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Premature Ejaculation: An Integrative, Intersystems Approach for Couples

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Premature ejaculation (PE) is arguably the most common male sexual disorder. While medical science continues to struggle to play an important role in the treatment of PE, various psychotherapeutic models, particularly couple-oriented approaches, have proved effective. This article depicts how PE and relational dynamics are intertwined and presents a model designed to treat the disorder. The model is both systemic and integrative, considering medical issues, and combining aspects of psychoanalytic conflict theory and psychodynamic family-of-origin work with basic sex therapy principles and exercises. A case example is provided for illustration.

KEYWORDS *premature ejaculation, male sexual disorder, relational dynamics, treatment*

Premature ejaculation (PE), sometimes known as rapid ejaculation (RE) is widely believed to be the most common male sexual problem, averaging between 20% and 30% prevalence (Althof, 2007). Studies utilizing data from the Global Study of Sexual Attitudes and Behaviors (GSSAB) also found that about one third of the men surveyed reported PE (Laumann et al., 2005; Montorsi, Sotomayor, & Sharlip, 2005).

PE DEFINED

Masters and Johnson (1970) once diagnosed a man with PE if he could not delay ejaculation long enough for his partner to reach orgasm 50% of the

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time. Most contemporary sex therapists see this definition as somewhat flawed. Polonsky (2000), for example, pointed out that women on average take longer than men to orgasm. Moreover, he reported that 30% to 40% of women cannot achieve intravaginal orgasms—a challenge to Freud's (1905/1953) coital/transfer theory, which postulated that women who could not achieve coital orgasm were neurotic and immature.

Requiring a man to control himself during the sexual process for what could be an inordinate amount of time might indeed be an unrealistic expectation for both partners. Most sex therapists feel that a more prudent objective would be that a man have enough control over his ejaculatory process to reasonably determine when he wishes to ejaculate and that his partner's needs be taken into consideration. In most cases, this will entail the man learning how to last long enough to please both he and his partner; in others, it may also include meeting the partner's needs prior to intercourse.

While there is no laboratory test for PE, many sexologists have resorted to measuring the number of intravaginal thrusts to define the disorder. Others have employed a stopwatch to measure the intravaginal ejaculatory latency time (IELT), or the time between the start of vaginal penetration and the onset of intravaginal ejaculation (Waldinger, Hengeveld, Zwinderman, & Olivier, 1998). The criteria used most often by clinicians to assess PE (Metz, Pryor, Nesvacil, Abuzzahab, & Koznar, 1997), however, and those used herein are taken from the *Diagnostic and Statistical Manual of Manual Disorders* text revision (*DSM-IV-TR*; American Psychiatric Association, APA, 2000). It is believed that the *DSM-IV-TR* is an appropriate reference for clinicians, particularly those who work with couples, because "it calls for judgment regarding lack of control of ejaculation and interpersonal difficulties" (Symonds, Roblin, Hart, & Althof, 2003, p. 362). Specifically, the manual states that the "essential feature of Premature Ejaculation is the persistent or recurrent onset of orgasm and ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before a person wishes it" (APA, 2000, p. 552). Further distinctions are made between lifelong (primary) and acquired (secondary) types, generalized and situational types, and due to psychological or combined factors (psychological and medical). The idiosyncratic nature of the sexual partner, age, context, and the frequency of sexual activity are also considered factors.

A formal definition for PE is certainly helpful to the clinician; however, couples present the disorder on a wide continuum. The majority report that the man ejaculates immediately after penetration. Others claim that the man ejaculates during foreplay and/or just prior to vaginal penetration. Because of this variation, and because it is common for partners to disagree as to the extent of their problem, it is vital for the clinician to obtain the couple's definition of their problem.

ETIOLOGY OF PE

PE is considered a disorder of the orgasm phase of the male sexual response cycle. Masters and Johnson (1966) found that during the first phase of this cycle, referred to as the sexual arousal or excitement phase, vasoconstriction occurs (i.e., increased blood in the tissues of the genitals) and culminates in an erection (Kaplan, 1979, 1995, later added that a Desire stage precedes this phase). A plateau phase follows in which arousal basically intensifies and a peaking of sexual pleasure and a release of sexual tension and rhythmic contraction of the perineal muscles and reproductive organs leads to a sense of "ejaculatory inevitability." The orgasm phase quickly follows and is characterized by a release of semen. A state of resolution completes the cycle. When a male cannot sustain a long-enough period of time engaged on the plateau stage, PE is the result.

