# Clinical Case: Treatment of Premature Ejaculation (PE) and Erectile Dysfunction (ED)

Premature Ejaculation (PE) and Erectile Dysfunction (ED) are the two most common male sexual dysfunctions. Both cause men considerable emotional and relational distress.

The definition of PE is difficult, but centers on orgasm occurring before the man wishes it to. Most men begin their sexual lives as premature ejaculators. As they gain comfort and experience, most men develop ejaculatory control. For reasons that are unclear, three in ten adult males fail to develop ejaculatory control and experience premature ejaculation as a lifelong problem. Not being able to control to their satisfaction when they have an orgasm, these men suffer quietly, feeling an unremitting sense of shame and humiliation that is reinforced by their partners' frustration and anger.

Erectile Dysfunction (ED) refers to men having difficulty obtaining or maintaining firm erections. By the age of 40, about 90% of men have experienced difficulty obtaining or maintaining an erection adequate for intercourse at least once. By the age of 50, over 50% of men report mild to moderate ED. If an erection problem does not remit within six months, the man (and couple) becomes trapped in a cycle of anticipatory anxiety, performance failure, and sexual avoidance.

Approach to Treating Premature Ejaculation and Erectile Dysfunction

My approach to treating PE and ED is primarily cognitive-behavioral, but includes other techniques such as hypnosis.  I recommend medication as an adjunct to sex therapy where this seems appropriate. For the sake of clarity, the process of change is described as four discreet steps. The steps are illustrated using the clinical case of a man experiencing primary premature ejaculation and secondary erectile dysfunction.

**Clinical Case**:  **Male Experiencing Primary Premature Ejaculation (PE) and Secondary Erectile Dysfunction (ED)**

Hugh, a computer programmer and single male in his mid 30s, called requesting help for premature ejaculation. He had read some literature about PE, and experimented with the stop-start technique, but without success. He had recently started to date a new woman whom he had feelings for, and was eager to solve his sexual problem before this relationship became sexual.

*STEP 1: Assessing the sexual problem*

In Step 1, a respectful, therapeutic relationship is established in which the client feels comfortable discussing sexuality. An assessment of the individual's current sexual

functioning, sexual history, and relationship history is conducted in order to define clearly the sexual problem. Treatment options are discussed and a therapeutic agreement is reached to work toward the resolution of the problem.

When Hugh arrived at the first session late, it was clear that he was uncomfortable. When I asked what it was like to be in my office, he stated, "This is the last place I thought I'd be." He stated that he prided his ability to handle problems on his own and he felt weak having to talk to me. I conveyed I understood how difficult it was for him to be talking to me, and asked what I could do to make the experience as comfortable as possible for him. Hugh said he didn't know, but would let me know if he thought of something. I then asked if it was okay to tell me what brought him to see me in more detail than in our telephone contact.

Hugh indicated that he had experienced premature ejaculation in all his relationships with women, and he was apprehensive about this occurring again with the woman he had met recently. Typically, Hugh ejaculated within one minute after intromission. If Hugh hadn't had sex in several weeks or was with a new partner, he would ejaculate within seconds after intromission. When Hugh ejaculated prematurely, he experienced his orgasms as weak and ungratifying.

An exploration of other aspects of Hugh's current sexual functioning revealed that he self-stimulated about three times a week. Typically, he masturbated in a goal-directed manner and reached climax in about five minutes. Hugh admitted to having typical sexual fantasies and occasionally using internet pornography to increase his arousal while masturbating. When asked, Hugh also admitted to variable erectile dysfunction. Although he had firm erections upon waking and when self-stimulating, typically he had difficulty maintaining his erection with a new partner, often losing it shortly after commencing intercourse. Once Hugh got to know the partner, he maintained his erection better but invariably ejaculated prematurely. Hugh denied any pain associated with sex. He reported being in good health, on no medications, and active physically.

An exploration of his sexual history revealed that Hugh had had no unwanted sexual experiences in childhood. He had learned to masturbate around age 14 in a goal-oriented manner focused on reaching climax quickly. Hugh's first experience of intercourse at age 21 had been a one-night stand in which he had ejaculated prematurely. His first experience of ED had occurred several years later when he met a woman he really liked, his first love.

An assessment of his relationship history indicated that Hugh had not felt confident enough to date as a teen. His first real relationship had been at age 23, when he met his first love through a friend. Hugh had felt devastated when this woman ended the relationship after nine months, largely he believes because of his sexual problems. After this, Hugh had ended relationships mostly himself after several months rather than face the painful rejection he anticipated. The exception had been when he had met a woman he really liked in his early 30s, but had again felt rejected painfully after one year. He had thought he wouldn't try again until he had met Glenda several weeks before calling me.

