9

Retarded Ejaculation — Ejaculatory Overcontrol

Retarded ejaculation is an involuntary inhibition of the male orgastic reflex. This condition is physiologically analogous to female orgasmic dysfunction. The retarded ejaculator is able to feel sexual excitement and have good erections, but even though he receives what should be ample stimulation, he has difficulty releasing this ejaculatory reflex. Severe overcontrol, i.e., the man who has never ejaculated at all, even on masturbation, is rare. This is fortunate because this extreme form of retardation is difficult to treat. In its milder forms ejaculatory retardation (or ejaculatory incompetence) is relatively common and has an excellent prognosis with sex therapy. In the moderate forms of this disorder the man can only ejaculate on masturbation when he is alone. Men suffering from milder retardation can climax in the presence of their partner but only in response to manual and/or oral stimulation. They cannot ejaculate in the vagina. Still milder forms are situational and some merely require excessively long and vigorous coitus in order to ejaculate.

The pathogenesis of ejaculatory overcontrol is similar to that of constipation, globus hystericus, and difficulty with starting the stream of urine. Defecation, swallowing, urination, and ejaculation or orgasm all depend on autonomically mediated reflexes which are normally brought under voluntary control. When the individual is in an emotionally aroused state or when he is under the domination of a psychological conflict, there may be an involuntary defensive reaction of inhibition of the reflex in question. The defensive reaction entails an

overcontrol, i.e., the inability to release the reflex from cortical control.

The source of the unconscious conflict and/or the content of the emotional state seems to be nonspecific. In other words it has not been possible to identify a specific psychodynamic constellation which would discriminate ejaculatory incompetence from impotence. The same kinds of deeply unconscious castration fears and superficial performance anxieties, as well as fears about commitment to the partner will result in erectile difficulties in one man and ejaculatory overcontrol in another. The conflicts seem the same, but the *defenses* are distinct. The retarded ejaculator will unconsciously "hold back," i.e., exercise control and so avoid anxiety, while the impotent man allows himself to be flooded with anxiety which then ruins his erectile response.

The main purpose of brief, active sex therapy with retarded ejaculation is to *distract* the man from his excessive need to control, so that his orgastic reflexes can discharge unimpeded. Often this strategy works very well. At other times some of the underlying conflicts must be recognized and resolved, at least in part, before the patient can relax enough to allow himself to be so distracted. For these patients a very important factor involved in the anxiety and inhibitory defense against this anxiety is the relationship with the partner. Considerable resolution of unconscious problems in the relationship usually needs to be accomplished before the patient can relax and have easy and pleasurable orgasms.

Treatment Strategy

Two basic treatment principles govern the therapy of retarded ejaculation:*

1. progressive in-vivo desensitization to intravaginal ejaculation (i.e., desensitization in the presence of the partner);
2. stimulation with concomitant distraction.

PROGRESSIVE DESENSITIZATION

Most retarded ejaculators can ejaculate under some condition and the basic strategy of treatment is to gradually shape the patient's ejac-

* The treatment rationale of retarded ejaculation of men and orgastic dysfunction of women is analogous.

ulatory response toward the desired goal of ejaculatory freedom on coitus. Techniques are structured with this principle in mind. Therefore, the specific behavioral prescriptions will vary with the individual case.

