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Male Sexual Dysfunctions – Premature Ejaculation

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Abstract

Objectives*: The objective of this case study is to explore the impact of cognitive-behavioral therapy (CBT) and sex therapy in reducing sexual distress, alleviating anxiety, and shifting the patient's focus from performance-based sexuality to sensory-based pleasure. The subject is a 35-year-old male experiencing premature ejaculation. The intervention aimed to diversify excitatory stimuli to enhance sexual satisfaction and maintain a healthy sexual and mental life.*

Keywords: Male Sexual Dysfunction, Premature Ejaculation, Stop-Start Technique, Penile Constriction Technique, Excitatory Continuum Technique, Masturbation, Sexual Pleasure and Relaxation.

Introduction

It is known that men with premature ejaculation (PE) often struggle with anxiety and negative emotionality, influenced by biological and cognitive-affective vulnerabilities, shaped by social and cultural contexts. Marian initially experienced normal sexual functioning, sustaining intercourse for about 5 minutes. However, after negative feedback from a recent partner, his performance anxiety increased, reducing his intravaginal ejaculatory latency time (IELT) to about 1 minute.

Most men with PE ejaculate within 1 minute of penetration. Treatment aims to improve ejaculatory control and enhance stimulation across all phases of the sexual response: desire, arousal, plateau, orgasm, and resolution.

Case Study

Patient: Marian, 35 years old
Duration of Therapy: 20 sessions over 20 weeks
Period: February – July 2021

Marian presented in therapy reporting that from childhood, he had been taught that erogenous zones were the key to strong arousal. This belief created a mental blockage, leading to disappointment, which evolved into performance anxiety and eventually premature ejaculation.

Methodology

The therapeutic intervention applied CBT techniques to analyze cognitions, behaviors, and emotions.
1. Standard Psychological Testing
2. Sexual Function Testing
3. Treatment Planning

Standard Psychological Testing Tools

The standard psychological testing tools utilized in this case study included a comprehensive combination of clinical assessments and validated questionnaires. The process began with anamnesis and clinical observation, followed by structured, semi-structured, and unstructured clinical interviews, as described by Delcea (2021). To assess the patient's emotional and psychological state, several standardized instruments were employed: the Generalized Anxiety Disorder 7 (GAD-7) scale to evaluate anxiety levels, the Patient Health Questionnaire (PHQ-9) for assessing depressive symptoms, and the Beck Depression Inventory II (BDI-II) for a more in-depth evaluation of depres-

sion. Additionally, the Trauma Symptom Checklist-40 (TSC-40) was used to identify potential trauma-related symptoms, while the Symptom Checklist 90-R provided a broad overview of psychiatric symptomatology. To gain insight into the patient's interpersonal dynamics and emotional attachment patterns, the Attachment Style Questionnaire developed by Diana Poole Heller was also administered.

For the sexual assessment, the Premature Ejaculation Severity Index (PESI) questionnaire was used, along with sexual interviews as outlined by Delcea (2021).

Sexual Testing Tools
- Premature Ejaculation Severity Index (PESI)
- Sexual interviews (Delcea, C., 2021)

Sex Therapy Methodology
Stimuli Understanding and Diversification:
Genogram of excitatory stimuli (Delcea, 2021) was used to redirect focus from the primary erogenous zones to other sensory triggers.

CBT Model (Cognition-Behavior-Emotion):
Applied for cognitive restructuring of dysfunctional beliefs and improving relational dynamics, intimacy, and communication.

Reduction of Sexual Distress and Anxiety
Techniques Included
- Relaxation techniques
- Anticipatory steps
- Distributive thinking
- Sexual anxiety management
- Management of distractors
- Relationship management (Standardized S+X model, Delcea 2021)
- Progressive desensitization
- Critical point awareness and self-responsibility
- Gaining control over ejaculation
- Communication improvement
- Intimacy barrier breakdown
- Acceptance of sexual dysfunction
- Sexual performance enhancement
- Conflict resolution

Psychoeducation Methods
- Understanding the human sexual response cycle
- Anatomy and physiology of male and female bodies
- Cognitive reframing through playfulness and positivity

Classification

Variable	Chronic PE	Acquired PE	Normal Values	Unique Variables
IELT	<1–1.5 min	<1–2 min	3–8 min / 3–30 min	Frequency: Constant/ Inconstant
Etiology	Neurobiological, Genetic	Medical, Psychological	Psychological	
Treatment	Medication + Therapy	Medication + Psychotherapy	Psychoeducation & Reassurance	Psychotherapy
Prevalence	Low	Low	High	High

Results
- PHQ-9 Score: 10 – No clinical depression.
- GAD-7 Score: 8 – Mild anxiety, correlating with performance anxiety.
- TSC-40 Score: 10 – No trauma-related symptoms.
- BDI-II Score: 12 – Mild mood disturbance, no clinical depression.
- SC 90-R – No Axis I or II psychiatric disorders.

Findings indicate Marian experiences mild performance-related anxiety. He holds unrealistic expectations, believing normal intercourse should last 30 minutes. He lacks ejaculatory control and sexual imagination, viewing sexuality as a performance rather than emotional exchange.

Theoretical Considerations
Global prevalence of male sexual dysfunctions is about 29%, with PE accounting for 27–30%. Emerging theories suggest that male sexuality operates through the balance of two systems:
Sexual Excitation System (SES):
Activated by visual, tactile, olfactory, and auditory stimuli, leading to arousal.

Sexual Inhibition System (SIS):
- SIS-1: Related to performance anxiety
- SIS-2: Related to fear of negative consequences (e.g., STIs, unwanted pregnancy)

Proper management of SES and SIS in therapy (often involving the partner) enhances sexual function. Educating the partner and integrating techniques that prioritize emotional closeness and non-penetrative satisfaction is key.

Case Conceptualization
Marian's PE was caused by early sexual education deficits and reinforced negative beliefs. Performance anxiety led to PE, sustained by repeated failure and lack of psychosexual skills.

Psychodiagnosis
Given the consistent reduction of IELT over more than six months and significant sexual distress, Marian meets the criteria for premature ejaculation disorder.

Therapeutic Methodology
Phase I (Sessions 1–4): Sexual Education
- Sexual anatomy and physiology
- Excitation awareness and control
- Excitation sequence techniques

• Relaxation (Mindfulness)
• Sensory focus exercises

Phase II (Sessions 5–9): Cognitive Restructuring
• Identified negative beliefs about sex
• Addressed vulnerability and guilt
• Used desensitization and mindfulness
• Introduced affirmations (e.g., "Sex is about mutual pleasure, not performance")

Phase III (Sessions 10–15): Arousal and Ejaculation Control
• Stop-Start technique
• Penile constriction technique
• Sensory focus
• Masturbation as a therapeutic exercise

Phase IV (Sessions 16–17): Excitatory Continuum in Solo Practice
• Self-stimulation and self-awareness
• Identified new excitatory stimuli: face, back, breasts, thighs (partner) and arms, legs, buttocks, chest (self)

Phase V (Sessions 18–20): IELT Improvement and Relapse Prevention
• IELT increased from 1 minute to 4 minutes
• Developed a sustainable self-regulation routine
• Built psychosexual skills
• Identified cues and transitions in sexual activity
• Established a relapse-prevention strategy

Conclusions

This five-month therapeutic program (1 session/week) yielded positive results. Marian acquired a deeper understanding of his dysfunction, expanded his repertoire of excitatory stimuli, gained control over ejaculation, and enhanced psychosexual awareness. The integration of cognitive restructuring, psychoeducation, and body-awareness techniques contributed significantly to restoring his sexual confidence and functioning.