Weill Cornell Medicine, Department of Psychiatry
PGY IV Conference, November 11, 2021

# Sex Coaching:
# Diagnosing & Treating Male Sexual Dysfunctions

**Michael A. Perelman, Ph.D.**
Founder & Chairman
MAP Education & Research Foundation
New York, N.Y. 10075 USA
Website: mapedfund.org

&

Co-Director, Human Sexuality Program
Clinical Emeritus Professor of Psychiatry,
Former Professor Reproductive Medicine & Urology
Weill Cornell Medicine
New York, NY, USA

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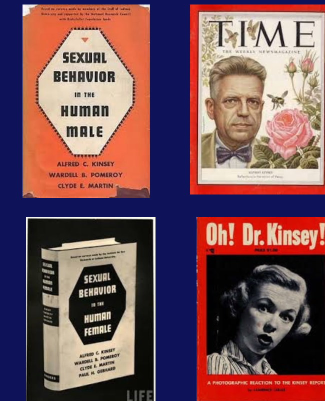
# The History Of MODERN SEX THERAPY & RESEARCH

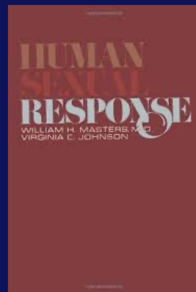
THE STORY BEGINS FOR US IN THE 1950s!

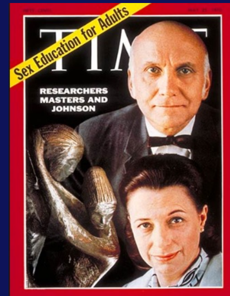
- **Kinsey** and the sex researchers in the 1950s
  - At Indiana University

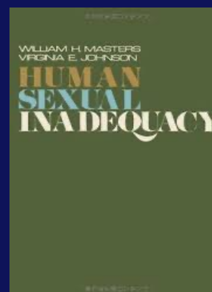



- **Masters & Johnson**

  Pioneer Sex Therapy in the 1960s



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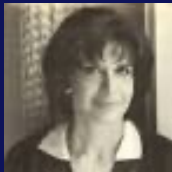
Perelman MA. "The History of Sexual Medicine." In APA Handbook of Sexuality and Psychology, 2014;

# MODERN SEX THERAPY'S EARLY BEGINNINGS

Cornell's Helen S. Kaplan's The New Sex Therapy adapted M&J's 2-week residential sex therapy program into an outpatient approach, that became the standard around the world.

- She described a psychosomatic model: with dual–control of human sexual motivation, prompting the emergence of academic sex therapy clinics as well as national and international training programs.



- We are the world's longest continuously running sex therapy conference.

1987

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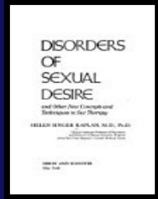
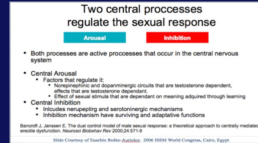
# MODERN SEX THERAPY & SEXUAL MEDICINE'S EARLY BEGINNINGS



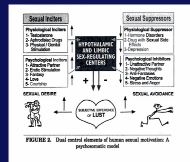
- M&J's did not designate sexual desire as a distinct aspect of sexual response.
- Corrected later Kaplan and Harold Lief.
- DSM 5 has made that controversial once again.

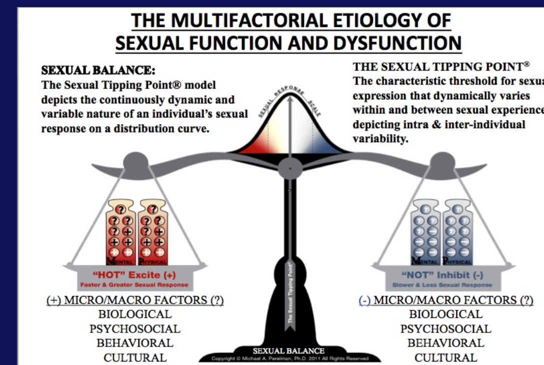
In 1999, Bancroft and Janssen Dual Control model provided important insight into the neurobiological basis of erectile function, by describing central mechanisms of arousal & inhibition.




- In 1999 , Perelman introduced the STP, a qualitative clinical etiological model that illustrates the intra & inter-individual variability of all male & female sexual response and its disorders.

Kaplan first described & illustrated sexual inciters & suppressors to sexual desire dysregulation, foreshadowing other dual control models.




*Bancroft, J., Graham, C. A., Janssen, E., & Sanders, S. (2009);*
Kaplan, 1974, 1995; Perelman MA, 2012, 2014;. Rosen & Rosen, 2009

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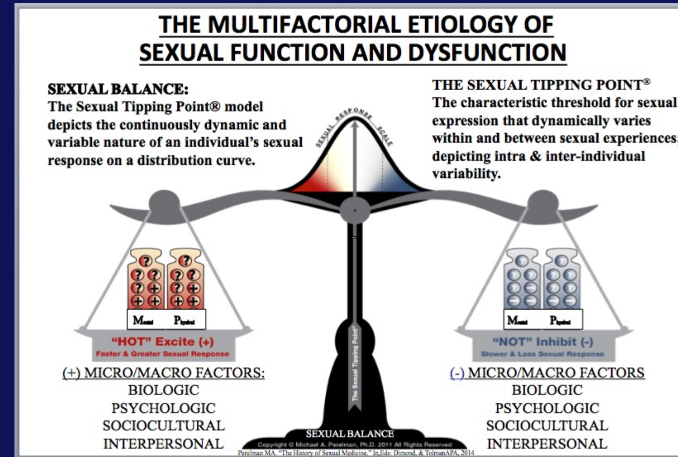
# The STP Model Helps Optimize The Diagnosis & Treatment Of SD




## AGENDA FOR TODAY

1. Describe the Sexual Tipping Point® model's integrated approach to illustrating the etiology, diagnosis and treatment of SD.
2. Taking a "sex status," within a STP framework.
3. Discuss etiology, diagnosis and treatment of MSD.

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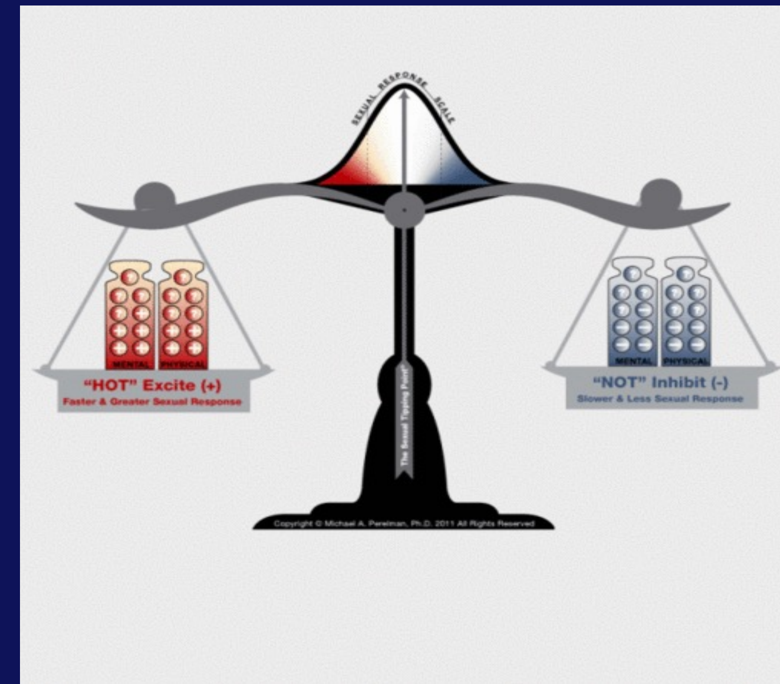
# The STP Model Helps Optimize The Diagnosis & Treatment Of SD

- The STP easily depicts both the mental and physical elements of sexual function and dysfunction.
- **Why is that important?**
- Sexual response is always both mental and physical.
- SDs are endpoints, that are not merely based on medical-biological factors.