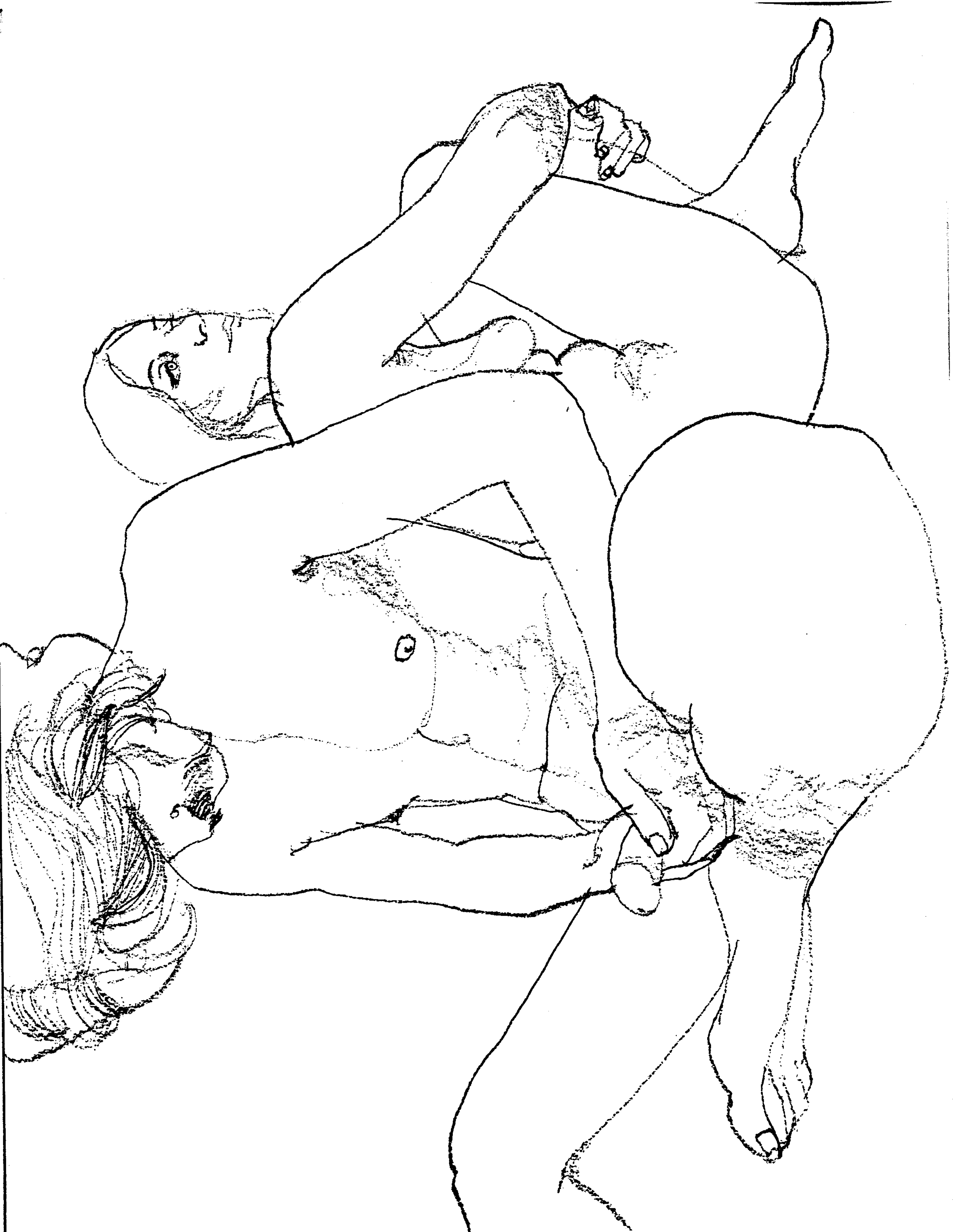
For example, a patient can ejaculate only if his wife has left the house and he is alone. If he then masturbates with petroleum jelly to a fantasy of being orally stimulated by a strange woman, he can predictably reach orgasm. When he tries to make love to his wife, he has pleasure, a good erection, intercourse, she is satisfied, but he does not reach orgasm no matter if coitus lasts for one hour. His erection slowly abates and he goes to sleep.

