

Article

## Psychosexual Therapy in Idiosyncratic Situational Delayed Ejaculation: A Case Study

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### ABSTRACT

Delayed ejaculation (DE) is a relatively uncommon male sexual dysfunction and remains insufficiently studied in clinical literature. This article reports on the psychosexual therapeutic approach employed in a rare case of primary, situational, and idiosyncratic DE. Clinical assessment revealed that the patient was only able to achieve ejaculation following arousal when he exited the bed and engaged in genital stimulation by rubbing his penis against the floor. A structured intervention grounded in psychosexual couples therapy was implemented. Across eight sessions, the couple was actively involved in therapeutic exercises. The therapeutic goal was to gradually transfer the conditions for ejaculation to the shared sexual setting. Initially, ejaculation was attempted on a hard slab placed on the bed, followed using a towel atop the slab to introduce new tactile stimuli, and subsequently by involving the partner's hand positioned between the towel and the slab. Individually, the patient was instructed to engage in standing masturbation using the sink surface, followed by a transition to a latex vaginal simulator. To enhance arousal, the use of an anal vibrator was later introduced. Once successful ejaculation was achieved using the latex device in a standing position, the next step involved simulating coitus by masturbating while the partner was positioned in a receptive posture on a table, transitioning to vaginal penetration immediately prior to climax. The final phase of the intervention involved vaginal penetration in the missionary position, with concurrent anal vibrator stimulation provided by the partner. This graduated desensitization and reconditioning strategy ultimately enabled the patient to ejaculate intravaginally.

### Terapia Psicosexual en la Eyaculación Retardada Situacional Idiosincrática: Estudio de un Caso

### RESUMEN

La eyaculación retardada (ED) es una disfunción sexual masculina relativamente infrecuente y sigue estando insuficientemente estudiada en la literatura clínica. En este artículo se expone el enfoque terapéutico psicosexual empleado en un caso poco frecuente de eyaculación retardada primaria, situacional e idiosincrática. La evaluación clínica reveló que el paciente sólo era capaz de eyacular tras la excitación cuando salía de la cama y se sometía a estimulación genital frotando el pene contra el suelo. Se llevó a cabo una intervención estructurada basada en la terapia psicosexual de pareja. A lo largo de ocho sesiones, la pareja participó activamente en ejercicios terapéuticos. El objetivo terapéutico era transferir gradualmente las condiciones de la eyaculación al entorno sexual compartido. Inicialmente,

#### Palabras clave:

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se intentó la eyaculación sobre una losa dura colocada en la cama, a lo que siguió el uso de una toalla sobre la losa para introducir nuevos estímulos táctiles y, posteriormente, la participación de la mano de la pareja colocada entre la toalla y la losa. Individualmente, se le indicó a la paciente que se masturbara de pie utilizando la superficie del lavabo, para pasar después a un simulador vaginal de látex. Para aumentar la excitación, se introdujo posteriormente el uso de un vibrador anal. Una vez conseguida la eyaculación con éxito utilizando el dispositivo de látex en posición de pie, el siguiente paso consistió en simular el coito masturbándose mientras la pareja se colocaba en postura receptiva sobre una mesa, pasando a la penetración vaginal inmediatamente antes del clímax. La fase final de la intervención consistió en la penetración vaginal en la posición del misionero, con la estimulación simultánea del vibrador anal por parte de la pareja. Esta estrategia gradual de desensibilización y reacondicionamiento permitió al paciente eyacular en la vagina.

## Introduction

Delayed ejaculation (DE) is considered one of the least prevalent male sexual dysfunctions, and as a result, it has received comparatively limited empirical attention (Abdel-Hamid & Ali, 2018; Butcher et al., 2015; Di Sante et al., 2016; Martin-Tuite & Shindel, 2020). According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; APA, 2013), the diagnostic criteria for DE require a clinically significant delay in ejaculation, or a marked infrequency or absence of ejaculation, occurring on the majority (75 %–100 %) of sexual encounters with a partner, and in the absence of a personal desire for such delay. To meet diagnostic criteria, these symptoms must persist for a minimum duration of six months and cause clinically significant distress to the individual (APA, 2013). The DSM-5 further classifies delayed ejaculation according to onset and context: it may be lifelong, indicating presence since sexual maturity, or acquired, emerging after a period of normative ejaculatory function. In terms of situationally, the dysfunction may be generalized, occurring across all sexual contexts, or situational, limited to specific types of stimulation, environments, or partners. Additionally, the DSM-5 delineates the severity of DE into three gradations: mild, moderate, and severe.

