2015

Treating Men's Orgasmic Difficulties.

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The Wiley Handbook of Sex Therapy

Edited by

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WILEY Blackwell

This edition first published 2017

Registered Office
John Wiley & Sons Ltd, The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

Editorial Offices
350 Main Street, Malden, MA 02148-5020, USA
9600 Garsington Road, Oxford, OX4 2DQ, UK
The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

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Library of Congress Cataloging-in-Publication data applied for

Hardback ISBN: 9781118510377

A catalogue record for this book is available from the British Library.

Cover image: borojoint/Gettyimages
Cover design by Wiley

Set in 9.5/11.5pt Galliard by SPi Global, Pondicherry, India

Printed in Singapore by C.O.S. Printers Pte Ltd

10 9 8 7 6 5 4 3 2 1

Contents

6

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David L. Rowland and Stewart E. Cooper

Introduction

Orgasmic difficulties in men are diverse and include premature ejaculation, delayed ejaculation, inhibited ejaculation, retrograde ejaculation, low volume ejaculation, partial ejaculatory incompetence (i.e., diminished volume, force, or sensation), anorgasmic ejaculation (when ejaculation occurs without orgasm), and painful ejaculation. This chapter focuses on the two ejaculatory conditions most commonly reported in clinical settings, namely premature ejaculation and delayed/inhibited ejaculation, both of which relate to the timing/occurrence of ejaculation. Men with either of these conditions can often be treated successfully and achieve (or regain) a satisfying sexual life.

In the following sections, we discuss these two conditions separately, providing information about definition, prevalence, etiology, diagnosis, and treatment. Although we encourage taking an integrated or holistic approach to each problem—considering biological, psychological, relationship, and cultural issues—we also recognize that particular therapeutic tools may be more suited to or preferred by some patients and healthcare providers than others. In choosing a treatment approach, treatment efficacy and patient satisfaction are the two primary considerations.

Taking an integrated approach to the treatment of ejaculatory/orgasmic disorders requires that the healthcare provider recognize that sexual response and dysfunction are influenced by many factors. Therefore, effective treatment will most likely involve a biopsychosocial approach, one that requires the healthcare provider to have at least a rudimentary understanding of the multiple factors that impinge on sexual problems and healthy sexual relationships.

Distinguishing ejaculation from orgasm

Within the framework of the sexual response cycle, orgasm (and ejaculation) in men is both a biological (reproductive) and psychological (reward) endpoint (see Rowland, 2006). Arousability and arousal—distinct but interrelated constructs—are precursors to this endpoint. Arousability and sexual libido are psychological constructs used to explain variability in the intensity and frequency of sexual response, and they might best be conceptualized as the person's readiness to respond. This state of readiness depends on both internal (e.g., hormonally "primed" diencephalic brain structures) and external (e.g., appropriate partner and situation) stimulus conditions. Sexual arousal or excitement—the organism's actual response to the stimulus conditions—represents both a subjective/cerebral state of sympathetic activation and a

The Wiley Handbook of Sex Therapy, First Edition. Edited by Zoë D. Peterson.

peripheral physiological response (i.e., erection) that prepares the man for sexual activity. During sexual activity, increasing levels of sexual arousal reach a threshold that triggers the ejaculatory response, which then typically terminates the sexual episode for the man. The subjective (i.e., brain) perception of urethral distension and bladder neck closure occurring at the emission phase of ejaculation is associated with the sensation experienced as "ejaculatory inevitability". The perception of the striated muscle contractions responsible for semen expulsion during ejaculation, mediated through sensory neurons in the pelvic region, gives rise to the experience of orgasm.

Although ejaculation and orgasm in men are concomitant events, they are not synonymous. Ejaculation is a spinal and peripherally-mediated neural response, whereas orgasm is a brain-mediated response; that is, orgasm is a central "response to/perception of" the peripheral ejaculatory response. In men, these two events, because they nearly always coincide, are often presumed to be one and the same. However, rare instances occur whereby these events become dissociated. Ejaculation may occur without the experience of orgasm and/or orgasm may occur in the absence of ejaculation. However, because such dissociations are rare, in this chapter we deal with difficulties with orgasm as if they were difficulties with ejaculation.

Understanding Premature Ejaculation (PE)

The prevalence of PE in the general population of men has been estimated to be anywhere from 5–30%, depending on how the condition is defined, who makes the judgment (i.e., healthcare provider vs. self-report), the populations that are sampled, the timeframe indicated (currently or over the lifetime), the type of PE being assessed (lifelong or acquired), and whether distress about the PE—often manifested by treatment-seeking behavior—is considered a necessary criterion for diagnosis. Presumably then, the actual prevalence lies somewhere between these numbers, although most recent studies tend to place it closer to 5–10% than 30% (Althof *et al.*, 2014; Rowland & Neal, 2014).

Defining PE

Recognizing the need for an evidence-based definition, the International Society for Sexual Medicine (ISSM) recently developed a consensus definition for "lifelong" PE (PE that has been present during the man's entire sexual life), which has three essential components: an ejaculatory latency of about one minute or less after penetration, the inability to delay the ejaculatory response, and distress or other negative consequences to the individual and/or partner (Althof *et al.*, 2014). Recently, the American Psychiatric Association followed suit by including the one-minute cutoff latency to define PE, and including text indicating that ejaculation must occur "before the individual wishes it" and that it must cause "clinically significant distress", in the DSM-5 diagnosis for premature (early) ejaculation (American Psychiatric Association, 2013, p. 443). In contrast, the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10) definition currently uses a 15-second cutoff (World Health Organization, 1992); whether the ICD-11 adopts the one-minute criterion in its anticipated revision is yet to be determined.

Although the one-minute cutoff has some empirical support, it might be viewed as an index of both "risk" and "convenience," more so than a true determinant of dysfunctional status. Specifically, this criterion captures the idea that the man with PE ejaculates shortly after penetration (the shorter the latency, generally the higher the risk for PE), and it is a convenient and discrete numeric (compared with something like 85 seconds or 110 seconds). However, the one-minute criterion has its own problems, as it somewhat arbitrarily excludes men who have longer latencies but otherwise meet the criteria for PE (Rowland & Neal, 2014).

Lifelong vs. acquired PE Healthcare providers have traditionally distinguished between lifelong and acquired PE. Lifelong has been present throughout the man's sexual life and typically has no clear etiology. Acquired PE occurs after some period of normal function and typically results from psychological or pathophysiological changes. The one-minute latency criterion mentioned above applies specifically to lifelong PE for the ISSM definition; for the DSM-5 definition, no distinction between latency requirements for lifelong or acquired is made. However, ISSM has also recently published a consensus definition for acquired PE, specifying parameters similar to those for lifelong PE with respect to the inability to delay ejaculation and distress to the individual and/or partner (Serefoglu *et al.*, 2014). However, an ejaculatory latency of about three minutes or less is suggested for acquired PE (in contrast to one minute for lifelong); notably, this cutoff reflects a consensus of expert opinion rather than an empirically derived value. This criterion was based on the rationale that men who had acquired PE, having experienced normal latencies for most of their sex lives, would find any significant reduction in or control over ejaculatory latency as distressing.

Most definitions also encourage the provider to specify whether the condition occurs in all situations with all partners, or is limited to certain situations or partners. Although such information is helpful to the healthcare provider in providing clues regarding etiology, it may have only moderate bearing on the treatment choice made by the patient or couple.

Risk factors for and etiology of PE

The biopsychosocial approach attempts to identify not only those factors that lead to a particular sexual problem, but also those that might impact treatment outcomes and satisfaction. Sexual problems such as PE typically involve one or multiple factors, including physiological, psychological, relationship, and cultural factors. Here we identify common risk factors associated with PE that the healthcare provider might explore during assessment with the patient or couple. These risk factors may occur independently or simultaneously in any given man at any given time, and exploring them with the patient or couple may help in understanding the nature of the dysfunction, how it affects the patient, how it affects his partner, and how it affects the relationship.

Physiological/pathophysiological risk factors Biological risk factors may be either physiological or pathophysiological. Physiological risk factors are those that are inherent to the system—part of the person's hardwired neurophysiology. Pathophysiological risk factors, in contrast, are disruptions of normal biological processes and include disease, trauma, medication, and other biological conditions.