Individual Biological/Physiological

The origin of PE can sometimes be attributed to an individual man's unique physiological structure. Waldinger et al. (1998) discovered that a range exists among men in their ejaculatory speed—as if ejaculatory time existed on a continuum. The authors found that some men ejaculated very rapidly, some at an average speed, others slowly, and some not at all. They also discovered that 91% of men with lifelong PE had a first relative with lifelong PE. Neurological studies have indicated that ejaculation is mediated in the brain; neurotransmitters transfer messages from one nerve to another (Waldinger, 2002). Serotonin (i.e., 5-HT) has long been felt to be the primary transmitter regulating ejaculation. There is evidence that lifelong PE is related to decreased central serotonergic neurotransmission, 5-HT2c receptor hyposensitivity and/or 5-HT1A hypersensitivity (Waldinger, 2003).

Physical illnesses attributed to PE include arteriosclerosis, diabetes, endocrine irregularities, epilepsy, multiple sclerosis, and other degenerative neurological disorders. Urological problems such as urinary tract infections, and perhaps the most common cause, prostatitis or prostate infection have also been found to result in the disorder (Metz & Pryor, 2000; Metz et al., 1997). Temporary or permanent physical injury such as pelvic fractures can also cause PE (Metz & McCarthy, 2003; Metz et al., 1997).

Pharmacologic side effect PE is a distinct form of PE that can result from the chronic use of or withdrawal from certain drugs, particularly opioids such as heroin (Barada & McCullough, 2004; Seagraves & Balon, 2003). There is, however, some evidence that opioid use can correct a previous PE problem (Palha & Esteves, 2002). Certain tranquilizers as well as over-the-counter cold medications such as pseudoephedrine (Sudafed) can also cause PE (Metz & McCarthy, 2003). Men who chronically use or abuse alcohol can develop PE upon withdrawal because they may have relied too

heavily on the alcohol to delay their ejaculation rather than having learned appropriate behavioral strategies (APA, 2000; see Case Study).

Individual Psychological

PE can also be caused by individually oriented emotional issues. Anger, frustration, low self-confidence, mistrust, negative body image, and psychosocial stress associated with financial difficulties, occupational problems, and the death of a significant other may be factors (Metz & McCarthy, 2003; Metz & Pryor, 2000). A man in his middle 20s presented with acquired PE. Although he apparently never experienced this problem in previous relationships, he claimed that he lacked confidence that he would be able to please his new, experienced girlfriend who he saw as "special." He maintained this notion about himself even though his girlfriend did little to warrant his concern. She was gentle and supportive of him, particularly when it came to sex.

Chronic psychological disorders such as bipolar disorder, dysthymic disorder, generalized anxiety disorder, obsessive-compulsive disorder, and posttraumatic stress disorder can produce PE. Temporary psychological difficulties like adjustment disorders with anxiety and/or depression can result in the disorder as well (Metz & McCarthy, 2003).

Some clients who suffer from other sexual disorders, most notably erectile disorder, can eventually develop PE. Out of fear of losing their erections, these individuals "stuff" their penises inside their partners and try to ejaculate as soon as possible (before they lose their erections). The origin of the erection problem may be physiological or psychological or both.

Masters and Johnson (1970) recognized the role psychosexual skills played in the development of ejaculatory control. The sex researchers wrote that coital encounters in "semiprivate situations under the pressure inherent in dual concern for surprise or observation" (p. 88) encouraged premature ejaculation. They specifically cited sexual encounters in the back seats of cars, and the practice of the "withdrawal technique" in which the man withdraws from intercourse before he reaches the stage of ejaculatory inevitability.

Cognitive-behavioral sexologists support behavioral and social learning perspectives. Metz and Pryor (2000), for example, reported that men with psychosexual skill deficit tend to be lacking in dating and interpersonal skills. As a result, they might "experience a lack of awareness of body management techniques, such as the pubococcygeal muscle in ejaculatory management" (p. 302). A high school senior convinced his parents to allow him to seek treatment after an embarrassing experience he had with PE on his first date ever. Apparently, he was so excited that he ejaculated within seconds after his date began kissing him. The date also complained that he kissed like a "fish" and was too rough when feeling her breasts. The young

man was so horrified with his performance that he considered never dating again.

Psychoanalytic theory views premature ejaculation as a neurotic symptom representative of a man's unresolved ambivalence toward women (Kaplan, 1974). This ambivalence or conflict is anchored in an unconscious struggle against remaining dependent on his mother; it manifests in a desire to give the woman something of himself that he values (i.e., his semen), but a need to exact revenge (i.e., PE) "for the disappointments of love to which as a child his mother subjected him, and which he finds repeated again in later years" (Abraham, 1917/1949, p. 297).

Couple/Dyadic Factors

Systemic therapists, whether predominantly cognitive-behavioral or psychodynamic believe that PE can be symptomatic of relationship issues. Power or control struggles, fear of commitment, fear of intimacy, and unrealistic expectations about sexual performance generated by the demands of a partner are thought to be causal factors of PE to which both partners contribute (Betchen, 2001; Metz & McCarthy, 2003).

