzosin, silodosin, etc.) for benign prostatic hypertrophy and medication, even in low doses, for baldness inhibit alpha-adrenergic innervation of the ejaculatory system and are thus associated with DE (Vale, 1999; Witt & Grantmyre, 1993; Sadowski, Butcher, & Brannigan, 2016). Finally, both depression and the pharmaceuticals often used to treat it (presumably serotonin-mediated) can lead to DE (Segraves, 2010; Nurnberg et al., 2008). Comprehensive tables listing all such agents and many antihypertensive, anti-adrenergic agents, and antipsychotic drugs that can cause ejaculatory delay are readily available online (Sadowski et al., 2016).

The Sexual Tipping Point Model

Biopsychosocial models are often described as "the gold standard" because of their recognition of the "complex interplay of biological, psychological, interpersonal, and sociocultural factors . . . which are . . . the foundation for clinical theories and paradigms including the sexual tipping point, the dual-control model, and systemic sex therapy" (Rullo, Faubion, Hartzell, Goldstein, Cohen, et al., 2018). There are a number of popular biopsychosocial models used to comprehend sexual function and dysfunction (Bancroft, Graham, Janssen, & Sanders, 2009; Basson, 2005; Giraldi, Kristensen, & Sand, 2015). Kaplan, 1995; Levin, 2017; Perelman, 2009; Pfaus, 2009). My preferred model to explain the etiology of any sexual dysfunction, including DE, is the Sexual Tipping Point (STP) model, which also provides a pathway for diagnosis, treatment, and follow-up (Perelman, 2009, 2016c). The STP is defined as the interaction of constitutional sexual capacity with the various biomedical, sexual, relational and cultural factors that determine a sexual response. Evidence supporting the STP model as a clinical and teaching heuristic is currently limited to expert opinion. The STP model is neither binary nor categorical; instead, it illustrates the full spectrum of all the exciting–inhibiting mental and physical factors intrinsic to sexual response and its disorders (Perelman, 2018a, 2018b). As such, it is best described as a "variable switch" model, reflecting our increasing knowledge about the human body (Perelman, 2018a, 2018b). The factors can be described as "sliders" (*mapedfund.org*) or as "dimmer switches," as illustrated in Figure 7.1. Two pans, labelled "Excitation" and "Inhibition" each hold two pairs of interconnected containers. The "Mental" containers include, but are not limited to, factors related to cognition, emotion, social/interpersonal factors, and culture. The "Physical"

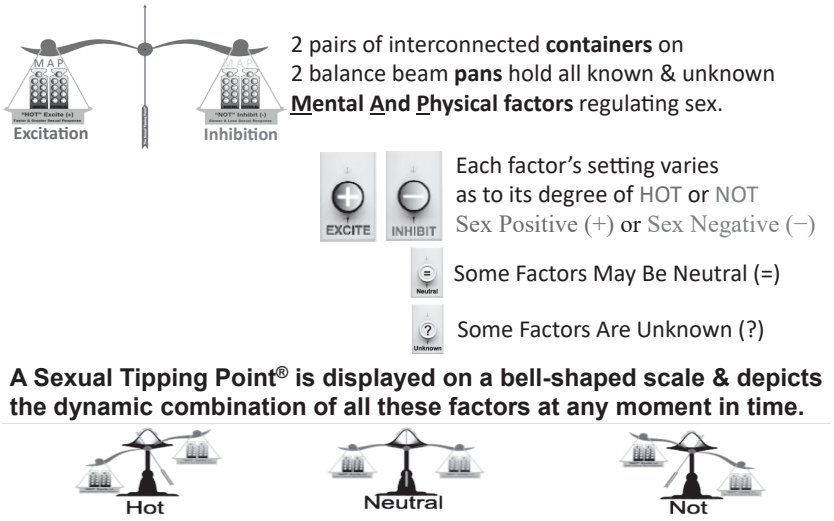

FIGURE 7.1. Key to the symbols used in the STP model. Circles inside the Mental And Physical containers represent dimmer switches, whose varying intensity and polarity contribute to the STP. Used with the permission of the MAP Education and Research Foundation (*mapedfund.org*). Copyright © 2018.

