


# When Ejaculation Becomes the Goal in Itself: A Psychodynamic Approach to Delayed Ejaculation

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## Abstract

There are a group of men with delayed ejaculation (DE) where the etiology as well as the consequences of the dysfunction are unclear. The aim of the present study was to explore, from a psychodynamic perspective, personality traits among men seeking treatment due to DE. During a 2.5-year period, a consecutive series of 14 men with DE were seeking help at Karolinska University hospital, Sweden. Full medical history and physical examination, sexological case-history and psychological assessments were performed by physicians and a psychotherapist. The results found all patients to be healthy. Mean age was 34 years (range 20–43 years). No other sexual dysfunction occurred. With one exception, they were sexually active. The psychological assessment (The Karolinska Psychodynamic Profile; KAPP) found patients to have difficulties in areas of dependency and separation, control and impulse control, regression in the service of the ego, coping with aggressive affects, alexithymic traits, sexual function, and satisfaction. The results add a deeper understanding of personality traits among healthy patients with DE, which may be a tool for the case history, and offer new treatment strategies. We suggest that DE can be the physical manifestation of some specific personality difficulties, and thus, ejaculation becomes the goal in itself and not the climax of an enjoyable adventure.

## Keywords

Delayed ejaculation, retarded ejaculation, sexual dysfunction, psychodynamic profile, personality assessment

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Both clinicians and scientists seem to be in consensus when viewing delayed ejaculation (DE) as the most challenging male sexual dysfunction. In comparison with other male sexual dysfunctions, the interest in DE has been relatively scarce. From a clinical perspective, relatively few patients with DE are seeking help—not even in health services and departments specializing in sexual medicine and men's sexual health. Today, most authors seem to rely on definitions that are in accordance with both the *International Classification of Diseases* version 11 (ICD-11; World Health Organization, 2019) and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V; American Psychiatric Association, 2013)—that is, difficulties or impossibilities to ejaculate despite adequate sexual stimulation and a desire to achieve ejaculation followed by personal distress. We agree with Waldinger and Schweitzer (2005), who have pointed out that male orgasmic dysfunction should not be mixed with DE, as these phenomena are separate entities. However,

ejaculation and orgasm often occurring simultaneously in men without sexual dysfunction (for a review of definitions on sexual dysfunctions, see McCabe et al., 2016).

Few epidemiological studies on DE have been published (i.e., orgasmic dysfunction not included). In an extensive review of epidemiological data on male sexual

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dysfunctions (Fugl-Meyer et al., 2010), only two evidence-based investigations were found: in France, the prevalence of DE was found to be 4% and in Sweden, 2%. Studies on male orgasmic difficulties show higher prevalence (e.g., Mercer et al., 2003). Unfortunately, this confusion of terms can be found even in newer investigations. For example, two new Scandinavian population studies (Firsch et al., 2019; Public Health Agency of Sweden, 2019) both found 7% of sexually active men to, at the very least, often have difficulties obtaining orgasm. These results are of course interesting but problematic to interpret with respect to DE.

Over the last decades, a somewhat new interest in DE can be discerned, mainly focusing on biological factors. Neurological, vascular, endocrine and urological diseases/injuries, surgical procedures and medication/drugs with central or peripheral control of ejaculation, nerve supply to the vas deferens, bladder neck, pelvic floor, or penis have been reported as risk factors for DE (for an overview, see e.g., Waldinger & Schweitzer, 2005; Seidman, 2006; Corona et al., 2011; Cruz & Porst, 2012; Perelman, 2016). Additionally, a population-based twin-study investigated genetic and environmental factors in men with DE without findings supportive of a genetic influence (Jern et al., 2007).

