

Retarded ejaculation

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Abstract Retarded ejaculation (RE) has a relatively low prevalence (<3%), yet this condition results in considerable distress, anxiety, and lack of sexual confidence for those suffering from it. Furthermore, men with partners often experience impairment of both the sexual and nonsexual aspects of their relationships, with such negative effects compounded when procreation is a consideration. The definition of RE is ambiguous, due to the variability and paucity of data regarding normal coital ejaculatory latency. RE is influenced by both biogenic and psychogenic components, which may vary over time both between and within individuals. While specific pathophysiology can often be identified, further elucidation of the biogenic components of this dysfunction will require greater understanding of the physiological mechanisms underlying ejaculation. Yet, the most useful strategies for understanding RE will integrate rather than isolate the various biogenic and psychogenic aspects of this dysfunction. Evidence based evaluation and treatment protocols for this disorder are lower than for other sexual dysfunctions, but reports suggest better treatment

efficacy when the etiology is predominantly psychogenic. As with erectile dysfunction (ED) and premature ejaculation (PE), if safe and efficacious oral pharmaceuticals are eventually developed for this condition, the treatment algorithm is likely to undergo significant alteration. Even then, however, the most effective treatments are likely to result from a combination treatment that integrates sex coaching with pharmacotherapy.

Introduction

Retarded ejaculation (RE) is probably the least common, and least understood of all the male sexual dysfunctions. RE is one of the diminished ejaculatory disorders (DED), which is a subset of male orgasmic disorders (MOD) [1]. Diminished ejaculatory disorders is a collective term for an alteration of ejaculation and/or orgasm that ranges from varying delays in ejaculatory latency to a complete inability to ejaculate, anejaculation, and retrograde ejaculation, as well as reductions in volume, force, and the sensation of ejaculation. Similar to the term “premature ejaculation,” the most commonly used term—“retarded ejaculation”—is sometimes avoided because of its pejorative associations. In fact, the abbreviation “EjD” has been suggested as a less stigmatized term, encompassing all disorders of ejaculation [1].

The American Psychiatric Association’s diagnostic and statistical manual of mental disorders, fourth edition, text revision (DSM-IV-TR) defines RE as the persistent or recurrent delay in, or absence of, orgasm after a normal sexual excitement phase during sexual activity that the clinician, taking into account the

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person's age, judges to be adequate in focus, intensity, and duration. The disturbance causes marked distress or interpersonal difficulty; it should not be better accounted for by another Axis I disorder or caused exclusively by the direct physiologic effects of a substance or a general medical condition [2]. Similarly, the World Health Organization 2nd consultation on sexual dysfunction defines RE as the persistent or recurrent difficulty, delay in, or absence of attaining orgasm after sufficient sexual stimulation, which causes personal distress [3].

Failure of ejaculation can be a lifelong (primary) or an acquired (secondary) problem. It can be global and happen in every sexual encounter or it may be intermittent or situational. Many men with secondary RE can masturbate to orgasm, whereas others, for multiple reasons, will or cannot. Interestingly, correlational evidence suggests that masturbatory frequency and style may be predisposing factors for RE, since a substantial portion of men who present with coital RE typically report high levels of activity using an idiosyncratic masturbatory style [4–8].

Similar to men with other types of sexual dysfunction, men with RE indicate high levels of relationship distress, sexual dissatisfaction, anxiety about their sexual performance, and general health issues—significantly higher than sexually functional men. In addition, along with other sexually dysfunctional counterparts, men with RE typically report lower frequencies of coital activity [9]. A distinguishing characteristic of men with RE—and one that has implications for treatment—is that they usually have little or no difficulty attaining or keeping their erections—in fact they are often able to maintain erections for prolonged periods of time. Yet, despite their good erections, they report low levels of subjective sexual arousal, at least compared with sexually functional men [10].

Prevalence of RE

In general, RE is reported at low rates in the literature, rarely exceeding 3% [1, 11, 12]. Since the beginning of sex therapy, RE was seen as a clinical rarity, with Masters and Johnson [13] initially reporting only 17 cases. Apfelbaum reported 34 cases [14] and Kaplan fewer than 50 cases [15] in their respective practices. However, based on clinical experiences, some urologists and sex therapists are reporting an increasing incidence of RE [1, 12, 16]. The prevalence of RE appears to be moderately and positively related to age, which is not surprising in view of the fact that ejaculatory function as a whole tends to diminish as men age.