Poor couple communication can cause sexual problems for a couple according to Gottman (1994). Moreover, it is a good predictor of divorce. Following a passionate, prolonged bout of foreplay, the wife of a man with PE would mount him and have intercourse at a frenzied pace—usually a process that her husband could only withstand for seconds until he ejaculated. The wife, a virgin when she married, believed that this was the way to truly please her husband—she never thought to ask if this assumption was true. Not wanting to hurt his wife's feelings as well as accept the fact that he could not keep up with her, the husband refrained from requesting to either reduce the foreplay period and/or pace the intercourse in a more manageable way conducive to pleasing both he and his wife. It was only when the couple began to communicate more effectively that they were able to compromise and alleviate their PE.

Sex is a common context for power and control struggles in couples (Betchen, 2001, 2006). This is true in part, because partners need to cooperate with one another to create a healthy sex life. When one partner wants something one way and the other a different way, struggles often ensue. For example, a young man and his girlfriend agreed that he lasted through approximately 15 min of continuous thrusting, but the girlfriend desired 30 min of intercourse at a rapid pace. Apparently, when the young man would slow down to preserve himself his girlfriend would become frustrated and speed the pace up by thrusting into him harder and faster. Although bothered by his girlfriend's behavior, the young man perceived himself as having PE and requested that he get help in learning to last

45 min. This dynamic exemplified a power and control struggle as well as unrealistic expectations in the bedroom.

It is nearly impossible to have a fear of intimacy without a fear of commitment. Couples can certainly commit to cohabitate, but if there is an aversion to intimacy they will most likely find a way to distance within the relationship in order to gain much needed space or to sabotage in an effort to achieve complete freedom. A commitment under such conditions would thus be considered a physical one at best, not necessarily an emotional one. Given the correlation of sex with such powerful relational concepts as attraction, desire, and love, sexual dysfunction can be enlisted, consciously or unconsciously, as a representative of these fears.

A middle-aged man's acquired PE was found to be symptomatic of his unconscious desire to end his long-term marriage—a desire that was too painful for him to admit to himself given the guilt he would experience over putting his three young children through a divorce. Rather than separate, this man attempted to satisfy his immediate sexual needs by ejaculating quickly in his wife without demonstrating any concern for her needs. It was his way of communicating to her that he was no longer committed to the relationship. It was also eventually revealed that the man preferred that his wife end the relationship thereby sparing him the pain of having to face his children. He eventually achieved his goal.

Family-of-Origin Factors

Sexual disorders, PE included, can be symptomatic of psychological conflicts emanating from the family of origin (Betchen, 2001, 2005). Once these conflicts are internalized they can be passed down from generation to generation and manifest into the same or different symptoms. Bowen (1978) referred to this process as the multigenerational transmission process. He postulated that the greater the influence that the family or origin had on the individual, the lower the individual's differentiation of self and hence, the greater the odds of the individual being symptomatic. Bowen recommended the genogram as a tool to assess family-of-origin influences; others (DeMaria, Weeks, & Hof, 1999) contended the genogram could also be used to assess sexual influences (see Assessment: Constructing the Sexual Genogram).

A newly married man reported with acquired PE that developed soon after he married. By examining the man's family of origin, it was determined that the PE symptom was a direct result of the severe parentification he had experienced as a child. Once the man married, he began to feel burdened or reparentified by his new responsibilities. He also perceived his new wife as more demanding of him than she was prior to their marriage. The man's PE symptom was a metaphor for his feelings of burden. He was exhibiting the following message through his disorder: "I want to get my needs met for

once, without having to worry about anybody else." This reaction was an artifact of his family of origin.

Sociocultural Factors

Kaplan (1974) wrote that the factors that damage our sexuality are rooted in our families and the association between sex and sin promoted by Judeo-Christian religions. According to Klein (2006), our society now enables a renaissance of the blurring of church and state, which has contributed to a backlash against sexual freedom. Mirrored by many families, this development has helped to produce and/or exacerbate sexual conflict and dysfunction.

It still holds true that growing up in a home with rigid religious values and/or a strict moral code can produce conflict about satisfying one's sexual urges. Receiving negative messages about sex (e.g., sex is dirty) can do the same. Thus, when an attempt is made to quell these urges via masturbation or otherwise, feelings of anxiety, guilt, and shame may be evoked (Betchen, 1991; Kaplan, 1974; Metz & McCarthy, 2003). More than one man with this type of upbringing has presented to me with PE. These men believed it was acceptable to have sex, particularly with their spouses, but not enjoy the sexual process. As a compromise, they did their manly duty as quickly as possible while numbing themselves to the pleasure of the orgasmic experience.