Multiple factors have been implicated in the aetiology of DE. Abdel-Hamid and Ali (2018) broadly categorized these into two primary domains: psychological and organic. Psychological contributors encompass a wide spectrum of intrapsychic and interpersonal variables, including fear of pregnancy or loss of control, internal conflict related to sexual orientation, hostility, unresolved resentment, obsessive-compulsive personality traits, performance anxiety, diminished self-assertiveness, reluctance to engage in emotional intimacy, rigid religious beliefs, autosexual orientation, and reliance on idiosyncratic masturbatory techniques. Additionally, relationship discord, hypoactive sexual desire, insufficient sexual arousal, and the presence of sexual dysfunction in the partner may also contribute. Depression and other psychological disorders are also frequently cited. On the other hand, organic aetiologies may include aging, genetic predispositions, neurobiological and neurodevelopmental abnormalities, congenital anatomical anomalies, neurogenic conditions, inflammatory or infectious processes, endocrine dysregulation, and pharmacological effects (Abdel-Hamid & Ali, 2018).

Reported prevalence rates of DE may vary considerably across studies. According to Di Sante et al. (2016), DE affects approximately 1 % of men in cases of lifelong DE, and up to 4 % in acquired forms. Broader epidemiological estimates suggest a prevalence ranging from 0.15 % to 11 % (Butcher & Serefoglu, 2017;

Laumann et al., 1999; Nathan, 1986; Rowland et al., 2004; Rowland, 2017; Spector & Carey, 1990). The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition indicates a prevalence between 1 % and 5 % among men in the United States, although international figures may reach up to 11 % (APA, 2013).

Given the limited number of published studies reporting effective interventions for delayed ejaculation (DE), it is frequently regarded as a particularly challenging sexual dysfunction to manage (Blair, 2017). Current therapeutic recommendations typically fall into two main categories: pharmacological and psychological interventions (Martin-Tuite & Shindel, 2020). Pharmacological strategies may include agents such as cabergoline, alpha-adrenergic agonists, bupropion, buspirone, oxytocin, testosterone, bethanechol, yohimbine, amantadine, and cyproheptadine, among others (Martin-Tuite & Shindel, 2020).

Psychotherapeutic approaches are grounded in the classic frameworks developed by Masters and Johnson (1966) and Kaplan (1979), which emphasize techniques such as systematic desensitization, sensate focus, intensive non-coital penile stimulation, and modifications to sexual technique. Contemporary sex therapy models underscore the role of self-directed stimulation, with a particular focus on masturbatory retraining, enhancement of sexual arousal and satisfaction, and reduction of performance-related cognitive interference (Althof, 2012; Apfelbaum, 2000; Cabello-Santamaría, 2010; Hawton, 1989). As summarized by Piché et al. (2020), once the dysfunction has been identified, the underlying aetiology must be explored, followed by patient psychoeducation and tailored psychosexual intervention.

The aim of this article is to present a successful case of psychosexual treatment in a patient diagnosed with idiosyncratic situational delayed ejaculation, detailing the therapeutic progression to provide clinical guidance for practitioners working with similar presentations.

## Method

### Participant

FAI is a 36-year-old male employed as an administrative clerk in a stable occupational role. He has been in a romantic relationship for six years and married for the past four. The couple does not have children. His partner comes to the clinic with him. She is 37 years old and works as an economist, although she has been unemployed for two months. He came to the clinic because he was unable to ejaculate during intercourse. He claimed that he could only ejaculate when masturbating by rubbing his penis on the floor, rubbing himself against a slab.