Etiology

Just as a pathophysiological etiology should not be assumed without a thorough medical investigation, a psychogenic etiology should not be assumed without an appropriate psychosexual history. Of course, biogenic and psychogenic etiologies are neither independent nor mutually exclusive classifications—not only do the categories themselves overlap, but also the causes of sexual dysfunctions often include a mix of factors involving both domains.

Biogenic

In some instances, a somatic condition may account for RE, and indeed, any procedure or disease that disrupts sympathetic or somatic innervation to the genital region has the potential to affect ejaculatory function and orgasm. Thus, spinal cord injury, multiple sclerosis, pelvic-region surgery, severe diabetes, and medications that inhibit α -adrenergic innervation of the ejaculatory system have been associated with RE [17–19]. Nevertheless, sizable portions of men with RE exhibit no clear somatic factors that account for the disorder.

It is essential to distinguish those factors that are “physiological” from those that are “pathophysiological.” “Physiological” refers to factors that are biologically inherent to the system, through genetic and normal maturational processes. “Pathophysiological” refers to those factors that occur through disruption of the normal physiological processes, through disease, trauma, surgery, medication, etc. Pathophysiological causes of RE are far more readily identifiable; they generally surface during a medical history and examination, and they typically stem from predictable sources: anomalous anatomic, neuropathic, endocrine, and medication (iatrogenic). All types of RE show age-related increases in prevalence, independent of age, increased severity with lower urinary tract symptoms [20, 21]. Commonly used medications, particularly antidepressants, may delay ejaculation as well. A comprehensive list of such pharmacological agents may be found in Perelman et al. [1].

More difficult to identify are inherent physiological factors that account for variation in ejaculatory latency and thus might play a role in RE. Low penile sensitivity, most often associated with aging [22, 23], may exacerbate difficulty with reaching orgasm, but it is an unlikely primary cause. Alternatively, variability in the sensitivity of the ejaculatory reflex may be a factor. More likely, however, ejaculatory response and latency are influenced by central (cognitive-affective-arousal) processes than dominated by the simple hardwiring of the spinal reflex components [24].

Psychogenic

Multiple psychosocial explanations have been offered for RE, with unconscious aggression, unexpressed anger, and malingering recurring as themes. In addition, pregnancy fears have been emphasized, as professional referral has often been tied to the female partner's wish to conceive. Masters and Johnson [13] were the first to suggest an association between RE and religious orthodoxy, positing that certain beliefs may limit the sexual experience necessary for developing the knowledge necessary to learn to ejaculate or may result in an inhibition of normal function.

Religious orthodoxy may play a role in RE for some men, but the majority of men with RE do not fall into this category. A number of relevant behavioral, psychological, and relationship factors appear to contribute to difficulty reaching orgasm for these men. For example, men with RE sometimes indicate greater arousal and enjoyment from masturbation than from intercourse. This "autosexual" orientation may involve an idiosyncratic and vigorous masturbation style—carried out with high frequency. Apfelbaum [14] labels this as a desire disorder specific to partnered sex. Perelman [4–8] defines "idiosyncratic masturbation as a technique not easily duplicated by their partner's hand, mouth, or vagina". Specifically, many men with RE engage in self-stimulation that is striking in the speed, pressure, duration, location and intensity necessary to produce an orgasm, and dissimilar to what they experience with a partner [6, 8, 25]. Almost universally, these men failed to communicate their preferences for stimulation to either their doctor or their partners, because of shame, embarrassment, or ignorance. Thus, they may predispose themselves to difficulty with a partner and experience secondary RE. Disparity between the reality of sex with the partner and the sexual fantasy (whether or not unconventional) used during masturbation is another potential cause of RE [26, 27]. This disparity takes many forms, such as partner attractiveness and body type [5, 10], sexual orientation, and the specific sex activity performed. In summary, high-frequency idiosyncratic masturbation, combined with fantasy/partner disparity, may well predispose men to experiencing problems with arousal and ejaculation.