Even religious groups that encourage sex between spouses can, because of their laws, create sexual skill deficits leading to PE and other sexual disorders. In treating Hassidic Jews, I found the concept of refraining from premarital sex in conjunction with isolating from the popular culture/media to be important factors in their erectile difficulty and their inability to control the ejaculatory reflex. Because of inexperience, some of these men demonstrated very little knowledge about the general mechanics of intercourse.

Ethnic and cultural influences can be factors in determining PE. According to Montorsi et al. (2005), men of Southeast Asia who follow the Kama Sutra and Latin American men who are more accepting of female sexuality may be more concerned with female orgasm and thus more likely to report a problem with PE. Conversely, men in countries who do not concern themselves as much with pleasing women may be more prone to develop PE but not necessarily define it as a problem. This supports the belief that clinicians need to consider cultural differences and always ask clients what their definition of the problem is.

A SYSTEMIC TREATMENT MODEL FOR COUPLES WITH PE

The model offered is primarily for those clinicians who work with couples and believe that sexual disorders are often intricately linked to the nonsexual

dynamics and/or symptoms in a relationship. A systemic model can be used with couples who present with a wide variety of symptoms and it has been found to be particularly effective with those who suffer from sexual disorders such as PE (Betchen, 2001, 2005), erectile disorders (Weeks & Gambescia, 2000), and hypoactive sexual desire (Weeks & Gambescia, 2002).

The proposed model combines aspects of psychoanalytic conflict theory (Freud, 1910/1957) and psychodynamic family-of-origin work (Bowen, 1978) with basic sex therapy principles and exercises (Kaplan, 1974, 1989). Medical needs are addressed as well. The specific psychotherapeutic objective is for each partner to work towards uncovering and resolving any unconscious conflicts that are rooted in the family of origin. These conflicts can be responsible for many deleterious dynamics and/or symptoms (sexual and nonsexual) presented.

Kaplan (1974) was less than optimistic about the prognosis of a sexual symptom treated primarily via psychoanalytic and psychodynamic therapies. She therefore advocated for the use of psychodynamic interventions if and when behavioral interventions/sexual exercises were first met with overwhelming resistance. In the model presented, behavioral exercises are employed; however, the application of any exercise is left to the discretion of the clinician. Exercises may be assigned simultaneously with the psychodynamic work and other times the psychodynamic work is at the forefront of the treatment. A medical evaluation is mandatory.

The Therapeutic Process

Structuring the treatment

The clinician must control the structure of the treatment process or the couple will endlessly play out in the session the dynamics that they play at home (Weeks, Odell, & Methven, 2005). Because this is a conjoint model, both partners are urged to attend the first session. This allows the clinician to quickly evaluate each partner as an individual and in the context of the interaction. Berman (1982) contended that seeing both partners together serves to balance the treatment, helps to ensure that the therapist is viewed as neutral, and increases the chance that the couple will envision their problem as systemic rather than the sole responsibility of one partner.

Following the first session, each partner is seen individually for the next two consecutive sessions. Other individual sessions are added at the discrepancy of the clinician. Individual sessions may be useful in conjoint treatment to resolve certain therapeutic blocks. These may occur when the clinician feels that vital information is being withheld (e.g., an affair) or when a sexual history or sexual disorder proves too embarrassing to discuss in conjoint mode, when countertransference issues must be processed, or

when internalized conflicts result in an especially rigid relational system (Berman, 1982; Weeks, Gambescia, & Jenkins, 2003).

Assessment: Constructing the sexual genogram

The sexual life of an adult is greatly impacted by family history and in turn, plays a major role in the life of a couple (DeMaria et al., 1999). Incorporated into the genogram process is a sexual examination replete with questions regarding each partner's sexual history and current sexual status. Many of these questions are based on Kaplan's (1983) assessment procedure and listed in her book, *The Evaluation of Sexual Disorders: Psychological and Medical Aspects*. Kaplan's overriding objective in the evaluation stage is to achieve an accurate diagnosis of the sexual problem presented, determine the origin of the problem, and to set up an efficient and effective treatment plan. The evaluation herein usually can be completed in one or two sessions, depending on the complexity and cooperation of the couple. However, the genogram process is ongoing as the clinician can, at any time, add new information or make adjustments to his or her initial hypotheses.

Medical treatment

Segraves and Balon (2003) wrote: "Treatment of premature ejaculation with pharmacological agents is feasible, practical, and well tolerated" (p. 281). After the assessment is completed, it is recommended that the man be immediately referred for a complete physical examination (if he has not had one recently), preferably by a urologist with a background in working with sexual dysfunctions. Although there are no pharmacological agents currently approved to treat PE, selective serotonin reuptake inhibitors (SSRIs) such as paroxetine (Paxil), sertraline (Zoloft), and fluoxetine (Prozac) have been found to be significantly effective in the off-label treatment of PE. Paxil was found to produce the strongest ejaculatory delay (Waldinger, Zwinderman, Schweitzer, & Olivier, 2004).