containers include, but are not limited to, factors related to anatomy, genetics, endocrinology, drug(s), disease, surgery, and the environment. These Mental And Physical containers symbolically then, hold all of the exciting (+) and inhibiting (–) factors that influence male ejaculatory response.[8] Each of these factors (dimmer switches) is variably charged, and has varying intensity as to the degree it contributes to a man's manifest sexual response at any moment in time. Some of these factors may also be neutral (=), while others have not yet been discovered (?). The STP reflects the net sum of all Mental And Physical factors displayed on a balance scale. Even when manifest DE symptoms appear to be the same, it is hypothesized that a range of conflicting forces dynamically maintain it. These key factors become the treatment targets.

Evaluation and Functional Assessment

Neither pathophysiology nor psychogenic etiology should be assumed without both medical investigation and a focused psychosexual history (our most important therapeutic tool). Evaluation of a man with DE should uncover

[8]The capitalization of "And" is meant to reflect the fact that the line between mental and physical is porous, since thoughts become translated into biochemical electrical components.

underlying potential physical, psychological, and any learned causes of the disorder. For me, evaluation is primarily a functional assessment, and the preferred methodology is a focused sexual history taking or a "sex status exam" (Perelman, 2003b). Such a focused interview process helps rule out the probability of anatomical, hormonal, neurological abnormalities and pharmaceutical causes by identifying a time line that juxtaposes circumstances in which ejaculation was/is successful with those where it was/is not. A comprehensive sexual history, along with an understanding of the current level of sexual functioning (the sex status), can differentiate DE from other sexual problems by reviewing the conditions under which the man can ejaculate. The problem's developmental course should be noted, including variables that improve or worsen performance (particularly those related to psychosexual arousal). If orgasmic attainment was possible previously, life events and circumstances temporally related to ejaculatory changes should be reviewed. Events in question may include pharmaceuticals, illness, or a variety of psychological stressors.

Questions that are especially relevant for the evaluation of DE include (1) "What is the frequency of your masturbation?"; (2) "How do you masturbate?"; (3) "In what way does the stimulation you provide yourself differ from your partner's stimulation style, in terms of speed, pressure, and so forth?"; and (4) "Have you communicated your preference to your partner(s), and if so, what was the response?" It is also important to assess the patient's subjective experience during solo and partnered sexual activity, including the degree to which he is focused on arousing thoughts and pleasurable sensations versus anti-erotic intrusive thoughts (e.g., "It's taking too long!"). Follow-up questions may be asked to give greater specificity to the putative role of masturbation in the disorder and to clarify other, relevant etiological factors. Perceived partner attractiveness, the use of fantasy during sex, anxiety surrounding coitus, and masturbatory patterns all require meticulous exploration. Important causes of DE might be identified by juxtaposing the patient's cognitions, sense of pleasure, and the sexual stimulation he experiences during masturbation (including fantasy, watching/reading pornography) with a partnered experience. Some patients might balk at these personal questions, but once they are assured that research has shown that such information is critical to successful outcome, refusal to answer is rare.

As a recent sexual experience is explored in depth, the patient is likely to indicate the relevance of partner issues. Look for implicit or explicit expressions of either anger or hurt feelings, which are often antithetical to good sex and can result in DE. Relationship issues can cause/exacerbate DE and must be ruled out and/or explored. Such factors include, but are not limited to, power struggles, intimacy blocks, poor communication, and inadequate conflict resolution skills. Successful treatment benefits from a supportive available partner; however, sex therapists should be sensitive to patient preference regarding partner participation, as patient and partner cooperation is more critical to successful treatment than partner attendance at office visits

(Perelman, 2018a). Sexual and relationship inventories in general, and even those specific to ejaculation, such as the Male Sexual Health Questionnaire (Rosen et al., 2004), improve research methodology but in my experience provide only limited diagnostic enhancement.