The above patterns suggest that RE men may lack sufficient levels of physical and/or psychosexual arousal during coitus to achieve orgasm. Apfelbaum [14] has suggested that the couple interprets the man's strong erectile response as erroneous evidence that he sufficiently aroused to attain orgasm. Consistent with this idea, Perelman posits that inadequate arousal may be responsible for increased anecdotal clinical reports of

RE for men using oral medications for the treatment for ED [16]. While most men using phosphodiesterase inhibitors type 5 (PDE-5s) experienced restored erections and coitus with ejaculation, others experienced erection without adequate psycho-emotional arousal. That is, they did not experience sufficient erotic stimulation before and during coitus to reach orgasm, confusing their erect state as an indication of sexual arousal when it primarily indicated vasocongestive success [26].

Finally, the evaluative/performance aspect of sex with a partner often creates "sexual performance anxiety" for the man, a factor that may contribute to RE. Such anxiety typically stems from the man's lack of confidence to perform adequately, to appear and feel attractive (body image), to satisfy his partner sexually, to experience an overall sense of self-efficacy, and to measure up against the competition [28, 29]. Anxiety surrounding the inability to ejaculate may draw the man's attention away from erotic cues that normally serve to enhance arousal. This "ejaculatory performance" anxiety interferes with the erotic sensations of genital stimulation, resulting in levels of sexual excitement and arousal that are insufficient for climax (although more than adequate to maintain an erection).

An integrated biopsychosocial approach

Comprehending the factors that account for variation in latency to ejaculation following vaginal intromission is key to understanding any MOD. As with many bio-behavioral responses, variation in ejaculatory latency is undoubtedly under the control of both biological and psychological-behavioral factors. One contemporary way of conceptualizing the interaction of these systems has been proposed by those who study evolutionary psychology [30]. The ejaculatory latency range for each individual may be biologically set or predisposed (e.g., via genetics), but the actual timing or moment of ejaculation within that range depends on a variety of contextual, psychological-behavioral, and relationship-partner variables [25]. Such thinking is clearly supported by the fact that ejaculatory latency in men with ejaculatory disorders (either PE or RE) is often quite different during coitus than during masturbation [31].

The most useful approach to understanding biobehavioral responses is that of integrating—rather than isolating—the biological and psychological-behavioral components, with the goal of identifying those organismic elements—peripheral and/or central—that contribute to and explain variation in the response. Genetic predispositions are likely to affect the typical

speed and ease of ejaculation for any particular organism; however, some components are undoubtedly influenced by the past experiences and present contexts in which the response is occurring. Retarded ejaculation, then, is best understood as an endpoint or response that represents the interaction of biological, psychological, relationship and cultural factors.

Evaluation

The diagnostic evaluation of ejaculatory dysfunction should focus on uncovering potential physical and specific psychological/learned causes of the disorder.

The sexual tipping point™ model

Perelman's [32] sexual tipping point™ (STP) model offers a clinically useful heuristic for evaluating the role both biogenic and psychosocial factors play in determining the etiology of sexual dysfunction (SD) generally, and RE in particular [8]. The STP is the characteristic threshold for an expression of a sexual response for any individual, which may vary dynamically within and between sexual experiences. There is variable expression of this response, which may be

inhibited or facilitated due to a mixture of both psychogenic and biogenic factors, as the mind and body can both inhibit and excite sexual response (Fig. 1). The specific threshold for the sexual response is determined by these multiple factors for any given moment or circumstance, with one factor or another dominating as others recede in importance. For instance, every man, whether he experiences a "normal" ejaculatory latency, or premature or retarded ejaculation, has a multidimensional predetermined "ejaculatory tipping point" (EjTP) [25]. Appropriate assessment requires an appreciation of the interdependent influence of all these factors on the endpoint dysfunction for a particular individual, at a particular moment in time.