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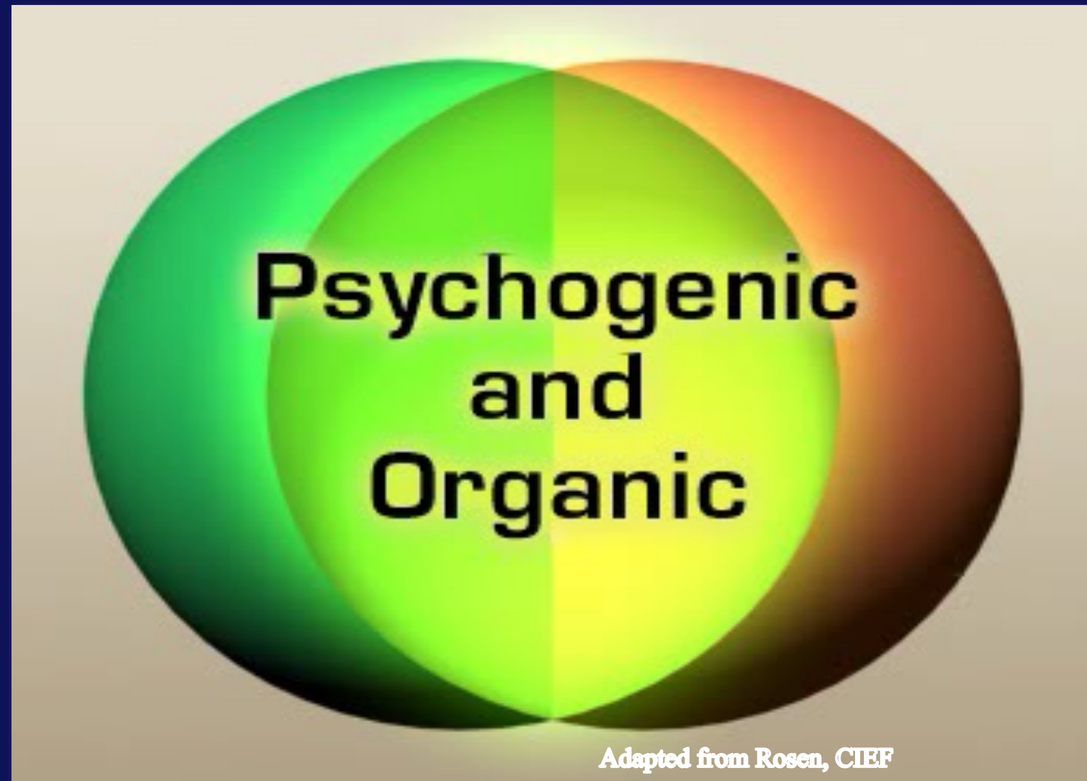
Perelman MA. *J Sex Med.* 2006; 3:1004-1012;
Perelman MA. *J Sex Med*, 2009;6(3):629-32.

**Because sexual response is <u>best</u> understood as an endpoint, representing the cumulative interaction of <u>every</u> cognitive, behavioral, social and cultural factor, not merely the medical-biological determinants!**



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# Sex is Always Mental and Physical

The mind can "turn you on" and the mind can "turn you off."
The body can "turn you on" and the body can "turn you off."
Positive mental and physical factors increase sexual response.
Negative mental and physical factors inhibit sexual response.

**The dynamic combination of all these factors determines a unique Sexual Tipping Point®**

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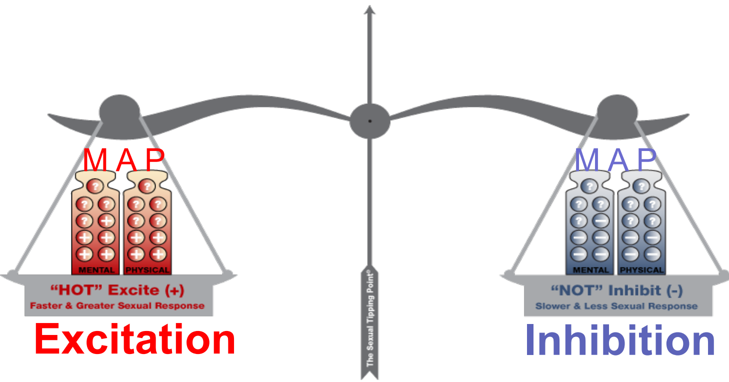
# KEY TO THE SEXUAL TIPPING POINT® MODEL SYMBOLS




2 pairs of interconnected **containers** on
2 balance beam **pans** hold all known & unknown
**Mental And Physical factors** regulating sex.

Each factor's setting varies
as to its degree of HOT or NOT
Sex Positive (+) or Sex Negative (-)

Some Factors May Be Neutral (=)

Some Factors Are Unknown(?)

**A Sexual Tipping Point® is displayed on a bell-shaped scale & depicts the dynamic combination of all these factors at any moment in time.**

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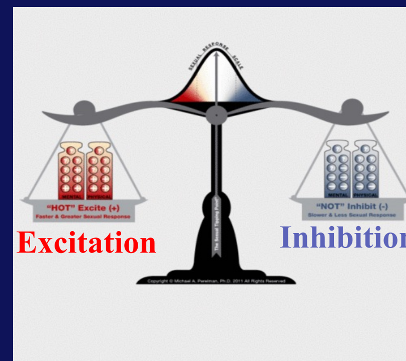
# IT'S "VARIABLE CONTROL," NOT DUAL CONTROL

THE SMALL CIRCLES SYMBOLIZE THE FACTORS IN THE MENTAL AND PHYSICAL CONTAINERS AND FUNCTION LIKE DIMMER OR A MICRO VARIABLE SWITCHES.

EACH FACTORS' DIMMER HAS VARIABLE **POLARITY** (+,-,=) AND **MAGNITUDE**

THE NET SUM OF ALL FACTORS DETERMINES THE STP DISPLAYED ON THE SCALE AT ANY GIVEN MOMENT IN TIME AND CAN BE DISTILLED INTO:




Perelman MA. The Sexual Tipping Point is a Variable Switch Model. Curr Sex HealthRpts 2018;10:1.

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# Whether Etiology Is > "Physical" = Bio-Medical Etiology

Exciting stimulation is insufficient to overcome the biological inhibitions

Insipient Metabolic Syndrome

Manifest Metabolic Syndrome

"HOT" Excite (+)

Faster & Greater Sexual Response

MENTAL PHYSICAL

"NOT" Inhibit (-)

Slower & Less Sexual Response

MENTAL PHYSICAL

The Sexual Tipping Point®

SEXUAL RESPONSE SCALE

INHIBIT

Excitement "NOT"

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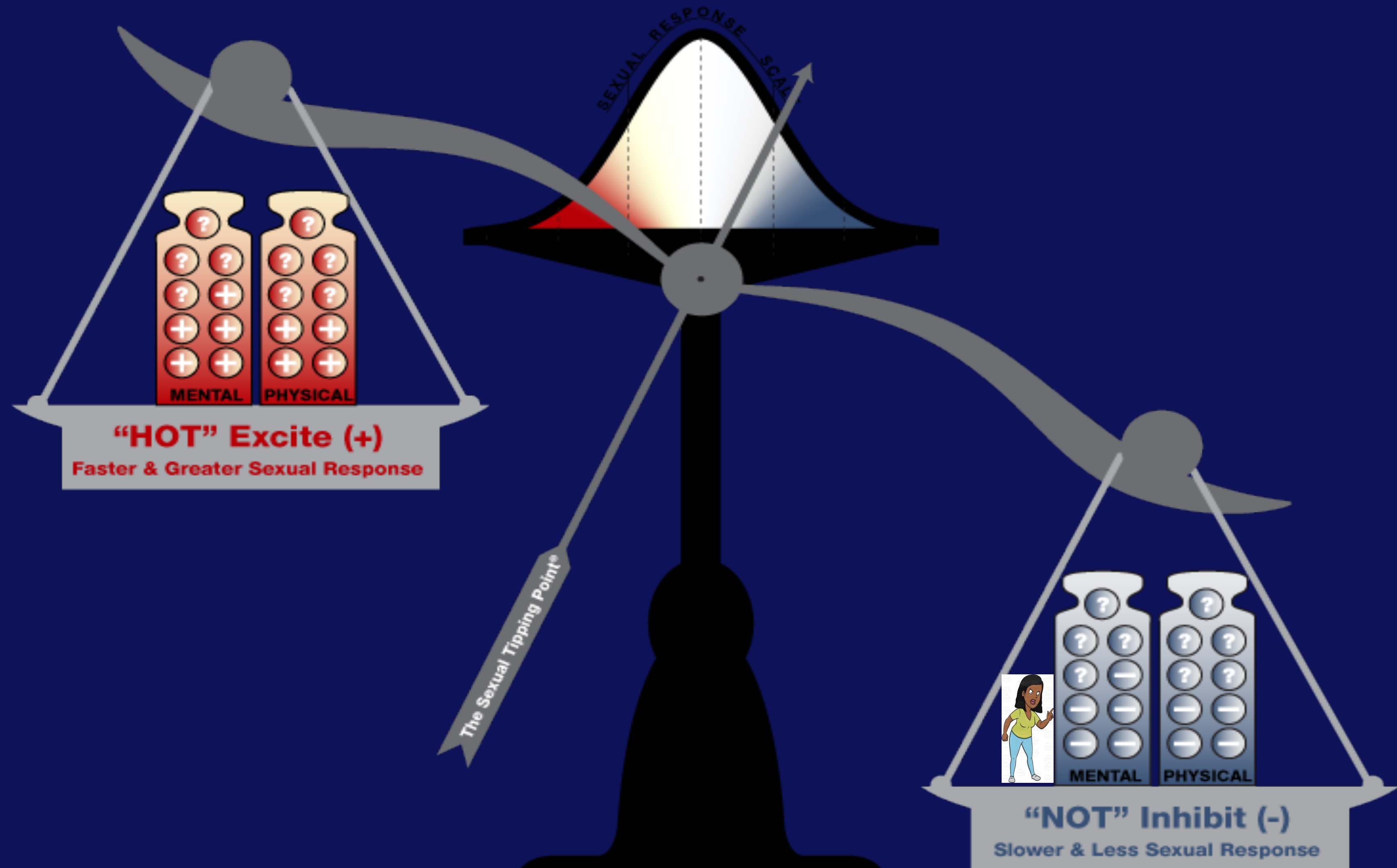
# Or Mental = Psychosocial & Cultural

