COMMENT

Comment on “Similarities and differences between men with self-reported lifelong and acquired difficulty reaching orgasm.”

Michael A. Perelman [1,2]✉

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This is an invited commentary on “Similarities and differences between men with self-reported lifelong and acquired difficulty reaching orgasm” [1]. In their study, individuals with symptoms of delayed ejaculation (DE) were identified from large online populations. The DE individuals were classified as “acquired” or “lifelong” sufferers, and the authors performed a series of statistical comparisons between these two groups. The manuscript is very well written, and statistical methods appear sound. While the study effectively acknowledged its limitations, many are a function of its internet survey methodology; a structure that can fail to offer clinically meaningful information. Those limitations highlight some important issues that require further investigation and inquiry.

This commentary will highlight three points for consideration for both the study’s authors and *IJIR* readers. First, the use of the common classification system terms “acquired vs. lifelong” requires further consideration by all of us. The study’s methodology does not allow for the exploration necessary to answer many of the key questions discussed in its Introduction section, especially regarding the role of predisposition in the etiology of DE. Second, the conclusion that the subject’s self-rating of anxiety as their orgasmic difficulty’s primary cause does not in and of itself prove that anxiety is indeed the primary cause of their difficulty reaching orgasm, as suggested by the article’s conclusion. Alternatively, it may reflect inadequate self-awareness for men themselves, as well as limitations regarding the options the survey offered. This author proposes that reframed questions and offering of alternative answer choices would result in “inadequate stimulation” emerging as the primary obstacle to successful functioning during partnered sex. Therefore, a future study for these well-suited investigators could undertake would be is to identify the differences in greater detail between men who can masturbate successfully and orgasm during partnered sex, vs. men who are only able to orgasm during masturbation and not with their partners. For sex therapists and many urologists, the latter is the most common clinical presentation independent of whether there are other confounding medical, surgical, and/or pharmacological concurrent etiological factors. The experimental methodology used in this current study failed to obtain that critical information, which would be best accomplished by a directed assessment of the man’s perception of the differences in his experience with masturbation (when he typically reaches orgasm) vs. the experience he has with a partner(s) where he is unable to orgasm and/or finds difficulty doing so. Such an assessment regarding stimulation he is using must include inquiry into the differences in his cognitions during those experiences as well as a detailed investigation into the behavioral differences in terms of type of stimulation, wet, dry, intensity, speed, and location concentration, etc. [2, 3]. While the information obtained by Rowland et al. [1] is useful, a specific assessment of masturbatory style, technique, and thought processes is critical for a comprehensive clinical evaluation and treatment of this type of secondary DE.

“LIFELONG” VS. “ACQUIRED” VS. “PRIMARY” VS. “SECONDARY,” VS. “GENERALIZED” VS. “SITUATIONAL”

In their study, the authors [1] request that respondents characterize themselves as suffering from “lifelong” vs. “acquired” DE. The subjects were divided into subtypes, but the most common situational subtype comparisons were not adequately included: men who orgasm with masturbation but are unable to orgasm with partners vs. men who cannot orgasm at all regardless of who is providing the stimulation. Men who can orgasm themselves with masturbation, but never with a partner, suffer from a situational “lifelong” disorder, but must be differentiated from men who cannot orgasm regardless of who provides the stimulation can also suffer from a “lifelong,” but generalized disorder. Assessing the differences between these two lifetime subtypes is critical to understanding etiology and for treatment planning and intervention strategies.

In Rowland et al. [1], the selection of lifelong vs. acquired, which was based on the subjects’ self-reports, did not recognize the subtle distinctions required for understanding how biological predisposition works, whether based on neurology, endocrinology, anatomy, or otherwise. The study tended to be dismissive of threshold theory as a predisposing DE factor. However, such dismissal is unfounded if one considers how multiple etiological factors intermix in ways that are unique to individuals and can become lost when viewing large cohort data. The nature of the threshold or predisposition could be both lifelong and acquired, depending on the specific circumstances. Ejaculatory latency and orgasmic capacity are spread in a cloud-like manner that typically cluster around a mean. A predisposition to an ejaculation disorder determined by genetic factors, such as a hereditary condition affecting the nervous system or hormonal regulation, might be lifelong if the disorder manifests itself from birth in all situations.