## Instruments

- a) Clinical Interview (Cabello-Santamaría, 2010). A structured clinical interview specifically designed to assess individuals presenting with sexual difficulties. The interview explored multiple domains, including the current complaint, sexual behaviour patterns, medical and psychiatric history, cognitive factors, psychosexual development, relationship dynamics, sexual education, family background, significant life events, and lifestyle factors. Informed consent for clinical evaluation and treatment was obtained from the patient.
- b) Millon Clinical Multiaxial Inventory–III (MCMI-III) (Millon, 1998), Spanish adaptation by Cardenal and Sánchez (2007). This self-report inventory comprises 175 dichotomous items (True/False) and evaluates personality traits and psychopathological features in accordance with DSM criteria. The MCMI-III is structured into several scales: Clinical Personality Patterns (e.g., schizoid, avoidant, dependent, histrionic, narcissistic, compulsive), Severe Personality Pathology (e.g., borderline, paranoid, schizotypal), Clinical Syndromes (e.g., anxiety, somatoform disorder, dysthymia, PTSD, substance-related disorders), and Severe Clinical Syndromes (e.g., thought disorder, major depression, delusional disorder). It also includes validity indices (e.g., response sincerity, social desirability, devaluation, and disclosure). The instrument demonstrates strong psychometric properties, with test–retest reliability ranging from 0.84 to 0.96, and internal consistency coefficients above 0.80.
- c) Golombok Rust Inventory of Sexual Satisfaction (GRISS) (Rust & Golombok, 1986), Spanish validation by Cabello-Santamaría et al. (2021). This instrument assesses the presence and severity of sexual dysfunctions across nine dimensions: Non-communication, Dissatisfaction, Non-sensuality, Avoidance, Impotence, Premature Ejaculation, Anorgasmia, and Vaginismus. Separate versions exist for male and female respondents, each comprising 28 items rated on a 5-point Likert scale (Never, Almost Never, Occasionally, Usually, Always). Internal consistency ranges from 0.86 to 0.92.
- d) Expanded Sexual Excitement Inventory (ESEI) (Chambless & Lifshitz, 1984), Spanish adaptation by Aluja & Torrubia (1994). This 28-item instrument assesses sexual arousal, sexual anxiety, and sexual satisfaction in both men and women. Responses are recorded on a 7-point Likert-type scale ranging from –1 to 5. The instrument has demonstrated good internal consistency, with a Cronbach’s alpha of 0.85.

## Procedure

A single-case experimental design was employed (del Río et al., 2018), incorporating a pre-treatment assessment using the psychometric instruments and structured clinical interview. Post-treatment evaluation was conducted through clinical interviews to assess changes and therapeutic outcomes. Written informed consent was obtained from the patient for the publication of the case.

## Data Analysis

Initially, the results obtained from the psychometric instruments were scored and interpreted based on the normative data provided by the respective authors, to establish both the diagnostic profile and severity of the dysfunction. To evaluate therapeutic progress, a qualitative analysis was conducted based on clinical reports provided by both the patient and his partner across the treatment sessions.

## Case Presentation

During the initial clinical interview, FAI reported that he had never experienced orgasm through manual masturbation or during penetrative intercourse. He described a pattern in which, following his partner’s orgasm, he would lie on the bed and stimulate himself by rubbing his penis against a hard slab surface until ejaculation occurred—typically within one minute. He did not report any other sexual difficulties. The patient stated that he experienced adequate erectile function. Although he initially felt pleasure during intercourse, he noted a progressive decline in arousal as intercourse continued. His typical masturbation frequency was three times per week, exclusively involving rubbing and compressing his penis against the floor.

FAI and his partner did not engage in verbal communication during sexual activity, as he found it distracting. He reported having erotic fantasies—particularly involving his wife with other women—though he rarely incorporated these into sexual activities. He described his level of sexual desire as “normal,” rating it as 7 out of 10. While he expressed no strong desire to have children, he stated that he would have liked to help his wife conceive.

The couple reported infrequent sexual activity, primarily due to FAI’s fatigue after long workdays. His partner disclosed avoiding sexual encounters, perceiving herself as physically unattractive to him. The patient had no significant medical history, was not on any medication, and presented with normal laboratory results, except for mildly elevated liver transaminases, which his general practitioner attributed to non-alcoholic fatty liver disease.

FAI was uncertain about the origins of his condition but speculated that it might relate to a traumatic childhood experience. At age 10, he was deceived by strangers into allowing them to photograph him naked near a swimming pool. He also recalled engaging in self-stimulatory behaviour involving the floor at the same age, although he did not associate it with sexual arousal at the time. His first sexual intercourse occurred at the age of 26 with a sex worker; although penetration was achieved, he was unable to ejaculate.

## Functional Analysis

A functional analysis of the patient’s sexual behaviour identified multiple antecedent variables that may have contributed to the onset of the dysfunction. These include: an early sexual encounter with a sex worker during which ejaculation did not occur; a potentially traumatic childhood event at age 10 involving non-consensual nudity and possible genital stimulation against a pool surface; inadequate sexual education; and the presence of avoidant personality traits.

The primary precipitating factor appears to be performance anxiety triggered prior to sexual activity with his partner. In terms of maintenance mechanisms, several reinforcing contingencies were identified: the reliable positive reinforcement associated with floor-based genital stimulation (i.e., consistent orgasm), the partner's unintentional reinforcement of the behaviour by accommodating existing routines, and the rigid repetition of maladaptive sexual patterns, which limit the development of alternative arousal pathways.