Factors related to psychological causes and DE have mainly been reported to be related to psychiatric diseases, anxiety, fear, performance anxiety, and also hostility and relationship problems (Apfelbaum, 2000; Cruz & Porst, 2012; Kaplan, 1974; McCabe & Connaughton, 2014; Munjack & Kanno, 1979; Robbins-Cherry et al., 2011; Rowland et al., 2005; Waldinger & Schweitzer, 2005). From a psychodynamic perspective, studies on personality traits are, to our knowledge, relatively few and old. For example, Ovesey and Meyers (1968) suggest that men with DE show signs of paranoia. In contrast, Cooper (1968) investigated a group of 53 men with different sexual dysfunctions and found men with DE to be within the normal range, and thus, well functioning and socially established in terms of family, work, and finances. Based on one case, Gagliardi (1976) described serious “forced” neurotic personality traits as a cause for DE.

Studies on sociodemographic and cultural factors seem to be rather few: DE more often affects elderly men (see Fugl-Meyer et al., 2010). Religious factors were suggested by Masters and Johnson (1964) and also by Kaplan (1974) to be involved in men with DE. As far back as 40 years, Munjack and Kanno (1979), in a review of 49 publications on DE, concluded that there is a lack of objective data, demographics as well as analyses of psychological development and couples' interactions. Several publications have concluded the necessity of learning more about DE. Dekker (1993) also pointed to

the absence of studies with structured interviews with men who primarily seek help due to DE.

The aim of the present study was to explore, from interviews with a psychodynamic perspective, personality traits among men seeking treatment due to DE—thus adding one piece of information to the complex psychological picture of men with DE.

## Material and Methods

This cohort study included a series of 14 men referred to the Center for Andrology, Karolinska University Hospital, Stockholm, Sweden, due to problems with DE. The study period was 2.5 years and all referred men were included in, and fulfilled, the present study.

### Medical Assessment

All men underwent a full medical history and a careful physical examination, performed by an andrologist/endocrinologist, screening for medical or surgical causes for DE (i.e., anatomic, neurogenic, infective, or endocrine). Laboratory tests (general blood tests, including kidney and liver status, cholesterol) and endocrine screening (testosterone, SHBG, LH, FSH, prolactin, cortisol, thyroid status [TSH, T3 and T4], blood sugar). Iatrogenic and pathophysiological causes could be excluded. All of them were found to be without any psychiatric or medical disease or impairment. None were on medication and denied use of (earlier or current) “recreational drugs.” Thus, all were found to be healthy.

### Personality Assessment

The Karolinska Psychodynamic Profile (KAPP) is a well-used, valid, and reliable instrument (Weinryb & Rössel, 1991; Weinryb et al., 1991a; 1991b; 1997) for personality assessment based upon psychoanalytic theory; developed for clinical practice and research. Data from a reference population as well as non-psychiatric and psychiatric patients are available.

The information is obtained through an interview procedure. When using the KAPP-instrument, interpretations and counter-transference are included in the assessment as well as the total interaction between the patient and the psychotherapist. The interview method is built upon Kernberg's (1984) structural method: during the interview, the investigator asks the patient to describe himself, his closest relationships, and their difficulties. By using additional questions and according to KAPP, 18 subscales can be described (Table 2), reflecting the patient's self-image and relationship with others. Each subscale has its own definition with three defined levels. There are two additional intermediate levels

resulting in a five-point scale: 1, 1.5, 2, 2.5, and 3. Level 1 represents “most normal” and level 3 “least normal” (Weinryb & Rössel, 1991).

The subscales can be described under the following seven headings: quality of interpersonal relations, specific aspects of personality functioning, affect differentiation, the body as a factor of self-esteem, sexuality, own social significance, and the core of the individual’s personality.

In the present study, all patients were interviewed by the first author, ES—an experienced psychotherapist who had more than 10 years of clinical practice in sexology/sexual medicine. Three to four sessions of 45 min per patient were held, with one session per week.

### Sexological Assessment

A thorough sexological case-history was taken by the psychotherapist ES. *The diagnosis of DE* was established after the patient’s own description of the ability/inability to ejaculate in the presence of a partner during a sexual situation. Kaplan’s (1974) diagnosis of levels of DE was included: (a) mild: can reach orgasm and ejaculate in vagina in special circumstances; (b) moderate: can ejaculate in the presence of another person but never during vaginal intercourse; (c) severe: can ejaculate only when alone; (d) very severe: have never experienced ejaculation. It was noted whether the dysfunction was life-long or acquired. All men were judged to have a psychogenic origin of the DE.