Medical history

A genitourinary examination and medical history may identify physical anomalies associated with ejaculatory dysfunction as well as contributory neurologic, endocrinologic, or erectile factors. Attention should be given to identifying reversible urethral, prostatic, epididymal, and testicular infections. Particularly with secondary RE, adverse pharmaceutical side effects—most commonly from serotonin-based prescriptions—should be ruled out.

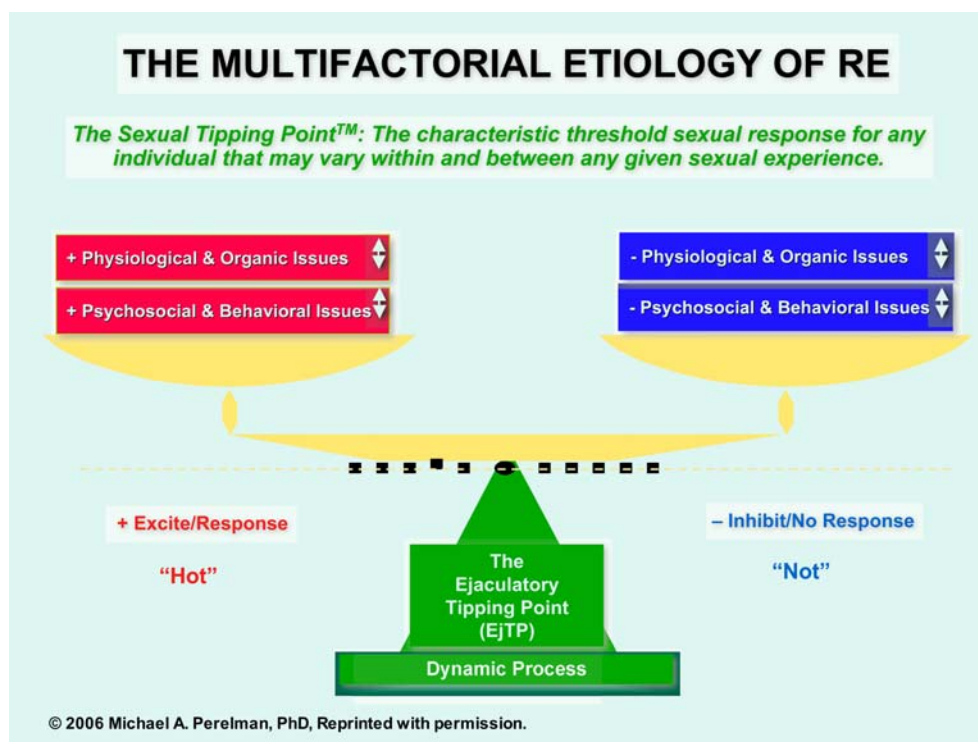


Fig. 1 The multifactorial etiology of RE. The sexual tipping point™: the characteristic threshold sexual response for any individual that may vary within and between any given sexual experience

While recognizing the likelihood of ejaculatory variability and appreciating other potential organic components, clinicians should also note relevant psychosocial determinants. To this end, a focused psychosexual evaluation is critical and typically begins by differentiating this sexual dysfunction from other sexual problems and reviewing the conditions under which the man is able to ejaculate. The developmental course of the problem—including predisposing issues of religiosity—and variables that improve or worsen performance, particularly those related to psychosexual arousal, should be noted. Perceived partner attractiveness, the use of fantasy during sex, anxiety-surrounding performance, and coital and masturbatory patterns all require exploration. Consistent with this last inquiry, the patient should be asked: (1) “What is the frequency of your masturbation?” (2) “How do you masturbate?” Additional questions may be used to give greater specificity to the potential role of masturbation in the disorder and to clarify these and other relevant etiological factors.

If orgasmic attainment had been possible previously, the clinician should review life events/circumstances temporally related to orgasmic cessation—events in question might include pharmaceuticals, illness, or a variety of life stressors and other psychological factors previously highlighted.

Since many men attempt their own remedies, the patient’s previous approaches to improving ejaculatory response should be investigated, including the use of herbal or folk therapies, prior treatments, and home remedies (e.g., using particular cognitive or behavioral strategies). Information regarding the partners’ perception of the problem and their satisfaction with the overall relationship is often helpful. Once this body of knowledge is complete, an appropriate treatment plan, developed in conjunction with the couple, can be implemented.