The majority of men with PE do not exhibit a pathophysiological problem, but if they do, their PE condition is most likely acquired and often detectable through a medical history and examination. Examples of pathophysiological problems associated with PE include lower urinary tract symptoms (LUTS) and endocrine problems—particularly those related to thyroid function (Rowland & McMahon, 2008; Waldinger, 2008)—as well as changes brought on by medications, recreational drugs, and aging. It might be noted, however, that effects on ejaculatory response from these latter sources tend to be transient and inconsistent. Men with organic erectile dysfunction (ED) appear to be at greater risk for PE as well, although for such men, determination of which problem—PE or ED—is primary and which is secondary is crucial to a treatment program.

Physiological risk factors are more difficult to identify. They are part of the person's hardwired or inherent biological functioning and thus should show variation across individuals. It has been hypothesized (and in some instances, empirically demonstrated) that men with short ejaculatory latencies might be hypersensitive in terms of their penile sensory response, or hyper-responsive in terms of their autonomic and/or somatic neuromuscular response (Colpi,

Fanciullacci, Beretta, Negri & Zanollo, 1986; Fanciullacci, Colpi, Beretta & Zanollo, 1988; Motofei & Rowland, 2005; Paick, Jeong, & Park, 1998; Rowland, 2010). Although to date no indisputable evidence exists to support one explanation over another, most would agree that, as with any bio-behavioral response, natural variation occurs in ejaculatory latencies among men—presumably a positively skewed distribution—with some men ejaculating rapidly, others after a number of minutes and thrusts, and still others only after an extended period of time. Multiple physiological systems including sensory receptor sensitivity, neurochemical production, utilization, and degradation, and neuromuscular response could all contribute to such individual variation.

From the healthcare provider's perspective, pathophysiological and physiological factors have several implications. First, any man suspected of having developed PE recently should be referred for a medical exam that might include attention to urinary tract and endocrine abnormalities. Second, the healthcare provider might educate the patient regarding possible inherent (and naturally occurring) biological differences in the hardwiring of ejaculatory response, thereby removing some of the burden of guilt and responsibility often associated with this sexual dysfunction.

Psychological risk factors Psychological factors, including culturally derived, learned behavioral patterns, as well as the man's own performance expectations, anxiety, and guilt pertaining to partner interactions, may all influence a man's sexual response, including his ejaculatory patterns (Rowland, 2012). Furthermore, psychological and biological components may precede one another or offer reciprocal maintenance. Reciprocating effects from sexual failure or impairment might include lowered self-confidence, sexual self-efficacy, and relationship efficacy (Althof, 2007; Melnik, Glina, & Rodrigues, 2009; Perelman, 2006; Rowland, Adamski, Neal, Myers, & Burnett, 2015). Any of these may create a mindset of failure that maintains or intensifies the problem. Sometimes underlying learned response patterns used by the man to counter the problem actually worsen the condition, and may foster a sense of inability to regain control over the condition, for example, attempting to postpone ejaculation through non-arousing or distracting thoughts. Indeed, anxious attempts to control the ejaculatory response may sometimes result in less overall control.

From the healthcare provider's perspective, an understanding of the man's personal experience of his impairment is useful: how it makes him feel, how it affects his thoughts and feelings, how it affects his relationship with his partner, and so on. Furthermore, the healthcare provider could benefit from knowing about the patient's current or past history involving depression, anxiety, psychopathological disturbances, or unusual psycho-behavioral patterns, as these may help explain risk, etiology, or exacerbation of the PE symptoms or issues pertinent to the man's relationship with his partner.

Relationship factors Although PE is the man's problem, it may well affect his partner. The partner may share in the distress, self-doubt, and dissatisfaction associated with this condition (McCabe, 1997; Rowland & Cooper, 2011), and a lack of satisfying sexual encounters can negatively impact the dyadic relationship. In addition, a partner with her/his own sexual issues (e.g., sexual dysfunction, negative attitudes about sex, certain religious beliefs) may exacerbate the problem or, equally important, interfere with an effective treatment program.

From the healthcare provider's viewpoint, evaluating both the man and his partner to determine the impact of PE on the couple's relationship may be helpful; it is also important, if possible, to engage the partner in the therapeutic process so the partner becomes part of the solution. Finally, addressing both sexual and non-sexual relationship issues—which are often intertwined—usually results in more positive outcomes than merely addressing narrow response sets such as ejaculatory latency.

Cultural and other sociodemographic factors Gender and sex role expectations may place further burden on the man and his partner to behave in specific ways within the sexual and dyadic context. Indeed, research by Kinsey and his colleagues (Kinsey, Pomeroy, & Martin, 1948) noted differences in reported ejaculatory latencies across countries, as well as differences in attitudes and expectations surrounding men's ejaculatory response and timing across different ethnic and religious traditions (McMahon, 2007). Besides gender and sex role cultural expectations, other sociodemographic variables such as religion, socioeconomic status, nationality, geographical region, age, race/ethnicity, sexual orientation, and degree of physical and emotional ability may affect an individual's sexual performance and sexual performance expectations. Each person's sexual knowledge, attitudes, and behavior may be differentially affected, more or less, by each of these cultural and sociodemographic variables, in isolation and in interaction with each other.

From the healthcare provider's perspective, cultural influences on the perception of ejaculatory problems may be an important aspect of the development of PE. Social stigmatization, gender expectations both within and outside the dyadic relationship, religious beliefs about sexuality, and partner considerations may all affect how the man and/or his partner view the effects of the short ejaculatory latency and whether they are likely to seek medical or clinical advice.

Treating PE

Perhaps one of the greatest values the biopsychosocial approach brings to the treatment of sexual problems such as PE is an understanding of the complex ways in which one's physiology, emotions, thoughts, and behaviors interact to produce a functional or dysfunctional response. Thus, although no one really knows why some men seem unable to delay their ejaculatory response and others seem capable of doing so, the healthcare provider can probe the various psychobiological domains to determine where concerns and treatment goals lie and, following from that, what types of treatments are likely to be most effective. For PE, such treatment goals typically lie not only in the somewhat immediate problem of increasing the man's ejaculatory latency, but also in the broader goal of helping the couple to develop a more sexually satisfying and durable relationship. First, we discuss biomedical/physical treatment options separately from psychosexual therapy so there is an understanding of the variety and efficacy of tools currently available to healthcare providers. Then, in a later section, we suggest ways to integrate treatment modalities within a brief therapy context.

Assessment and diagnosis

Assessing and diagnosing PE in men involves two stages: (1) ensuring that the patient truly falls within the broad diagnostic criteria for PE; and (2) addressing specific elements critical to the man, partner, and relationship affected by PE-related problems, as noted above. Regarding the first stage, the healthcare provider should ensure that the ejaculatory latency is relatively short (less than a minute or two) and does not actually fall within or near the normal range for men (about six to ten minutes following penetration for most men). Men often complain of ejaculating before they wish despite the fact that their latency is typical. In addition, the healthcare provider should verify that the rapid termination of sexual intercourse results from an inability to delay ejaculation rather than from loss of erection or some other reason (e.g., hurrying sex due to fear of interruption from family).

Regarding the second stage, healthcare providers should obtain a medical and psychosexual history to rule out complications from medications, illnesses, surgeries, or other biological issues. Brief psychological and relationship histories, as well as assessment of current sexual

functioning, can help to assess the quality of the individual's sexual response cycle—desire, arousal, and orgasm—and may call attention to individual or relationship idiosyncrasies (Rowland & Cooper, 2011). Additional information gathered during assessment might include relationship quality with the partner, partner's sexual health and problems, cultural background, and developmental information about the patient's PE experiences. Understanding such issues will help in treatment planning as well as assessing the patient's or couples' level of motivation for change. Standardized assessment tools (see Table 6.1) may be used to assist in the assessment of the problem, but these should not substitute for a formal diagnostic interview.

Integrating available treatment options

Clinical experience and preliminary data suggest that multimodal approaches to treatment may result in the best outcomes for sexual problems (Althof, 2007; Melnik *et al.*, 2009; Perelman, 2006; Perelman & Rowland, 2006; Rowland, 2011; Rowland, Cooper, & Macias, 2008). For example, behavioral interventions to address short ejaculatory latency along with couples therapy to address relationship and sexual satisfaction may generate better and more enduring positive outcomes than either approach used in isolation. Additionally, the inclusion of biomedical options may offer both hope and a renewed sense of self-efficacy.

Currently, the healthcare provider has a variety of options available for the treatment of PE, including (1) pharmacological methods that decrease penile sensation and/or centrally inhibit

Table 6.1 Examples of useful assessment instruments for PE and relationship functioning.