**STP depicting secondary ED where his only thoughts during sex are of the humiliation experienced with his ex-wife and the fear it will happen again this time.**

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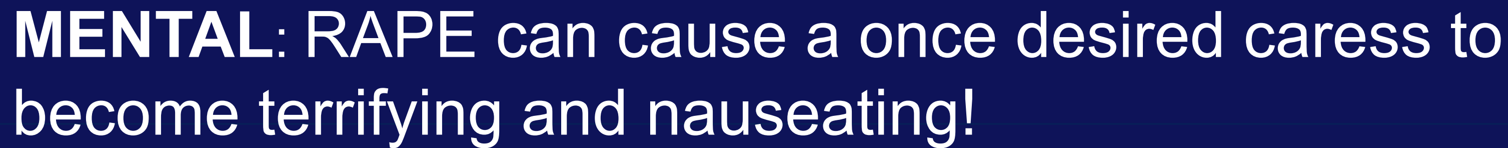
# But Both Mental & Physical Factors Can Be Bi-Directional

THERE CAN ALSO BE CHANGES IN
A FACTOR'S POLARIZATION AND MAGNITUDE

Excite

INHIBIT



**MENTAL**: RAPE can cause a once desired caress to become terrifying and nauseating!

**PHYSICAL**: Aging, Illness, etc, can all inhibit a once robust response

**Drugs and/or side-effects can have bi-directional impact!**

Sex Medicine Rx.

Cardiac, Psychiatric, Etc. Rx.

**FETISH**: Neutral objects can become eroticized,
**Like Mrs. Robinson's stockings!**

Neutral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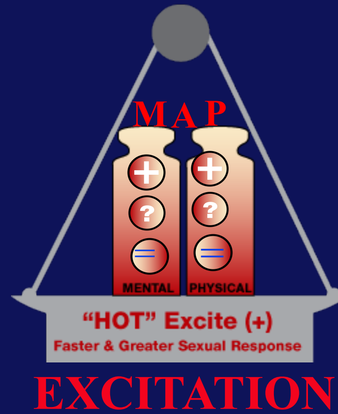
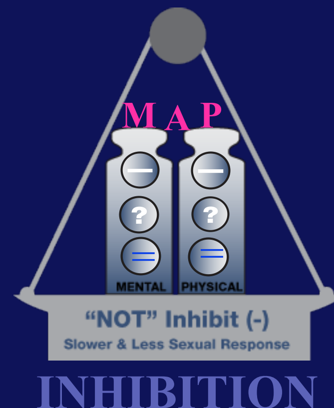
# So What's The First Take Away?

First:
Recognize that SD is always determined by Bio-Medical Psychosocial-Behavioral & Cultural Factors




Third:
Identify the key interfering factors as initial treatment targets.***

Second:
An individual's sexual function at any given moment in time, is determined by the net sum of those factors.




Fourth:
Inspire hope by explaining the STP formulation and the initial treatment targets to the patient.

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# 2nd Agenda Item: Sex Status

**Getting a sex status is the key to a successful, rapid, rapport-based history taking.**

- The sex status is not a questionnaire or a test.
- Unlike a complete review of systems, it is a flexible, focused history taking method to uncover key bio-medical-psychosexual and cultural factors.

Kaplan HS, The Sexual Desire Disorders 1995;

Perelman MA. *Int J Impot* 2003; Res (15 Suppl 5):S67-74;

Perelman MA, FSD. In: Goldstein et al, 2005.


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# STP & Sex Status: Key Concepts to Optimize Diagnosis & Treatment Of Sexual Dysfunction

**How do we do that?**

**Ask focused questions; step back and then probe again, depending on the patient's comfort with the inquiry.*****

What questions?
Think "F"

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Perelman M. *Int J Impot* 2003; Res (15 Suppl 5):S67-74;
Perelman MA. *J Sex Med.* 2006; 3:1004-1012.

# Key Concepts & Questions To Optimize Diagnosis & Treatment Of Sexual Dysfunction

A good Sexual Status creates a "video picture" in your mind about the friction, frequency, fantasy and feelings the patient is experiencing, by identifying the factors that precipitate and maintain the chief complaints.

HOW DO YOU DO THAT?

Althof, Rosen, Perelman, Rubio. SOP for Sex History, JSM, 2013
Perelman MA. *Int J Impot Res.* 2005;15(suppl 50:S67-S74.
Perelman, In Balon & Segraves, 2005
Perelman, In Goldstein, FSD, 2005

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# SEX STATUS: Taking a focused sex history is critical!

- **Depending on your time (the patient's responses and comfort level, and your own), probe for needed details and sexual experiences that illuminate the key factors.**

- **Ask specific questions, listen, clarify:**
  - ***" Tell me what you mean by DE."  ( the CC)***
  - ***" Tell me what you mean by PE."  ( the CC)***
  - ***" Tell me what you mean by ED."  ( the CC)***
  - ***" Tell me what you mean by no desire."  ( the CC)***

  - ***Ask: " What do you think is causing this problem?"***

- **This will vary with your new patients vs. established patients who are in your practice for years.**

Perelman MA. *Int J Impot Res.* 2005;15(suppl 50:S67-S74.
Perelman, In Balon & Segraves, 2005; Perelman, In Goldstein, FSD, 2005

© 2014 Michael A Perelman, PhD

# Sexual Status Exam

## ASK, LISTEN, CLARIFY

- For me, the best single question you can ask is:***
  “ Tell me about your last sexual experience”

- That gives me a “video picture” in my mind,
  that helps me identify immediate and remote causes.

Perelman MA. *Int J Impot Res.* 2005;15(suppl 50:S67-S74.
Perelman, In Balon & Segraves, 2005
Perelman, In Goldstein, FSD, 2005

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# Sex Status Exam

## What Are The Critical Evaluation Issues?

You want to answer these questions:

1. Does the patient have a sexual disorder, and what is the diagnosis?
2. What are the key underlying organic and/or psychosocial factors?
   a. What are the "immediate" maintaining psychosocial factors (current cognitions, emotions, behaviors, etc)?
   b. Any potential "deeper" psychological causes (predisposing, precipitating)?
3. Do any underlying organic or psychosocial factors require pre-treatment, or can they be bypassed, modified, or treated concurrently?

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Kaplan, 1983; Perelman, 2000, 2005

# STP Approach To Treating SD

- Once those treatment targets are identified,
  interventions can be timed,
  & based on whether a factor is:
  - **Predisposing,** **(constitutional, prior life experience)**
  - **Precipitating,** **exacerbating and/or**
  - **Maintaining, a sexual dysfunction, disorder or concern.**

EXPLAINING THE STP AND TREATMENT TARGETS,
NOT ONLY PROVIDES HOPE,
BUT BEGINS THE RECOVERY PROCESS
BY REFRAMING PATIENT COGNITIONS!