In addition to the aforementioned inquiries, the sexual history should include questions regarding previous treatment approaches, including the use of herbal therapies and home remedies, and if there was any benefit. Referral for medical evaluation, usually by a urologist, is especially important in those cases in which the DE is generalized (occurring across all situations, including masturbation) whether primary (lifelong) or secondary (acquired). Typically, a urologist would conduct laboratory studies including a genitourinary examination that may identify physical anomalies, as well as contributory neurological and endocrinological factors (Corona et al., 2010; Corona, Jannini, Vignozzi, Rastrelli, & Maggi, 2012). While abnormally low androgen levels are frequently referenced in medical literature as a typical cause of DE, recent scientific evidence indicates that for men who are able to ejaculate with masturbation, routine androgen evaluation is not necessary (Morgentaler et al., 2017). The exam and medical history also help to rule out organic causes of DE related to trauma sequela, whether from an accident, surgical complications, or other iatrogenic causes.

It must be emphasized that dichotomizing etiology and diagnosis into classifications such as psychogenic and biological are too categorical. Genetic predispositions affect the typical speed and ease of ejaculation for any particular organism; however, many of these components are influenced by past experiences and present context. By the end of the evaluation session(s), it should be possible to offer the patient a formulation that highlights the immediate cause(s) of his problem, and a treatment plan that instills hope may thus be formulated (see Figure 7.2).

Treatment

A variety of techniques have been used alone or in various combinations to treat DE. Those historically used by mental health professionals have included, but are not limited to, sex education, psychodynamic exploration of underlying conflicts, and/or couple therapy, cognitive-behavioral therapy, mindfulness, and of course, a variety of sex therapies. The goals of therapy for DE are evoking higher levels of psychosexual arousal and pleasure within a mutually satisfying experience. Current sex therapy approaches usually emphasize integrating a behavioral masturbatory retraining within a nuanced sex therapy (Apfelbaum, 1989; Masters & Johnson, 1970; Perelman, 2003b; Perelman & Rowland, 2006; Sank, 1998).

It is useful to help men with primary DE learn to identify their sexual arousal preferences through self-exploration and stimulation. Masturbation training for men is similar to models described for women with anorgasmia,

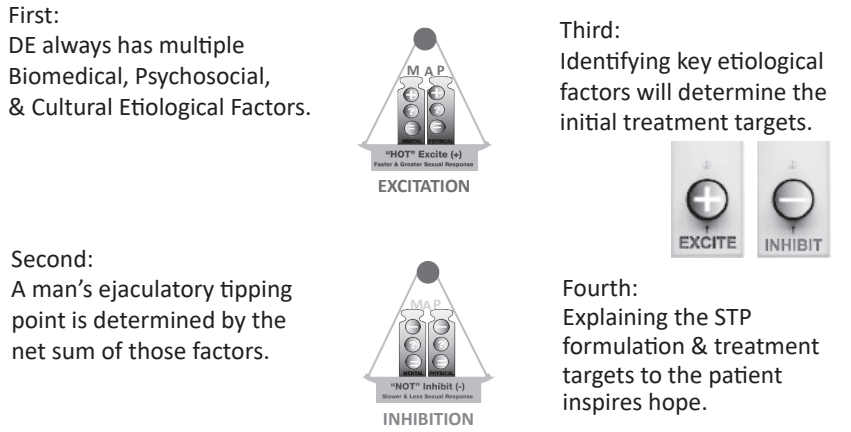

FIGURE 7.2. Use of the STP model in treatment formulation. Used with the permission of the MAP Education and Research Foundation (*mapedfund.org*). Copyright © 2018.