He felt really drawn to Glenda, a single parent, and had decided it was time to deal with his sexual problem by calling me.

When I asked Hugh how he had attempted to deal with his PE, he reported he had tried to distract himself by thinking about work or sports. I explained that this strategy reduced sexual arousal, thereby increasing the risk of ED, without increasing ejaculatory control. Hugh's other strategy had been to have a second intercourse as quickly as possible. He had found the second orgasm less satisfying, and received feedback from partners that they had felt more like an object during the second intercourse.

Based on my assessment, I informed Hugh that PE was the primary sexual problem and ED the secondary problem. The PE had occurred first, and the ED had developed later as a consequence of the PE. He had developed ED in part as the result of his attempt to avoid ejaculating quickly by distracting himself.

Although there is neither an agreed-on physical cause of PE, nor a generalizable psychological issue or underlying conflict that causes PE, I suggested that anxiety was a factor in maintaining his PE. As the result of anxiety, he was less aware of his level of sexual arousal, resulting in a lack of ejaculatory control. I indicated that for men under 40, most ED is psychogenic (related to psychological factors) rather than biogenic (related to physical or medical factors). I suggested that his ED was psychogenic because he had had firm erections upon waking and when self-stimulating. His ED was maintained by anticipatory and performance anxiety. Hugh seemed relieved to hear that both PE and ED were treatable, and that it was best to treat both concurrently.

I explained that both PE and ED could be treated by medication or sex therapy, or a combination of these approaches. In treating PE medically, Hugh could take an antidepressant in either a daily small dose or a moderate dose four hours before sex. The downside of treating PE medically is that when the antidepressant is stopped, PE returns (a rebound effect), sometimes more severely. One option would be to practice ejaculatory control exercises (sex therapy) while taking medication, and then gradually phasing out the medication. Another option would be first to try sex therapy, which focuses on learning and mastery, with medication as a fall-back. The latter option appealed to Hugh, who was reluctant to use medication.

In treating the ED medically, I explained that Hugh could take Viagra, or one of the newer oral erectogenic agents, Cialis or Levitra. These PDE-5 inhibitors block a chemical (PDE-5) that causes the degradation of cyclic GMP, a chemical which creates erections. Oral erectogenic agents also serve as a positive psychological stimulus to reduce performance anxiety. One option would be to take an oral erectogenic agent while using sex therapy to develop erectile confidence. Another option would be to try sex therapy first, with medication as a fall-back. Once again, Hugh opted for the latter option.

I suggested to Hugh that there was no quick fix to developing ejaculatory control and erectile confidence with sex therapy. If he was willing to commit to a process of change

requiring five to ten sessions, and to do practice exercises consistently between sessions, he could develop ejaculatory control and erectile confidence.

*2: STEP Developing ejaculatory control and erectile confidence concurrently*

In Step 2, the client is introduced to self-stimulation exercises to develop ejaculatory control. Concurrently, the client is encouraged to enlist the support of a partner as a sexual friend to increase erectile confidence.

In introducing self-stimulation exercises as a means to develop ejaculatory control, I explained that ejaculation, like bladder control, is a voluntary reflex. Just as Hugh had learned to bring bladder function under voluntary control as a child, so also he could learn how to bring the ejaculatory reflex under voluntary control as an adult.

I introduced Hugh to the notion of an 11-point arousal scale, where zero represents no sexual arousal, and ten represents ejaculation. Men who ejaculate prematurely during intercourse move rapidly from low levels of arousal to ejaculation. In learning control, the challenge is to stay at a constant, high level of arousal, between 7.5 and 8 on the 11-point arousal scale.

I introduced self-stimulation exercises as a strategy for learning ejaculatory control. In phase 1, I instructed Hugh to masturbate with a dry hand in his usual way until he felt an orgasm approaching. He was to pay particular attention to the sensations in his penis and groin in order to heighten his awareness of what it felt like to approach orgasm. When he felt the orgasm approaching, he was to stop masturbating and take a few deep breaths, waiting anywhere from 10 seconds to a minute until his arousal had dropped significantly. He was to repeat the process, and on the fourth repetition allow himself to reach orgasm. I instructed him to do this exercise three times a week for two weeks.