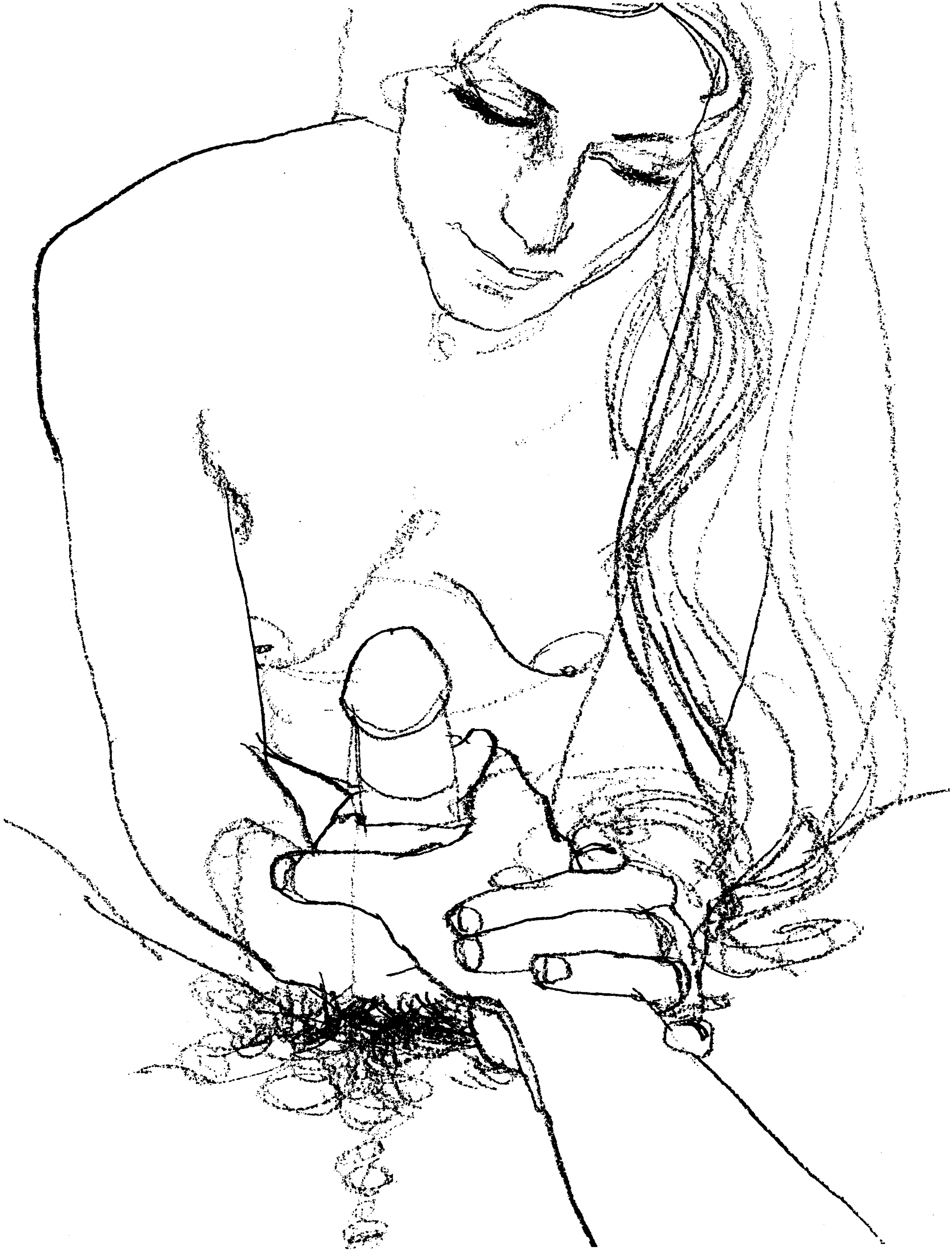
This material is openly discussed with both partners. The first behavioral prescription in this case might be that he masturbate in his usual fashion with his usual fantasy behind locked doors while his wife is downstairs. If this is successful, several days later he might repeat the procedure while his wife is in the adjacent room. Next, while she is in the same room. Later on, they make love and after she is satisfied, he goes to the bathroom to masturbate to orgasm. This sequence begins to establish an association between the heterosexual act and orgasm. A key point in treatment occurs when the patient's wife can manually stimulate him to orgasm. She uses the petroleum jelly and he is advised to use his fantasy while he is being stimulated. These may be covert or openly talked about with his wife during the sexual act. [This use of fantasy is an expression of the second principle of treatment: *distraction* from excessive control and self-observation during stimulation.]

After the patient has been brought to orgasm by his wife, further lone masturbatory release is prohibited. He can only now ejaculate in the presence of and with the participation of his wife. Ejaculation progressively nearer the vagina is the next sequence of treatment.

The *male bridge maneuver* is employed after the patient can reliably have orgasm with her manual manipulation. The woman stimulates the man with the petroleum jelly until he is near orgasm. Then he enters. She stimulates his penis with her hand while he thrusts. Figures 32 and 33 illustrate two coital positions wherein this technique is comfortable and feasible.