but the use of vibrators, often recommended by urologists, is rarely needed (Nelson, Ahmed, Valenzuela, Parker, & Mulhall, 2007; Perelman, 2016a). Masturbation exercises progressing from neutral to pleasurable sensations (without ejaculation initially) can remove the "demand" aspects of performance (Apfelbaum, 1989). Fantasizing can help block thoughts that might otherwise interfere with arousal. In general, a clinician should validate (not encourage) an autosexual orientation when encountering it in a man, as this helps remove the stigma that DE is a form of withholding from a partner. General anxiety reduction techniques may also be helpful in treating some men with DE. Finally, couple therapy, when appropriate, often involves encouraging the man and his partner to share their sexual preferences, so that the needs of both are met.

Therapy for secondary DE shares similarities with treatment for primary DE. However, patients with secondary DE are rapidly counseled to suspend masturbatory activity *temporarily* and limit orgasmic release to their desired goal activity (usually coital orgasm). Reducing or discontinuing masturbation (typically requiring ~14–60 days) often evokes patient resistance. Temporarily refraining from ejaculating alone usually causes a man's need/desire for release to increase, as his threshold for ejaculation decreases, thus making it easier to ejaculate during partnered sex. Recently, during the first conjoint session, a 60-year-old man in a 6-month relationship with a 55-year-old woman he cared for deeply realized how unaware he was of her emotional pain over his lack of coital ejaculation. In sex therapy, he spontaneously acknowledged his hidden masturbation pattern, which was immediately upsetting to her, but was mollified by his equally immediate willingness to temporarily stop

it completely on my suggestion. Stopping was difficult for him, but he also risked sharing what kind of foreplay (oral stimulation) he wanted from his partner for the first time, and she surprised him with her eagerness to provide it. They postponed the subsequent session, as they wanted more time for themselves to process and put into effect what they had learned. They canceled the following session again, but both called separately to thank me for their now revitalized sex life, which, within 3 weeks, included twice weekly coitus, with orgasm for them both. A 6-month follow-up call to each of them indicated that they were now living together happily, having coitus with mutual orgasm weekly, and his masturbation occurred only on business trips, making sure to leave at least a 72-hour abstinence period for their next mutual sexual encounter. Curtailing solo masturbation is most typically not sufficient to solve the problem on its own, but the probability for success during partnered sex is increased greatly.

The clinician must provide support to ensure compliance for a solo masturbation hiatus and can emphasize that the need for such restraint is only temporary and not a permanent injunction against masturbation. Sometimes the amount of time away from solo masturbation must be negotiated and a compromise reached, although it is worth noting that an unwillingness to at least consider doing so is diagnostic of poor motivation and a negative prognostic signal. When a patient refuses to stop solo self-stimulation, I typically negotiate a masturbation frequency reduction, with a minimum commitment of no ejaculation within 72 hours (expert opinion) of the next partnered experience. A man who insists on continuing to masturbate alone may continue to progress as long as his normal routine is disrupted, and he is encouraged to alter style (e.g., "switch hands"). Instead of his familiar pattern, he is instructed to try and approximate the stimulation likely to be experienced from his partner (Perelman, 2016a; Perelman & Rowland, 2006). The goal is to limit his orgasmic outlet from his easiest current ejaculatory capacity (usually a specific style) and "shape" it progressively to approximate the desired partnered experience. This is typically followed by his learning to ejaculate from manual, then oral, and finally coital stimulation from his partner, as each provides differing sensations, although that will vary based on the couple's sexual script and perception as to what is erotic.

Besides suspending noncoital orgasmic release, initially at least, the patient should use fantasy and bodily movements during coitus that approximate the thoughts and sensations experienced in masturbation. Single men should use condoms during masturbation to rehearse "safe sex." Sexual fantasies may be realigned, so that thoughts experienced during masturbation better match those occurring during coitus.