In phase 2, I instructed Hugh to try to keep the arousal at a constant, high level, between 7.5 and 8 on the arousal scale. As he approached "6" or "7", he was to slow the rhythm of masturbating in order to maintain a constant, high level of arousal. By way of analogy, I suggested he think about driving a stick shift car and keeping it stationary on a hill. With his left foot on the clutch, and his right foot on the accelerator, he was to keep the car from either moving forward or rolling back by balancing the two. It was okay if he didn't gauge his arousal accurately and suddenly ejaculated. The challenge was to go a little slower the next time, paying attention to keeping the level of arousal high and constant. He was to do this three times a week for up to 15 minutes. I stressed the importance of practice in learning control, drawing a comparison with how athletes use repetition to master a particular skill.

In phase 3, the only difference was the addition of a lubricant (e.g., KY Jelly, Astroglide). I explained that the lubricant simulates more the sensation of the penis being in a lubricated vagina, which is more stimulating than "dry" masturbation. Hugh agreed to repeat the exercise, and to pay attention to how this felt different.

At the same time that Hugh was developing ejaculatory control by practicing the self-stimulation exercises, at my suggestion he was “going slow" getting to know and trust his new female friend, Glenda. When I suggested that he consider telling Glenda about his sexual issues in order to ask for her understanding and support as a sexual friend, he wasn't sure this was a good idea. He was afraid she would dump him. When I suggested that it would be better to face possible rejection early on rather than down the road, he agreed to talk with her. He was surprised that she responded positively, indicating she wanted to help him with his sexual issues.

I indicated that the foundation for regaining erectile comfort and confidence is nongenital and genital pleasuring. I recommended that he and Glenda engage in a special type of touch called "nondemand" pleasuring. I explained that nondemand pleasuring is touching that is valued for itself, with no pressure or demand for intercourse. In phase 1, they were free to engage in any type of sensuous and playful touch short of orgasm and intercourse. As examples, I suggested that they sensuously massage each other, or touch while cuddling in bed, or playfully "fool around" on the couch or in the car. The goal of this touch was to experience pleasure and to feel close rather than to turn each other on.

While engaging in nondemand pleasuring, I suggested that a crucial strategy toward regaining erectile confidence was for Hugh to become comfortable with the waxing and waning of his erections. Men are used to going to intercourse and orgasm on the first erection, so when an erection fades, they panic and give up. Hugh confirmed that this was true for him. He would "spectator" by observing his penis, and the moment his erection waned, he would feel devastated and give up. I informed him that the process of waxing and waning of erections can occur 2 to 5 times in a 45 minute pleasuring session. I assured him that by resuming pleasurable touch and stimulation, he would regain his erection. As Hugh and Glenda engaged in nondemand pleasuring with a temporary ban on orgasm and intercourse, Hugh developed confidence in the ability to regain his erections.

In phase 2, I instructed Hugh and Glenda to engage in any type of erotic stimulation culminating in orgasm, but excluding intercourse. The goal was to arouse and turn each other on. Fortunately, both were comfortable giving and receiving manual and oral sex. I suggested that they heighten their arousal while giving and receiving manual and oral sex by using multiple stimulation (e.g., fantasy, kissing, touching breasts and testicles).

While engaging in erotic touch, I informed Hugh that a second strategy for overcoming the performance anxiety that maintained his ED was to know that he could pleasure Glenda fully with his ten fingers and tongue, without a firm penis. Having repeated experiences of pleasuring Glenda in this way would eliminate all performance anxiety because he would know that giving Glenda pleasure did not depend on a firm penis.

Hugh was skeptical initially, but reported that although Glenda liked intercourse, she had expressed real satisfaction with how he was pleasuring her. Knowing that he didn't have to have a firm penis to pleasure Glenda really did reduce his performance anxiety. What surprised him the most was that he was having terrific orgasms.

A third strategy for developing erectile confidence was to separate out the negative thought process that mediated his anxiety. Following the Voice Therapy approach to cognition, I explained that it was common for men with ED to "listen" to a negative thought process preceding sex that mediated anticipatory anxiety, during sex that mediated performance anxiety, and following sex that mediated guilt and self-blame. I suggested that listening to a negative thought process has a strong negative influence on erectile functioning because "the penis is attached to the heart".

Hugh identified readily his negative thought process. Before sex, he would tell himself, "I'm not going to keep it up, and even if I do, I will come too soon. What's the point of trying? I should just avoid sex." During sex, he would tell himself, "I'm not going to keep it up. See, it's softening. I'm losing it." After losing his erection, he would say to himself, "I've disappointed her again. I'm a lousy lover. She won't want to stay with me."