Medical/psychological assessments	
Index of Premature Ejaculation (IPE)	Ten items assessing control over ejaculation, satisfaction with sex life, and distress in men with PE (Althof *et al.*, 2006, pp. 474–475, copyrighted, special access)
Premature Ejaculation Diagnostic Tool (PEDT)	Reliable, easy, and fast 5-item tool assessing diagnostic criteria for PE (Janini, McMahon, & Waldinger, 2013, p. 383) http://www.baus.org.uk/Resources/BAUS/Documents/PDF%20Documents/Patient%20information/PEDT.pdf
Premature Ejaculation Prevalence & Attitudes (PEPA)	Assesses basic PE parameters in five questions, including whether PE is considered a problem by the man and/or his partner (Patrick *et al.*, 2005, p. 361; Porst *et al.*, 2007, p 816.)
Male Sexual Health Questionnaire (MSHQ)	25-item questionnaire measuring erection, ejaculation, and sexual satisfaction with a focus on ejaculatory function; greater cultural sensitivity compared with some tools (Rosen *et al.*, 2007, pp. 805–809).
Relational assessments	
Dyadic Adjustment Scale (DAS)	Self-report measure of relationship adjustment, and partners' perception of satisfaction (Spanier, 1989) http://trieft.org/wp-content/uploads/2010/09/DAS+1.pdf
Golombok-Rust Inventory of Sexual Satisfaction (GRISS)	28-item questionnaire that assesses sexual satisfaction and dysfunction; may be used to track improvement over time as the result of medication or therapy (Rust & Golombok, 1985) http://www.psychometrics.cam.ac.uk/productsservices/psychometric-tests/GRISS
Self-Esteem and Relationship Questionnaire (SEAR)	Short questionnaire for measuring sexual relationship, confidence, and self-esteem (Cappelleri *et al.*, 2004) http://www.nature.com/ijir/journal/v16/n1/fig_tab/3901095t1.html

the ejaculatory response, (2) behavioral options that attenuate penile sensory input, (3) behavioral/cognitive/affective strategies that may both increase awareness of penile sensations and help establish a positive framework for change, and (4) relationship strategies that encourage patient–partner interactions and that focus on enhancing sexual enjoyment (Rowland, 2012).

Biomedical options

Biomedical treatments for PE have typically taken one of two forms: (1) anesthetizing substances or physical barriers applied to the penis that attenuate penile sensitivity and (2) orally-based neurotransmitter reuptake inhibitors—especially selective serotonin reuptake inhibitors (SSRIs)—that act primarily by affecting central serotonergic activity.

Topical ointments, creams, gels, and sprays Topical ointments, creams, gels, and sprays are local anesthetics that diminish sensation in the sensory organ, in this case the penis. These preparations—often available over-the-counter—typically contain lidocaine, prilocaine, or various proprietary preparations, and may more than double the ejaculatory latency for men with PE, as well as increase reported ejaculatory control and quality of life (e.g., Dinsmore *et al.*, 2007). The major downside, although preventable by using a condom, is diminished vaginal sensitivity and possible female anorgasmia in partners. However, this group of treatment options often provides an expedient and inexpensive means to increase the man's ejaculatory latency.

Neurotransmitter reuptake inhibitors This class of medications has been shown to have varying effects on delaying the ejaculatory response. Pharmacological agents for the treatment of PE have most often involved daily dosing, although a number of recent studies have demonstrated substantial efficacy when used "on-demand", with the man taking the drug several hours prior to anticipated sexual activity. Two types of drugs are most often used.

Selective serotonin reuptake inhibitors (SSRIs), known most for their antidepressant use, can effectively delay or inhibit ejaculation. Paroxetine appears to be the most effective SSRI compound, typically delaying ejaculatory response by up to five minutes. None of these compounds has received regulatory agency (e.g., US Food and Drug Administration [FDA]) approval for treatment of PE, although they have been prescribed "off-label", typically at lower doses than when used as an antidepressant.

Dapoxetine is the first compound developed specifically for the treatment of PE. This drug also acts as an uptake inhibitor (like the SSRIs) and, given its other pharmacokinetics (rapid onset and short half-life), is designed to be taken on-demand one to two hours prior to intercourse. Its efficacy appears to be moderate, increasing latency from about one to several minutes (Pryor *et al.*, 2006). Although dapoxetine has been approved for use in a number of European and Asian countries, at this time it has not been approved by the US FDA.

Treatment of PE and comorbid erectile dysfunction may also be attempted by combining anti-ejaculatory and pro-erectile drugs. About a third of men with PE also report problems with erection, and in these instances, it is important to determine which problem is primary and which is secondary. For example, if a man is ejaculating quickly in order to avoid losing an erection, then the erectile problem needs to be addressed. In some instances, PE and ED are concomitant, with no clear etiological sequence, and these men may be candidates for treatment with both an SSRI and a phosphodiesterase-5 (PDE-5) inhibitor, such as sildenafil (Viagra). Because SSRIs themselves can exacerbate an erectile problem, the addition of a PDE-5 inhibitor helps the man maintain his erection and reduce performance anxiety while delaying his ejaculation (Sommer, Klotz, & Mathers, 2005).

Psychobehavioral treatment options

Psychological therapy options may be seen as nested within the behavioral, cognitive, affective, and relational domains (Rowland & Cooper, 2011). These options can be implemented individually or fully integrated, depending on the severity of the PE and the extent of its collateral effects on individual and relationship functioning. In addition, these approaches may be integrated with pharmacotherapy, with their combination typically being more effective than medication alone (Althof *et al.*, 2014).

Behavioral approaches Behavioral approaches, which were first popularized in the form of Semans' (1956) and Kaplan's (1974) start-stop method as well as Masters and Johnson's (1970) squeeze method, continue to play important roles in the treatment of men with PE. Both the start-stop and squeeze methods involve periods of penile stimulation followed by stimulation withdrawal as the man reaches increasingly higher levels of arousal. Such methods are based on a learning paradigm in which the man (1) learns to recognize the sensations of impending ejaculatory inevitability and (2) successfully inhibits further stimulation until the sensation ceases. Both squeeze and start-stop methods can be used in conjunction with other behavioral adjustments designed to slow the man down and/or to speed the partner up. These methods might include specific types of foreplay that avoid direct penile stimulation and focus on arousing the partner, particular intercourse positions (e.g., partner on top), specific movements during intercourse (e.g., manual stimulation of the partner's genitals during quiescent non-thrusting intervals), as well as relaxation and deep breathing exercises that may slow hyperarousal. Some men may also benefit from a procedure utilizing masturbation exercises (e.g., using a handheld vibrator), with the intention of increasing awareness of sensations under moderate levels of penile stimulation (Jern, 2013).

Research on these methods suggests moderate benefit for most men, with success rates ranging from about 40–75% after six months (see Rowland & Cooper, 2011). However, men suffering from ante-portal ejaculation (ejaculation prior to partner penetration) or very short latencies (e.g., within 10–15 seconds following penetration) may not benefit from behavioral strategies without the inclusion of pharmacotherapy. Specifically, pharmacotherapy, when introduced early in the treatment process, may be used to build the man's confidence and, equally important, lengthen the ejaculatory latency in order to provide a greater pre-ejaculatory timeframe for recognizing the premonitory sensations of ejaculation.

Because these behavioral procedures are relatively straightforward, couples can often implement them using bibliotherapy (e.g., Metz & McCarthy, 2003) or internet counseling, or under the guidance of a non-specialist healthcare provider (see Connaughton & McCabe, this volume, and van Lankveld, this volume, for further discussion of minimal contact therapies).

Cognitive approaches Cognitive approaches generally play no direct role in lengthening ejaculatory latency, but they can be used to lessen the patient's negative disposition regarding his PE. Additionally, these interventions help to instill a positive attitude, which is important to successful treatment outcomes and overall satisfaction. For example, one set of cognitive techniques focuses on identifying and countering mental processes that may be exacerbating the PE, such as self-defeating thoughts or distorted expectations about sexual performance. Examples of self-defeating thoughts include: "My having PE now and in the future is inevitable because I had PE yesterday" or "My partner is worried that I will ejaculate before she/he is sexually satisfied." Examples of distorted expectations are: "I should always be able to bring my partner to orgasm in every single sexual encounter" or "Non-penetration-induced orgasms are inferior."

Furthermore, evidence-based strategies such as the "Decibels" and "Counters" techniques can be applied to assist men in reframing their cognitions surrounding their sexual problem

(see Rowland & Cooper, 2013, for a more detailed description). Briefly, in the Decibels technique (Ellis, 1992), the patient addresses a series of questions regarding his dysfunctional condition, including:

1 What irrational belief do I want to reduce?
2 What evidence exists for the falseness of this belief?
3 What evidence exists for the truth of this belief?
4 What are the worst things that could actually happen to me if I don't get what I think I must (or if I do get what I think I must not)?
5 What good things could I make happen if I don't get what I think I must (or if I do get what I think I must not)?

