

# COMING OF AGE: AN INTEGRATED APPROACH TO PREMATURE EJACULATION

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## Definition: How Little, How Soon?

During ejaculation, which is mediated by a sacral spinal reflex, semen is released through the urethra via contractions of the striated muscles that surround the bulbar urethra. While orgasm is generally the result of both genital and psychological stimulation, central stimulation alone may trigger orgasm. The defining characteristic of premature ejaculation (PE, also known as rapid ejaculation or early ejaculation) is the fact that the man feels he has little or no control over when ejaculation occurs, which commonly leads to feelings of shame and inadequacy. It is difficult to define precisely. Urologists argue that normative data on ejaculation latency time obtained by the stopwatch method in the general male population are mandatory to really establish the prevalence of lifelong PE, defined as an ejaculation time of less than 1 minute in men with complaints of PE (a quantitative measure).<sup>1</sup> Psychiatrists and psychologists, however, have repeatedly suggested that definitions of PE that used a specific duration of intercourse as the dividing line or that specified a minimum number of penile thrusts before ejaculation should be discarded, favoring qualitative measures like female partner satisfaction or the extent of voluntary control experienced by the man.<sup>2-5</sup> Lack of standardization of the definition poses a clinical conundrum as to what constitutes a problem and a confusion over efficacy endpoints of treatment methods.

PE is ejaculation that occurs sooner than desired, either before or shortly after penetration, causing distress to either one or both partners. The definition assumes the absence of partner sexual dysfunction.<sup>5</sup> It is important to add that up to 70% of women may be non-orgasmic in intercourse<sup>6</sup> and couples may forget the continuation of pleasuring which is possible after ejaculation. Another important qualifier is that PE is defined according to whether the couple consider it a problem; rapid ejaculation is not a problem if both partners 'agree that the quality of their sexual encounters is not influenced by efforts to delay ejaculation'.<sup>7</sup>

## Prevalence

PE was the third commonest problem seen in men attending a Sexual Dysfunction clinic in Central London, which has an Asian Population of up to 20%.<sup>8</sup> Data from the National Health and Social Life Survey, a major prevalence study of sexual dysfunction in the United States completed in the mid-1990s, have revealed a prevalence of 21% in men ages 18 to 59 in the United States.<sup>9</sup> The main problem with these data is that there are no large-scale population studies that examine

the normal range of ejaculatory latency. PE is thought to be a common problem, especially amongst Asian males, where some authors describe as Dhat syndrome.<sup>10</sup> The partner may be the main 'complainant' because the problem interferes with her enjoyment. Locally, PE may be a cause of non consummation of marriage, where the husband ejaculates outside the woman's vagina.

## Etiology

Etiology of PE is not clear. Various hypothesis have been proposed but there is no general agreement, and neither early experiences nor the nature of the current relationship provide adequate explanations. Animal studies have demonstrated that it is activation or inhibition of postsynaptic 5-HT<sub>2c</sub> and 5-HT<sub>1A</sub> receptors that determines whether ejaculation becomes rapid or delayed.<sup>1</sup> Assuming congruency between rodent and humans neuroreceptors, Waldinger speculates that PE may be understood as a hypofunction of the 5HT<sub>2c</sub> receptor or a hyperfunction of the 5HT<sub>1A</sub> receptor.<sup>1</sup>

Penile sensitivity and a constitutionally more rapid bulbocavernosus reflex may predispose men to develop PE. However, well-controlled studies have failed to support the involvement of the bulbocavernosus reflex in men with PE.<sup>1,5</sup> Other possible causes of PE include: trauma to the sympathetic nervous system during surgery for aortic aneurysm, spinal cord injury related to trauma at the T12-L1 level, pelvic fracture, prostatitis, urethritis, drug withdrawal from narcotics and thyrotoxicosis.

Postulating a 'single' cause of PE is short-sighted; there is no agreed on physical cause and no generalizable psychological issue or underlying conflict. There have been suggestions that PE is not a single disorder and that there are several subtypes with both biologic and psychologic contributions. Even if the cause in a particular case is entirely organic, this would not preclude the man having a psychological reaction that further complicates or perpetuates the problem. Men with PE are not always hypersensitive to stimulation but are typically rather anxious about the disorder or other aspects of sexual functioning.

Coper et al have distinguished between primary or lifelong premature ejaculators, and those with secondary or situational PE (i.e., one that arises after a period of satisfactory sexual functioning).<sup>11</sup> The authors found that men with primary PE were generally younger and had higher levels of sexual anxiety and increased libido. In contrast, patients with secondary PE had a higher incidence of erectile dysfunction and other performance difficulties. The acquired form seems to be the result of relationship discord or medical illness. Life events which provoke guilt or a loss of confidence can result in loss of control of ejaculation.

Erectile difficulties can also occur if a premature ejaculator struggles to control his sexual arousal by using distraction. The irony is that if he succeeds too well in distracting himself from involvement in the sexual encounter, he may lose his erection.<sup>2</sup> PE may be associated with other sexual disorders: desire or orgasmic difficulties in his partner, low sexual desire for both men and women, and sexual aversion in both men and women. When devising interventions, the therapist would need to determine which dysfunction developed first and how two sexual disorders are interwoven.