In addition to this, considerable reassurance is required for men and their partners who suffer from DE secondary to aging. As men age, there is an expected lengthening of ejaculatory latency, lengthening of their refractory period, and inconsistency of both ejaculatory and orgasmic attainment. Accepting this knowledge is critical in helping men avoid the antisexual

thoughts that will inhibit ejaculation/orgasm from taking place if more is expected from an aging body than is reasonable.

Medical Treatments

There are no drugs proven to treat DE, as there is no evidence beyond reported anecdotal success in decreasing ejaculatory latency, and there are no pharmaceuticals approved for DE by the FDA. However, for a detailed description of drugs (and the rationale for choosing them) that many physicians prescribe for DE, despite the low level of evidence supporting such treatments, the interested reader should seek out selected references (e.g., Abdel-Hamid & Ali, 2018; Butcher, Welliver, Sadowski, Botchway, & Köhler, 2015; Butcher & Branigan, 2016; Butcher & Serefoglu, 2017). Additionally, testosterone (T) was also considered as a first-line treatment, but unless T levels are meaningfully below normal levels, this has not proved to be helpful (Abdel-Hamid, Elsaied, & Mostafa, 2016; Morgentaler et al., 2017). Researchers have also explored other "antidotes" such as yohimbine; however, this research was typically confined to animal experiments (Carro-Juáreza & Rodríguez-Manzo, 2003). To date, research has failed to identify a drug that will decrease orgasmic latency for patients whose compliance is challenged when experiencing antidepressant-induced DE, although some experts still believe that Wellbutrin holds promise for some (Clayton et al., 2004; Blair, 2017; Perelman, 2018a).

Case Discussion

Jack, 59, sought treatment, complaining of progressively more severe DE of a few years' duration, as well as more recent ED. His urologist (whom he first consulted) hoped that prescribing sildenafil would help both Jack's DE and ED, but as is so often the case, a sole pharmaceutical approach was insufficient. Initially, sildenafil did help restore Jack's erections, but understandably, it did not improve Jack's DE, as his ED was secondary to his DE rather than the reverse. Ironically, sildenafil had indirectly even made Jack's DE worse, as will become evident below. In his initial phone call to me, Jack reported, "The Viagra is not working at all."

During the first sexual status interview, Jack indicated (referencing penile vaginal intercourse), "Even if I get inside, I can't cum. . . . I love my wife [Jill, 58], and she still looks great!" Further inquiry indicated Jack was distracted during sexual activity, with negative thoughts (e.g., "Oh, sh*t, this will not work again"). As such, his arousal level never reached an STP sufficient for him to ejaculate, even when his sildenafil-assisted erections allowed for coitus, let alone once he actually began losing his erections. Initially, he and his wife became upset when coitus lasted more than 20 minutes with no ejaculation at all many times. He importantly reported that he was avoiding partnered sex,

and masturbated secretly, which unfortunately was making coital DE more probable. While very distressed about his DE and his erections, Jack was eager to restore "what was a great sexual relationship" between himself and Jill, his wife of 20 years, with whom "I have a wonderful marriage." The sex status had revealed a lack of any direct foreplay for Jack beyond kissing and cuddling, as he only concentrated on Jill. He quipped, "I never needed it before." Again, he was unable to keep any erotic thoughts in mind when attempting coitus, even with a sildenafil-assisted erection.

Jack was confused about why he was not able to ejaculate during coitus: "My wife is unhappy and questions if I still am attracted to her. It's just not like it was." I explained about the normal need for more direct sexy stimulation (friction) and thoughts (fantasy) as one ages, using the illustration in Figure 7.1. At the end of the evaluation, I suggested that he masturbate while taking his prescribed sildenafil, and that he experiment with erotica. He was to take his time and make it fun, and not a test. Jack's confidence was boosted as we spoke. He seemed hopeful and optimistic. Jack said Jill was eager to have sex with him, and she reportedly wanted to participate in the sex therapy. We scheduled a follow-up couple appointment, with an option for Jill to have some individual time if desired.