SSRIs do, however, possess numerous drawbacks. There is a required chronic dosing, which lasts only when the drug is in the body, the therapeutic response is unpredictable, and they have a delayed onset of action and a long half-life. Side effects may include diminished libido, drowsiness, fatigue, nausea, diarrhea, headaches, and dry mouth (Barada & McCullough, 2004).

Off-label use of other antidepressants such as monoamine oxidase inhibitors (MAOIs) and tricyclic antidepressants (TCAs), particularly clomipramine (Anafranil), have also been proven effective (Waldinger et al., 2004). Clomipramine, however, can completely interfere with orgasm during sexual activity; it has also been found to produce such side effects as

light headiness, sleepiness, nausea, dry mouth, and vision problems (Strassberg, de Gouveia Brazao, Rowland, Tan, & Slob, 1999).

Neuroleptics, α-blockers, β-blockers, anxiolytics, smooth muscle relaxants, topical anesthesia (e.g., prilocaine-lidocaine cream), and oral phosphodiesterase 5 (PDE5) inhibitor agents such as sildenafil citrate (Viagra) have also been used to treat PE (Symonds et al., 2003). Some individuals believe that the success PDE5 agents have produced may have more to do with reducing performance anxiety than treating the PE per se. Topical creams, although effective, interfere with sexual spontaneity and can cause significant penile hypoesthesia and transvaginal absorption, which unless used with a condom can lead to genital numbness in the man and his partner, female anorgasmia, and an undesired loss of erection after 30 to 45 min (Atikeler, Gecit, & Senol, 2002; Montorsi et al., 2005).

While few men refuse to obtain a medical evaluation, many will reject medication, particularly when it is prescribed in the absence of an organic problem. This may be a convenient way to block treatment success and should be dealt with as resistance; other men may be realistically concerned about the side effects of medication and/or prefer to deal with the problem via psychotherapy. Additionally, if the man is in a relationship, his partner should be included in this and any treatment discussions. When medications are considered, the clinician should correspond with the consulting physician in an attempt to comfort the man and to find the most effective medication with the least deleterious side effects. The man should be made aware that the body sometimes adjusts to medication or a spontaneous remission of any drug-related sexual problems may occur. This may be the case for SSRIs and MAOIs but not TCAs; apparently, the anorgasmia that TCAs produce does not remit spontaneously (Komisaruk, Beyer-Flores, & Whipple, 2006). Nevertheless, if the man still refuses medical treatment and there is no organic basis for the problem the clinician can work with him and his partner. If there is an organic problem the man should be urged to follow up with the physician. While psychotherapeutic gains might be limited, the couple can benefit from modified prescriptions and opportunities to discuss their issues.

PE exercises

The clinician may assign sex therapy exercises if he or she feels the underlying relationship dynamics will allow for success. The basic tenet of treatment is to help the man learn to tolerate increasing levels of stimulation while in control of his ejaculatory reflex. This is accomplished through incremental exercises that allow him to tolerate more stimulation, become aware of his premonitory ejaculatory sensations or the sensations prior to the point of ejaculatory inevitability, and learn to pace himself and have intercourse in a way that minimizes friction or stimulation of the penis until he is ready to ejaculate.

If the couple proves ready, sensate focus exercises are initially assigned (Masters & Johnson, 1970) because they tend to create a more intimate atmosphere for the couple and help to reduce any anxiety that may be associated with the couple's sexual process (Weeks & Gambescia, 2009). If, however, a couple is not in need of such a preliminary experience, more sophisticated exercises specifically designed for PE are immediately offered. In this model, the stop-start method (Semans, 1956) as applied by Kaplan (1974, 1989) is the exercise method of choice.

The stop-start method will specifically allow the male to become aware of his premonitory sensations so that he can control ejaculatory latency while enjoying the sexual process; numbing either emotionally or physically to prolong ejaculation is considered counterproductive. Toward this end, in the first exercise the man is asked to lie on his back and have his partner stroke his penis with a dry hand while he pays attention to the erotic feelings in his penis. When he feels near orgasm, but before the point of ejaculatory inevitability, the partner is to stop stroking and allow the man's erotic feelings to dissipate (but not long enough for him to lose his erection). If the man does not have a partner, he can practice the stop-start technique while alone.