Treatment

Treatment strategies for sexual dysfunction (SD) in general and RE specifically may be conceptualized as balancing the STP; this process most often benefits from cooperation of the sexual partner. Discussion of a potential biologic predisposition is often helpful in reducing patient and partner anxiety and mutual recriminations, while simultaneously assisting the formation of a therapeutic alliance with the urologist [6].

Masters and Johnson [13] were among the first to advocate specific exercises as part of the treatment for RE. Current sex therapy approaches to RE continue to

emphasize the importance of masturbation in the treatment of RE; however, much of the focus now is on masturbatory retraining, integrated into sex therapy [1, 14, 27, 33–35]. As characterized by Perelman, masturbation serves as a type of “dress rehearsal” for sex with a partner. By informing the patient that his difficulty is merely a reflection of “not rehearsing the part he intended to play,” the stigma associated with this problem can be minimized and cooperation of both the patient and partner can be evoked.

Of course, masturbation retraining is only a means to an end, and the goal of most current therapeutic techniques for RE (either primary or secondary) is not merely to provide more intense stimulation, but rather to stimulate higher levels of psychosexual arousal and, eventually, orgasm within the framework of a satisfying experience.

Primary RE

Men with primary anorgasmia, like their female counterparts, typically need help in determining their sexual arousal preferences through self-exploration and stimulation. Masturbation training may use a modification of the model described by Barbach [36] for women, although for men the use of vibrators, recommended by some urologists, is rarely necessary [37]. Progressing from neutral sensations to the ability to identify and experience pleasurable sensations is encouraged, but this need not be aimed at achieving orgasm, at least initially.

Typically, self-stimulation techniques incorporating fantasy can be used to achieve incremental increases in arousal. Fantasy can help block-inhibiting (often critical) thoughts—often a significant step that might otherwise result in interference with the progression of sexual arousal. An important component in the treatment of any type of RE is the removal of “demand” or “performance” anxiety [14]. To reduce anxiety, treatment may include recognition of RE men’s over eagerness to please their partners, validation of (though not necessarily encouragement of) the man’s autosexual orientation, removal of stigmas suggesting hostility or withholding toward their partner, and general anxiety reduction techniques such as relaxation and desensitization. Finally, like a previously anorgasmic woman, the man is taught to effectively communicate his preferences to his partner so that both their needs are incorporated into the sexual experience.

Secondary RE and the management of resistance

Therapy for secondary RE follows a strategy similar to that of primary anorgasmia. However, the clinician or

urologist should counsel these patients to suspend masturbatory activity and limit orgasmic release to only the desired activity, which is typically coitus. Advice to temporarily reduce and/or discontinue masturbation for any length of time (e.g., 14–60 days) is usually met with significant resistance by the patient. As a result, the clinician will need to provide strong support and encouragement to the patient to ensure that he adheres to this suspension. In addition to suspending masturbation, the patient should be encouraged to use fantasy and bodily movements during coitus, which help approximate the thoughts and sensations previously experienced in masturbation. Resistance is minimized and the success of the process enhanced when the partner is supported by the urologist and understands that the alteration in coital style represents temporary successive steps to reaching a long-term goal of mutual coital harmony and satisfaction.

Sometimes the issue of masturbation interruption must be compromised and negotiated with the patient. A man who continues to masturbate, for example, may be encouraged to alter the style of masturbation (“switch hands”) and to approximate (in terms of speed, pressure, and technique) the stimulation likely to be experienced through manual, oral, or vaginal stimulation by his partner [8].

Partner issues

To increase satisfactory outcomes from treatment, the partner needs to cooperate with the therapeutic process, finding ways to pleasure the man that enhance arousal and that can be incorporated into the couple’s lovemaking. Sexual fantasies may have to be realigned so that thoughts experienced during masturbation better match those occurring during coitus. Efforts to increase the attractiveness and seductive/arousing capacity of the partner and to reduce the disparity between the man’s fantasy and the actuality of sex with his partner may be useful, as significant disparity tends to characterize more severe and recalcitrant RE and relationship problems, with a consequent poorer treatment prognosis [4, 5].