Somewhat similarly, using the Counters technique (Hackney & Cormier, 2009), the patient creates concise believable counter-statements that might be rehearsed frequently to offset distorted cognitions.

Other cognitive techniques focus on the use of self-instructions—known as coping thoughts (McMullin, 2000)—such as "just relax and enjoy" or "I can slow down and stop moving if I feel like doing so." Such self-directives may then be practiced both overtly during sexual encounters and covertly through imagery practice.

A final set of cognitive methods focuses on modifying PE-related affect, that is, having men with PE develop awareness of negative feelings during sexual interactions, which then might be recast into positive feelings. Mindfulness techniques provide one possible effective strategy for achieving this goal, not only enabling improved somatic/interoceptive awareness, but also reducing symptoms associated with sexual problems such as anxiety, self-judgment, and ruminating thought patterns.

Affective approaches Affective approaches have not typically been used in the treatment of men with PE, but may be considered when emotional problems interfere with treatment progress. The rationale for supporting interventions with this focus emerges from research indicating that emotions play a role in the development and maintenance of PE by increasing anxiety surrounding sexual interactions and reinforcing negative expectations (Rowland & Cooper, 2005). The main form of affective-oriented intervention is emotion-focused therapy (Greenberg, 2004; see also Johnson, this volume), which assists patients in experiencing and expressing emotions if their suppression is creating difficulties, or regulating emotions if overexpression is creating difficulties.

Relational approaches Relational approaches view PE as embedded in the man's relationship with his partner; thus the PE may be better treated with the partner included in the treatment. Such approaches are most relevant when sexual impairment has a broader impact on the couple's interactions (e.g., guilt, blaming, avoidance), but may also assist in bringing the man and his partner toward a closer understanding of each other's experiences as related to the dysfunction.

Relationship-based strategies may focus on communication within the couple or on behaviors they engage in with each other. Couples therapy can also be used to address broader issues within the relationship, including intimacy, quality of interactions, and overall satisfaction. Relationally-based techniques specific to PE may include permission-giving, specific suggestions, sensate focus exercises, start-stop or squeeze methods, stimulus reduction strategies, relapse prevention, or intensive couples therapy. A full range of couples counseling approaches may be used if relational issues beyond the PE are germane to treatment success.

Couples counseling may take any number of different forms, including communication (Gottman, 1993; Satir & Baldwin, 1983), cognitive-behavioral (McMullin, 2000), strategic

(Haley, 1990), and narrative (White, 2007; see also Findlay, this volume) therapies. Communication approaches, for example, seek to examine and alter the overt and covert messages between partners that affect their perceptions, thoughts, and feelings in order to validate each person's sense of self-worth. As applied to PE, such approaches would seek to alter each other's messages about their sexual bodies and experiences, with the goal of promoting congruence and validating each person's self-worth. Couples cognitive-behavioral therapy may be helpful in reinforcing positive behaviors within the couple's sexual and interpersonal exchanges. The strategic therapy approach, emanating from a systems perspective, would emphasize moving the couple beyond a homeostasis that sometimes occurs when they adapt to sexually dysfunctional interactions. The narrative approach could assist couples in creating a productive accounting for the dysfunctional response and make attempts to reduce or eliminate the problem by working towards change as a collaborative team.

In addition to these specific approaches, the therapist may also use a wide variety of techniques. Negotiating; altering the couples structure; using parallel questioning with each partner; generating interactions; altering coalitions; confronting discrepancies between thoughts, feelings and actions; reconstructing boundaries; reframing; giving directives; and using paradox and symptom prescription may all help the couple to construct a more helpful alliance for reducing their PE-related issues (Hackney & Courmier, 2009). Selection of the approaches and strategies to employ with the couple would be tailored to their dynamics and needs.

Although none of the above approaches directly addresses short ejaculatory latencies typical of PE, they may help the couple deal with relationship problems that result from or exacerbate the problem, and thus lessen the impact of therapeutic strategies. Given that professionally trained therapists are typically familiar with a broad range of therapeutic tools and approaches within their counseling practices, they could selectively apply elements of one or more approaches as necessitated by the specifics of the couple's situation.

Understanding Inhibited Ejaculation (IE)

Sometimes referred to as "retarded" or "delayed ejaculation," herein we categorize all situations in which men have difficulty reaching orgasm/ejaculation—whether merely delayed or fully absent—under the nomenclature of inhibited ejaculation (IE), recognizing that in some circles, IE refers specifically to the complete inability to reach ejaculation. The prevalence of IE is unclear, in part because data defining the maximum duration of "normal" ejaculatory latency are essentially nonexistent. Furthermore, larger epidemiological studies have not subdivided men into various types of diminished ejaculatory function. For example, the continuum (and/or overlap) from delayed to absent ejaculation has not been adequately explored.

Nevertheless, in the past, IE had been reported at fairly low rates in the literature, typically around 3–5%, and thus it had been seen as clinically uncommon. However, based on more recent clinical impressions, some urologists and sex therapists are reporting increasing incidence of IE (see Rowland *et al.*, 2010), leading to higher population estimates of up to 10–15% (see Lewis *et al.*, 2010). The prevalence of IE appears to be moderately and positively related to age—not surprising in view of the fact that ejaculatory function as a whole tends to diminish with age. However, no large-scale studies have systematically investigated the strength or reliability of this putative relationship

Defining IE

No clear guidelines are available for defining IE. DSM-5, which uses the terminology "delayed ejaculation," characterizes the dysfunction as a marked delay in ejaculation or marked infrequency or absence of ejaculation on at least 75% of occasions involving partnered sex; the

condition causes clinically significant distress and has persisted for at least six months. Using these general parameters, we suggest the following three conditions for IE as ones that parallel those for PE: (1) Given that median ejaculation times are around 7–10 minutes (±3–4 minutes), men who take more than about 15 minutes (i.e., more than about two standard deviations above the average) on at least 75% of occasions during partnered sex to reach ejaculation or who terminate intercourse without ejaculation due to frustration or exhaustion; (2) men who are unable to advance their ejaculatory response; and (3) men who are distressed or bothered by the situation or whose partners are bothered or dissatisfied, are candidates for an IE diagnosis.

Lifelong vs. acquired IE As with PE, healthcare providers traditionally distinguish between lifelong and acquired IE. Lifelong IE has been present throughout the man's sexual life and typically has no clear etiology. Acquired IE occurs after some period of normal function and typically results from pathophysiological, psychological, or relational changes. In some instances, it is also relevant to specify whether the IE is specific to situations, partners, or type of activity (e.g., intercourse vs. masturbation) or a more general condition that occurs during any sexual situation.

Risk factors for and etiology of IE

Physiological/pathophysiological risk factors As with PE, biological risk factors for IE may be either physiological or pathophysiological. Men with IE based in a pathophysiological condition most typically have acquired IE, information that will probably emerge through a medical history and examination. Specifically, any procedure, disease, or condition that disrupts sympathetic or somatic innervation to the genital region has the potential to affect ejaculatory function and orgasm. Thus, spinal cord injury, multiple sclerosis, pelvic-region surgery, severe diabetes that leads to diminished penile sensitivity, LUTS, and medications that inhibit α-adrenergic innervation of the ejaculatory system (e.g., alpha blockers used to control high blood pressure) have been associated with IE. Nevertheless, a sizable portion of men with IE exhibit no clear pathophysiology that can account for the disorder.

No clear physiological factors are known to account for delayed or inhibited ejaculation. As with PE, natural variation occurs in ejaculatory latencies among men, with some consistently falling toward the right tail of the distribution. Multiple physiological systems including diminished sensory receptor sensitivity (e.g., due to aging); reduced neurochemical production, utilization, and degradation; and reduced neuromuscular response could all contribute to a tendency toward longer latencies, but evidence suggesting any particular component or system is scant.

From the healthcare provider's perspective, pathophysiological and physiological factors have two implications. First, any man having recently acquired IE should be referred for a medical exam that might include attention to the pelvic area, recent medications, or other disease conditions or states. Second, the healthcare provider might educate the patient and his partner regarding possible inherent (and naturally occurring) biological differences in the hardwiring of ejaculatory response, thereby removing some of the burden of guilt and responsibility often associated with this sexual dysfunction.