### Ethics

All procedures performed in these studies were in accordance with the ethical standards of the National Research Committee and with the 1964 Helsinki Declaration and its later amendments. All patients were informed of the study and were guaranteed confidentiality and anonymity. They were advised that participation was voluntarily and that they could withdraw from the study without impact on their treatment. Written informed consent was obtained from all participants.

### Results

Mean age was 34 years (range 20–43 years), and all were of North European origin (Table 1). One patient was homosexual; the others had a heterosexual orientation. All but one lived in a stable partner relationship, and two had biological children.

Given reason for seeking treatment was, for three of the patients, personal sexual problems/distress due to DE. The other 11 were seeking help due to a wish to father a child or the partner experiencing the patient’s DE as distressing.

**Table 1.** Some Characteristics of 14 Healthy Men Seeking Help due to Delayed Ejaculation (DE).

	n = 14 (%)
Age, median (range)	34 yrs. (20–43 yrs.)
Ethnicity	All Caucasian
Relationship status:	
Living with partner/Single	13 (92,86)/1 (7,14)
Biological children	2 (14,29)
Victim of violence or abuse	None
Sexual orientation:	
Heterosexual/Homosexual	13 (92,86)/1 (7,14)
Age at sexual debut:	
Adolescence	10 (71,43)
25 yrs	1 (7,14)
30 yrs	2 (14,29)
38 yrs	1 (7,14)
Sexually active at present	13 (92,86)
Masturbation; idiosyncratic	None
Concomitant sexual dysfunction:	
Low sexual desire/interest	None
Erectile dysfunction	None
Ejaculatio praecox	None
Genital sexual pain	None
Level of DE <sup>1</sup>	
1. Mild	2 (14,29)
2. Moderate	11 (78,57)
3. Severe	0
4. Very severe	1 (7,14)
Occurrence of DE:	
Lifelong	13 (92,86)
Acquired	1 (7,14)

<sup>1</sup>According to Kaplan (1974).

Ten of the 14 patients made their sexual debut during adolescence, one man when he was 25 years, two men when reaching 30, and one at the age of 38 years. None reported having experiences of being sexually abused/harassed or being victim of any other form of trauma. Concerning occurrence of sexual dysfunctions, there was no patient with erectile dysfunction or genital sexual pain and all 14 reported sexual desire/sexual interest occurring at least quite often.

The patients who were in a relationship reported being sexually active with intercourse 1–2 times/week or more often. Furthermore, they masturbated, on average, once a week and with no idiosyncratic masturbation style. The patient who was single had not been sexually active within the last 2 years, neither with masturbation nor with partner-related activities.

Regarding severity level of DE, according to Kaplan (1974), it was found that one of the patients had only had ejaculation during sleep (level 4), 11 could ejaculate during masturbation and in the presence of a partner (level

**Table 2.** Mean Values and Range on The Karolinska Psychodynamic profile (KAPP) in 14 Men With Delayed Ejaculation (DE) and in a Swedish National Representative Sample\*.

KAPP subscales	Men with DE Mean (range)	National representative group Mean
<i>Quality of interpersonal relations:</i>		
1. Intimacy & reciprocity	1.14 (1–3)	1.2
2. Dependency & separation	1.85 (1–2.5)	1.4
3. Controlling personality traits	1.67 (1–2.5)	1.4
<i>Specific aspects of personality functioning:</i>		
4. Frustration tolerance	1.35 (1–1.5)	1.2
5. Impulse control	2 (1.5–2.5)	1.4
6. Regression in the service of the ego	2.14 (1.5–2.5)	1.5
7. Coping with aggressive affects	2.21 (2–2.5)	1.5
<i>Affect differentiation:</i>		
8. Alexithymic traits	2.78 (2–3)	1.5
9. Normopathic traits	1.25 (1–1.5)	1.4
<i>Importance attached to the body as a factor of self-esteem:</i>		
10. Conceptions of bodily appearance and their significance for self-esteem	1.14 (1–2)	1.3
11. Conceptions of bodily function and their significance for self-esteem	1.07 (1–2)	1.3
12. Current body image	1.21 (1–2)	1.4
<i>Sexuality:</i>		
13. Sexual functioning	3 (–)	1.3
14. Sexual satisfaction	1.89 (1.5–3)	1.5
<i>Own social significance:</i>		
15. Sense of belonging	1.35 (1–2.5)	1.2
16. Feeling of being needed	1.28 (1–2)	1.1
17. Access to advice and help	1.28 (1–3)	1.1
<i>The core of the individual personality:</i>		
18. Personality organization	1 (–)	1.2