While a number of other partner related issues may affect a males’ ejaculatory interest and capacity, two require special attention: fertility/conception and anger/resentment. Under either circumstance, it is often a significant challenge to any health care provider (HCP) to identify a process that allows a couple to experience coital ejaculation while simultaneously maintaining a therapeutic rapport with both. Regarding conception, the pressure of the woman’s “biological clock” is often the initial treatment driver. The

woman—and often the man as well—usually meet any potential intrusion on their plan to conceive with strong resistance. If the urologist or other HCP suspects the patient’s RE is related to fear of conception, he may inquire about the patient’s ability to experience a coital ejaculation with contraception (including condoms) but not during “unprotected” sex. Such a “test” can serve as a powerful diagnostic indicator: if the RE occurs with high probability only during unprotected sex, the HCP can assume that conception is a primary factor causing/maintaining RE. Under such circumstances, the HCP must find an acceptable way to refocus the treatment, at least temporarily, on the underlying issues responsible for his ambivalence. Resolving this issue typically requires individual consultations with the man and occasionally with the partner.

Whether related to fertility or not, the man’s anger (expressed/unexpressed) toward his partner may be an important intermediate causal factor and must be ameliorated through individual and/or conjoint consultation. Anger acts as a powerful anti-aphrodisiac, and while some men avoid sexual contact entirely when angry at a partner, others attempt to perform, only to find themselves only modestly aroused and unable to maintain an erection/and or reach orgasm. While the man’s assertiveness should be encouraged, the HCP should also remain sensitive and responsive to the impact of this change on the partner—the object of the newly expressed anger—and the resulting alteration in the couple’s equilibrium.

As treatment progresses, interventions may be experienced as mechanistic and insensitive to the partner’s needs and goals. In particular, many women respond negatively to the impression that the man is essentially masturbating himself with her various body parts, as opposed to engaging in the type of connected lovemaking she may prefer. This perception is exacerbated when men need actual pornography/erotica rather than mere fantasy to distract themselves from negative thoughts and emotions in order to function sexually. Indeed, because these men are often quite disconnected emotionally from their partners, the HCP must help the partner become comfortable with the idea of postponing gratification of her needs. Once the patient has progressed to a level of functionality, the urologist can then encourage greater sensitivity on the man’s part.

Treatment efficacy and conclusion

While anecdotally viewed by urologists as a difficult-to-treat sexual dysfunction, some sex therapists have

reported good success rates, in the neighborhood of 70–80% [13, 35]. This disparity in success rates may reflect clinically different treatment populations. Furthermore, although this review has concentrated on the use of counseling methods, a number of pharmacological agents have been used off-label to facilitate orgasm in patients taking SSRI antidepressants and other drugs known to delay or inhibit ejaculatory response. Although not approved by regulatory agencies for the treatment of RE, the anti-serotonergic agent cypheptadine and the dopamine agonist amantadine have been used with moderate success in this population of patients [38]. However, the lack of large, controlled studies with these and other ejaculatory-facilitating agents suggests a high ratio of adverse effects to potential efficacy. Furthermore, a lack of efficacy in men with RE may result, in part, from the potentially strong psychological and relational contributions to this dysfunction. Nevertheless, as research continues to uncover greater understanding of the ejaculatory process, the likelihood of finding pro-ejaculatory agents increases.

Finally, the treatment for RE described herein would typically consume more of the urologist's time than treating other SD symptoms such as ED. Depending on comfort level, preference, resources, and availability, the urologist may choose to treat the man with RE or refer him to a sex therapist colleague [34]. As with PE and ED, should safe and effective pharmacological options become available for RE, treatment for this dysfunction will undergo a major paradigm shift, with combination drug and sex therapy protocols likely producing the greatest efficacy and best outcomes in terms of patient satisfaction [39]. In the future, urologists might consider the STP model to conceptualize a treatment in which sex coaching and sexual pharmaceuticals are integrated into diagnosis—addressing physiological, psychological, and cultural elements all in one—and thereby achieving a more satisfactory efficacious treatment, [6–8, 32, 40].

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