Psychological and relationship factors Both psychological and relationship factors may well account for long or increasing ejaculatory latencies. Psychological factors may involve specific emotions and cognitions that associate anxiety and negative performance expectations with sexual intimacy. Relationship factors may be associated with current interpersonal dynamics or with longer-term relationship developmental changes. In some instances, sex with the partner may be insufficiently arousing for the man to reach ejaculation, a situation that may involve any

number of factors operating individually or together. For example, the amount of penile sensation and psychosexual arousal may be attenuated due to diminished stimulation provided by the partner (e.g., loss of vaginal elasticity with aging). In some instances, the man may have a strong "autosexual" orientation that involves an idiosyncratic and vigorous masturbation style—carried out with high frequency—which does not "match" vaginal stimulation. As a result, vaginal stimulation may no longer be sufficiently arousing to induce ejaculation. In other instances, disparity between the reality of sex with the partner and the man's sexual fantasy used during masturbation is another potential cause of IE (Perelman & Rowland, 2008). This disparity may involve multiple factors, such as partner attractiveness and body type, sexual orientation, and the specific sexual activity performed. Such behavioral and cognitive patterns may well predispose men to experience problems with ejaculation, resulting from the lack of sufficient psychosexual arousal during coitus to achieve orgasm.

Finally, the evaluative/performance aspect of sex with a partner can create "sexual performance anxiety" for the man, a factor that may contribute to IE. Specifically, anxiety surrounding the inability to ejaculate may draw the man's attention away from erotic cues that normally serve to enhance arousal. Some such men may be over-conscientious about pleasing their partner and lose focus on arousing stimuli (Apfelbaum, 2000).

From the healthcare provider's perspective, it is useful to have an understanding of the man's personal experience of his impairment—how it affects his thoughts and feelings, how it affects his relationship with his partner, and so on. Furthermore, evaluating both the man and his partner to determine the impact of IE on the couple's relationship may be helpful. For the treatment of men with IE in particular, it is also important, when possible, to engage the partner in the therapeutic process, as she/he is an important part of the solution. Finally, addressing both sexual and non-sexual relationship issues—often intertwined—may result in more positive outcomes than merely addressing ejaculatory latency.

Treating IE

A holistic, biopsychosocial approach to the treatment of IE allows exploration of interrelated physiological, psychological, and relationship issues that affect sexual response and dysfunction. For IE, the immediate problem is that of increasing arousal in order to decrease the man's ejaculatory latency, but the broader goal involves helping the couple achieve a more sexually satisfying relationship. As with PE, we discuss biomedical/physical treatment options separately from psychosexual therapy. Then, in a final section, we suggest a more integrated treatment process.

Assessment and diagnosis

Assessing and diagnosing IE in men typically includes three steps: (1) ensuring that the patient truly falls within the broad diagnostic criteria for IE; (2) referring the man for a medical evaluation if pathophysiological factors are suspected, for example, if the IE is a recent development; and (3) addressing specific contexts critical to the man, partner, and relationship that may help in understanding the etiology, dynamics, and consequences of the IE problem. Regarding the first step, the healthcare provider should ensure that the ejaculatory latency is relatively long and indeed falls substantially beyond the normal range for men, or, alternatively, that the man terminates intercourse out of frustration or exhaustion. In addition, the healthcare provider should verify whether the long latency to ejaculation is specific to the partner (e.g., does not typically occur during masturbation) or is generalized to all sexual situations and activities.

The healthcare provider should obtain a medical history to rule out complications from medications, illnesses, surgeries, or other biological issues, particularly if the condition developed recently (i.e., suspected acquired IE). Brief psychological and relationship histories, as well as assessment of current sexual functioning and intercourse dynamics with the partner (how much and what type of foreplay, sexual positions, etc.), can help to assess the quality of the individual's sexual response cycle (desire, arousal, and orgasm) and may reveal individual or relationship idiosyncrasies, as well as identify personal or relational events that might help explain recent changes in the ejaculatory latency. Additional information to include in assessment might include questions about relationship quality with the partner, partner's sexual health and problems, cultural background, and developmental information about the patient's IE experiences. Understanding such issues will help in treatment planning as well as in evaluating the patient's or couple's level of motivation for change.

Integrating available treatment options

As noted previously, multimodal approaches to treatment may result in the best outcomes for sexual problems. For example, addressing long ejaculatory latency along with relationship and sexual satisfaction is likely to generate better and more enduring positive outcomes than just addressing latency. The inclusion of the partner is particularly important, as exercises designed to overcome IE often include a critical role for her/him.

Currently the healthcare provider has a variety of options available for the treatment of IE, including (1) behavioral options that increase and/or modify penile sensory input; (2) cognitive/affective strategies that enhance arousal as well as help establish a positive framework for change; and (3) relationship strategies that encourage patient–partner interactions that focus not only on enhancing arousal, but also on increasing the sexual enjoyment of both partners.

Pharmacological options In contrast to several pharmacological options for the treatment of PE, safe and effective medications are only now being investigated for IE, and as of this publication, none show extraordinary promise. In fact, pharmacological options have been used most often to counter the ejaculatory-inhibiting effects of other medications. For example, some full-strength antidepressants (e.g., paroxetine [Paxil]) make it more difficult for men (and women) to reach orgasm, so substitution with another antidepressant such as bupropion or buspirone may have a lesser effect (Rowland *et al.*, 2010).

With regard to IE not related to medication, few options are available. The anti-serotonergic agent cyproheptadine and the dopamine agonist amantadine have both shown, somewhat anecdotally, moderate success, but the potential adverse effects, lack of controlled investigation, and lack of regulatory approval prevent wide-scale use of these agents for IE treatment. As research continues to uncover greater understanding of the mechanisms that trigger the ejaculatory response, the likelihood of finding pro-ejaculatory agents will increase. In the meantime, IE appears to respond quite well to non-pharmacological strategies, including behavioral, psychological, and relationship therapies.

Psychobehavioral approaches

Similar to treating men with PE, therapeutic interventions for men with primary or secondary IE may be nested within behavioral, cognitive, and relational approaches (Rowland & Cooper, 2011, 2013). This section summarizes interventions in these three domains and is followed later in this chapter by the presentation of a structured brief treatment framework that providers can use with men with either PE or IE, relying on key process interventions that might be broadly applied to either orgasmic disorder.

Behavioral approaches Behavioral approaches to treat IE, whether primary or secondary, were first pioneered by Masters and Johnson (1970) and have continued to be a mainstay in the psychosexual treatment of men with this condition. As an underlying justification for the effectiveness of these techniques, many of those with IE report greater satisfaction from masturbation than from intercourse. Specifically, some men with IE report engaging in a high frequency of masturbation; others exhibit vigorous masturbation with idiosyncratic speed, pressure, duration, and intensity that is inconsistent with the experience of partnered sex. Men with IE sometimes show a combined pattern of styles—high frequency and vigorous masturbation—which may contribute to their inability to reach orgasm with a partner.

Disparity between the sexual fantasy used in masturbation and the real-life sexual experience with a partner may also contribute to IE (Perelman & Rowland, 2006). Sources of the disparity may involve the attractiveness and body type of the partner (which may have changed over time) and the specific sexual activity performed (which may be less arousing if it is less preferred by the man).

Such etiological factors indicate that the inability to reach orgasm in many men may result from insufficient psychosexual arousal during intercourse. Notably, this problem with lack of arousal may extend to men using PDE-5 inhibitors such as Viagra or Cialis. In such cases, men's ability to get an erection is enhanced by the medication; thus, lower levels of subjective arousal are required for an erection, and these levels may be insufficient for ejaculation and orgasm. As a consequence, strategies to overcome IE typically include steps to increase psychosexual arousal in the man.

A longstanding behavioral approach for IE is masturbatory retraining, integrated into sex therapy as a form of "dress rehearsal" for sex with a partner (Perelman, 2006). Initially, the goal of such masturbatory retraining is to determine sexual stimulation preferences and to use them to identify and experience sexual arousal and pleasurable sensations. At this stage, orgasm is not the sought endpoint, simultaneously lessening pressure and facilitating the association of partner touch and interaction with stimulation and arousal.

The end goal of masturbation retraining is to stimulate sufficiently high levels of psychosexual arousal within the experience of partnered sex, so the man is able to reach orgasm with his partner. At times, and especially for those men with IE who have a strong autosexual orientation, an interim phase may involve suspending all masturbatory activity—or permitting masturbation only with the non-preferred hand in order to counter particularly vigorous or idiosyncratic patterns—for a period of time (e.g., two weeks to two months) during the treatment process. Although a patient may resist this mandate if he has a strong autosexual orientation, both the therapist and partner can offer support and encouragement as the man learns to redirect his arousal toward partner cues and stimulation and away from autosexual cues. The patient and his partner may be encouraged to engage in mutual masturbation, using fantasy, various forms of erotica, and body movements more consistent with partnered sex. During such sessions, the partner can observe the kinds of stimulation the man with IE prefers, simulating those as a prelude to intercourse. At the same time, the partner's masturbatory activity can become a means for enhancing the man's own sexual arousal level.