Jack began the second session, reporting, "Good news and bad. . . . Masturbating with the Viagra worked well! But a few days later we tried having sex. . . . I got an erection using Viagra but still couldn't come!" I asked them to describe their last sexual experience in detail, which is a great question for initiating follow-up discussions. Jill interrupted Jack as he began to speak and asked if she could speak with me alone. Jack left the room temporarily.

Jill expressed desire to be with Jack, mentioning how pleasing the foreplay was, but grimaced when discussing their coital failures. She cried, "I want sex because it used to be so good. When it goes on for so long now, it starts to hurt, and I lose interest. . . . We are so confused." She indicated that her own orgasms, usually experienced during oral sex foreplay, were now more muted since menopause, and that initially, "menopause hit me like a ton of bricks . . . hot flashes, the whole nine yards." Not surprisingly, she indicated that it now took longer to lubricate and become aroused. When I reassured her of these being normal, age-related changes, she cried and indicated that aging bothered her, and she wanted back what they used to have. "His erection and ejaculation problem is just making the whole thing worse. My gynecologist says it's normal to stop at our age. I tried the lubes she suggested, but he felt less, and it still hurt." Jack rejoined us and self-consciously admitted he was aware that sex was hurting her now. He clearly felt guilty knowing this, but with her encouragement, he would try intercourse anyway. They reported never talking explicitly about her pain, but it was clearly an additional distraction and worry for them both.

The case was formulated using a typology of immediate, midlevel, and remote factors using the STP model. The primary immediate factor contributing to Jack's DE and ED was his lack of adequate stimulation, both mental

("I'm hurting her . . . ") and physical (no foreplay for him). He had never needed much foreplay previously, and mistakenly was not seeking it now when his aging and continued masturbation had diminished his ejaculatory and later his erectile capacity.[9] His positive sexual thoughts were being overwhelmed by his inhibiting cognitions of "failure" and causing his wife pain, negating his arousal and thus also limiting his ejaculatory capacity, even when erect with assistance from sildenafil. I believed that temporary continued use of the sildenafil would provide increased assurance that his erections would remain adequate even if he had some intermittent negative thoughts. His rate of detumescence would be reduced by the pharmaceutical restriction of blood outflow. As his confidence increased, his sexual thoughts (fantasy) would be unchallenged by a diminished prevalence of inhibiting ones. Combined with more effective physical stimulation (friction), both sustained erection and ejaculation would be more probable.

Importantly, both partners were clinging to their previous sexual script in which his erections and subsequently their sex together was automatic and spontaneous. Reeducation regarding that script and other age-related themes were initiated from the beginning and continued throughout treatment. Jack and Jill agreed to a "no intercourse" rule until further notice, which reduced performance pressure on them both. Their initial attempt to pursue their old script of coitus almost as soon as an erection appeared required correction. Jack was to masturbate again (with Jill's knowledge) in order to increase awareness of his own likes–dislikes, so that he could eventually communicate them to Jill, who was eager to learn more about what pleased him. She was previously unaware of his masturbation and had alternated between thinking she was no longer attractive to Jack and worrying that something was wrong with Jack physically. Jack was told he would be weaned from sildenafil during treatment, as it would probably not be necessary long term, but to initially continue with his doctor's prescription to help facilitate erectile maintenance. During that ensuing 3-week period, in response to my suggestion for further medical evaluation, Jill's gynecologist prescribed dilators and an estrogen-based cream, which Jill used diligently. She very quickly found that her pain with penetration diminished and began experiencing orgasms while doing so.

The sex therapy continued, and by the fifth session, Jack reported being able to orgasm from Jill's manual stimulation. The previous week, he had masturbated himself in her presence. A few days later, she had learned to use a similar technique to bring him to erection and ejaculation. During this fifth session, Jack was now told to temporarily desist from masturbating until further notice. She had effectively communicated techniques she wanted him to use when stimulating her during foreplay, which resulted in her experiencing "better orgasms than ever!" They were instructed to repeat that exercise and assured that their expressed desire to incorporate oral stimulation into their

[9]As men age, the latency of their refractory period for both erection and ejaculation increases.