After the man has penetrated the vagina with a combination of hand





and vaginal stimulation, he begins to signal when he is at the point of orgasm so that she can withdraw her hand and let the coital thrusting bring about the actual orgasm. A position wherein the woman keeps her legs tightly closed during coitus (see Figure 34) increases penile friction and is sometimes useful at this stage of treatment.

STIMULATION AND DISTRACTION

The crucial principle which governs the treatment both of retarded ejaculation of the male and orgastic inhibition of the female is that the person be physically stimulated intensely, while at the same time mentally distracted from inhibitory vigilance. It has already been mentioned that mental absorption in erotic fantasy while genital stimulation is being experienced, is an ideal method of releasing the orgasm reflex. However, some patients require more complete or concrete distraction, because they are unable to lose themselves in their imageries and fantasies. In such cases I might advise that the patient read erotic literature or view sexually stimulating pictures while stimulation occurs. Thus for example, one woman has her first orgasm when reading an erotic novel while she stimulated herself with a vibrator.

Incompletely Retarded Ejaculation

There is a rare syndrome which conceptually belongs under the category of retarded ejaculation—which I have called *incompletely or partially retarded ejaculation.* In this syndrome only one phase, the ejaculatory component of the orgasm response, is inhibited, while the other component of the male orgasm, emission, is not impaired. The male orgasm consists of first, *emission,* which is a sympathetically mediated contraction of the vas deferens, prostate, and seminal vesicles. This gathers the ejaculate into the posterior urethra. This response is perceived without pleasure as the "sensation of ejaculatory inevitability." The ejaculatory component of this male orgasm normally follows a fraction of a second later. It consists of rhythmic contractions of

the striated muscles at the base of the penis. This part of the response is associated with the intense pleasure of orgasm and this produces the squirting action of ejaculation.

The man who suffers from incomplete retardation has good and pleasurable erections. But at the point of climax he only experiences the emission phase of the response. Perceptually he feels a "release" but *no* orgasmic pleasure. Physiologically there is only a seepage of semen and also a very slow detumescence (because the vasocongestion is not "pumped out" by the muscle contractions).

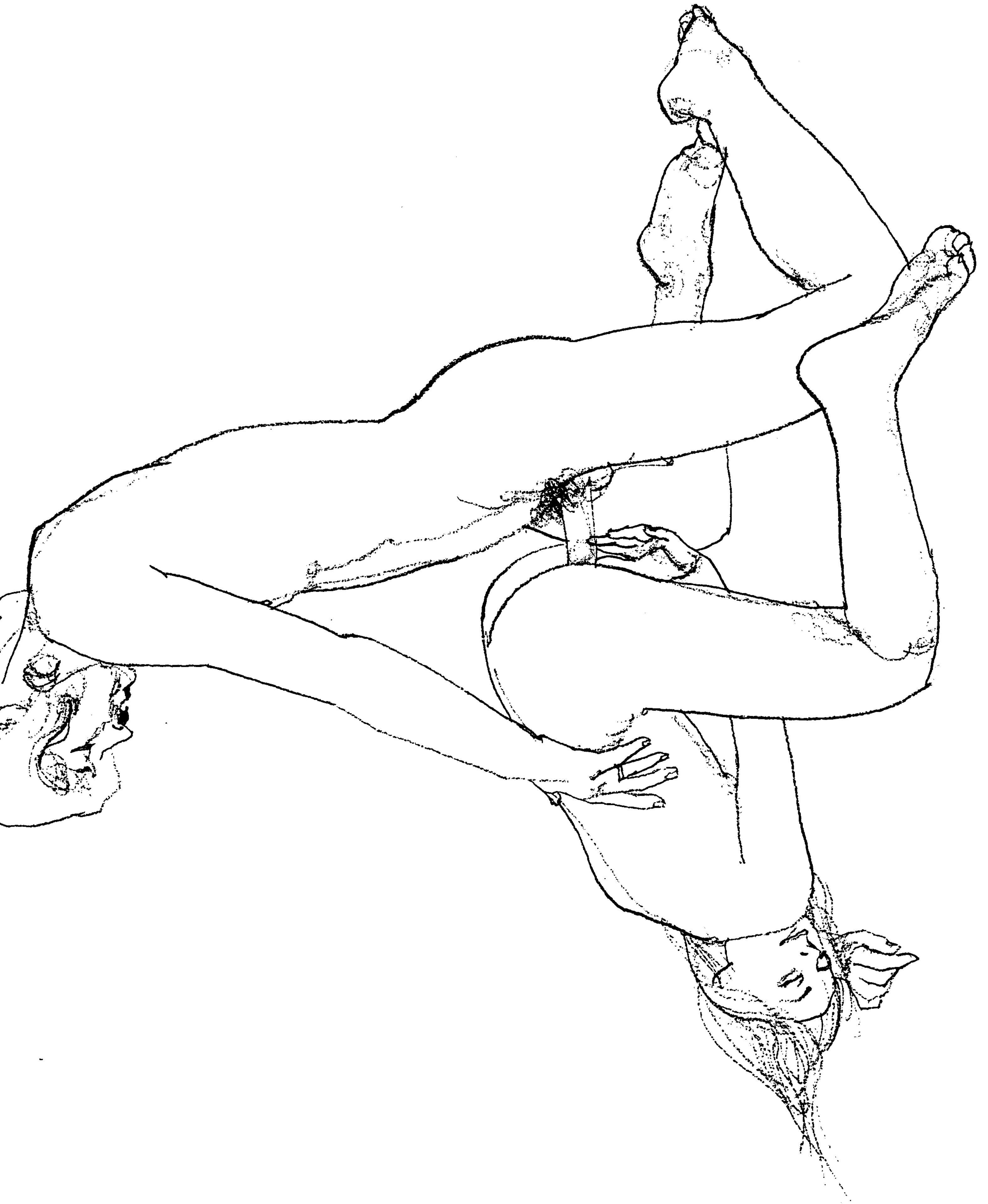
This extremely rare syndrome is sometimes confused with retrograde ejaculation which is quite different. In retrograde ejaculation the ejaculate empties into the bladder because the internal vesicular sphincter is paralyzed by anticholinergic drugs or by disease. The muscles at the base of the penis contract normally and orgasm is pleasurable in all respects but it is "dry," i.e., there is no external ejaculate.