## Treatment

Based on the clinical assessment, a structured psychosexual intervention was designed, incorporating techniques drawn from established therapeutic models (Althof, 2012; Apfelbaum, 2000; Cabello-Santamaría, 2010; Hawton, 1989). The intervention consisted of eight sessions, with the first seven conducted monthly and the final follow-up session held three months later. All sessions included the participation of both partners. The primary therapeutic goals were: (1) to reduce FAI's anticipatory anxiety prior to sexual activity; (2) to enable FAI to achieve intravaginal ejaculation; and (3) to promote sexual repertoire expansion, introducing new behaviours to disrupt entrenched patterns.

Following the initial assessment during the first session, the couple was assigned structured home-based exercises. These included viewing erotic imagery for approximately two minutes prior to bedtime and engaging in self-stimulation using a ceramic slab placed on the bed, aiming to elicit ejaculation without the need to transition to the floor. Additionally, reciprocal erotic massage was introduced: one partner would begin by massaging FAI, followed by a reversal of roles. Although framed as an erotic exercise, the emphasis was placed on relaxation rather than arousal.

A paradoxical intention strategy was implemented (Porcel-Medina & González-Fernández, 2005; Ruiz-Fernández et al., 2017), instructing the patient to focus on not becoming aroused, but instead to maintain a state of relaxation by concentrating on the area being stimulated and mentally visualizing that specific body part. This was followed by mutual non-demanding caressing, designed to facilitate gradual arousal and simulate spontaneous sexual interaction, culminating in self-stimulation using the slab on the bed as a transitional step toward altering his masturbatory pattern.

At the next session, the patient and his partner attended together, both being motivated by the improvements achieved, as he had managed to ejaculate onto the slab on the bed instead of on the floor. At the end of the second session, he was given the individual task of self-stimulation while standing with his penis resting on the sink. As a couple, they were to proceed to orgasmic eroticisation but ejaculating on the slab on the bed covered by a towel. Once that task was successfully completed, his partner would proceed to put her hand between the slab and the towel.

At the third session, FAI reported that he had successfully performed the exercise of ejaculating onto the towel with his partner's hand underneath on three separate occasions but had refrained from repeating it more frequently due to fear of failure. He also noted significant progress, having practised almost daily by masturbating while standing, with his penis resting on the sink. At the conclusion of the third session, the assigned tasks were as follows: self-stimulation while standing at the sink using

a latex vagina, continuation of mutual massage, and repetition of ejaculation onto a towel placed over his partner's hand on top of the slab.

At the fourth session, FAI reported having experienced arguments with his partner, which had led to her reluctance to participate in the joint tasks. Nevertheless, he had continued to masturbate daily in the bathroom and reported good results using the latex vagina. The assigned tasks remained the same as in the previous session—mutual massage and repetition of ejaculation onto a towel placed over his partner's hand on the slab—while also incorporating the promotion of communication and conflict resolution within the couple.

At the fifth session, they reported successful completion of the assignments, and both appeared more satisfied. For the fifth session's homework, they were instructed to engage in the shared erotic massage, with ejaculation this time occurring directly into her hand. Individually, he was to continue self-stimulation while standing, using the latex vagina, and was additionally advised to incorporate an anal vibrator to facilitate arousal and orgasm.

At the sixth session, the couple reported that the assigned tasks were being completed satisfactorily. At the end of the session, the patient was instructed to engage in intercourse with his partner lying on an elevated surface, such as a table, while stimulating himself in a standing position using the latex vagina (as previously done at the sink), initiating penetration when close to the ejaculatory point.

During the seventh session, FAI reported that he had succeeded, on several occasions, in ejaculating inside his partner's vagina. However, he noted that he needed to wait until he was near the ejaculatory point of no return to initiate penetration and added that he found the process easier when using the anal vibrator. The homework for this session consisted of engaging in sexual activity freely—defined as doing whatever they wished in the moment—while the partner stimulated him with the anal vibrator during vaginal penetration in the missionary position.

At the eighth session, the couple expressed satisfaction, reporting a significant increase in their sexual frequency and that the patient had been able to ejaculate in nearly every encounter with the assistance of the anal vibrator. They stated that their sexual relationship had improved substantially and requested to conclude treatment. They were encouraged to continue practising the previously assigned tasks and were given some guidance to enhance eroticism, thereby concluding the therapeutic process.

## Results

The results of FAI's pre-treatment assessment are presented below. On the various scales of the Millon Clinical Multiaxial Inventory (Millon, 1998), the following scores were obtained: schizoid, 96; phobic, 83; dependent, 111; histrionic, 24; narcissistic, 26; antisocial, 41; aggressive, 34; compulsive, 97; passive-aggressive, 45; self-destructive, 53; schizotypal, 97; borderline, 46; paranoid, 84; anxiety, 40; somatoform, 38; hypomanic, 11; dysthymia, 44; alcohol abuse, 52; drug abuse, 39; psychotic thinking, 71; major depression, 24; psychotic delusions, 72.