"outercourse" pleasuring was fine. The "no penetration" rule, in combination with limited sexual frequency (no more than once weekly was instructed), increased their biological need/capacity when stimulating each other both manually and orally.

The following week, they reported "no sex at all. . . . Other responsibilities and life got in the way." This often happens during sex therapy. During the course of treatment, other issues did emerge, which were managed directly using a problem-solving cognitive-behavioral approach that I always integrate into the sex therapy. This method simultaneously models how to keep "sex alive" in the face of normal life stressors. Jill was helped with a variety of matters, including her job, management of her "disabled" sister, and issues surrounding her grown children from her previous marriage. Jack was assisted with his stress about various work challenges. All of this was managed within the aforementioned weekly, 45-minute conjoint sessions. As couples begin to improve sexually, it is useful to use session time to help stabilize and ensure continuation of the progress being made by beginning to deal with issues that might potentially trigger a relapse.

At their seventh visit, Jack and Jill sheepishly reported successful "unauthorized intercourse" with mutual orgasms. They were delighted and pleased with their progress, and since the sex was so good, they decided to try again the next day. Not surprisingly, Jill was tender, and while Jack was able to become erect and orgasm, she experienced pain, and in the session she expressed concern for their future. Reassurance, education about how age-related sequela may limit sexual frequency, reminders about "outercourse" options, and guidance on the use of lubricants were all suggested and accepted.

The next weekend, Jill initiated sex when they returned home after dinner. They had successful intercourse with mutual synchronous orgasms. This occurred again the following week. Enhancement techniques (e.g., teaching clitoral stimulation by self or partner with guidance as to positions) were discussed during the next few sessions. As their sex life improved, so did their mood and confidence. Jack was asked to wean himself from the sildenafil with his urologist's concurrence over the next 3 weeks. Treatment concluded after three more sessions spaced over 8 weeks (during which time Jack weaned himself successfully from sildenafil) with a follow-up session scheduled for 6 months later.

I always try to schedule a follow-up session, as it seems to help keep the lessons learned more predominant in patients' minds. If there is a relapse and patients have not returned earlier for reasons of shame/embarrassment, it allows them to show up "disgrace" free. In this case, the news was good, and the couple reported an average of three successful intercourse experiences per month, with occasional manual or oral sex to orgasm occurring for variety's sake. They enthusiastically reported that their general stress levels about sex were lessened, and that it was "no longer a big deal at all. . . . We no longer need to 'line up our ducks' so everything was just so, like you taught us in sex therapy. . . . Instead it is kind of like it was in the good old days. . . . yet

somehow a bit different . . . less intense and automatic but in a nice relaxed way."

Treatment Outcome

I offer the case of Jack and Jill not to suggest that DE can always be treated so successfully, but rather to emphasize the importance of obtaining specific sexual experience data throughout evaluation and subsequent sessions, because of their profound ability to direct the course of treatment and influence outcome. Successful treatment depends on the patient's willingness to follow therapeutic recommendations, which are influenced by the extent of organicity, relational issues, and potentially deeper patient–partner psychodynamics. Naturally, more complex cases require more time for treatment.