Althof et al, JSM, 2005; Althof et al, JSM, 2009;
Basson R. JSMT. 2000;
Hawton K. Br J Hosp Med 1985

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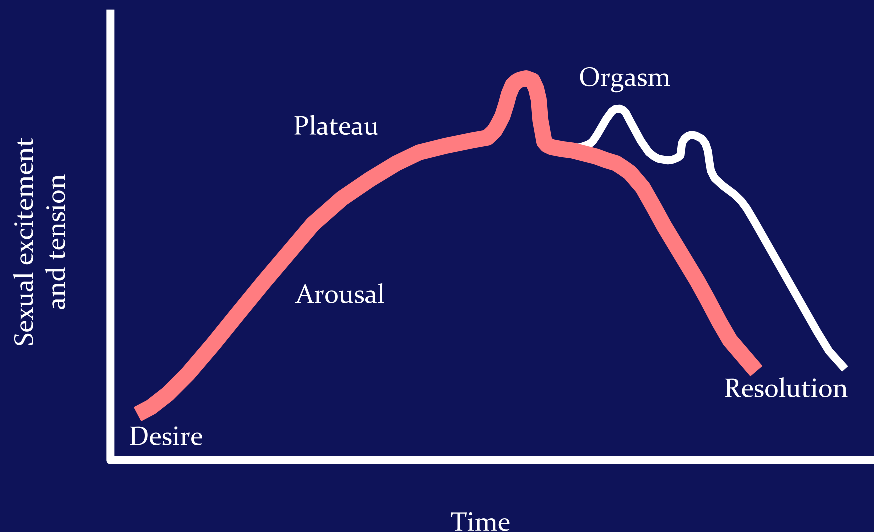
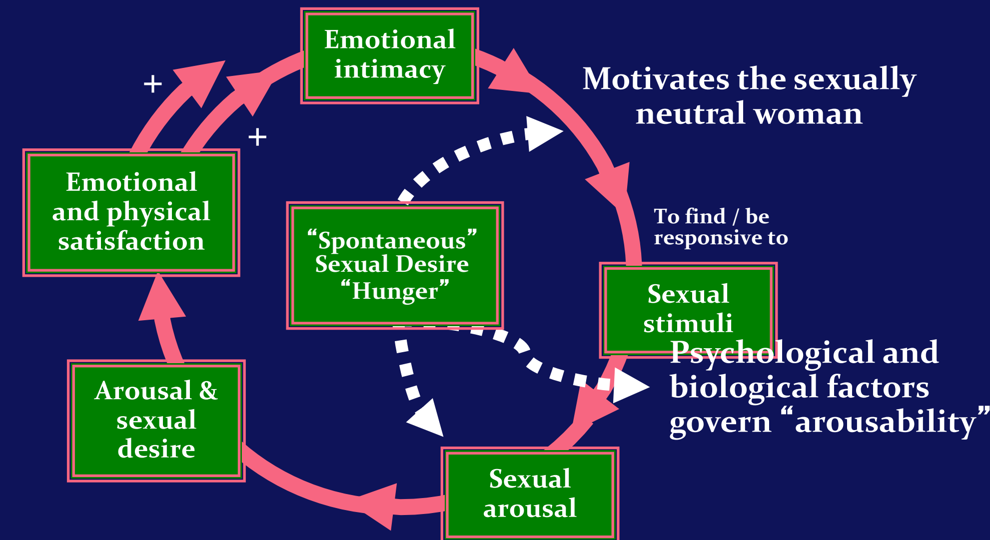
# Sex Disorders Are Identified as Variants of Imperfect Sexual Response Cycle Models

- Traditional, "Linear" Model of M&J and Kaplan




- Contemporary, Non-Linear, Subjectivity-Based: Rosemary Basson Model




Adapted with Permission from: Basson R. Obstet Gynecol 2001;98:350-3.

# Male Sexual Disorders: What Is Usually Seen!

- Male Erectile disorder (ED)
- Male hypoactive sexual desire disorder
- Premature (early) ejaculation (PE)
- Delayed ejaculation >10 minutes (DE)
- Male sexual pain disorders
- We often see the sex related consequences of illness/trauma (Peyronie's disease) and the sequela of medical/surgical treatments, eg Pharma, Pca,

Ishak & Tobia: DSM-5 Changes in Diagnostic Criteria of Sexual Dysfuntions, Reprod Sys Sexual Disorders, 2013

# Erectile Dysfunction (ED)

- **Definition: the consistent or recurrent inability of a man to attain and/or maintain a penile erection sufficient for sexual activity[1]**
- **Multifactorial – may impact well-being and quality of life[2-4]**

1. Lue TF et al, eds. *Sexual Medicine: Sexual Dysfunctions in Men and Women.* Paris, France: Health Publications; 2004:605-630. 2. Laumann EO et al. *JAMA.* 1999;281:537-544. 3. Jonler M et al. *Br J Urol.* 1995;75:651-655. 4. Fabbri A et al. *Hum Reprod Update*. 1997;3:455-466.

# ED Prevalence and Pathogenesis

- **ED is highly prevalent.**
  - **Up to 30 million men in US[1]**
  - **Up to 152 million men worldwide[2]**
  - **Worldwide projection for 2025: ~322 million[2]**


1. NIH Consensus Development Panel on Impotence. *JAMA.* 1993;270:83-90.
2. Aytaç et al. *BJU Int.* 1999;84:50-56.
3. Lue. *N Engl J Med.* 2000;342:1802-1813.


© 2006 Michael A Perelman, PhD

# ED More Prevalent Than Common Chronic Conditions

| | Men in the United States (millions) |
|---|---|
| Asthma | 7.1[1] |
| Diabetes | 7.8[2] |
| Obesity | 19.5[3] |
| ED | 30[4] |

1. National Institute of Allergy and Infectious Diseases (NIAID). Focus on Asthma. NIAID Web site. Available at: http://www.niaid.nih.gov/newsroom/focuson/asthma01/default.htm. Accessed July 18, 2003. 2. National Center for Health Statistics. Fast Stats A to Z: Diabetes. Centers for Disease Control and Prevention (CDC) Web site. Available at: http://www.cdc.gov/nchs/fastats/diabetes.htm. Accessed July 18, 2003. 3. National Institute of Diabetes & Digestive & Kidney Diseases (NIDDK). Statistics related to overweight and obesity. NIDDK Web site. Available at: http://www.niddk.nih.gov/health/nutrit/pubs/ statobes.htm. Accessed July 18, 2003. 4. Benet AE, Melman A. *Urol Clin North Am*. 1995;22:699-709.