Cognitive approaches Cognitive approaches also have application to treatment of men with IE. First, it may be important to "normalize" or reframe the situation. Specifically, some men with IE might benefit from understanding that time to ejaculation approximates a normal distribution, with some men naturally falling at the higher end of this distribution. Additionally, cognitive therapy methods may be included as part of the treatment process. As one example, men with IE may be overly focused on rigid performance expectations; on pleasing their partner (to the point of distracting from their own sexual arousal); or on fear of dissatisfaction, disparagement, or disapproval by their partner. Cognitive approaches, including the Decibels technique described under the treatment of PE, could be used to successfully counter such

thought patterns. Another cognitive strategy, thought-stopping, could prevent men from engaging in self-defeating predictions that often escalate anxiety and other unwanted behaviors (such as giving up or even avoiding intimacy altogether). Such strategies, when combined with positive self-talk or positive self-instructions, may enable the man to focus on actions and sensations that increase psychosexual arousal. Finally, men can learn mindfulness methods to enhance their awareness of somatic and subjective experiences of arousal and to reduce sexuality-related distress.

Relational approaches Relational approaches are critically important in the treatment of men with IE, so partners should be included whenever possible. From a relational perspective, a man's total sexual stimulation level represents the combination of physiological/tactile/sensory stimulation and emotional/relational processes; thus, arousal can be enhanced through changes to the relational interactions. For example, the couple may share sexual fantasies; the goal is to heighten sexual arousal during intercourse and to align, when possible, masturbation fantasies with intercourse fantasies. The partner might engage in behaviors and mannerisms aimed at increasing his/her seductiveness to the partner, and the couple might expand their sexual styles and sexual behavioral repertoire. At times, underlying issues associated with stress related to conception/procreation and with anger/resentment may need to be explored and worked through.

Whatever relational strategies are explored and decided upon by the therapist and couple, the willingness and collaboration of the partner is critical (Perelman & Rowland, 2008). Unless the partner is fully engaged as therapy progresses, the partner may feel that she/he is simply providing a substitute for the partner's masturbatory activity (e.g., adjusting sex to his preferred speed, enacting his preferred fantasies). Such feelings might well be valid, and the therapeutic process may require interim steps that address the partner's feelings of self-worth. The therapist, as well as the patient, needs to approach such issues with sensitivity and reassure the partner that greater intimacy and satisfaction for both partners is the ultimate goal.

A Multimodal Approach to Treating Men's Orgasmic Difficulties

An integrative, multimodal treatment approach for PE or IE may be implemented in a variety of ways. Such integrative treatment could involve pharmacological (if available), behavioral, cognitive, relational, and cultural intervention strategies as best fit the patient's needs. While avoiding specific formulas, herein we describe one approach that healthcare providers might emulate or borrow as they develop and implement a treatment plan for men and couples with PE or IE.

Specifically, we propose a four-phase process—involving approximately two to six sessions—of a modified PLISSIT model (Annon, 1976) to help men with PE or IE. A modified version of the PLISSIT model is suggested because this model is well known to most practitioners and because it engages the patient at increasingly deeper levels during each subsequent session, allowing the patient/couple to opt out at any point in the process if they are satisfied with their gains. Specifically, the PLISSIT model has four levels of intensity beginning with Permission, continuing with Limited Information, Specific Suggestions, and Intensive Therapy (Annon, 1976). Furthermore, the PLISSIT model provides the healthcare provider with an overarching structural framework for approaching treatment, tailored by the patient and the provider in an emergent fashion, to the patient's/couple's particular treatment issues and goals.

Brief therapy is suggested for two reasons:

1 Barriers to treatment (cost, effort, access) need to be kept low; this is particularly relevant for treating men's orgasmic concerns because only a limited percentage of men with PE or with IE muster the courage to seek help.

2 Most of the relevant issues and strategies related to orgasmic difficulties in men can be handled in a limited number of sessions (Althof, 2006).

Specifically, brief therapy may productively address PE or IE in men who would not be willing to consider longer-term medical or psychosexual treatment.

A sample treatment plan

A sample treatment plan is summarized in Figure 6.1.

Phase 1 This phase, usually completed in a single session, involves four parts:

1 Gathering relevant psychosexual, relationship, and medical information, including comorbidities, and making appropriate medical referrals (if necessary). Much of the patient's history can be obtained through questionnaires, formal assessments, and/or interview. Examples of useful instruments for assessing psychological and relational aspects of PE are provided in Table 6.1. No standardized instruments are available for IE, but an innovative healthcare provider could easily adapt one of the PE tools for use with men with IE. A standard practice is to have the patient and his partner complete several assessment tools prior to the initial session so the healthcare provider can focus on any unusual or revealing responses as part of the interview.
2 Educating the patient/couple about the sexual response cycle and dysfunctions; in other words, providing the Permission plus the Limited Information in the PLISSIT model. Specifically, the educational component might include a brief description of the components of the sexual response cycle; the physiology underlying these processes; the many ways in which the processes can be disrupted through medical, biological, cognitive, behavioral, relationship, and sociocultural factors; and permission-giving for alternative strategies for achieving sexual enjoyment. This information could be supplemented with bibliotherapy homework. Bibliotherapy can be a useful form of preliminary treatment to educate patients about the problem; normalize patient feelings, thoughts, and behaviors; and suggest behavioral techniques to affect ejaculatory latency (Kempeneers *et al.*, 2012; Perelman, 2006; Rosen & Althof, 2008). Four useful up-to-date bibliotherapy materials related to treatment of men with PE and IE are:
   - *Sexual Dysfunction in Men* (for both PE and IE; Rowland, 2012);
   - *Coping with Premature Ejaculation: How to Overcome PE, Please Your Partner, and Have Great Sex* (Metz & McCarthy, 2003);
   - *Practical Tips for Sexual Counseling and Psychotherapy in Premature Ejaculation* (Rowland & Cooper, 2011); and
   - *Retarded and Inhibited Ejaculation* (Perelman & Rowland, 2008).
3 Discussing treatment options and modalities. The healthcare provider may continue the session by reviewing the variety of treatment options, the value and limitations of each, and how they might be combined in mutually enhancing ways.
4 Setting goals, building a personal treatment plan, and managing expectations. The patient and healthcare provider will want to set realistic and achievable goals related to sexual response, individual psychological/sexual health, and relationship satisfaction.

Phase 2 In preparation for the second phase one to two weeks later, the patient will have reviewed the bibliotherapy materials about PE or IE and will have learned some specific techniques that might be helpful. From the standpoint of the PLISSIT model, this phase focuses on giving further Permission, providing additional Limited Information, and offering Specific