Couples are to do the stop-start exercises three to five times per week. When the man achieves enough control that he only has to stop two to three times in a 10-min period, the couple may move on to the next exercise. The second exercise entails repeating the first exercise only this time the partner is to stroke the male using a water-based lubricant; the lubricant serves to increase the level of sensitivity and to further prepare the male for intercourse. As an adjunct exercise, during the week the man is to practice Kegel exercises by contracting his pelvic floor muscles at the point before ejaculatory inevitability—this may result in better ejaculatory control (Kegel, 1952).

The third exercise is called slow-fast penile stimulation. The man is to have his partner stroke him until he reaches a high level of sexual excitement, then slow down rather than come to a complete stop. The fourth exercise entails the partner stroking the man at a high level of arousal continuously without stopping. During the fifth exercise the partner is to mount the man (female superior position) and use the man's penis to caress her vagina; the partner stops caressing just before the point of ejaculation. The female superior position allows the man to relax his lower body muscles and to better concentrate on the point of ejaculatory inevitability.

In the sixth exercise, the partner inserts the man's penis but only moves to maintain the orgasm (quiet vagina or nondemand coitus). This can be repeated as a seventh exercise with partners lying side by side. In the eighth and final exercise the man mounts his partner (male superior position) and practices speeding up and slowing down his thrusting

(as opposed to stopping it altogether)—this better simulates intercourse (gay couples can adapt all exercises accordingly).

Some couples insist on exercises for PE even if the clinician feels they are in too much conflict to complete them successfully. The clinician can first warn the couple that they should wait but if he or she senses that the couple will prematurely terminate the treatment unless exercises are immediately prescribed, it is recommended that sensate focus exercises be assigned because they will usually do little damage if unsuccessful. If the couple is not ready for exercises they will rarely get through sensate focus and return to treatment with the realization that they have problems (e.g., relationship issues) that need to be addressed before their sexual symptom can be alleviated. Other couples will collude in using their failure to prematurely end treatment.

Even when couples seem ready for exercises, it is quite common for one or both partners to sabotage them (e.g., engaging in a fight right before the exercises are to begin), thus indicating ambivalence about solving their problem. Some couples engage in control struggles about when to do the exercises or disagree about who should initiate them. Others insist on improvising or fail to follow the clinician's instructions. The clinician should be as clear and detailed as possible about the exercises assigned. For example, insisting that the couple agree on the time, place, and frequency of the assignments helps to ensure success. It is also important to agree on who will initiate the exercises (one or both partners) and how long they should last. Often times the partner will feel taken advantage of in the exercise process. The clinician can discuss whether or not the partner wishes to have their needs met prior to beginning each exercise and how the couple can accomplish this objective (noncoital stimulation performed on the partner may be a solution).

The clinician may find it useful to supply the couple with handouts detailing all exercises. However, because couples differ in introspective ability, motivation, levels of resistance, degree of experience, and degree of sexual difficulty, the exercise regimen should be considered by the clinician to be a general framework for treatment and not one automatically applied to all couples. As previously noted, the definition of PE is dependent to a great deal on what the couple brings to the clinician. This specific definition will in turn help to determine how PE exercises, if any, are utilized.

A couple presented with great motivation to conquer their problem with PE as quickly as possible. During sexual activity, the man ejaculated within three minutes of penetration, however, his wife could achieve a vaginal orgasm within 5 min of intercourse. The couple decided to learn how to stretch their lovemaking a little longer for optimum satisfaction. No psychodynamic work was required in this case, and there was no need to assign sensate focus exercises. Because the man could last as long as he wanted via manual and oral sex, the couple chose to proceed right to the

sixth exercise (i.e., stop-start with penile insertion) with great success. As noted, a couple with more anxiety and a penchant for resistance may need to delay exercises until a sufficient amount of psychotherapy has taken place.

Exposing conflicts and facilitating differentiation

While the exercises are in progress, the clinician helps each partner to uncover any individual conflicts that may be responsible for the PE symptom. Unveiling and working on these conflicts contributes to an increased level of differentiation from the family of origin. This in turn allows for a resolution of the conflicts and a reduction in both sexual and nonsexual dynamics and/or symptoms presented by the couple. In order to uncover these conflicts, the clinician must recognize any relevant patterns of behavior put forth and interpret any contradictions that the couple exhibits.

Uncovering conflicts on the interactional level

On this level the clinician observes the couple's interactional style and looks for patterns and contradictions that represent conflicts and collusions that may be responsible for their sexual symptom. These may show themselves in a sexual and nonsexual context. For example, a wife may complain vociferously that her husband never initiates a conversation about their relationship issues. But, when he does open his mouth, the clinician notices that she dominates the interaction with a lecture. This demonstrates an interactional conflict and/or contradiction on the wife's part: She claims to desire verbal interaction with her husband but blocks it from occurring. The husband demonstrates his conflict about wanting a voice in the relationship, as well as his collusiveness in the relational dynamic by failing to stop his wife from interrupting him.