### Sex therapy and behavioural approaches

When evaluating a man with PE, it is crucial to understand the meaning of sexuality to the man, as well as his ability to be comfortable in an intimate relationship, and the role PE may play in the dyadic relationship. There are sex therapists who believe that PE is not a sexual dysfunction and that couples should be encouraged to explore and appreciate other forms of intimacy. In treatment, it is important to assist the man psychologically to develop a better sense of his own sexual confidence or control.

It would be ideal to include the partner in the assessment and treatment of the condition. In many cases education, reducing distracting cognitions, reducing performance demands, and the reduction of anxiety produced by sensate focus, relaxation and improved communication can have the effect of delaying ejaculation sufficiently to enable satisfactory intercourse. The couple's expectations of intercourse should be discussed and misconceptions (e.g., that the only 'good' orgasm in a woman is produced by intercourse and is prevented by the man's climaxing first) should be dispelled. If the circumstances under which intercourse occurs are conducive to rapid climax (e.g., anxiety about being heard by others in the house or little time for sexual play), practical strategies include restructuring the setting.

In sex therapy, the basic treatment package consists of the following steps:

1. Ban on sexual intercourse until the orgasmic response is retrained
2. Education about sex, basic anatomy and physiology of sexuality, exploring the couple's sexual vocabulary, and providing a vocabulary for future sessions
3. Incorporate relaxation techniques
4. Non-genital sensate focus
5. Genital sensate focus
6. Penetration (initially without pelvic thrusting). This is generally performed in the female superior or lateral positions for most sexual problems except for male retarded ejaculation
7. Use of different sexual positions and resumption or commencement of full sexual life.

Some men find that they can overcome PE on their own, e.g., by using a condom to cut down on genital sensation, using alcoholic beverage, having a second orgasm – that is, they would have had one orgasm and then attempt intercourse

within the next two or three hours.<sup>2</sup> The rearousal process may well require some assistance from the female partner, and lubricating oils may come in handy for this purpose.

In the stop-start technique the man learns, in homework exercises, to delay ejaculation in self-stimulation by approaching the 'point of inevitability' and then ceasing the stimulation until the urge abates. The penis becomes quite refractory after a successful trial of this, and the man finds that he can, by successively stopping and starting, delay ejaculation for up to 15 minutes. He is then asked to repeat the homework using bodily oil or a similar lubricant on his hand, until he can again last for 15 minutes. His partner then stimulates him in a similar way, with a dry and then a lubricated hand, and they again do this on several occasions until he can last for 15 minutes. The technique can then be used in intercourse, the couple stopping their movements as the 'point of inevitability' is reached and then resuming when the urge has abated. Partners should not be made to feel used, and the exercises should also seek to heighten their pleasure.

Not all patients are able to identify the 'point of inevitability'; they may have a short arousal phase and an almost non-existent plateau phase of their arousal cycle.<sup>7</sup> With some men the 'stop-start' technique is insufficient to prevent orgasm. The 'squeeze' technique is another option. The couple are asked to perform genital sensate focus but once the man signals high arousal, the woman is asked to grasp the corona of his penis with her fore and middle fingers against her thumb, applying firm pressure for approximately 20 sec. Caution needs to be exercised as it can be painful if too much pressure is applied. Alternatively, the man can perform this manoeuvre himself. Whoever performs the technique, the same pattern of practising this three to four times is followed during genital sensate focus before proceeding to orgasm. The 'stop-start' technique of Semans is similar in essence to the 'squeeze' technique recommended by Masters & Johnson,<sup>2</sup> but easier to teach and easier to use. Locally, for some couples, it may be difficult to enlist the co-operation of the woman who is afraid or reluctant to touch the man's external genitalia.

The 'quiet vagina' technique refers to an elaboration of the 'stop-start' maneuver that involves intercourse. The woman sits astride or lies on top of the man and, without any thrusting or movement, puts his penis in her vagina. This exercise serves to desensitize the man to the wet, warm sensations of the vagina. After the man can master 'quiet vagina' for a prolonged period of time, movement is gradually introduced.

Whereas initial reports suggest that conditioning techniques (i.e., 'stop-start', 'squeeze') are successful in more than 90% of cases, more recent studies indicate a much lower overall success rate.<sup>12</sup> Several explanations have been offered for the apparent decrease in effectiveness of sex therapy treatments for premature ejaculation, including the greater availability of self-help materials and resulting decrease in 'straightforward' cases presenting for sex therapy, as well as methodological limitations of earlier studies.<sup>3</sup>

Some Asian men may have religious or cultural objections to using the standard 'Stop-Start' and 'squeeze' techniques, as

both require masturbation which is unacceptable and a taboo in Asian cultures.<sup>8,10</sup> Semen is considered to be a precious substance in Indian and Chinese cultures. Atharva-ved, one of the ancient Indian religious books, mentions that a hundred drops of blood are required to make one drop of semen. Its loss is inevitably seen as a loss of strength and vitality.<sup>8</sup> According to Indian belief, weak semen will not produce a male child, which is of great importance in Indian culture.<sup>10</sup>

Penile constriction rings, when used with or without the vacuum pump in the treatment of erectile failure, sometimes make ejaculation difficult. Their use in sex therapy, however, has not been properly evaluated.