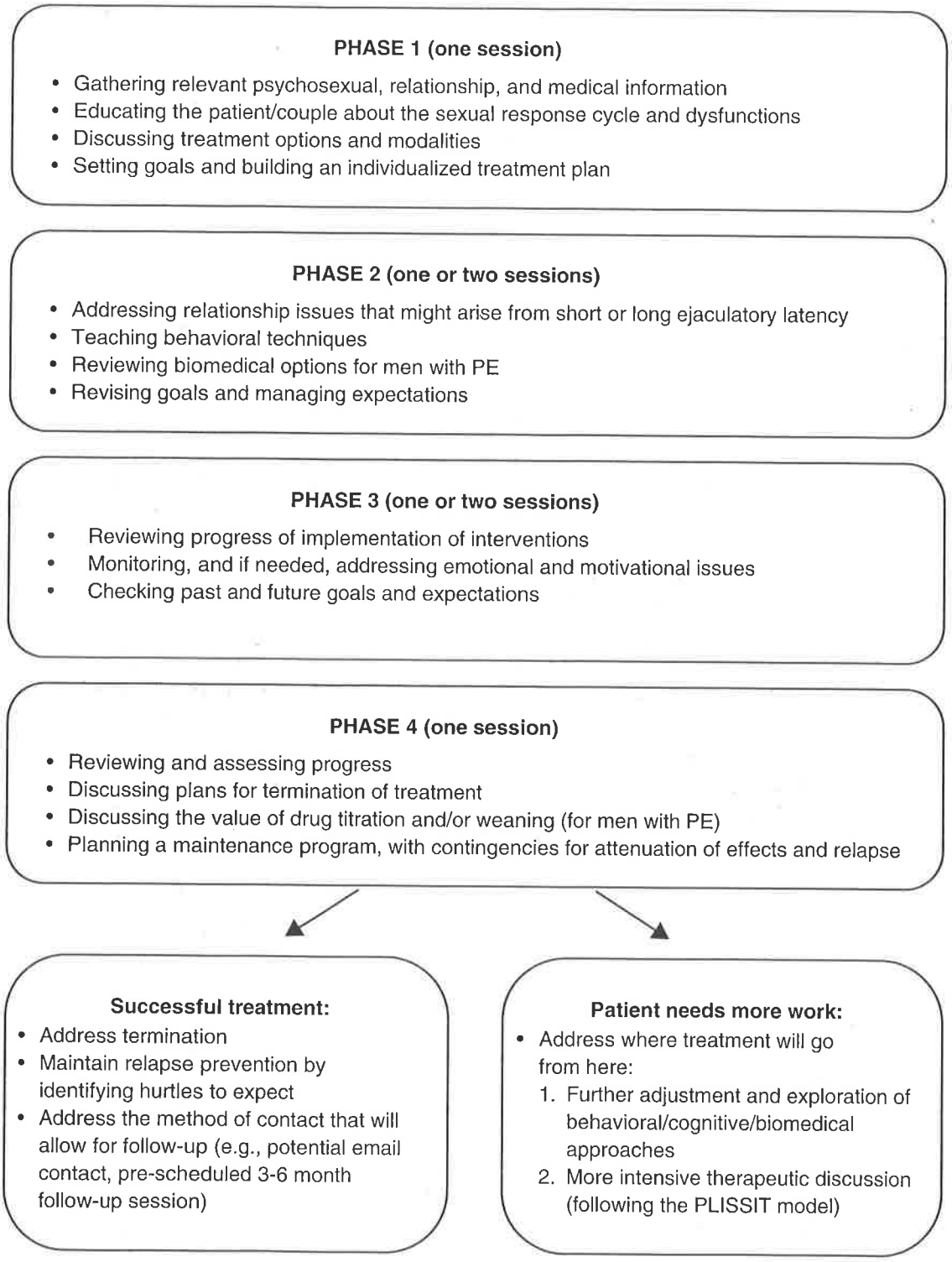

Figure 6.1 Integrative treatment flow chart for PE/IE.

Suggestions. The next one to two sessions might begin with the suggestion that the patient keeps a sex log to provide accurate information for all parties. A sex log may include any information deemed relevant by the healthcare provider, the patient, and his partner (see Table 6.2 for an example).

Subsequent to describing the sex log and its utilization, the provider and patient could focus on the following steps:

1 Addressing relationship issues that might arise from short or long ejaculatory latency, including strategies to improve the relationship through communication, acceptance, and mutual satisfaction. This might also involve expansion of the sexual repertoire. Discussion of relationship issues may reveal the nature and depth of the problems (e.g., lack of confidence, guilt, anger), or the relationship may not be problematic at all. In either case, practicing positive communication skills can be done proactively if the patient's partner is participating in the therapy, and assessment of the partner's support for the therapeutic process is important (DeCarufel & Trudel, 2006; Graziottin & Althof, 2011; Pridal & LoPiccolo, 2000). This initial focus on dyadic interactions may help to ensure a high functioning relationship, which is likely to optimize the effects of treatment.
2 Teaching behavioral techniques, including practical tips that focus on intercourse position, stop-start and squeeze exercises, foreplay strategies, sensate enhancement techniques, arousal enhancement, or masturbation retraining with attention to premonitory sensations of ejaculation. Patients/couples also can be provided with information about the general efficacy of these procedures, which have success rates of about 40–75%, depending on the couple's motivation and adherence. The patient/couple may want to discuss physical limitations or issues preventing them from using specific techniques. The healthcare provider also may spend time on nonsexual strategies, such as sensate focus and mindfulness, to increase relaxation, focus, and somatic awareness, which may help the couple to discover alternative strategies for mutual pleasure.
3 For men with PE, discussing the benefits and limitations of physical/medical interventions (i.e., condom, anesthetizing cream, on-demand SSRI, daily SSRI) with the goal of deciding which, if any, to try. If they have not yet tried a physical/medical intervention, the couple might select one or more options to "test drive" during the next several weeks. Discussion of how physical/medical and behavioral techniques can be integrated can guide the couple towards the most effective use of these treatment aids, with suggestions as to how they might be woven into sexual activity.
4 Revisiting goals and managing expectations. Depending on patient progress after the second phase, and at the healthcare provider's discretion, there may be differing lengths of time between the second and third sessions in order to accommodate patient needs. If it appears that more intense relationship exploration could be beneficial, the healthcare provider may provide a referral for couples therapy (Intensive Therapy in the PLISSIT model).

Phase 3 Phase 3 might involve only one or two sessions, unless the patient or couple opts for more intensive individual or couples therapy. This phase would address the following steps.

1 Reviewing progress thus far, including the efficacy of various behavioral techniques and, when applicable, physical/medical interventions. Much of this session continues to incorporate Specific Suggestions in the PLISSIT model. At this point, the patient and healthcare provider should assess whether treatment seem to be working, or whether there needs to be a shift in the treatment process to better help the patient. For men with PE, this assessment may include a discussion of the use of physical/medical options and whether the patient sees them as beneficial as a short- or longer-term strategy.
2 Monitoring and, if necessary, addressing on a limited basis any issues related to unrealistic expectations and negative thoughts and emotions. Therapeutic interventions could include countering cognitive distortions, processing negative feelings or thoughts, addressing inaccurate beliefs, and promoting sexual self-efficacy (Rowland, 2013).

3 Checking past and future goals and expectations, including whether and how treatment should proceed. At this point the patient/couple may be progressing well and need minimal further assistance such that maintenance will soon be the new and final focus, or they may not be doing so well and thus need a modified treatment plan. Patients who are doing well may suspend further sessions or schedule the final phase in several weeks, and those who are still having negative sexual experiences may schedule an interim working session (or two) before their final session.

Phase 4 This final phase might be scheduled two to three weeks later, unless additional working sessions are needed to discuss referrals for individual or couples therapy or to address issues that might have arisen during Phase 3. In the case of the latter, a follow-up session within one week may be preferred. Phase 4 is the final step in the process, so the session focuses on the following goals.

1 Reviewing and assessing progress, including ejaculatory latency, continued use of behavioral and physical/medical strategies, and general psychological (cognitive, affective) and relationship health. If the patient has not had much success thus far, two additional strategies might be considered: (a) further adjustment and exploration of behavioral/cognitive/biomedical approaches or (b) more intensive therapeutic discussion (following the PLISSIT model) concerning interpersonal or relationship problems that may be connected to the patient's sexual problems or preventing the full effect of the treatment process. Whichever strategy is pursued, the patient's feelings should be validated and processed, followed either by an adjustment to the patient's current treatment plan or by referral for individual, couples, or group therapy.
2 Discussing plans for termination of treatment, with attention to adherence to previously successful techniques, as well as longer term goals.
3 Discussing the value of drug titration and/or weaning (for men with PE). Specifically, the couple may want to try weaning themselves from SSRI medication if they are using it; because such medications must be used as part of each intercourse, the couple may want to attempt intercourse occasionally without this aid, relying exclusively on psycho-behavioral techniques.
4 Planning a maintenance program, with contingencies for attenuation of effects, relapse, and so on. Specifically, the patient and healthcare provider can discuss lapse/relapse prevention, hurdles to expect, and when the situation might warrant a "refresher" or "support" session (see McCarthy & McCarthy, 2009, for strategies to keep the sexual relationship vibrant).

Process issues Although our description of the progression through Phases 1 to 4 has focused on "content"—the information, skills, and techniques conveyed to the patient—within any counseling environment, the healthcare provider must pay equal, if not greater, attention to "process" issues. Process involves two elements: (1) the strategic use of verbalizations (Rowland & Cooper, 2011, 2013)—what Busse and colleagues (Busse, Kratochwill, & Elliott, 1999) defined as "message control" and "message process"—which guide the patient in defining goals and developing self-identified strategies to meet those goals and (2) the manner in which the content elements described above are implemented within the relationship between the healthcare provider and patient/couple. Process elements of integrative therapy most relevant to PE and IE are: (a) developing a positive healthcare provider–patient relationship; (b) expressing empathy, genuineness, and positive regard; (c) promoting motivation to change, a process that typically involves working through resistance; (d) identifying PE/IE-related affect, cognitions, and behaviors (including interactional patterns with partners); and (e) supporting self-efficacy. Each of these is described in greater detail in Rowland and Cooper (2011).