# ED: Barometer of Men's Health

The Deadly Quart

Diabetes

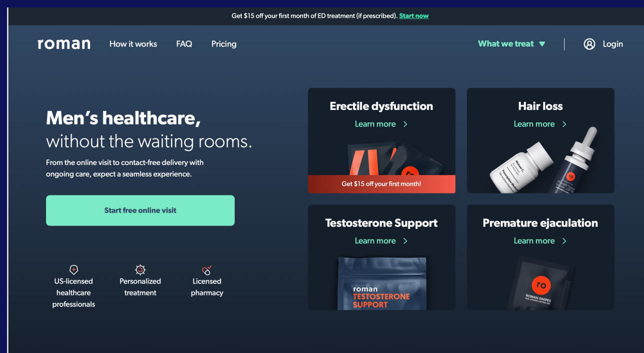
Obesity

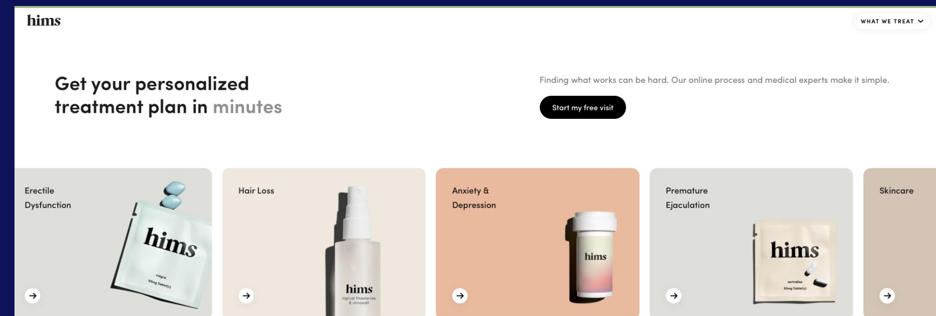
Hypertension

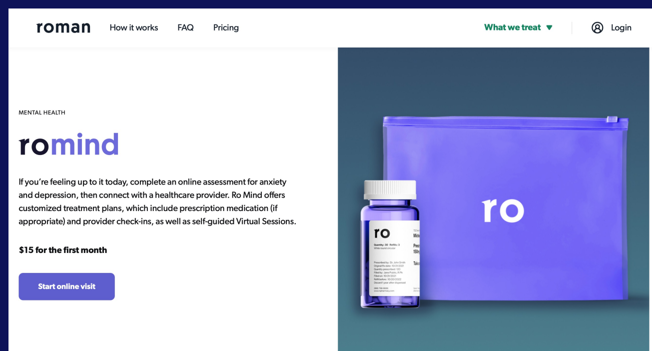
Dyslipidemia

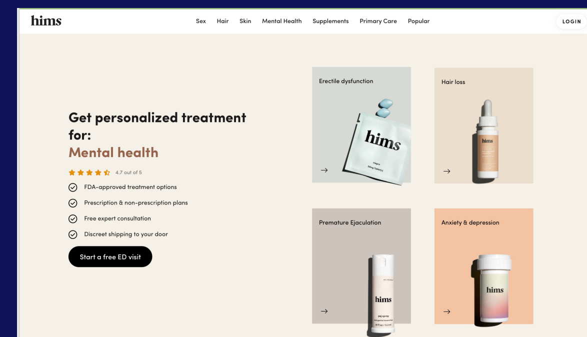
# Commercial Online Therapies & Pharmacies to Treat Male Sexual Disorders

- There are numerous commercial online programs offering diagnosis and treatment of sexual disorders amongst other conditions.




Tens of millions of dollars spent by men suffering with SD

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# WHAT NOT TO ALWAYS DO!

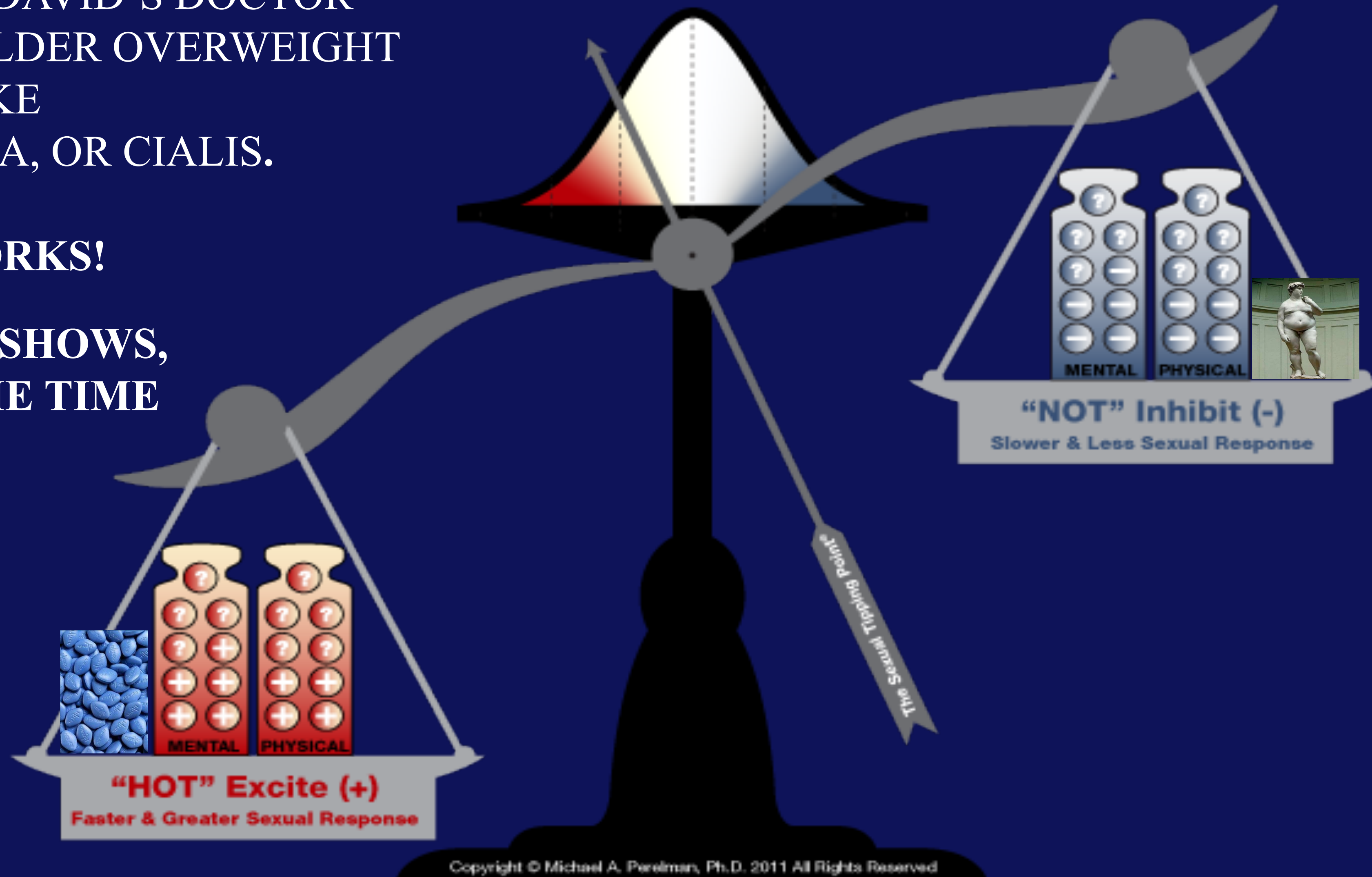
## TYPICAL ED TREATMENT FOR A METABOLIC SYNDROME PATIENT.

TYPICALLY, FAT DAVID'S DOCTOR WILL GIVE AN OLDER OVERWEIGHT MAN A PDE-5, LIKE VIAGRA, LEVITRA, OR CIALIS.

**OFTEN THIS WORKS!**

**BUT RESEARCH SHOWS, THAT 50% OF THE TIME IT DOES NOT!**

**Why?**

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# Factors Contributing to PDE5 Inhibitor Treatment Nonresponse

| Factor | Patients (n) |
| --- | --- |
| Did not use highest recommended dose | 45 |
| Use after meal | 32 |
| Use just before sexual activity | 22 |
| Use without sexual stimulation | 12 |
| Use of maximum dose despite contraindications | 8 |