Sex therapy exercises will also allow the clinician to identify interactional conflicts and contradictions in the sexual context of the couple. For example, a husband may claim to want to alleviate his PE symptom but find numerous excuses to avoid doing his sex exercises. If and when he does embark on these exercises his wife may start an argument with him thereby sabotaging them. It might be helpful if the clinician discusses some of the potential difficulties that may impede the exercises. These can be based in part, on the clinician's knowledge of the couple and their potential for control struggles. The couple is helped to understand how their struggles may represent unconscious conflict(s) that can sabotage their stated treatment goal(s).

The couple's interactional style will also show itself in contexts other than the one presented in therapy. If a couple grasps this concept, they may be better able to see that their problem might not be limited to

their specific sexual symptom. A PE sufferer who has avoided treatment, for example, may have trouble giving others what they want in general; his wife may have difficulty getting what she wants in other contexts as well. To expand the process in this case, the clinician can explore these issues to see if there is a pattern correlated to the marital and sexual dynamics.

Uncovering conflicts on the psychodynamic level

While some couples may be aware their interactional style is contributing to their PE symptom, they are almost never aware of the underlying psychodynamic contributions to the problem. The clinician may use the genogram to help each partner become conscious of these conflicts by probing each partner's family of origin with a series of questions. The objective is to make the connection between the conflicts, interactions, and the PE symptom. As noted, this procedure should continue throughout treatment.

The genogram of a man with PE revealed that he was engaged in a lifelong struggle for independence from the women in his life, dating back to his dominant mother. His conflict was that he needed a woman, but he also struggled against becoming too dependent on one. His PE served as a vehicle to create a control struggle that allowed him to be partially committed; this bought him the tolerable amount of space and closeness he needed to be in the relationship. His partner experienced a distant father and a history of dating distant men. Her conflict was that she longed for a loyal, loving man in her life but feared that if she became too close to one she might reexperience abandonment; she thus chose men who were ambivalent about committing to her.

The clinician can see this conflict in the man's family of origin and in the dating history of this man and explore with him how his unconscious conflict is in charge of his interactional relationships with women and his PE symptom. The clinician can ask what it feels like for him to be dominated by women and explore how this might have been related to his PE. The partner can be led to explore her fear of abandonment and asked what it feels like to not to be fully committed to, and how these issues might be related to her marital dynamic.

Crucial to therapy is helping partners move away from mutual "blame mode." The clinician can use the uncovered conflicts to show them that they are complementary, not necessarily "opposites." In the preceding example, both partners had a conflict with giving and getting and, in turn, an issue with intimacy. To foster mutual empathy the clinician can frame this in the following manner: "While your individual conflicts manifest somewhat differently, neither of you trusts that you will be reciprocated if you give of yourselves."

Resolving conflicts and increasing differentiation

The major difficulty with resolving conflicts lies in the fact that real solution of a conflict involves the frustration of both sides of a conflict. Simply put, gain on one side entails a loss on the other. Partners do not seem to accept this notion and will spend inordinate amounts of energy trying to find a way to "have it all," even after their conflicts are made clear to them. They are afraid that changing will make things worse. The ability to choose a different way of life most often depends on the degree of anxiety partners can tolerate and their ability to bear frustration.

The man with PE who struggled over independence–dependence issues with women had to come to the realization that he could not maintain his relationship with his partner at a safe distance; it was symptomatic of a lack of differentiation from his mother, responsible for his negative projections onto his female partner, and symptomatic of his PE. He had to decide whether he wanted to tackle the anxiety that came with taking the risk of giving up some of his freedom in a relationship with a woman. If he did so, he might achieve intimacy and sexual health, but he might lose the degree of control and independence that he fought for most of his life.

The man's partner had to differentiate from her distant father and decide whether she could take the risk of allowing a man to want her free of ambivalence—to see if she was really loveable. She would have had to give up on her father, but in the process she could discover that she really was worthy of love. Both partners, of course, could choose not to do the work and either stay in their same dilemma or terminate the relationship. Ultimately it is the couple's choice as to whether they want change—the therapist's main job is to show them the conflicts and help them to explore their options.

Termination

Treatment success is predicated on the alleviation of the PE symptom; the timeline for this success varies. While improved individual differentiation and a more functional couple interactional style are often prerequisites for success, if the PE is found to be solely organic in origin and is treated successfully with medication, treatment will obviously be brief. In most cases, however, the PE symptom will not dissipate until psychodynamic conflicts have improved—this often takes longer. In other instances, the PE symptom is alleviated but the underlying conflicts produce another symptom (i.e., symptom replacement); in this situation, the clinician should warn the couple that their underlying problem lives and gently encourage them to continue treatment. They should also know that their PE symptom could return if they end prematurely.