Case Study

Steven and Rochelle, a couple in their mid-40s, met when both were in college studying business. They married subsequent to graduation and had three children, who were aged 18, 15, and 10 years at the time of treatment. Both Steve and Rochelle had wanted this size of family and felt fortunate to have three healthy children, as they had friends who had experienced fertility issues. Steven was employed as a marketing executive with a mid-sized manufacturing firm, and Rochelle worked as the comptroller for a local hospital. As a dual-career couple, money was not a major issue, but with children and aging parents to care for, time for each other and the relationship was a limited commodity. The current quality of their marriage was neither highly conflicted nor highly satisfying. Along with a general diminishment of marital satisfaction over the prior few years, however, the quality of their sexual life had deteriorated significantly. This had manifested in issues of low sexual interest for Rochelle and a mix of IE and periodic erectile dysfunction (ED) for Steven. Recently, they had stopped having sexual relations and realized that this must be addressed if the marriage was to thrive and perhaps even survive.

Steven and Rochelle sought a referral from their primary physician to a healthcare provider (HCP) in a urology practice with a background in the treatment of sexual dysfunctions. The HCP utilized an integrative care approach that included an in-facility therapist with expertise in behavioral and psychotherapy methods for sexual and relationship problems. The couple contacted the specialized urology practice and an initial appointment was set for two weeks. A brief screening had taken place on this call to provide the HCP with an initial presentation of the treatment issues. The couple was informed that they would be receiving several questionnaires in the mail ahead of the assessment interviews, which they were to complete (independently) and bring with them. The particular questionnaires included a modified version of the Premature Ejaculation Prevalence & Attitudes (PEPA) measure (Patrick et al., 2005; Porst et al., 2007) such that IE rather than PE was the focus of the questions, the Male Sexual Health Questionnaire (MSHQ; Rosen et al., 2007), and the Golombok-Rust Inventory of Sexual Satisfaction (GRISS; Rust & Golombok, 1985).

Relevant psychosexual, relationship, and medical information, including comorbidities, were assessed during the initial meetings with the HCP and the therapist. The HCP focused on the historical and current medical and biological aspects of their sexual functioning, and the therapist focused on the psychosocial, relationship, and cultural aspects of these. The HCP and therapist jointly met with the couple to review their proposed treatment plan. This plan included educating the couple about the sexual response cycle and dysfunctions. They were given three supplemental readings to augment the in-session education, specifically Sexual Dysfunction in Men *(Rowland, 2012),* Sexual Dysfunction in Women *(Meana, 2012), and* Discovering Your Couples Sexual Style: Sharing Desire, Pleasure, and Satisfaction *(McCarthy & McCarthy, 2009). They were instructed to peruse these resources before the next treatment session. The HCP and therapist discussed possible treatment options with Steven and Rochelle. The couple elected to use medication (a PDE-5 inhibitor such as Viagra or Cialis) to help Steven regain confidence that he could keep his erection sufficiently long for prolonged intercourse due to his IE. In addition, they were offered a brief therapy regime to address both sexual enhancement and broader relationship satisfaction. The HCP and therapist each conveyed that, although the likelihood of improvement was high, the couple should expect occasional setbacks. Finally, the therapist instructed the couple in the use of a sex log (see Table 6.2).*

Steven and Rochelle came to the clinic for their second session two weeks later. They reviewed their sex log with the HCP and discussed the effects—wanted and unwanted—of the medications. Steven and Rochelle then met with the therapist. They used this time to address relationship issues that arose from particular incidents of long ejaculatory latency that they had experienced since the initial assessment session. Strategies to improve the relationship through communication, acceptance, and mutual satisfaction, including some ideas on expansion of the sexual repertoire, were covered in this session. To enhance their sexual functioning, the therapist helped the couple

Table 6.2 Example log of sexual experiences to be given as homework.

Sex Log								
Date	Time of day	Time until ejaculation	Techniques or methods	Feelings (before, during, after)	Successes and/or challenges	Patient's satisfaction: rated (1-5)	Partner's satisfaction: rated (1-5)	Physical/medical intervention used (condom, cream, medication)

learn behavioral techniques, including practical tips that focused on intercourse position (e.g., identifying a position that provides maximal stimulation for Steven), foreplay strategies (e.g., allowing Steven to guide Rochelle regarding the kinds of stimulation that are most arousing for him), masturbation retraining (e.g., including Rochelle in masturbatory exercises that use varying types of penile stimulation), and fantasy sharing (e.g., revealing sexual scenarios that Steven and Rochelle find particularly arousing). At the end of this second session, the couple faced a decision about whether to add more sessions to focus more deeply on their broader relationship issues or to keep the focus more on a restoration of their sexual functioning as a couple. Steven and Rochelle elected the latter, so the treatment plan was for the couple to return for two to three more sessions depending on progress made.

Steven and Rochelle returned three weeks later. They met with both the HCP and therapist to review progress, including the efficacy of various behavioral techniques and medical interventions. The couple had had a positive therapeutic response from the medication, but Steven complained of some unwanted side-effects; thus, adjustments were made in the dosage of medications used. For the counseling component, the therapist used the time with the couple to help them more deeply process their respective underlying cognitions and affects surrounding their sexual encounters and relationship. As a result of the prior sessions, Steven and Rochelle reported being more expressive and open about their wants and dislikes and more flexible in the ways they incorporated sexual touch and contact together, given their overly busy lives. At this time, they also were encouraged to use some of the techniques provided by McCarthy and McCarthy (2009) to rejuvenate their sexual interest.

Steven and Rochelle returned for the next session three weeks later. As before, they again met with both the HCP and therapist. The session began with a review and assessment of progress, including ejaculatory latency, behavioral and medical strategies, feelings of sexual interest and intimacy by each partner, and general psychological (cognitive, affective) and relationship health. The couple reported making gains regarding better and more open communication as well as feelings of stronger arousal and intimacy for both, but they acknowledged that, on two occasions, they had experienced setbacks in which the IE reoccurred during sexual encounters. Details of both the successes and the setbacks were discussed. Discussion took place as to whether to schedule a follow-up session or to continue on their own with medication and the techniques they had learned in the psychotherapy, calling for an appointment only if needed or desired. Steven and Rochelle elected the latter. The couple felt they had made sufficient progress to discontinue the therapy. The therapist used the remainder of this fourth session to help the couple address challenges of adherence to and compliance with previously attempted techniques, as well as longer-term goals. Attention to relapse prevention and the importance of having realistic expectations was covered, with added reference to the bibliotherapy resources. The HCP then met with Steven and Rochelle to discuss the value of drug titration and/or weaning from the medication and to plan a maintenance program, with contingencies for attenuation of effects. Both the therapist and the HCP included discussion of the couple's situation that might warrant a "refresher" or "support" session. With improved communication and intimacy, and significant progress regarding their sexual relationship and satisfaction, the couple left feeling optimistic about their longer-term outlook.

Conclusions

The brief therapy PLISSIT model as described here represents a conceptual composite rather than an empirically tested, formulaic treatment program for orgasmic disorders. That is, we have provided a series of progressive steps supported by various general treatment strategies and have included specific strategies effective in the treatment of PE and IE. Furthermore, the brief counseling model we have described assumes a traditional delivery format—namely face-to-face sessions. With the advent of electronic media, a significant portion of this

interaction could be accomplished through the internet, websites, or email. Indeed, internet counseling has provided a particularly effective way of reaching patients in remote places, patients who lack easy access to specialized healthcare providers, or patients who have limited financial resources (van Lankveld, Leusink, van Diest, Gijs, & Slob, 2009). Prescribed email communications may provide an option for periodic updates that could obviate the necessity for additional sessions. We presume that a significant amount of the content described in the two- to six-session brief therapy model could, depending on the preferences of the therapist and patient, be handled through an online format.

Finally, the use of the sex log of activities fits well into the growing movement known as "practice-based evidence." Practice-based research relies on the ongoing collection and utilization of data to target problem areas and assess the overall effectiveness of the treatment in order to increase the likelihood of change. The idea is to constantly monitor and adjust the treatment approach as warranted by the data (Miller, Duncan, & Hubble, 2004). In addition, assessment of the patient–therapist alliance (a process issue) and the patient's satisfaction with the therapeutic process and outcomes provide important data-based endpoints, so these should be assessed as well.

In conclusion, the combination of a variety of therapeutic tools based on a biopsychosocial approach, a rigorous but brief counseling format that incrementally progresses to deeper levels of engagement, and an embedded assessment process could render the therapeutic approach for PE and IE both effective and cost-efficient.

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