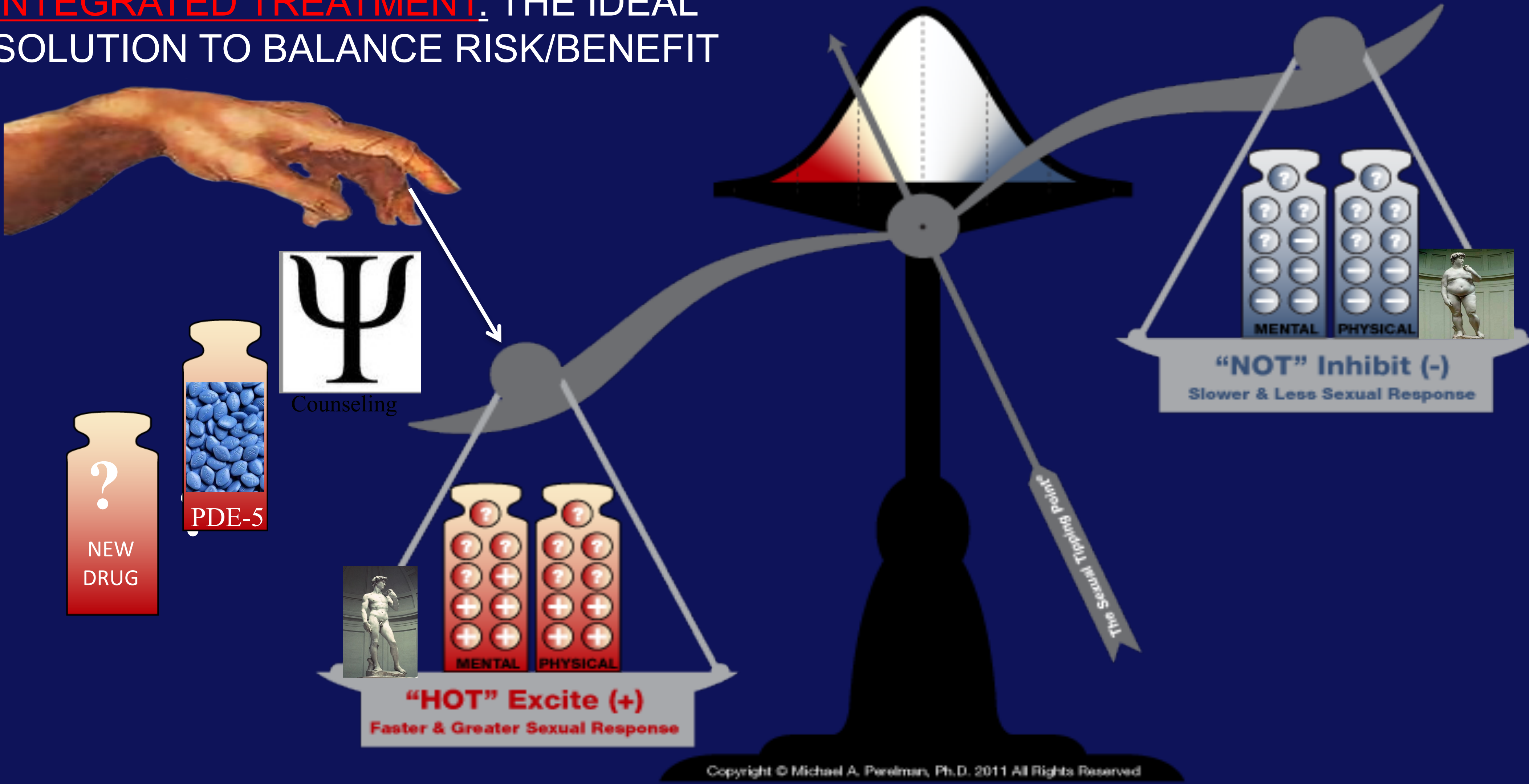
PDE5=phosphodiesterase type 5.

N=100.

Adapted with permission from Hatzichristou D et al. *Eur Urol*. 2005;47:518-523.

# Among All Specialties You As Psychiatrists Are Best Positioned To Offer The Most Elegant Solution!!!!!

INTEGRATED TREATMENT: THE IDEAL SOLUTION TO BALANCE RISK/BENEFIT

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# Therapeutic Probe

**Follow-Up Sessions Will Reveal The Reasons for Initial Treatment Failure If You Reassess Using the Sex Status Questions.**

– **Pharmaceuticals Act As A Therapeutic Probe**

Viagra prescribing information, January 2000. . McMahon CG. Poster presented at: 4th Congress (Biennial Meeting) of the European Society for Sexual and Impotence Research; September 30-October , 2001; Rome. Porst H, et al. *Int J Impot Res*. 2001;13:192-199. Kaplan, 1974; Altolf,IJIR, 2002; Barada, 2002; Hatzchristoau, 2002

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# Weaning & Relapse Prevention

- Using this approach, patients may be weaned from the drug or their medication can be reduced, further improving the risk / reward ratio.

- When greater illness or stress changes the STP, more medication and/or coaching maybe added to the equation.

Perelman, IJIR,2004;
Perelman M. *Handbook of Sexual Dysfunction* 2005
Perelman, In Goldstein, FSD, 2005

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# Definition of PE

Three constructs necessary to define PE:

1. ISSM & ICSM Emphasize Intravaginal Ejaculatory Latency Time (IELT): ~1 or ~ 2 min

Intravaginal Ejaculatory Latency Time (IELT)

2. Lack of voluntary control--inability to delay

3. Negative personal consequences

Consensus mtgs: Despite claiming the definition was based on "objective evidence," from global studies there was subjective data interpretation!

Perelman, Reexamining the Definitions of PE and DE, JOURNAL OF SEX & MARITAL THERAPY, 2016.

**Disproportionately, the findings from those studies document that the majority of men's IELT range is approximately 4 to 10 minutes.**

MAP: PE: 2-4 min **if it causes distress** DE >10 min **if it causes distress!**


McMahon CG, Althof SE, Waldinger MD, et. al. An Evidence-Based Definition of Lifelong Premature Ejaculation: Report of the International Society for Sexual Medicine (ISSM) Ad Hoc Committee for the Definition of Premature Ejaculation. J Sex Med 2008;5:1590–1606



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# Premature Ejaculation:

- **Most common male sexual disorder –"climaxing too early"**
- **Reportedly affects 25-35% of men ages 18-59 and older***

  **Actually, it's more like 12.5-15%**
- **Primary (lifelong) vs Secondary (acquired)**
- **Distresses patients and partners; especially affects perception of control and sexual satisfaction**
- **There are currently (2009) no regulatory or FDA-approved treatments for PE in the U.S.**

*Laumann EO, Paik A, Rosen RC. Sexual dysfunction in the United States: prevalence and predictors. JAMA. 1999;281:537-544.
Symonds T, Roblin D, Hart K, Althof S. How does premature ejaculation impact a man s life? J Sex Marital Ther. 2003;29:361-370.
McCabe M. Intimacy and quality of life among sexually dysfunctional men and women. J Sex Marital Ther. 1997;23:276-290.

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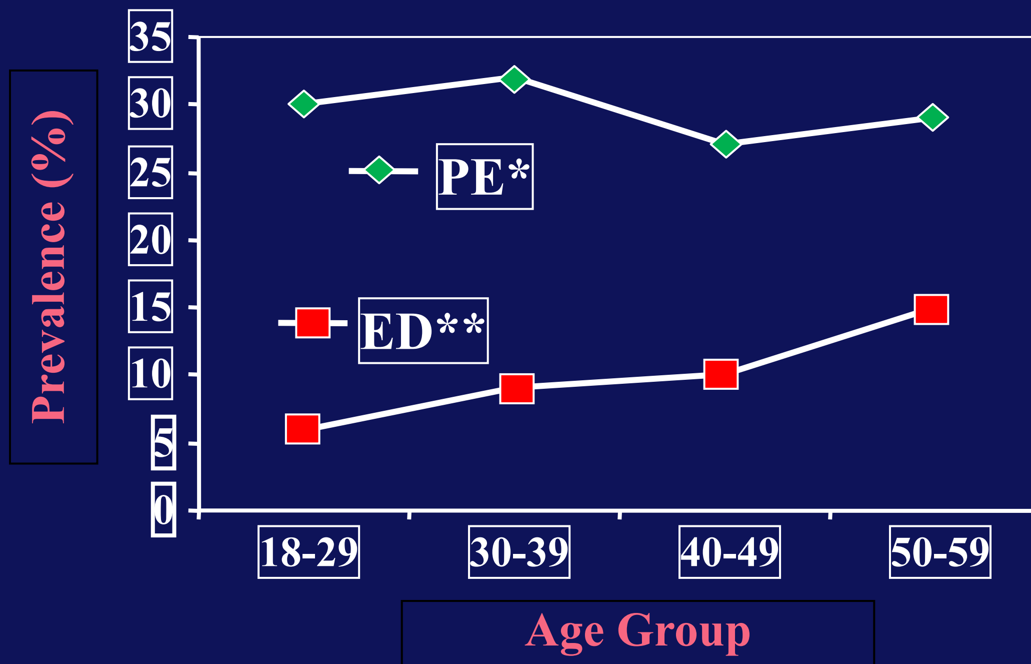
# Concurrence of PE and ED

- Some men with PE also have erectile dysfunction (ED)
  - **While the prevalence of PE is constant across age groups, the incidence of ED increases with age[1,2]**




- Pharmacologic PE agents are likely to be used concurrently with PDE-5 inhibitors in some patients

*PE defined as "climax too early" (n=1,243)[1]

**ED defined as "trouble maintaining or achieving an erection" (n=1,244)[1]


1. Laumann et al. JAMA. 1999;281:537-544; 2. Porst. ESSM. 2004.

# Current PE treatment options

1. **Self-help treatment ?**
2. **Behavioral therapy- Risk of relapse**
3. **PDE5 inhibitors- only when secondary to ED.**
4. **Topical treatment (local anesthetics)**
5. **SSRI / tricyclic antidepressants (always will relapse, unless…)**
6. **Tramadol_NO**
7. **Neurotomy of dorsal penile nerve fibers_NO**

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Gurkan et al. (2008) Asian J Androl 10:102-109
Fischer Santos et al. (2001) Int J Impot Res 13(Suppl 1):S11

# Use of Antidepressants in PE

- Clomipramine - first 5-HT-based drug used in 1973 (Eaton, 1973) but has a high incidence (5-15%) of adverse effects
- SSRIs (citalopram, paroxetine, sertraline, fluoxetine fluvoxamine) introduced for depression in 1980s
- Delayed ejaculation is a recognised side effect of SSRI treatment in depression
- First trials of SSRIs in PE conducted in 1995 (sertraline)
- Effects mainly measured on IELT & not other patient-related measures (control, satisfaction, bother)
- Most studies have used chronic not prn dosing

Waldinger MD, Olivier B. Utility of selective serotonin reuptake inhibitors in premature ejaculation. Curr Opin Investig Drugs. 2004;5:743-747.
Montague DK, Jarow J, Broderick GA, et al. AUA guideline on the Pharmacologic Management of Premature Ejaculation. J Urol. 2004;172:290-294.
McMahon CG, Samali R. Pharmacological treatment of premature ejaculation. Curr Opin Urol. 1999;9:553-561. Mendels J, Camera A, Sikes C. Sertraline Treatment for Premature Ejaculation. J Clin Psychopharmacol. 1995;15:341-346.