Generally, the termination of a case is a decision made by the couple and the clinician together. The termination process may take one or several sessions to accomplish. The couple can be told that booster sessions will be available given the chances of relapse (Metz & McCarthy, 2003). This gesture often eases the separation process.

CASE STUDY

Dave and Roselyn were married and in their early 50s. Dave presented with acquired, specific PE, but during the evaluation process he admitted that he may have had the disorder his whole life but never realized it because he usually had a drink or two to prepare him for intercourse. It is only with Roselyn that he became fully aware of his problem in part, because he stopped using alcohol to comfort him prior to having sex. A complete physical from his urologist prior to presenting for treatment cleared Dave of any organic problems.

Dave never experienced PE during oral and manual sex, but with intercourse he could only last a maximum of three thrusts (or a few seconds) before ejaculating. "There is something about intercourse that gives me problems," he said. Both partners were frustrated by this situation because Roselyn was capable of achieving intravaginal orgasms without a great deal of stimulation. Dave often brought her to orgasm prior to intercourse, but it was clear that both partners wanted him to last somewhat longer.

The interactional style of the couple presented itself across a variety of contexts. Whether it was the way Dave dealt with his business colleagues or clients, friends, his exwife, or his children, he failed to set limits, and in turn, was exploited and at times failed to reach his goals. Roselyn's reaction was always the same—she would chastise Dave for not being able to stand up for himself and for proving to be incompetent. She also felt that Dave did not defend her against others. Roselyn's mantra to Dave was, "That was just stupid Dave, just plain stupid." Dave did not counter Roselyn's complaints; he too believed that something was wrong with him and he wanted to grow stronger and be more successful. Neither partner initially realized that this issue was connected to their PE symptom.

During the course of the treatment it became obvious that Roselyn was right about Dave's behavior. For a bright man with a great deal of ambition, his judgment in certain situations, and his lack of control demonstrated an emotional conflict about being successful that was at least partially responsible for his relationship and sexual symptom. Roselyn's interactional conflict manifested differently. She continuously stated how much she wanted a better life for her and Dave but her overreaction to his behavior enabled her to feel miserable about her marriage and her life in general. She also claimed to want Dave to feel empowered and to stand

up for himself; but, her constant chastising reduced him and/or highlighted his incompetence.

Because the couple reported that affection and foreplay were not issues, the stop-start method was prescribed in the second session and the couple progressed until it was time for Dave to penetrate Roselyn. Dave then began to sabotage and in turn, Roselyn began to punish him verbally. As their conflicts were revealed, however, Dave and Roselyn came to realize that they were similar in a very important way—they both had conflicts about being "big" (the couples word for empowerment and success) that were anchored in the depreciative way their parents treated them in their respective families of origin. This insight helped them to empathize with one another and to decide "to be big" together—a sign of increased differentiation.

Although the couple colluded to sabotage several stop-start exercises (Dave was passive aggressive and Roselyn cajoled), they eventually succeeded in eradicating their PE symptom. The treatment took approximately 14 months, addressing what Dave and Roselyn considered a long-range cure to their relationship and sexual problems.

FUTURE CONSIDERATIONS

It is hopeful that medical science will someday offer a greater contribution to the alleviation of PE. Nevertheless, a primary concern for many sex therapists, particularly those who advocate the integration of couples and sex therapy, is that the treatment for PE, like erectile dysfunction (ED), will eventually become grossly skewed toward a medical solution. McCarthy (2001) wrote, "Both the general public and medical community now prefer use of a medical intervention first, and only if that is unsuccessful are psychological or sex therapy assessment and interventions considered" (p. 1).

Many physicians prescribe medications while failing to ask questions about their patients' relationships, ignoring any underlying psychological or systemic issues at play. Often, the partner is omitted from the decision to take medication. As a result, individuals continue to suffer from associated relationship dynamics—dynamics that may continue to plague the couple's sex life or other nonsexual areas. This short-sightedness also exists within the field of psychotherapy. Despite the evidence supporting the correlation between relationship and sexual problems, many professionals still look to the individual symptom bearer as the sole identified patient.

The model presented is comprehensive and systemic. It contends that exposing conflicts and differentiating from the negative effects of the family of origin leads to the resolution of these conflicts and any accompanying sexual symptoms. It is a complicated process with many skills required; eliminating one treatment option over another or simplifying the process

either from a psychotherapeutic or medical perspective only deprives the couple of appropriate treatment (Althof, 2007; Barnes & Eardley, 2007; Perelman, 2006). Clinicians need to be broad-minded in the treatment of couples who present with sexual problems and consider a myriad of factors in order to help the couple achieve a more prospering intimate relationship, free of sexual difficulty.

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