[1]Human Sexuality Program, Psychology in Psychiatry, Reproductive Medicine & Urology, Weill Cornell Medicine, NewYork-Presbyterian, New York, NY, USA. [2]MAP Education & Research Foundation (mapedfund.org), New York, NY, USA. ✉email: drpnyc@mac.com

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In other individuals, a genetic predisposition will only manifest when triggered. Examples might be nerve damage from surgery or trauma, side effects from certain medications, or even high stress levels, for the disorder to shift from latent to manifest. Under such circumstances, the biological predisposition is "lifelong," but the diagnosis applied to the symptom would be "acquired." One could easily postulate that the differential impact of medication's side effects on orgasm will trigger a disorder in some and not others because of a biological predisposition of greater or lesser sensitivity based on threshold theory. Similarly, even with a genetic predisposition that would be considered lifelong (resulting in a disorder for some), others would require that cognitive (erotic vs. non-erotic thoughts), behavioral (type of stimulation), or relational triggers be present to shift the latent orgasmic disorder to a manifest one. In such cases, the symptom would also be diagnosed as secondary and acquired. Often, it is the categorical parsing that is the problem when dealing with thresholds that are distributed continuously rather than threshold theory itself.

The Sexual Tipping Point® (STP) model accounts for such unique and multidetermined etiology and how such combinations can result in a disorder for some based on predisposition, while not impacting others, as the thresholds for different variables interact with each other to produce manifest symptoms [4]. The STP expanded biopsychosocial model illustrates (see mapedfund.org) how some men may be more vulnerable on a "lifelong" basis to the impact of a predisposing factor on their ability to delay or accelerate their ejaculatory latency time. In other words, predisposing latent threshold reasons would cause them to react to a particular medication (a serotonin activating/deactivating one for instance) more severely than other men do. In this manner, a man might find either DE or premature ejaculation symptoms triggered, and that manifest behavioral change would then be diagnosed as "acquired," yet the underlying etiological predisposing condition would be "lifelong." The predisposing factor would be contributing to a "primary" condition, and the change in the latency symptom would be "secondary" to the introduction of a medication that triggered it. Such multilayered concepts are regrettably convoluted to describe and complicated to understand. However, attempts to simplify and provide objective data using surveys like the ones employed by Rowland et al. [1] do not allow for the collection of the data necessary for a nuanced understanding. However, a sophisticated clinician could obtain the needed information (via a qualitative focused sexual history or sex status) to help patients better understand and cope with the new found distressing symptoms. So, rather than suggesting that the data do not support a threshold hypothesis as implied in the Rowland [1] study, we need to suspend judgment until a more sophisticated study and analysis is provided.

"ANXIETY/DISTRESS" IS CONFOUNDED WITH "INADEQUATE STIMULATION"

In this [1] and in another study, Rowland et al. identify "anxiety/distress" as the primary self-attributed cause for the subjects' acquired orgasmic disorder [5]. However, a study that provided a thorough examination of subjects' concurrent cognitions during a given sexual experience might suggest that anti-erotic performance-oriented "fear of failure" related thoughts are the primary culprit in underlying the subjects' reported emotions of anxiety/distress regarding their failure to reach orgasm. In other words, evaluation of erotic vs. anti-erotic thought is a critical component of assessment when dealing with delayed/inadequate orgasmic disorders, which in the end would be labeled "inadequate stimulation" or the net effects of both mind and body.

Rowland et al. [1] documented that younger men tend to use more pornography and tend to be more likely to have a lifelong vs. an acquired orgasmic disorder. But pornography helps focus the mind on erotic thoughts, while simultaneously blocking/minimizing the distracting anxiety-inducing anti-erotic thoughts that he may experience in partnered sex. While the subjects remember the anxiety/distress, they may remain oblivious to the role thought plays in triggering their feelings and impacting their bodies emotions and behavior. So, helping a man focus on erotic thoughts (with or without pornography) when he is with a partner becomes crucial if one wants to assist a patient to orgasm with a partner vs. solo masturbation. Often, rather than using pornography with a partner (the suggestion of which can trigger "resistance"), he can be taught to focus on what he finds most attractive about his partner, the sensations of pleasure he is receiving, or by fantasizing about good sexual past experiences, or even what he likes best when watching pornography. Bottom-line, sexual thought and sexual stimulation need to be increased with a partner to match or at least approach the level of stimulation received during solo masturbation.