# Is Incorporating Assessment of His Capacity To Discern The Difference Between PS & Emission Necessary ?

Yes!

Patients usually relapse when withdrawn from medical treatment!

Current approaches (pills, topical creams or sprays), all emphasize symptomatic improvement, w/out considering long- term learning, relationship issues, or relapse with discontinuation.

Medical Tx. of PE is limited, by PE's multi-dimensional etiology.

Treating PE Is More Than Just Improving IELT.

AUA PE Guidelines, 2004;
Perelman, M. Handbook of Sexual Dysfunction, 2005
Perelman MA. *J Sex Med.* 2006;3:1004-1012.

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# Key Concepts & Questions For Diagnosing & Treating PE

**First:** Ask specific questions, listen, clarify:

- " What do you mean by PE."
- " What do you think is causing this problem?"

  *rule out ED…*

**Second:** For me, the best single question you can ask again is:

**" Tell me about your last sexual experience?"**

- That "video picture," helps me identify immediate and remote causes.
- I focus on the predisposing & **maintaining** causes…
- Its sex coaching not deep psychotherapy.

Perelman MA. *Int J Impot Res.* 2005;15(suppl 50:S67-S74.
Perelman, In Balon & Segraves, 2005; Perelman, In Goldstein, FSD, 2005

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# Most Important Diagnostic Issue To Clarify, Is Whether He Can Differentiate PS From Emission (EI) & Ejection

**PE FINAL PATHWAY:**

Men with PE typically lack skill in identifying PS and/or adequately managing their body's response to PS (progressively escalating sensations of sexual arousal during coitus), regardless of other predisposing etiological factors; whether genetic serotonin thresholds, nerve transmission rates, or psychosocial-cultural variables.

Perelman M. J Sex Med 2006;3:1004-1012

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# Three Common Errors Made By Men With PE

1. **Some cannot discern Premonitory Sensations (PS)**
   - Too fast for awareness: > muscle tension, > heart rate,  testicular elev. etc.
   - Some recognize but ignore PS and hope they don't "cum" yet.
2. **Some confuse PS and the Emission Phase:**

   He's thinking "Uh-Oh, I'm going to cum!" It's really, "Shoot I'm coming." He's confusing strong PS, with the emission stage of his ejaculation.

   For him, it is too late to stop or slow down. No choice point!
3. **Subsequently: Ejection and Orgasm take place**

   **2-4 seconds later, no matter what he does.**

   - Trying to "hold back" only, results in an unsatisfactory partially RE.

Perelman, 2005 SMSNA PE Debate; What do PE & A Sneeze Have in Common

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# How to Integrate Medical Treatments & Sex Coaching.

**First :**

- Teach ejaculation's two stage physiology.
  - Teach the difference between **PS, Emission** and **Ejection.**
- If he is unaware of PS during coitus, assess if he is able to delay with manual (self/partner) or oral stimulation? If so, how?

**If he doesn't do the same during coitus, how might he ?**

- Instruct him how he must adjust his mind & body when experiencing PS
- Suggest he practice with stop/start & slow/fast/slow masturbation.
- Encourage foreplay & focusing on sensations, not avoiding them.
- As needed, suggest discussion points to have with his partner.

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# STP Model: Integrate Medical Treatments With Sex Coaching?

**Follow-up Visit(s):**

- Reassessment: Repeat taking a Sex Status
- What went well, what were the difficulties?
- Offer suggestions for each of the obstacles.
- Opportunity to wean, and provide relapse prevention guidance.

Referral?

- Frequently, you will be able do this sex coaching!
- But, with > psychopathology and relationship strife, the less likely medication, education and coaching alone will succeed.
- Identifying psychosocial factors doesn't require you to treat them.

When to refer for adjunctive sex therapy?

- Upon patient request
- Or when you decide your sex coaching is insufficient.

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# RETARDED EJACULATION (RE): DEFINITION

- **RETARDED EJACULATION (RE) is the persistent or recurrent difficulty, delay in, or absence of attaining orgasm following sufficient sexual stimulation, which causes personal distress (DSM IV-R, WHO)**

  **- Life long (primary) or acquired (age, partner, disease, etc.)**

  **- Global or situational - masturbation, manual, oral,**

DSM IV-R, 2000; WHO, 2004

DELAYED EJACULATION!

Control
Distress
Time

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# DSM- 5TR

PERELMAN'S DRAFT DEFINITION OF DE SUBMITTED TO APA

- "The essential feature of delayed ejaculation is a marked delay in or inability to achieve ejaculation or marked infrequency of ejaculation on all or almost occasions of partnered sexual activity, despite the presence of adequate sexual stimulation and the desire to ejaculate (Criterion A). In order to qualify for a DSM-5 diagnosis of delayed ejaculation, the symptoms must have persisted for a minimum duration of approximately 6 months (Criterion B) and must cause clinically significant distress in the individual (Criterion C). The partnered sexual activity may include manual, oral, coital, or anal stimulation. In most cases, the diagnosis is made by self-report. , although for men in heterosexual partnered relationships, it is frequently the female partner's distress that motivates treatment seeking. It is common for men who present with delayed ejaculation to be able to ejaculate with self-stimulation, but not during partnered sexual activity (Perelman 2017)."

# DE PREVALENCE

- DE IS REPORTED AT LOW RATES, RARELY EXCEEDING 3%.[1]
- SINCE THE BEGINNING OF SEX THERAPY, RE WAS SEEN AS A CLINICAL RARITY.

  -- Masters and Johnson initially reported only 17 cases.[2]

  -- Apfelbaum reported 34 cases.[3]

  -- Kaplan reported fewer than 50 cases.[4]

- NONE THE LESS SOME UROLOGISTS & SEX THERAPISTS ARE NOW REPORTING > INCIDENCE OF RE.[5,6,7]

  - PERELMAN HAS REPORTED ON OVER 300 CASES


1. Simons J, Carey MP (2001) Prevalence of sexual dysfunctions: results from a decade of research. Arch Sex Res 30(2):177–219
2. Masters WH, Johnson VE (1970) Human sexual inadequacy. Little, Brown & Co: Boston.
3. Apfelbaum B (2000) Retarded ejaculation; a much-misunderstood syndrome. In: Lieblum SR, Rosen RC, eds, Principles and practice of sex therapy, 2nd ed, Guilford Press: New York, pp 205-241.
4. Kaplan H (1995) The evaluation of sexual disorders: psychologic and medical aspects. Brunner/Mazel: New York.
5. Perelman M, McMahon C, Barada J (2004) Evaluation and Treatment of Ejaculatory Disorders. Atlas of Male Sexual Dysfunction, Current Medicine LLC, Philadelphia, pp 127–157.
6. Perelman MA (2003). Regarding ejaculation: delayed and otherwise. J Androl 24:496.
7. Perelman MA, Rowland DL. "Retarded Ejaculation." *World Journal of Urology,* 2006 Dec;24(6):645-52.