Additional Obstacles to Therapeutic Success

Despite being the patient–partner's initial goal, coital ejaculations, once obtained, may be surprisingly disappointing, less pleasurable, and less intense than masturbatory ejaculations for some men. Sometimes these men need clinician support to express their preference for noncoital ejaculations, especially when their coital ejaculations are less satisfactory and only obtained by painstaking effort (Perelman, 2017). An additional common pitfall for the sex therapist to remain alert for is when treatment is experienced as being mechanistic and/or insensitive to the partner's needs and goals. Understandably, a female partner responds negatively to the impression that man is essentially masturbating with her body as opposed to engaging in connected lovemaking. Indeed, some men are emotionally disconnected from their partners. The clinician must empathically help the partner become comfortable with the idea of temporarily postponing the desired intimacy level during sexual activity, while simultaneously encouraging the importance of making intimate connections outside of sex to help mitigate the partner's sense of rejection. Once the patient is functional, the clinician can encourage a man–couple toward greater overall intimacy, presuming that is what they desire. Sometimes both partners may be disconnected from each other but are otherwise in a stable relationship they deeply value. In such cases, it is important that the therapist support patients' goals, and not push the man (couple) toward the clinician's own preordained concept of a relationship.

As mentioned in the section on etiology, fecundity issues can meaningfully complicate treatment. Women (and sometimes men) often resist any suggestions that may cause a delay to their plan to conceive. For some couples, fertility issues can be bypassed by using artificial insemination with the husband's sperm supplied by masturbation, as treatment for DE often requires that coitus be postponed. As a rule of thumb, a clinician who suspects that the patient's DE is related to conception fears should note any disparity between

sex when contraception is used and "no contraception" sex. If the DE only occurs during "unprotected" sex, the clinician can assume that impregnation reluctance is a primary variable. Fertility issues typically require individual and often conjoint work with the man and his partner. Resolution of the conflict can be challenging.

Often the most difficult cases are men suffering sexual sequelae subsequent to seriously debilitating diseases such as prostate cancer, whether treated surgically, medically, or with radiation. Here the previously deprecated vibratory devices become more necessary, as greater intensity of stimulation is required secondary to the damage caused by the disease and/or its treatments (Nelson et al., 2007; Tajkarimi & Burnett, 2011). Sex therapists may find themselves extremely challenged when rehabilitating a response that is severely anatomically limited. As described in the fifth edition of this text, a patient treated for postprostatectomy changes was helped to face his own limitations: "It used to feel like a jet engine. . . . It became a "paperclip" after surgery. You've got me back to a prop plane and that is what I need to live with." Certainly, the greater the anatomical damage, the more psychotherapy facilitates adjustment to the loss rather than restoration of function (Perelman, 2014).

Conclusions

In summary, high-frequency idiosyncratic masturbation, sometimes combined with fantasy–partner disparity, can predispose men to experience problems with arousal and ejaculation. These factors occur disproportionately in many patients who will be seen by sex therapists, but a clinician's approach to DE must always be an individualized one, based on a focused history. Clearly, a good "sex status" will help identify a variety of key factors (the previously discussed masturbation-related ones and others) that result in diminished arousal, leading to an inability to ejaculate. The sex therapist must identify and prioritize these targets. An individually nuanced sex therapy that is derived from an appreciation of all potential factors determining the multidimensional etiology of the patient's DE, as well as multidisciplinary cooperation within an integrated treatment, is the optimal approach. The STP model can provide a useful framework for helping the patient (and partner) understand DE etiology, diagnosis, and treatment. The sex therapist can explain simply how the mental and physical erotic stimulation a man is receiving is insufficient for him to ejaculate in the manner he prefers, and how this can be changed to achieve the desired result. Successful treatment will depend on the patient's willingness to follow therapeutic recommendations, which, of course, will be influenced by the extent of organicity, his psychodynamics, and relational issues.

For now, many sex therapists do report good success rates (as high as 75%) when treating DE (Masters & Johnson, 1970; Perelman, 2017; Perelman

& Rowland, 2006). However, their results should be viewed as exploratory, albeit encouraging. Althof and Leiblum (2016) note the difficulty in evaluating sex therapy treatment outcomes, because the published studies use small samples, uncontrolled, nonrandomized methodologies, and lack validated outcome measure. Disparity between the results of different professionals may well reflect clinically different treatment populations. Only well-designed multicenter clinical trials will establish a more definitive answer. Nevertheless, at present, sex therapy remains the best option for men suffering from DE.

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