DIFFERENCES BETWEEN SOLO MASTURBATION AND PARTNERED SEX

In the introduction to this Commentary, this author emphasized a critical study that Rowland et al. [1] would hopefully undertake to identify in detail the differences between men who can masturbate successfully and orgasm during partnered sex vs. men who are only able to orgasm during masturbation and not with their partners. In an article published in another journal and using a similar data set, Rowland et al. wrote: "DE can be lifelong or acquired; it presumably has physiological/somatic, pathophysiological, and/or psychological origins" [5]. That study concluded similarly to this current study: "Men who have difficulty reaching ejaculation/orgasm identify putative reasons for their problem, ranging from anxiety/stress, inadequate stimulation, and low arousal to partner issues and medical reasons." While those are all key distinguishing factors characteristic of DE, the suggestions made in this Commentary's previous section on "inadequate stimulation" would help a future study to recognize some additional salient questions for inquiry when assessing the differences between the two subtypes. What follows though is a single critical question that should always be asked in such studies and in clinical practice, although there will be multiple answers that typically all need follow-up: "In what way is your experience different when engaging in masturbation vs. partnered sex?" Answering is often difficult for men as it requires an awareness of what they are doing to arouse themselves (both their erotic thoughts and physical technique) that often does not exist when engaging in masturbation, given its typically over-rehearsed nature: "it just seems to work fine." Answering about partnered sex may be difficult for the opposite reason: "it just doesn't feel the same and doesn't work." A knowledgeable clinician must pursue and help the person focus on the different types of stimulation he experiences from a partner and not just the physical, but his own difference in cognitions as the experience is happening. Such an approach to treating orgasmic disorders is spelled out in detail in several of this author's publications [2–4] but it would be wonderful to have Rowland and his team of researchers investigate this in a manner that would provide objective evidence to help support this reported clinical experience.[a, b] To date, at least, that approach has not been adequately explored in any published study (which has sufficient power), so a new standard of treatment could be embraced by sexual medicine and sex therapy.

NOTES

a. As an aside, for those readers with clinical inclinations, here are two tips that can be used to help a man address his lack

of awareness: ask if he is able to orgasm when using the opposite hand from how he typically masturbates. As this usually is atypical for him to consider, it usually improves awareness of what he is doing to arouse himself as it focuses his attention on sensations that frequently were not within his conscious awareness. While some men can orgasm with their "opposite" hand, almost inevitably, it is more difficult to do so and requires more effort and time. Others cannot do so, no matter how hard they try. This allows for an interpretation, "if you cannot orgasm as easily using your opposite hand during masturbation when the communication is within your own brain, then how do you expect to do so with a partner, unless you're communicating to your partner all the instruction necessary, and it is then practiced?"

b. Second, the frequency of masturbation must be assessed. While younger men can ejaculate more frequently than older men, that too is distributed on a bell curve. Men will frequently seek treatment not only when they cannot function effectively with a partner, but also when they can no longer masturbate successfully at the frequency they did when younger. That, of course, provides an opportunity for education. They need to reduce, if not discontinue, masturbation temporarily, to recruit "mother nature" to their side. When denied an outlet, there is no question that the threshold amount of mental and physical stimulation needed to orgasm is lowered. If his body typically experiences multiple ejaculations per week, then not ejaculating by himself and only allowing himself to ejaculate with his partner (who should be trained to incorporate the patient's preferred technique (along with him using his own erotic fantasies) will be helpful. However, at times, he will need to first train himself to ejaculate with a method his partner is physically able to provide. For instance, if his masturbatory stimulation speed and pressure is greater than anything the partner can provide, he must first learn to orgasm with less speed and pressure. In such cases, the partner's ability to mimic or more closely approximate what the patient does himself needs to be improved simultaneously, until a middle ground that works for both is reached. But in the end, it is certainly this author's hypothesis that the reduction of masturbatory ejaculatory frequency will result in a lowering of the threshold of erotic stimulation needed to produce an ejaculation.

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The contributions were from a single author, MAP.

COMPETING INTERESTS

The author declares no competing interests.

ADDITIONAL INFORMATION

Correspondence and requests for materials should be addressed to Michael A. Perelman.

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