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# DE: TREATMENT

- Numerous drugs, herbs and medication dosing strategies have been described for in the treatment of antidepressant-related DE (there is some Level 3 evidence for PDE-5s.)
  -- Nurenberg, Segraves, Clayson, Ashton
- There are continued reports of experimentation by physicians seeking a pharmaceutical to reduce IELT, but no evidence to support these anecdotal claims.
  -- Helstrom et al, Ropinirole; Shabsigh,Duloxetine; Eliot, McMahon, & Waldinger,
  Cyproheptadine; Rabinowitz, Buproprion. (Personal communication & ISSM List Serve)
- Unfortunately, despite reports of highly effectiive approaches (up to 80% success reported) there is only low- level evidence recommending sex therapy for RE.

Perelman & Rowland, *WJU, 2006*; Perelman, WAS, 2007

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# Psychosexual Therapy Should be Considered First Line Therapy for the Management of Delayed Ejaculation

- "Sex Coaching (by any of you ) should be the first line therapy for SD. **You do <u>NOT</u> need to be a skilled sex therapist, to assist many men with DE.**
- You only need to ask key questions and provide crucial suggestions to make a difference in their lives!


Perelman, M, "What a Sex Therapist Wants You To Know About Treating Men With Sexual Disorders," In Essentials of Mens' Health, Ed. O' Leary, M and Bhasin, S. McGraw-Hill Global, 2020.

Perelman, M, Invited Commentary: Sex Coaching for Non-Sexologist Physicians: How to Use the Sexual Tipping Point Model. *The Journal of Sexual Medicine*, Vol.15, Issue 12. Dec. 2018.

Perelman, M. "Psychosexual therapy for delayed ejaculation based on the Sexual Tipping Point® Model," Translational Andrology and Urology-Focused Issue on Ejaculatory Dysfunction-Edited by Dr. Chris G McMahon, Home / Vol 5, No 4 (August 2016).


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# Why Is That?

- Overwhelmingly, the DE cases you will see are situational:
  - "Only occurring with certain types of stimulation, situations, or partners."
  - The vast majority of DE patients are complaining about DE during coitus and can usually ejaculate with self-stimulation.
  - The following information will allow you to help many men with SD, without the need for drugs and and may negate the need for a referral to a sex therapist!

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# WHAT TO DO FIRST?

- A good sex history will likely expose the psychosocial & cultural reasons for SD: insufficient penile or psychological stimulation, high frequency and/or idiosyncratic masturbation, preference for masturbation over partnered sex, and psychological conflict regarding ejaculation.
- These issues often combine and overlap.


https://www.auanet.org/guidelines/guidelines/disorders-of-ejaculation, accessed 2021.10.15

Perelman, M, Invited Commentary: Sex Coaching for Non-Sexologist Physicians: How to Use the Sexual Tipping Point Model. *The Journal of Sexual Medicine*, Vol.15, Issue 12. Dec. 2018.

Althof SE, Rosen RC, Perelman MA, Rubio-Aurioles, E. "Standard Operating Procedures For Taking a Sexual History." Journal of Sexual Medicine, September 2012;


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# Some Example Probes For Inquiry About Masturbation

Question the man meticulously regarding his:

- Masturbation habits, including technique and frequency, speed, pressure, etc.
- "Does technique change as ejaculation approaches?"
- "What is the latency time to ejaculation?"
- "Are lubricants used or dry; what is body posture…position?"
  - eg sitting, standing, or a more atypical techniques,
  - eg. grinding forcefully against the bed.

- Most importantly, " What's different in your experience of self-stimulation vs partner-stimulation?
- "What physical sensations and thoughts are different?"
- You are assessing for immersion in erotic vs anti-erotic intrusive thoughts: e.g, "It's taking too long!".
- "Have you communicated your preferences to your partner?"
  - "What was your partner's response?"

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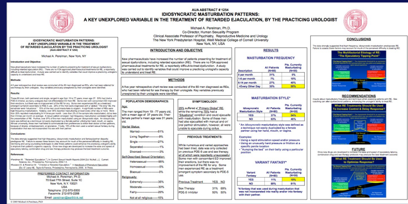
# If You Or Your Patient Are Uncomfortable With This Plan…

RECOGNIZE FOR YOURSELF AND TELL HIM:



- “Accumulating evidence indicates men suffering from DE, masturbate in a manner that is different from how their partner’s hand, mouth, vagina or anus feels.”
- “Understanding of how you stimulate yourself and if it differs from your partnered experience will help me assist you.”

The Psychology Today Blog called “Why Delayed Ejaculation Is More Common Than Folks Realize.” summarizes masturbation’s putative role in the etiology of DE.

Caveat: **However, only counsel to your and your patient’s comfort level.**

- **If either of you are too uncomfortable, refer to a clinician with sex therapy specialization, which then would be the best first line treatment.**

https://www.psychologytoday.com/us/blog/sexual-tipping-point/201812/why-delayed-ejaculation-is-more-common-folks-realize

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# DE Will Often Require Alteration of Masturbatory Habits: Whether Type of Friction, Frequency and/or Fantasy

- The solution is usually decreasing ejaculatory frequency while finding ways to increase the quality of friction and erotic thought per the Sexual Tipping Point Model.
- Typically, he must temporarily suspend masturbatory activity and limit ejaculatory release to his/their desired goal activity:
  -- Usually penetrative sex.
- Temporarily refraining from ejaculating alone, will cause the desire for a "release" to increase, and the stimulation needed to ejaculate during partnered sex to more easily occur.
- While this may not suffice to solve the problem entirely, success during partnered sex, has increased probability.

Perelman, M. "Understanding, Diagnosing and Treating Delayed Ejaculation Using the Sexual Tipping Point Model," In P. Nobre et al (eds), Encyclopedia of Sexuality and Gender, Springer International Publishing AG, 2021.

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# Exception

- The exception to the above are the limited number of primary DE cases.
- Psychosocial factors will still contribute,

  but the likelihood of biomedical etiology is high.

- Then AUA guidelines recommending a physical exam and/or laboratory testing, must be added to the always necessary good sexual history.

- Etiological factors including but not limited to anatomic, hormonal, neurologic, iatrogenic, and pharmaceutical factors must then be ruled out.

https://www.auanet.org/guidelines/guidelines/disorders-of-ejaculation, accessed 2021.10.15

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# Post-Prostatectomy
# Orgasmic Response & Sexual Rehabilitation

**WE KNOW THERE ARE  OTHER PRIORITIES**

- **" SAVE MY LIFE…**
  **GET THE CANCER OUT!!! "**
- **"SAVE MY CONTINENCE"**
- **"SAVE MY ERECTIONS"**

"Save my orgasm, " is probably last on this list, which is why we are late in recognizing its importance as a surviorship issue."

**Perelman, SMSNA, 2008**

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# Sexual Disorders Secondary to RP

- Diminished Desire
- Erectile dysfunction (ED)
- Penile length alterations
- Penile curvature
- Male Orgasmic Disorders (MOD) …DED
  - Anejaculation
  - Diminished Orgasmic Intensity or Force
  - Anorgasmia
  - Painful orgasm
  - Climacturia/Nocturia - Orgasm associated leaking urine

Barnas et al, BJUI, 2004
Mulhall, J, Current Opinion in Urology, 2008
Perelman M et al, Atlas of Male Sexual Dysfunction, 2004

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Perelman, SMSNA, 2008

# What Does a Sex Therapist Teach in the Way of Sexual Rehabilitation?

- These men often need help accepting, that their sex life has changed. Sexual efficacy, confidence and satisfaction will need to be defined in broader terms
- I teach how to increase the quality of friction and fantasy. Both erection and orgasm are reflex responses to pleasure. Helping him identify and request the sexual stimulation he enjoys most?

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# Peyronie's Disease

## IMPACT OF SD ON PARTNER-WHAT ABOUT THE CURVE?

What is the impact of his Peyronie' s Disease' s on his partner?

- Does her dyspareunia, impact his PE, ED, RE?
- What is the impact of their unconsummated marriage on their relationship.
- Is that the result of sexual dysfunction in either/both of them?
- Is it a lack of education or both.

## OTHER WAYS TO IMPACT PARTNER AND SEX

What lowers RECEPTIVITY AND/OR AROUSABILITY in a couple?

- Self or partner depression
- Medications: SSRIs, heart, diabetes, etc. Lifestyle stress – relationship stress

Perelman, JSM 2009;
Perelman, ESSM/ISSM, 2008

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# The STP Model Helps Optimize The Diagnosis & Treatment Of SD

## Thank You For Listening!

Other STP videos and related publications and presentations are available free at: **mapedfund.org**

For questions contact michael@mapedfund.org

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