### Pharmacological interventions

These include: antidepressant medications (e.g., paroxetine, sertraline, fluoxetine and clomipramine), topical ointments, PDE5 (phosphodiesterase enzyme type 5) inhibitors or combinations of the above. Paroxetine, sertraline and fluoxetine have all been found effective in increasing the latency to orgasm from less than 1 minute to between 2 and 6 minutes. Dosing of the various selective serotonin reuptake inhibitors (SSRIs) for the treatment of PE include paroxetine, 20 to 40 mg/day; fluoxetine, 20 to 40 mg/day; sertraline, 50 to 100mg/day; and fluvoxamine, 100/day. Paroxetine induced the longest delay in ejaculation, followed by fluoxetine and sertraline.<sup>1,4</sup>

Kim et al (1998) provide moderately strong evidence that clomipramine and sertraline can improve short-term sexual satisfaction for patients with PE.<sup>13</sup> Side effects were minor but common, especially for clomipramine. However, the study did not address the following issues: the efficacy of long-term usage, and the comparison with or a combination with behavioural therapy.

Kim et al (1999) treated 24 men on an as needed basis for primary premature ejaculation.<sup>14</sup> They chose oral sertraline from among the SSRIs because its large dose is not divided and peak plasma levels occur 4 to 8 hours after oral administration, making 5 pm a suitable time for administration (by which time a man may know whether sexual intercourse is likely to occur later that evening). Each patient was started on 50 mg daily for 2 weeks, and the dose was then adjusted to 50 or 100 mg on the day of intercourse only (PRN). Mean ejaculatory latency improved from 23 sec to approximately 5 min. This regimen is easy for the patient to use. However, as needed schedules, while preferred by patients, appear over time to be less effective than daily dosing.

Side effects of SSRIs are generally mild, dose related and diminish with time; dry mouth, headaches, drowsiness, gastrointestinal upset (mild nausea, loose stools), fatigue, yawning and perspiration have been reported. SSRI induced mania also is a well recognized adverse effect of this class of drugs. The duty of the physicians must include warning patients of the slight risk of a heightened sense of anxiety and at the extreme mania in the early stages of therapy. In clinical practice, SSRI treatment may give rise to complaints of decreased libido and slightly decreased rigidity of the erect penis.

Topical anesthetic agents may be applied to the penis prior to intercourse to delay ejaculation. Lidocaine(lignocaine)-prilocaine cream (2.5 gm) applied for 20 to 30 minutes prior to intercourse has been shown to increase latency time in 81% of men.<sup>15</sup> Men can titrate the degree of penile numbness by adjusting the exposure time to the cream. Numbness of the penis, reduction of penile sensation and numbness in the partner are potential side effects. It is pertinent to tell couples not to remove the condom or to wipe the cream from the penis if the condom is removed. The cream should be wiped off completely before intercourse to prevent vaginal numbness. Topical anesthetics are contraindicated in patients who are either allergic themselves or have partners who are allergic to any component of the product.

In men with acquired PE, PE may be a sign of early erectile dysfunction. In such men, PDE-5 inhibitors sildenafil, vardenafil and tadalafil would have a role to play. Sildenafil, in combination with sertraline, has also been reported to improve the latency ejaculatory time and sexual satisfaction mainly in older patients with a lifelong pattern of PE. PDE-5 inhibitors have no direct effect on the process of ejaculation. They allow many men to have a second or third erection, which makes it possible to prolong the sexual encounter. They also can increase a man's confidence in his sexual prowess, thereby diminishing the anxiety that leads to some cases of PE.

### Combination treatment

The benefits of drug therapy are rapidly reversed, i.e., ejaculation latency is known to shorten following withdrawal of the drug. There are grounds to use a combination of sex therapy and pharmacological intervention for men with PE. Couple communication training, sensate focus exercises, and 'stop-start' techniques would be the key components of such a strategy. Behavioural therapy is largely limited by the need for partner cooperation and a questionable long-term outcome. Given the propensity for success rates to diminish over time, clinicians need to implement relapse prevention strategies. Having booster sessions with the couple, e.g., on a 3-monthly basis, may help to maintain treatment gains over the long term.

### Patients without a partner

Single men with PE are reluctant to establish new relationships. Nevertheless, it is possible to treat such patients as well, with the objectives of enhancing their sexual knowledge, their own satisfaction and repertoire of sexual skills. It is argued that once their level of confidence improves, they may find it easier to find a partner.

### Gay men

Almost all PE definitions are heterosexist, i.e., referring only to heterosexual behaviour. A study revealed that 19% of a convenient sample of 197 gay men reported 'ejaculating too soon/too quickly'.<sup>16</sup> Most treatment strategies for PE are used for couples or individuals with heterosexual orientation, but these techniques can be adapted to gay men as well.

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