The few patients with partial retardation whom I have treated have all had trouble abandoning themselves to the sexual experience. They tended to be overcontrolled, overly-self-critical, and performance oriented. These defenses were evoked by a variety of unconscious insecurities and conflicts. Treatment follows one of the same principles as retarded ejaculation: stimulation with concomitant relaxation and distraction.

One of my patients had his first complete and pleasurable orgasm when he was being stimulated by his partner while he was absorbed in watching an erotic film.

Another guide to the treatment of retarded ejaculation is to increase stimulation by structuring the tasks so that ejaculatory urgency builds up, while at the same time the obsessive defense of overcontrol is diminished. Patients who suffer from partial and total retardation tend to report that as pleasurable sexual tension builds up and they reach a stage premonitory to orgasm, they wonder "Will it be a good orgasm this time?" or "Will I have an orgasm soon?" If the patient experiences this, he is advised that he is *not* to ejaculate on that occasion. He is to withdraw his penis and desist from further stimulation. If it happens the next time he tries sex the admonition is repeated. He is only allowed to ejaculate if he does not stop to think about the process.

Position for female touching male's penis during coitus—male superior



Reactions

Again there is no data to justify the conclusion of specificity in sexual dysfunction. In other words we can not say that impotence is specifically caused by unconscious castration anxiety or by performance anxiety. *Any* source of anxiety is capable of impairing the erectile reflex. And while castration and performance anxieties are frequently encountered in this population, they are by no means the universal causes. Similarly conflicts of any sort and defenses against these can produce inhibition of the orgastic reflex. However two conflicts do emerge with predictable frequency when treating the *retarded ejaculator,* namely: fear of involvement with the woman, and related conflicts centering around hostility and sadistic impulses toward women. During the course of treatment with these couples it is often revealed that the man is really "holding back" psychologically as well as physiologically with his orgasm. Frequently also a great deal of hostility to women is evident of which man is unaware. The patient must often be confronted with this hostility. And more important its sources must often be explored and resolved before he can enjoy orgastic freedom. Most such patients are extremely guilty about their aggressive impulses and therefore defend themselves against these in elaborate and tenacious ways. Resolution of guilt through reassurance that these impulses are not evil, that when people are angry there is a good reason, that anger is basically a constructive and adaptive impulse, are all important parts of the treatment strategy with this patient population.