I suggested that Hugh say these thoughts in the 2nd person, "**You**", as if someone else was addressing him. Hugh stated: "**You're** not going to keep it up, and even if **you** do, **you** will come too soon. What's the point of trying? **You** should avoid sex.... **You're** not going to keep it up. See it's softening. **You're** losing it.... **You've** disappointed her again. **You're** a lousy lover. She won't want to stay with **you**." Hugh was surprised about how differently he experienced these thoughts when he said them in the 2nd person. He realized that listening to these thoughts caused him to anticipate sex negatively, contributed to losing his erection, and left him demoralized afterward.

When I suggested that he counter these thoughts from his healthy point of view in the 1st person, "**I**", he asserted: "Whether or not **I** get and maintain a firm erection doesn't matter. **I** can always regain my erection. Even if **I** don't, **I** don't need a firm erection to have wonderful sex with Glenda." Holding on to this healthy thought process increased his confidence and comfort with respect to erectile functioning.

As Hugh and Glenda engaged in erotic touch leading to orgasm but excluding intercourse, Hugh became increasingly aware of the negative thought process. He found that the mere awareness of the negative inner voice enabled him to "separate it out", and to refocus on giving and receiving pleasure in the moment. The more he stayed absorbed in the moment, the more pleasure and arousal he felt, and the more his erection took care of itself.

Hugh was experiencing ejaculatory control during the self-stimulation exercises. He was also experiencing erectile confidence. The next step was to extend ejaculatory control and erectile confidence to intercourse.

*STEP 3: Extending ejaculatory control and erectile confidence to intercourse*.

In Step 3, the goal is to experience ejaculatory control and erectile confidence with intercourse. A step-by-step process is used to make the transition to full intercourse.

When I asked Hugh how he felt about moving to intercourse, he stated he felt anxious but ready to take this step. I indicated it was understandable that he felt anxious, and that it would not be unusual if he lost control and came quickly, or lost his erection. He found it reassuring when I provided him with the following step-by-step process for resuming intercourse. As was typical of their love- making, they were to arouse each other with sensuous and erotic touch. Once they were aroused, because the hardest situation for ejaculatory control is with the man on top using short, rapid thrusting, I suggested that he begin by lying on his back with Glenda in the on-top position. The first step was for Glenda to insert his penis gradually, in stages, into her vagina until it was inserted fully. He was to pay attention to what that felt like without moving or thrusting. Once he felt in control and confident, the next step was for Glenda to begin moving slowly. Hugh's task was to pay attention to his level of arousal, trying to keep this between 7.5 and 8 by telling Glenda how much or how little to move. After getting close to coming three to four times, Hugh was to begin thrusting, allowing himself to climax.

If at any point in this process he lost control and ejaculated, he was to treat this as a learning experience. If at any point his erection began to wane, he was to be aware of any negative thought process, and to counter with his healthy point of view that he would be able to regain his erection. If either of these events occurred, he was encouraged to assume a "trust" position with Glenda, in which they held each other and felt close before talking about the experience and/or resuming love- making.

At the next session, Hugh reported that on their first attempt at intercourse he had ejaculated sooner than he wanted to, but that he had taken this in stride and not over reacted. He had also continued to pleasure Glenda to orgasm after he ejaculated rather than stopping, which helped them both to feel more positive about the experience. He was pleased that in subsequent sessions he had maintained control. He found it harder to maintain control while thrusting, but this too had improved with practice. He also reported that his penis had softened on one occasion during intercourse, but after assuming a "trust" position and resuming touch, he had regained his erection. I congratulated Hugh on his accomplishment, attributing his progress to his hard efforts. I also requested that he convey my commendation to Glenda for how supportive she had been as a sexual friend.

*Step 4: Maintaining treatment gains*

In Step 4, the client is introduced to strategies to maintain treatment gains. Relapse prevention is important, particularly in the treatment of PE, because outcome research shows that after treatment men tend to return to pretreatment levels of control.

I informed Hugh that research showed that if he wanted to maintain ejaculatory control over time, it was important to use strategies of relapse prevention. First, practice and frequency were the most effective strategies he could use to maintain control. I suggested he practice by continuing to have one session of self-stimulation each week in which he focused on maintaining a constant, high level of arousal. I recommended that he and Glenda establish a regular pattern of sexual activity in order to maintain a healthy sexual

frequency. Second, if he ejaculated quickly or lost his erection, it was important to accept these experiences as lapses to be learned from rather than as relapses to be feared. It was normal to sometimes not have a firm erection, and to lose ejaculatory control. Third, I recommended that he schedule a "booster" session with me in six months, as an opportunity to monitor and fine tune his progress.

*Conclusion*

PE and ED are common male sexual dysfunctions that cause considerable emotional and relational distress. Cognitive-behavioral sex therapy provides a change process for developing ejaculatory control and erectile confidence, and extending these changes to sexual intercourse.