On the Golombok Rust Inventory of Sexual Satisfaction, FAI obtained high scores on the Non-Communication and Infrequency subscales, indicating inadequate communication and low frequency

of sexual intercourse. Finally, on the Expanded Sexual Arousal Inventory, FAI scored high on arousal, medium on anxiety, and high on satisfaction. This result is somewhat unexpected, given that he sought clinical support to improve sexual relations with his partner. This suggests that the partner may have been the more motivated party in seeking change, while the patient may have experienced a degree of satisfaction with his idiosyncratic practice of rubbing his penis against the slab.

A record of the patient’s ejaculatory progress was also maintained, based on information obtained during clinical interviews (see Table 1). This record illustrates the patient’s progression following each session and the completion of the tasks assigned in the preceding session.

### Discussion

The changes achieved in FAI and his partner were significant, reflecting improvement with respect to the therapeutic objectives: a reduction in performance anxiety prior to sexual encounters, successful intravaginal ejaculation, and an expanded repertoire of sexual behaviours on the part of the partner. The intervention can therefore be considered successful. The sexual life of both FAI and his partner improved, contributing positively to their sexual and overall well-being.

Few studies have been published on the treatment of delayed ejaculation (Abdel-Hamid & Ali, 2018; Butcher et al., 2015; Di Sante et al., 2016; Labrador & Crespo, 2001; Martin-Tuite & Shindel, 2020), likely due to its low prevalence. This underscores the relevance of the present work, which draws attention to the idiosyncratic masturbation patterns observed in individuals with delayed ejaculation, as described by other authors (Perelman, 2005, 2006a, 2006b; Xia et al., 2013). Some researchers suggest that such idiosyncratic genital stimulation may represent a psychogenic etiological factor contributing to delayed ejaculation (Lipsith et al., 2003; Sank, 1998).

This study employed a cognitive-behavioural psychosexual treatment model, which is generally supported by strong empirical evidence for the treatment of sexual dysfunctions (Labrador & Crespo, 2001). Techniques applied included the visualization of erotic imagery, erotic play, and masturbatory exercises, as recommended by other authors (Hawton, 1989; Wincze & Carey, 2001), along with the use of a vibrator to facilitate

ejaculation—an approach supported in the existing literature (Bancroft, 1989; Hawton, 1989; Nelson et al., 2007; Wincze & Carey, 2001). Reported treatment efficacy for these methods ranges between 42 % and 82 % (Munjack & Kanno, 1979).

Alternative treatment models have also been reported, including hypnosis (Zilbergeld, 1975) and psychodynamic therapy (Blair, 2017), with documented therapeutic success. Nonetheless, cognitive-behavioural therapy remains the recommended approach, due to its structured format, ease of implementation, and the typically limited number of sessions required to achieve positive outcomes.

As demonstrated in the present case, the use of focusing techniques, enhancement of situational ejaculatory control, anxiety reduction, short-term task setting, and gradual progression toward the therapeutic goal, combined with partner involvement, constitute effective strategies for overcoming delayed ejaculation.

It is important to note the main limitation of this study. This is a single case, which may make it difficult to generalise the treatment. Additionally, this same factor limits replicability, a fundamental principle of scientific research (Bunge, 2013). Considering these limitations, future studies are encouraged to evaluate the efficacy of cognitive-behavioural treatment for delayed ejaculation through experimental research designs, including the use of case-control groups.

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### Conflict of Interest

The authors declare no conflict of interest. All authors state that they have no personal, financial, or professional interests that could have influenced the research or the interpretation of the results presented.

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**Table 1**  
Ejaculation Progress Recorded at Each Session

Sessions	Ejaculatory progress
1	Ejaculation occurs on the floor.
2	Ejaculation occurs on a slab placed on the bed.
3	Ejaculates in bed on a towel-covered slab with the partner’s hand underneath; also ejaculates while standing, with the penis supported on the sink.
4	Ejaculates using a latex vagina.
5	Ejaculates in bed on a towel-covered slab with the partner’s hand placed on top of the slab; also ejaculates using a latex vagina.
6	Ejaculates into his partner’s hand and with the aid of an anal vibrator.
7	Ejaculates into his partner’s vagina with the aid of an anal vibrator.
8	Ejaculates into his partner’s vagina with the use of an anal vibrator.

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