\*Weinryb and Rössel (1991a).

2), and two patients could sometimes reach ejaculation during intercourse and under special circumstances (level 1). For 13 patients, the DE was lifelong and thus, for one patient the dysfunction acquired.

Differences between the patients and the reference population (given by Weinryb et al., ref 1991a; 1991b) were found in eight of the 18 subscales in the KAPP instrument (Table 2). These were:

*Dependency and separation.* Thirteen of the 14 patients expressed fear of being emotionally dependent and abandoned, which they dealt with apprehensive adaptation. *Controlling personality traits.* Nine of the 14 described needs of routines, orderliness, and planning. Furthermore, they showed ambivalence when it came to choices. They were perceived as “chronically nice guys.” *Impulse control.* All 14 patients expressed an excessive control of emotions and impulses. Moreover, they had general difficulties claiming wishes and needs, to be demanding and critical. *Regression in the service of the ego.* All patients were perceived as embarrassed and inhibited but not totally unable to show some playfulness. *Coping with aggressive affects.* All patients had difficulties in experiencing and expressing

feelings of aggression; and in trying to be kind to avoid conflicts and others’ anger. *Alexithymic traits.* The patients’ descriptions were mainly very concrete and detailed. They had difficulties separating and nuancing emotions and distinguishing between affective states. They often expressed emotions as physical sensations. *Sexual functioning.* All patients were unable to function with ejaculation and reaching orgasm. *Sexual satisfaction.* Feelings of sexual desire and interest occurred quite often for all of the men. They expressed, to a certain degree, the ability to be close with the partner and at the same time they said that sex was something they could take or leave.

## Discussion

Sexual enjoyment and sexual satisfaction assume the ability to “let go” and to relax and have the courage, for a moment, to lose control and let emotions take over (Kernberg, 1995). The overall finding of the present study was that some specific personality traits that are important, or even necessary, to reach such a rewarding sexual life were weak or even lacking in this group of healthy

help-seeking patients with DE. The majority needed control of emotions and impulses, were perceived as embarrassed and inhibited, had difficulties expressing wishes and needs, playfulness, and fantasies, and often expressed emotions as physical sensations. Weinryb et al. (1997) also found alexithymia to be closely related to regression in the service of the Ego, which might be related to difficulties in object relations. In the present study, patients in relationships showed apprehensive adaptation to the partner, avoiding conflicts, and feared emotional engagement and being abandoned. Our interpretation is that these personality traits may lead to DE—that is, a physical manifestation of their psychological difficulties, mirroring the interplay between bio-psycho-social factors for men's sexual function and sexual satisfaction. In contrast, an Italian study of men seeking treatment at a sexological/urological clinic for DE, Michetti et al. (2013) did not find patients to have alexithymia traits but the authors suggest hyper controlling behavior to be of importance.

Rowland et al. (2004; 2005) found men with DE to have low levels of sexual arousal. This could not be confirmed in the present study, where all were without other sexual dysfunctions and in good health. A few patients had a high age for partner-related sexual debut, which was the only noticeable theme during the case-history, which supports the findings of the abovementioned personality traits. This finding can be a result of attachment difficulties. Most patients could masturbate, to ejaculation, in the presence of a partner (Kaplan, level 2). However, the interviews showed a gap in Kaplan's (1974) severity levels, and we suggest a further level that catches the patient who rarely and with great effort can ejaculate together with a partner but not during penetration. That is, a level in between level 2 and 3 according to Kaplan (1974). Interestingly, it has been found (Bronner & Ben-Zion, 2014; Perelman, 2016) that idiosyncratic masturbation is common among men with DE, but this was not confirmed in the present study.

Despite the patients' difficulties in expressing themselves, particularly when it comes to emotions, some are seeking help. Given reasons for seeking treatment were mainly inability to conceive a child and/or partners' sexual distress and dissatisfaction, which are in agreement with others (Apfelbaum, 2000; Perelman, 2005; Ribner, 2010). Together with the fact that the great majority did not experience DE as distressing for themselves, these findings support the patient's wish to adapt to the partner. This led us to the hypothesis that the threat of losing the partner is the motivation for seeking treatment. The personality characteristics found in the KAPP interviews support this, as separation is a most frightening factor. In other words, if the partner is unable to become pregnant, the patient can be replaced by another man who can fulfil her need of becoming a mother. Alternatively, if the

partner experiences herself as an insufficiently loved person, she has to find someone who will love her. In that way, a threat of separation will be the strongest driver for the patient's help-seeking. Our interpretation is that, for these men, ejaculation becomes the goal in itself and not the climax of an enjoyable adventure.

Interpretations and counter-transference are tools in the KAPP assessment (Weinryb & Rössel, 1991). When meeting patients with DE, in clinical practice, it is our experience that these meetings have a special character. Thus, these patients are often men of few words, answering as briefly and as concretely as possible, leaving the therapist with feelings of being locked out, angry, and dejected and, furthermore, provokes performance anxiety and flight feeling. Difficulties in creating a dialogue and the wish to have a dialogue are strong from the psychotherapist's perspective. This counter-transference can give an understanding of the sexual situation experienced by the patient and also for his partner. This is in contrast to other impressions of the patient, as they are seen as kind (but with few words), nicely dressed, socially established, often in a relationship, and have had an ordinary upbringing. These two pictures of the patient create complex and partly confusing feelings when it comes to understanding the man, the symptom and its causes. By and large, living a "normal" life with no problems related to work or finances was found among the investigated patients and moreover, Rowland et al. (2004) found men with lifelong DE to report high partner satisfaction. These findings are in agreement with Cooper (1968) and Ribner (2010).

In general, there is a lack of diagnostic instruments and few treatment suggestions for men with DE and couples where DE occurred. For a review of sexological treatment strategies, see Zgourides and Warren (1990); in recent years, Ribner (2010) suggested a model for healthy men with DE, while Perelman (2016) has developed a model including men with DE and different etiologies. However, the present study did not focus on treatment modalities as such but a possible tool for the case-history.

Knowledge of these personality traits can be one piece of the puzzle the clinician/psychotherapist faces when men with DE reach out for help. We believe that the findings are particularly valuable when there are no clear symptoms and signs in the physical examination and the sexological case-history.

### *Limitations and Strengths*

Most often, studies on DE rely on case histories or small samples of patients. These small samples can perhaps be due to the fact that men with DE are quite rarely seen in clinical practice. One reason is that they do not experience

the dysfunction as distressing (for themselves), which was confirmed in the present study. Moreover, epidemiological studies agree that DE is a rare condition in the male population. The sample in the present study may be small but a strength is the consecutive series of patients seeking treatment at a department specializing in man's sexual health and that all were found to be healthy. The interviews were not recorded, which could be seen as a limitation, questioning the reliability. However, they all had the same interviewer—a very experienced psychotherapist within the field of sexology. Moreover, following the procedures at the clinic, a well-established interprofessional team performed physical examination, endocrine screening, psychodynamic assessment, psycho-social and sexological evaluation and thereafter considered diagnosis and treatment suggestions. Moreover, the rating instrument used—the KAPP—is a well-recognized and valid instrument aimed at clinical practice use and research.

## Conclusion

It is essential to identify and clarify the source/sources of a sexual dysfunction and select treatment based on this in order to achieve good treatment opportunities and outcome. For healthy men seeking treatment due to DE, the findings of the present study may offer new treatment strategies when including the patient's personality assessment in the case-history. Intervention studies examining the outcome of treatment from a personality trait perspective are welcomed.

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